Federal Language Access Services Reimbursement:

The California Collaborative Experience

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Problem Statement

Question:

How can states provide quality services in a language that their patients can understand?

How do we minimize language barriers that impact access to healthcare?

What are Language Services?

• In August 2000, a letter from CMS (Centers for Medicare & Medicaid Services) reminded states of the availability of federal matching funds to offset the cost of language services for Medicaid and State Children's Health Insurance Program (SCHIP)

•Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.

• Anyone who answers **less than "very well"** to the question on the U.S. Census Survey: *How well do you speak English*?

What are Language Services?

National Demographics (based on 2000 U.S. Census)

- More than 46 million Americans speak a language other than English at
- Represents nearly one out of every five (17%)
- While the vast majority of those speak Spanish, there are over 300 different languages spoken in the U.S.
- Are trend to increase, based in increasing diversity
- Five states have higher than the U.S. average, at 23% – Arizona, Hawaii, Nevada, New Jersey, New York
- Three states have more than 30% - California, New Mexico, and Texas

Requirements for Language Services

- Problem Statement
- What are Language Services?
- What have states done?
- What is a broker system?

Case study: California --

- Background
- MCLAS Task Force
- Possible Obstacles
- Next Steps
- Advice for other states
- Questions?

Federal Requirements	CA Requirements
Title VI, 1964 Civil Rights Act	State Title VI look-alike (§ Business & Professions)
Executive Order 1316	Dymally-Alatorre
LEP guidance, Office of Civil Rights (OCR) (U.S. Health & Human Svcs. Agency)	Kopp Act
Culturally & Linguistically Appropriate Services (CLAS) Standards (Office of Minority Health)	Medi-Cal and Healthy Families contracts (Medicaid and SCHIP programs)
Federal Medicaid/SCHIP Managed Care contracts	SB 853 (Escutia, 2003) Health Plans

Requirements for Language Services

Federal Requirements

- Title VI:

"No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." - 42 U.S.C. § 2000d

- Executive Order #13166

"...each Federal agency shall...implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency." – Improving Access to Services for Persons with limited English proficiency, U.S. Dept. of Justice, Aug. 2000

- Federal Medicaid & State Children's Health Insurance Program (SCHIP) contracts

Each contract must comply with Title VI of the Civil Rights Act, requiring oral interpretation for all and written translation for all "prevalent" languages – 42 code of Federal Regulations Part 438.109(c), 67 Federal Register 40989 (2002)

What are Language Services?

Federal Requirements

• Office of Civil Rights, LEP Guidance

"No person may be subjected to discrimination on the basis of nation origin in health and human services program because they have a primary language other than English." – U.S. Health & Human Services, Office of Civil Rights (OCR) Notice regarding language (1980)

- U.S. Department of Health & Human Services (HHS) administers federal funds for health and welfare programs
- Office for Civil Rights (OCR) is charged with enforcement of Title VI.
- A recipient (of federal funds) is any public and private entity receiving federal funds including: state, county and local health welfare agencies, managed care organizations, hospitals, clinics.

• Office of Minority Health, CLAS Standards:

A total of 14 standards that include mandates, guidelines and recommendations based on Title VI that include: Culturally competent care, Language Access Services, including bilingual staff and interpreter service, Organizational support for cultural competence.

What are Language Services?

California Requirements

- Title VI Look-Alike:

Individuals have the right to sue, in discrimination cases based on race, national origin, ethnic group identification or color. Applies to "any program or activity that is conducted, operated or administered by the state or any state agency directly or receives any financial assistance from the state. – CA Govt. Code § 11135, 11139; 22 CCR § 982100 et seq

- Broader than federal Title VI
- Allows individuals to sue in "disparate impact" cases where an agency may hurt a group of people even if done so in its 'normal course of business'

- Dymally Alatorre (Bilingual Services Act of 1973):

"The effective maintenance and development of a free and democratic society depends on the right and ability of citizens and residents to communicate with their government."; Affects all state and local agencies – CA Government Code § 7290 et seq (1973)

What are Language Services?

