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Medicaid and SCHIP Funding for Language Services

According to 2005 U.S. Census Bureau data, almost 52 million people speak a language other than English at home. Indeed, more than 23 million (8.6 percent of the population) speak English less than "very well."[1] In a recent national survey, 63 percent of hospitals reported encountering limited English proficiency (LEP) patients either daily or weekly, with an additional 17 percent encountering LEP patients at least monthly.[2] Indeed, over 100 languages are spoken by patients in NAPH member hospitals. All public hospitals — as recipients of federal financial assistance — must ensure that individuals receive all necessary and appropriate care, regardless of language spoken,[3] and NAPH members have made great strides in providing sufficient language services. Yet there is often little or no reimbursement available for supporting language programs or encouraging innovation in culturally and linguistically appropriate care. So even though clear communication is a key component of high quality health care, adequate funding of interpretive services for LEP patients remains a key issue for public hospitals and health systems.

State Reimbursement for Language Services

Each state determines if, and how, it will reimburse hospitals and other health care providers for the costs of providing language services to Medicaid and State Child Health Insurance Program (SCHIP) recipients. Individual hospitals cannot seek reimbursement unless their state has elected to do so.

States face three primary decisions in establishing reimbursement procedures for language services:

- **Covered versus Administrative Expense:** Should the state include language services as a *covered* service (i.e., add language services to its state plan through a State Plan Amendment, which requires CMS approval), or should reimbursement for language services be an *administrative* expense? This decision affects the amount of Medicaid reimbursement provided by the federal government (either the states' regular federal matching assistance percentage [FMAP], if provided as a covered service, or 50 percent for administrative expenses). SCHIP administrative expenses are matched by the federal government at the same rate as medical services, but are subject to an overall cap of no more than 10 percent of SCHIP expenditures.
- **Types of providers assisted:** Which Medicaid and SCHIP providers should be able to seek reimbursement for language services? Most states pay for language services in fee-for-service outpatient settings,[4] but some states assist hospitals directly.
- **Types of language services paid for:** Should the state reimburse for all interpreters or only certain types? Most states reimburse contract or telephonic interpreters but do not reimburse interpreters on a hospital's staff who may interpret as all or part of their job responsibility.

Most states set Medicaid and SCHIP payment rates to bundle all of the costs of providing services to a patient into a single per capita fee, which does not vary based upon the patient's LEP status. These payment rates are supposed to cover both clinical and non-clinical costs (e.g., administrative and overhead) associated with providing care. For most states, language services are implicitly included in this combined fee. However, this bundling of costs is frequently problematic because it assumes that all hospitals will have the same level of need for interpreter services. Bundling

also averages the cost for such services across all hospitals in the state. Because public hospitals treat larger numbers of LEP patients than private hospitals, many safety net proponents argue that the costs of language services should be separately reimbursed to ensure adequate compensation. After analyzing the data, several states agree and have begun to exclude language services from the bundled rate for certain providers, offering separate reimbursement for language services.

What States are Doing

States have tremendous flexibility in establishing reimbursement procedures for language services. They can use disproportionate share hospital funds, require assistance from Medicaid managed care plans, or seek out local matching funds to help pay for language services.

In 2000, the Centers for Medicare & Medicaid Services (CMS) wrote state Medicaid directors reminding them that language services could be included as an optional covered service in their Medicaid and SCHIP programs and therefore allowing direct reimbursement of providers for these services.[5] Yet, only twelve states and the District of Columbia have elected to do so. The 12 states include Hawaii, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Vermont, Virginia, Washington, and Wyoming.[6] North Carolina recently took steps to initiate direct reimbursement for language services. Texas, meanwhile, enacted legislation in 2005 requiring a pilot program, but it has not yet been implemented.

Although most states' reimbursements for language services cover outpatient fee-for-service Medicaid enrollees, a few states assist hospitals directly by paying for language services in either inpatient or outpatient settings. These states (i.e., Utah, Washington, Massachusetts, and Texas) are examples of programs that could be replicated by other states. Their reimbursement mechanisms are described below.

