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CHILDREN'S POLICY INITIATIVE

A COLLABORATIVE PROJECT ON CHILDREN AND FAMILY ISSUES

LANGUAGE ACCESS: HELPING NON-ENGLISH SPEAKERS NAVIGATE HEALTH AND HUMAN SERVICES

by Ann Morse *January 2003*

A migrant worker from Oaxaca, Mexico, was committed to an Oregon state psychiatric ward, diagnosed as a paranoid schizophrenic. Psychiatrists noted that the patient became agitated when they attempted to speak to him in Spanish and English, and they concluded that he must be hallucinating because he would wave his arms wildly. Two years later, it was discovered that the patient spoke only an Indian dialect, Trique. After being interviewed by a Trique translator, the patient was diagnosed as mentally sane and discharged. More than $100,000 was wasted on unnecessary care.[1]

The Hmong language has no word for cancer, or even the concept of the disease. "We're going to put a fire in you," is how one inexperienced interpreter tried to explain radiation treatment to the patient, who, as a result, refused treatment.

Introduction

Language access has come to the forefront as a critical issue in quality and access to care as the nation's population – and languages – have become increasingly diverse. Public and private organizations have begun to address language barriers to ensure effective communication between service providers and patients, particularly in health care. The language gap can lead to delays in or denial of service, unnecessary tests, more costly or invasive treatment of disease, mistakes in prescribing and using medication, and deterrence in patient compliance with treatment. Language barriers are a contributing factor in health care disparities among racial and ethnic minorities and in a lack of health insurance among immigrants and minorities.

In a series of federal guidances since 2000, federal agencies have reminded recipients of federal funds of their obligation under civil rights law to provide meaningful access to their services for limited-English proficient individuals. The Office for Civil Rights in the U.S. Department of Health and Human Services (HHS) states that language assistance should result in accurate and effective communication between provider and client, at no cost to the client. Within the health and human services field, affected organizations include state and local health and welfare agencies, hospitals and clinics, managed care organizations, nursing homes, mental health centers, senior citizen centers, Head Start programs and contractors.

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In three federal programs, federal agencies have approved reimbursement for language services to applicants and recipients who are limited English proficient. HHS, in a November 1999 brief, approved the use of federal Temporary Assistance for Needy Families (TANF) and state Maintenance-of-Effort (MOE) funds to provide language services. In a 2000 letter to state Medicaid directors, the Centers for Medicaid and Medicare Services confirmed that federal matching funds for the State Children's Health Insurance Program (SCHIP) and Medicaid are available for state expenditures on interpretation and translation.

At least nine states – Hawaii, Idaho, Maine, Massachusetts, Minnesota, Montana, New Hampshire, Utah and Washington – have obtained federal matching funds for these services. Recently, other states have enacted legislation requiring interpreters in emergency rooms and hospitals (Massachusetts and Rhode Island, respectively); a health care interpreters council (Oregon); and an office to address racial and ethnic disparities in health care, including language and cultural competency (New Jersey).

Immigrants in the United States

Data from the 2000 census revealed the extent of the growth of the immigrant population in the United States, their diversity, and their resettlement beyond traditional gateways to "new" immigrant states. The foreign-born population increased 57 percent in the 1990s to 31 million, or 11 percent of the U.S. population.

- The top 9 source countries are Mexico, at 28 percent of the foreign-born population; Philippines and India, at 4 percent each; China, Vietnam, El Salvador and Cuba, at 3 percent each; the Dominican Republic at 2 percent; Nicaragua at 1 percent; and all other countries 48 percent.[2]
- Although most immigrants still resettle in six states (California, Florida, Illinois, New Jersey, New York and Texas), states in the south, midwest and Rocky Mountains saw their foreign-born population more than double in the last decade. North Carolina's Hispanic population, admittedly starting from a small base, saw explosive growth, at nearly 400 percent in 10 years. Table 1 notes states with significant increases in Hispanic and Asian populations.

Table 1.
States with High-Growth Hispanic and Asian/Pacific Islander Populations
1990-2000 Percent Change[3]

	Persons of Hispanic Origin (Any race)	Asians and Pacific Islanders (Race)
Indiana	117%	63%
Delaware	136	83
Utah	138	57
Oregon	144	58
Mississippi	148	48
Iowa	152	48
Nebraska	155	83
Minnesota	166	85
Kentucky	173	75
Alabama	208	50
South Carolina	211	68
Nevada	217	159
Tennessee	278	85
Georgia	300	134
Arkansas	337	75
North Carolina	394	126

English Proficiency

According to the 2000 census, more than 300 different languages are spoken in the United States. Nationally, nearly 18 percent of the U.S. population – 47 million citizens and noncitizens – speak a language other than English at home. This is an increase

from 31.8 million in 1990. Of these, 4.2 percent, or 11 million individuals, say they speak English not well or not at all. States that exceed the national average include Arizona at 6 percent; California, 10.7 percent; Florida, 5.6 percent; Hawaii, 5 percent; Illinois, 4.7 percent; Nevada, 5.8 percent; New Jersey, 5.4 percent; New Mexico, 5.0 percent; New York, 6.5 percent; and Texas, 7.4 percent.