California Requirements

- Kopp Act of 1983

"Access to basic health care services is the right of every resident of the state, and that access to information regarding basic health care services is an essential element of that right."; Affects all general acute care hospitals – California Health & Safety Code § 1259 (1990)

- Medi-Cal and Healthy Families contracts

"...each Federal agency shall...implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency." – Improving Access to Services for Persons with limited English proficiency, U.S. Dept. of Justice, Aug. 2000

- SB 853 (Escutia)
  - California state legislation passed in 2003 requiring all health plans to have language access
  - Regulations already developed and in first stages of implementation within CA state Dept. of Managed Health Care & Dept. of Insurance

What have states done?

Delivery of Language Services:

- 12 states currently provide language services
- 1 city provides services (Washington DC)
- 3 states are considering (TX, NC, CA)
- 1 state previously provided services (MA)

4 Models Nationally:

- Telephonic Interpreting (Language lines)
- Direct Interpreter Reimbursement (Independent Contractors)
- Direct Reimbursement to Providers
- Language Service Agencies & Language Brokers

What have states done?

Telephone Interpreter Services: (KS, WY, UT)

► Telephone or language lines are primary mode of interpretation, reimburse entities for use of phone lines

Kansas:

spent: $46 k in 2006

- Started in 2003 in response to a provider survey (Medicaid managed care)
- State's Medicaid fiscal agent, EDS administers two language lines

Wyoming:

spent: unknown

- Started in July 2006
- Also provide in-person interpretation

Utah:

spent: $180 k in 2006*

- Contracts with four language agencies, 2 use only telephonic interpretation
- Providers must call agency for language but all billing and reimbursement is completed through the agency(ies)

(*for both in-person & telephonic)

What have states done?

Payments to Interpreters (NH, MT, WY)

- Interpreter directly submit bills to the state

New Hampshire:

spent: $17 k in 2006

- Started in the 1980s; served about 331 Medicaid recipients/1763 encounters in FY 2005; started as covered service now an admin. service
- Interpreters are required to enroll as Medicaid providers in abbreviated enrollment process. Interpreters assigned number for reimbursement

Montana:

spent: less than $2 k in 2006

- Started in 1999 after an OCR complaint
- Includes reimbursement for Primary Care Case Management program; No certification requirements – providers responsible for ensuring competency

Wyoming:

spent: unknown; too early

- Started in July 2006; Reimbursement linked to medical service
- Interpreters must abide by national interpretation standards by the National Council on Interpreting in Health Care

What have states done?

Language Agencies & Brokers (HI,UT,WA,DC)

► Reimbursement made directly to agencies or broker

Hawai'i: spent approx: $144 k per year

- Started Title VI complaint against Dept. of Health; Approx. 2500 visits
- State contracts with two language agencies; agency responsible for

Utah: spent: $180 k in 2006*

- Started in 1995, contracts with 4 language agencies, 2 provide in-person
- Contracts established through RFP process (including quality, standards for interpretation, training, etc.)

(*for both in-person & telephonic)

Washington DC: spent: $895 for first 6 months

- Started in March 2006; Contracts with one language agency that provides telephonic services; Pays $130-190/hour

Washington: spent: $1 m per month

- Most developed broker system & intergovernmental agreements for public hospitals; State requirements for certification and testing

What have states done?

States Developing Language Services:

North Carolina:

- 2002 - Federal Dept. of Health and Human Services' Office of Civil Rights entered into a 'Voluntary Compliance Agreement' (VCA) with N.C. Dept. of Health and Human Services
- State has currently developed interpreter credentialing and reimb.