Utah

Utah pays for interpreters when three criteria are met: 1) the client is eligible for a federal or state medical assistance program (including Medicaid and SCHIP), 2) the client receives services from a fee-for-service provider, and 3) the health care service needed is covered by the medical program for which the client is eligible. Hospitals can use Medicaid-funded interpreters for fee-for-service Medicaid enrollees (but not Medicaid managed care enrollees) for any services covered by Medicaid on either an inpatient or outpatient basis. Medicaid managed care plans, however, are required to provide interpretation services for their patients as part of their contract agreements. For services covered by Medicaid but not the health plan,[7] Utah pays for interpreters.

The state contracts with four language service organizations to provide in-person and telephone interpreter services. Providers do not receive any rate enhancements for being bilingual or for having interpreters on staff, nor can they bill Medicaid directly; instead interpreters bill the Medicaid agency.

Washington

Washington has two reimbursement programs: one for interpreter services provided at government and public facilities, such as public hospitals or local health jurisdictions, and one for services provided at non-public entities. Non-public entities can use the Washington State Department of Social and Health Services' brokerage system to schedule interpreters for Medicaid clients. Rather than require clients to schedule interpreters, non-public providers — including fee-for-service providers, managed care organizations, and private hospitals — call a regional broker to arrange for an interpreter.

Public entities can receive federal reimbursement for language services expenses if they enter into a contract (e.g., inter-local or intergovernmental agreement) with the state and agree to:

- Provide locally generated private matching funds;
- Ensure that the local matched dollars are not also used as matching funds for other federal programs;
- Ensure that the local matched monies meet federal funding requirements;
- Ensure that the local matched funds are within the facilities' control;
- Use only interpreters certified by Washington's Language Interpretive Services and Translation, (LIST) program;
- Coordinate and deliver the interpreter services as specified by the state;

- Collect, submit, and retain client data as required; and
- Accept all disallowances that may occur.

Public facilities receive reimbursement for interpreter expenses that are both direct (e.g., interpreter services provided as part of the delivery of medical/covered services) and indirect (e.g., time spent coordinating/developing interpreter programs, billing, equipment purchasing). Specifically, they receive reimbursement for 50 percent of their costs (i.e., the federal administrative share). Because these entities act as the state for the purposes of reimbursement, the 50 percent state "match" is paid by the facility.[8]

Massachusetts

In April 2000, Massachusetts enacted the Emergency Room Interpreter Law, which mandates that "every acute care hospital … shall provide competent interpreter services in connection with all emergency room services provided to every non-English-speaker who is a patient or who seeks appropriate emergency care or treatment." The law also applies to hospitals providing acute psychiatric services.

Until last year, the state budget included an appropriation of $1.1 million to reimburse hospitals and acute psychiatric facilities for the costs of language services. The Division of Medical Assistance made payments to qualifying hospitals for interpreter services provided at hospital emergency departments, acute psychiatric facilities located within acute care hospitals, and private psychiatric hospitals. The distribution is based upon a formula that compares expenses submitted by each qualifying hospital to the total expenses submitted by all qualifying hospitals. In 2003, Massachusetts received approval of three State Plan Amendments (one each for psychiatric hospitals and inpatient and outpatient acute hospital care) to obtain federal reimbursement.

Massachusetts' Medicaid agency had also considered interpreter costs in its disproportionate share hospital (DSH) distribution formula. However, as part of its comprehensive Health Care Reform plan passed in April 2006 and approved by the federal government in July 2006, Massachusetts technically no longer has a DSH program. Instead, the Commonwealth has transitioned its federal DSH dollars, as well as other federal 1115 waiver-related dollars, into a new mechanism called the "Safety Net Care Pool." Safety Net Care Pool monies are used to provide subsidies to low-income individuals to purchase private coverage through the Commonwealth Care program (implemented October 1, 2006) and to fund a residual uncompensated care pool (UCP). Massachusetts allows hospitals to include the costs of language services in the base costs, which are used to develop Medicaid rates and the UCP cost-to-charge ratio.[9]

Texas

In 2005, Texas enacted legislation establishing a Medicaid pilot project for reimbursement of language services in five hospital districts.[10] The Health and Human Services Commission is developing the project and is identifying the most appropriate model for the pilot. There has been some delay because the majority of Medicaid enrollees in the designated hospital districts are in managed care. Because the managed care organizations' language service costs are already included in their capitated rate, the pilot project does not cover them. Thus, the Commission is working with hospitals to identify the best methods to track language services provided to fee-for-service and emergency Medicaid recipients.