Texas:

- 2005 – state legislation established a Medicaid pilot project for reimbursement in five hospital districts; some delay due to managed care

California

States Previously Providing Services:

Massachusetts:

- Offered reimbursement for language services for hospital emergency rooms in 2005; No funding included for 2006
- No discrete reimbursement to other due to finance 'bundling'

What have states done?

Provider Reimbursement (ID,ME,MN,VT)

► Providers responsible for service and reimbursed directly

Idaho:

spent: $87 k in 2006

- Started prior to 1990; Served approx. 7400 units of interpretive services
- Providers are responsible for hire of interpreter and billing for reimb; No certification standards; Includes Primary Care Case Management program

Maine:

spent: unknown

- Started in Jan. 2001 after interest in sign language & public hearings
- Providers must select interpreter then bill the state; Interpreters responsible for a 'code of ethics'

Minnesota:

spent: $1.6 m in 2005

- Started in 2001; Served approx. 15 k distinct recipients/42 k encounters
- Providers must arrange and pay for interpretation with other covered svc

Vermont:

spent: unknown

- Began a 'few years ago'; Providers hire interpreter
- State has contract with one language agency ; telephone not currently reimb.

Current State Reimbursements (2007)

State	Enrollees Covered	Providers Reimbursed	Who the State Pays	Reimbursement Rate	Admin or Service
DC	FFS	FFS < 15 emp.	Lang. agencies	$135-190/hr (in-person); $1.60/min tel.	Admin
HI	FFS	FFS	Lang. agencies	$36/hr ($9 per 15 min. increments)	Service
ID	FFS	FFS	Providers	$12.16/hr	Service
KS	Managed Care	(n/a; state pays lang. line)	EDS (fiscal agent)	Spanish – $1.10/min. other languages – $2.04/min.	Admin
ME	FFS	FFS	Providers	Reasonable costs	Service
MN	FFS	FFS	Providers	lesser of $12.50/ per 15 min. increment or usual & customary fee	Admin
MT	All Medicaid	All	Interpreters	$6.25/ per 15 min. increment or usual & customary fee	Admin
NH	FFS	FFS	Interpreters (who are Medicaid providers)	$15/hour $2.25/ per 15 min. increment after 1st hr	Admin
UT	FFS	FFS	Lang. agencies	$28-35 per hour (in-person) $ 1.10 / minute (telephonic)	Service
VA	FFS	FFS	AHEC & 3 health depts.	Reasonable costs reimbursed	Admin
VT	All	All	Language agency	$15/ per 15 min. increments	Admin
WA	All	Public entities	Public entities	50% expenses	Admin
WA	All	Non-public entities	Brokers (with language agencies)	Brokers receive an admin. fee Language agencies – $32/hour	Admin
WY	FFS	FFS	Interpreters	$11.25 / per 15 min. increment	Admin

What is a Broker System?

Overview: A Look at WA

- First in the nation to assemble a broker system, using existing Transportation system
- Comprehensive system (includes certification, testing)
- Pro's and con's with its implementation related to its history
- 8 Regional Brokers (changed from direct contracting with language agencies in Jan. 2003)
- Inter-Local Agreements (public healthcare institutions)
- Administrative (not covered service)
- Managed Care & FFS covered
- FFP (dollar match) = 50%
- Authorized 'Requestors' – Providers, DSHS staff (NOT clients and Interpreters)
- No cost to client

What is a Broker System?

Does not cover:

- In-patient (in-house staff), out-patient
- Broker model does not cover hospitals
- Requests not received within 48 hours (business days)
- Unauthorized ‘requestors’ (clients, interpreters)
- Cancellations (minor exceptions provided by DSHS administrations); No-shows are now compensated for ½ hour
- Early arrivals or late arrivals

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Broker

Department of Social and Health Services (DSHS)

Brokers

Language Agencies

Interpreters

Provider

Client

IGAs (public entities)

Department of Social and Health Services (DSHS)

Public Institutions

Agency staff

Provider

Client

What is a Broker System?

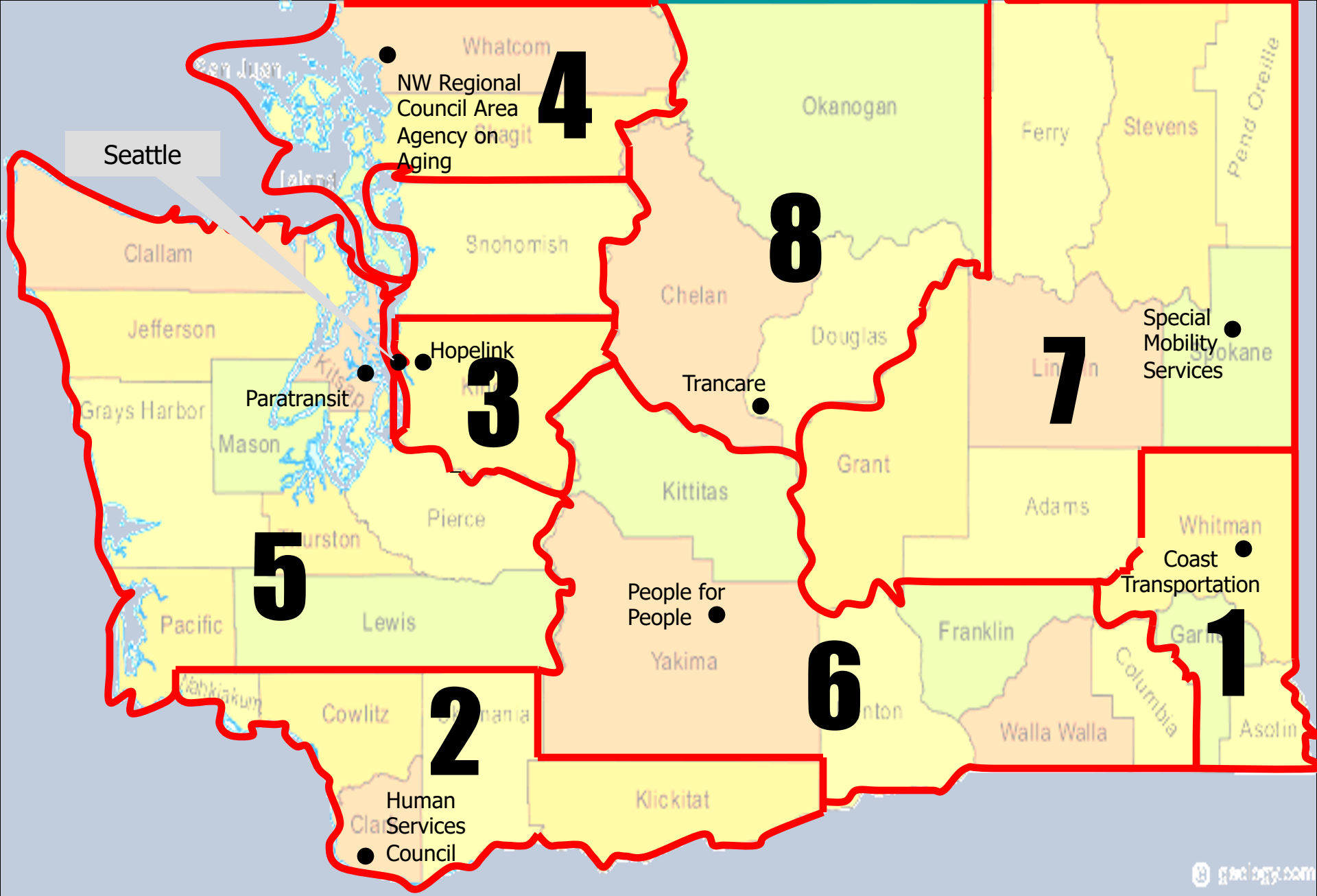
Timeline

- 1991
  - **Budget Surplus**
    - State agrees to pay for interpreting services for Medicaid patients
    - State-only funds, no federal dollars included
- 1996
  - **Statewide Budget Cuts**
    - DSHS is required to cut its budget
    - Interpreter reimbursement rates cut from $28 to $16.40 for contract interpreters and from $40 to $35 for agencies.
    - DSHS decides to contract only with agencies
    - Provider Identification Numbers issued to interpreters
      - –A result of ongoing fraud, prompts aggressive auditing
- 1998
  - **MAA negotiates waiver with CMS to attempt cost decrease**
    - Establishes inter-local agreements with public health care institutions around the state to pull Federal reimbursement funds
    - Interpreter services become “matchable” at a rate of 50% of the institutions’ Medicaid clients.

What is a Broker System?

Timeline

- **Providers that are not public entities**
  - DSHS began the Language Interpreter Services and Translation (LIST) program.
    - –The Dept. contracted directly with language agencies