Texas is using the administrative cost mechanism, and thus will receive 50 percent reimbursement from CMS. Because Texas' covered service FMAP rate is also 50 percent for Medicaid, there is no benefit to adding language services to its state plan. The pilot project will likely be financed through "fund certifications" from the participating hospital districts. A fund certification requires the hospital to certify that it has spent a certain amount on language services. Because the hospital districts act as the state for the purposes of reimbursement, the 50 percent state "match" is paid by the facility that will receive reimbursement for 50 percent of its costs. The program expires on September 1, 2009 if no further action is taken.

Summary

The need for providing language services continues to grow with an increasingly diverse population, yet only two percent of hospitals (five percent of not-for-profit hospitals)

report receiving any direct reimbursement of language services.[11] Given the large numbers of LEP patients treated by public hospitals and the increasing diversity of the country, there is much room for improvement in states' Medicaid and SCHIP reimbursement for language services in hospital settings, which can ensure that language barriers do not impede provision of high quality health care.

For more detailed information on how states are providing Medicaid reimbursement for language services, please see *Medicaid/SCHIP Reimbursement Models for Language Services, 2005 Update*, available at www.healthlaw.org/link.cfm?4931. ■

Notes

1. U.S. Bureau of the Census, *2005 American Community Survey: Table 16004*, available at http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&submenuld=&lang+en&ts.

2. Hasnain-Wynia, Romana, et.al., *Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey*, HRET and NHeLP, 2006, available at www.healthlaw.org.

3. Title VI of the Civil Rights Act ensures that federal money is not used to support health care providers who discriminate on the basis of race, color, or national origin. Title VI says: "No person in the United States shall, on 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." The United States Supreme Court has treated discrimination based on language as national origin discrimination. *See* Lau v. Nichols, 414 U.S. 563 (1974). Thus, recipients of federal funding must take reasonable steps to ensure that LEP individuals have meaningful access to their programs and services. 42 U.S.C. § 2000d. *See also* 45 C.F.R. § 80 app. A (listing examples of federal financial assistance, including Medicare, Medicaid, Maternal and Child Health grants).

4. Medicaid managed care contracts generally require the managed care plan to provide language services for its members. Thus, for hospitals treating patients enrolled in a Medicaid managed care plan, the hospital would not receive separate reimbursement unless the state excluded language services from the managed care plan's services.

5. Available at www.cms.hhs.gov/smdl/downloads/smd083100.pdf.

6. Massachusetts previously provided reimbursement to hospitals for language services provided in emergency rooms and in-patient psychiatric facilities but these payments were discontinued in 2006.

7. For example, pharmacy, dental and chiropractic services.

8. "Interpreter Services," Washington State Department of Social and Health Services (DSHS), Health Recovery and Services Administration. Available at http://maa.dshs.wa.gov/InterpreterServices.

9. See "Hospital-Based Interpreter Services," Massachusetts Department of Public Health, Office of Multicultural Health. Available at www.state.ma.us/dph/omh/interp/interpreter.htm.

10. S.B. 376 passed the Senate on March 17, 2005 and the House on May 9, 2005. A separate bill, H.B. 3235, was also enacted, requiring provision of interpreter services to deaf and hard of hearing Medicaid patients subject to the availability of funds.

11. Hasnain-Wynia, Romana, et.al., *Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey*, HRET and NHeLP, 2006. See Table 6, page 8. Available at www.healthlaw.org.

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