- 2002
  - **Governor Locke proposes elimination of all State support for interpreter services.**
    - Result in need to decrease costs
    - MAA proposes the brokerage model
- 2003 -2004
  - **DSHS changed Language Services system to a Regional Broker model**
    - –9 brokers for administrative scheduling of appointments
    - –Brokers contract with Language agencies
  - **MAA feels model successful**
    - Expenditures have been limited; complaints are down
    - Interpreters for over 180,000 encounters via the broker model
- 2006
  - The Council of State Governments award DSHS a 2006 Innovation Award for its development of the broker model.



Washington Regional Brokers

Background

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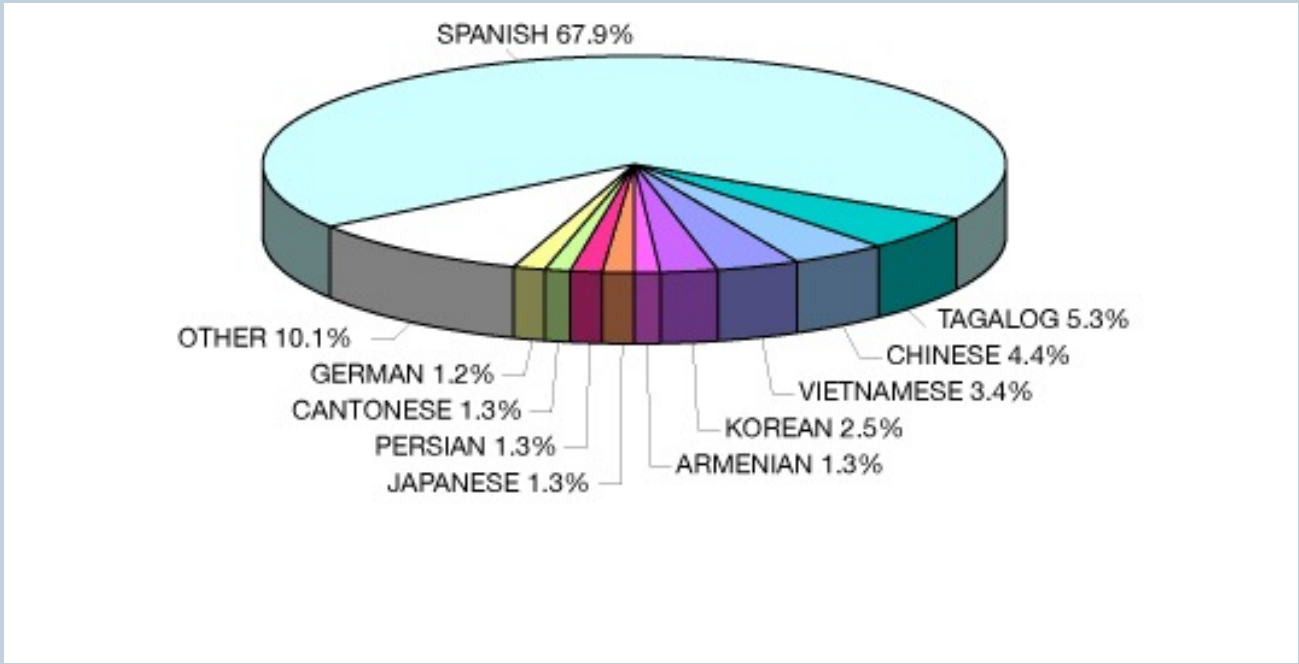
	WA	CA
Total Population (2006 Estimate)	6.4 million	36.5 million
LEP Population (2000 Estimate, Census 2000 PHC T37)	6.4% (~400k)	20% (~6.3 million)
Total Medicaid Population	900,000	6.5 million
Number of Languages Spoken (US Census Bureau 2000)	154	195
Estimated Cost for Language Svcs.	$ 1 million / per mo.	*Unknown*

Background

California

Most spoken languages in California

English is spoken by 60.52% of people over 5 years old in California.
Languages other than English are spoken by 39.47%.
Speakers of languages other than English are divided up as follows.



Background - LAAP

Language Access Advocacy Project

- Participating organizations:

Asian Pacific Islander American Health Forum (APIAHF), Asian Pacific American Legal Center (APALC), California Pan-Ethnic Health Network (CPEHN), California Primary Care Association (CPCA), Fresno Health Consumer Center, Latino Coalition for a Health California (LCHC), National Health Law Program (NHeLP)

- Formed in 2001 to coordinate statewide responses and develop policies to improve language access services in California
- Modeled after national project, NLAAP
- Funded by the California Endowment

Background – SB 1405

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SB 1405 (Soto) - 2006

- Sponsored by member-organizations of the Language Access Advocacy Project, state Senator Nell Soto
- Would have required the Dept. of Health Care Services to convene the Task Force on Reimbursement for Language Services of 15 members to be appointed by the Governor, Senate Pro Tem, Speaker of the State Assembly
- Passed through entire legislative process, stopped prior to Gov's signature

LCHC Latino Coalition for a Healthy California

CPCA California Primary Care Association

CPEHN California Pan-Ethnic Health Network

APIAHF Asian & Pacific Islander American Health Forum

Background – SB 1405

SB 1405 – Behind the scenes

- Used to leverage the issue with Schwarzenegger administration, Legislature, advocacy organizations and other healthcare stakeholders, provide general education on what language services are
- Simultaneous stakeholder process to solicit input on needs for delivery services
- Used to negotiate with the Department of Health Care Services, raise information of possible state weakness

Medi-Cal Language Access Services (MCLAS) Task Force

What is MCLAS?

- Negotiated with the director of the Department of Health Care Services, oversees the MCLAS Task Force
- Started in December 2006 and is due to end August 2008
- Includes 22 participants from CA Medical Association, CA Association of Family Physicians, CA Dental Association, CA Health Interpreters Association, CA Hospitals Association, Community Health Group (managed care), and advocates
- Includes Participation Agreement that outlines level of responsibility and participation

Medi-Cal Language Access Services (MCLAS) Task Force

Responsibility & Organization:

- Compile interpreter models in health care delivery system used by other states
- Compile existing interpretation and translation standards
- Identifying and evaluate oversight mechanisms on the delivery of language services
- Evaluating Federal financial participation options for State reimbursement of language assistance services
- Preparing an analysis of options for a California Medi-Cal language service delivery system
- Analyzing CA DHCS limited English proficient utilization data and develop a cost analysis for each considered language service system option.
- Preparing a final report to CA DHCS director

Medi-Cal Language Access Services (MCLAS) Task Force

Responsibility & Organization:

- All decisions made based on consensus decision-making

Governmental Agencies

- California State Association of Counties
- Department of Health Services (2)
- Department of Mental Health
- California Health and Human Services Agency

Health Providers

- CA Assoc of Hospitals
- CA Dental Association
- CA Family Physicians
- CA Healthcare Interpreting Assoc
- CA Medical Assoc
- CA Primary Care Assoc

Consumer & Advocates

- AACRE
- APIAHF
- CA Pan-Ethnic Health Network
- CA Black Health Network
- Fresno Health Consumer Center
- National Health Law Program

- Elected caucus chairs
- Elected Workgroup chairs
- Chairs have automatic position on Steering Committee

Medi-Cal Language Access Services (MCLAS) Task Force

Responsibility & Organization:

Steering Committee:

Includes 2 state staff representatives, 2 health providers, 2 consumer advocates (includes Task Force Co-Chairs)

Workgroups:

Delivery Workgroup	Quality & Standards Workgroup	Cost & Finance Workgroup
Responsible for developing method to deliver language services	Responsible for reviewing language standards and methods to ensure quality for consumers	Responsible for estimating total cost, based on number of LEP enrollees in Medi=Cal (Medicaid)

Medi-Cal Language Access Services (MCLAS) Task Force

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Preliminary Recommendations:

Delivery Workgroup:

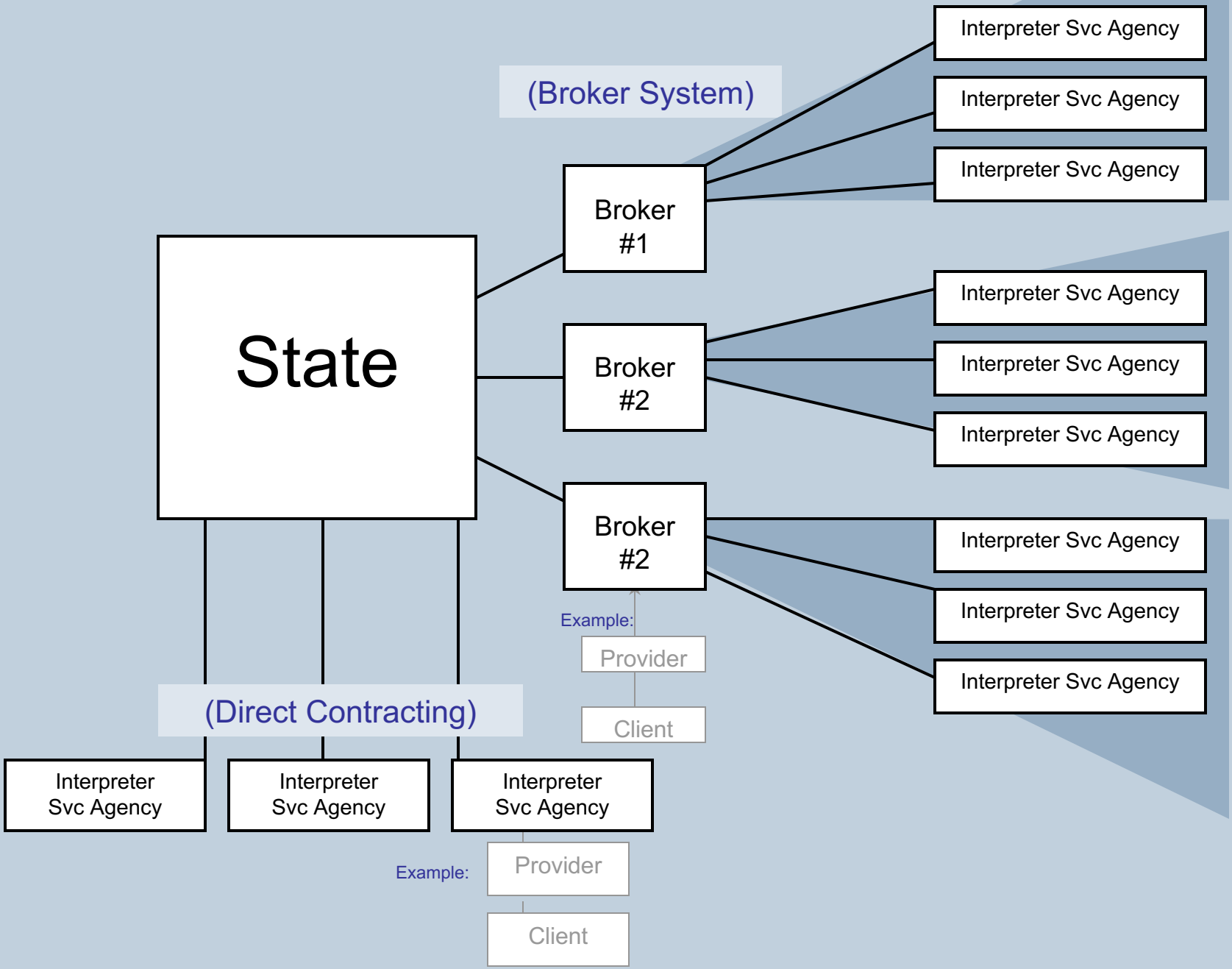
- Hybrid Model for Fee-for-Service, using Regional Broker systems and Direct Provider Reimbursement
- Managed Care: Opt-in ability with Regional Broker for a fee, recommending an exploratory study and strengthening of auditing and enforcement

Quality & Standards Workgroup:

- Certificate of completion of accredited program
- Quality Assurance Board (QAB) would advise the state implementation and monitoring

Cost & Finance Workgroup:

- Reimbursable Services (defined)
- Additional work at ‘tail end’ – estimated cost


(Broker System)
State
Broker #1
Broker #2
Broker #2
Interpreter Svc Agency
Interpreter Svc Agency
Interpreter Svc Agency
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Interpreter Svc Agency
Interpreter Svc Agency
Interpreter Svc Agency
Interpreter Svc Agency
Example:
Provider
Client
(Direct Contracting)
Interpreter Svc Agency
Interpreter Svc Agency
Interpreter Svc Agency
Example:
Provider
Client

Possible Obstacles

State's budget:

- $14.5 billion dollar deficit for next fiscal year which begins on July 1
- Current year (now until July) cash flow problem
- Proposed reductions that include reducing the number of "optional services" under Medi-Cal
- Share of state's General Fund (ongoing) in order to leverage federal funding (FFP)

Competing Interest:

- Provider reimbursement rates vs. interpreter reimbursement rate
- Increased use = increased cost as a disincentive
- Consumer education (vs. increased use)
- Gaining physician support; bilingual physicians and staff

Possible Obstacles

Technical Issues:

- Geographically large state
- Lack of existing infrastructure or network to provide delivery of system
- Difficulty with determining cost due to lack of data on LEP data (use data, frequency,
- Growing focus on managed care plans; Oversight on individual contract for managed care plans participating in Medi-Cal (on-going)
- Number of actual interpreters to meet demand; Number of actual training programs
- Providing for rare languages
- Lack of consistency across training programs
- Interpreter standards (national vs. state vs. industry)
- Quality assurance, oversight and appropriate oversight entity
- General incentives; foreknowledge of ‘safeguards’

Next Steps

- ☑ Focus on completing a report, pilot project, sequencing issues
- ☑ Continue to negotiate differences
- ☑ Continue to keep momentum up on needs of LEP population
- ☑ Mitigate competing interests
- ☑ Find the opportunity in the obstacles
- ☑ Next meeting: March, June 2008

Advice in the Process….

- Be aware of your ‘tools’ and know when to use them (ie: administrative advocacy vs. litigation)
- Coalesce with other allies
- Educate yourselves in order to educate others
- Spend the time to develop a strategy (short-term vs. long-term)
- Take funding into consideration
- Be prepared to address the issue over the long-term
- Be realistic with your time and resources
- Some progress is better than no progress

Closing

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Any questions?

For More Information:

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