Table 2.
Ability to Speak English for the Population Age Five and Older, for the United States and States: 2000.[4]

State/Jurisdiction	Population age 5 and older	Speak language other than English at home		Speak English very well or well		Speak English not well or not at all		Speak English not well		Speak English not at all	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
United States	262,375,152	46,929,311	17.9	35,964,744	13.7	10,964,567	4.2	7,620,719	2.9	3,343,848	1.3
Alabama	4,152,278	162,483	3.9	129,560	3.1	32,923	0.8	25,565	0.6	7,358	0.2
Alaska	579,740	82,708	14.3	71,893	12.4	10,815	1.9	9,323	1.6	1,492	0.3
Arizona	4,752,724	1,227,910	25.8	940,538	19.8	287,372	6.0	179,879	3.8	107,493	2.3
Arkansas	2,492,205	123,715	5.0	90,707	3.6	33,008	1.3	22,914	0.9	10,094	0.4
California	31,416,629	12,396,557	39.5	9,044,846	28.8	3,351,711	10.7	2,227,798	7.1	1,123,913	3.6
Colorado	4,006,285	603,827	15.1	455,611	11.4	148,216	3.7	98,054	2.4	50,162	1.3
Connecticut	3,184,514	583,851	18.3	479,463	15.1	104,388	3.3	81,713	2.6	22,675	0.7
Delaware	732,378	69,498	9.5	55,424	7.6	14,074	1.9	10,332	1.4	3,742	0.5
District of Columbia	539,658	90,370	16.7	69,843	12.9	20,527	3.8	14,827	2.7	5,700	1.1
Florida	15,043,603	3,472,392	23.1	2,631,798	17.5	840,594	5.6	550,678	3.7	289,916	1.9
Georgia	7,594,476	750,747	9.9	529,844	7.0	220,903	2.9	152,939	2.0	67,964	0.9
Hawaii	1,134,351	302,107	26.6	245,703	21.7	56,404	5.0	50,426	4.4	5,978	0.5
Idaho	1,196,793	111,861	9.3	86,214	7.2	25,647	2.1	17,733	1.5	7,914	0.7
Illinois	11,547,505	2,219,779	19.2	1,678,872	14.5	540,907	4.7	387,847	3.4	153,060	1.3
Indiana	5,657,818	362,015	6.4	293,368	5.2	68,647	1.2	53,679	0.9	14,968	0.3
Iowa	2,738,499	159,899	5.8	124,697	4.6	35,202	1.3	27,213	1.0	7,989	0.3
Kansas	2,500,360	218,602	8.7	166,033	6.6	52,569	2.1	37,815	1.5	14,754	0.6
Kentucky	3,776,230	148,402	3.9	119,432	3.2	28,970	0.8	23,255	0.6	5,715	0.2
Louisiana	4,153,367	382,322	9.2	340,156	8.2	42,166	1.0	36,749	0.9	5,417	0.1
Maine	1,204,164	93,953	7.8	86,272	7.2	7,681	0.6	6,991	0.6	690	0.1
Maryland	4,945,043	622,391	12.6	511,458	10.3	110,933	2.2	88,142	1.8	22,791	0.5
Massachusetts	5,954,249	1,115,292	18.7	902,144	15.2	213,148	3.6	160,266	2.7	52,882	0.9
Michigan	9,268,782	778,407	8.4	651,423	7.0	126,984	1.4	102,781	1.1	24,203	0.3
Minnesota	4,591,491	389,304	8.5	308,997	6.7	80,307	1.7	63,320	1.4	16,987	0.4
Mississippi	2,641,453	95,476	3.6	78,074	3.0	17,402	0.7	13,723	0.5	3,679	0.1
Missouri	5,226,022	264,095	5.1	215,811	4.1	48,284	0.9	39,394	0.8	8,890	0.2
Montana	847,362	44,326	5.2	40,423	4.8	3,903	0.5	3,643	0.4	260	0.0

Source: Census 2000 Summary File 3
(Table generated by the Migration Policy Institute)

Table 2.Continued
Ability to Speak English for the Population Age Five and Older, for the United States and States: 2000.[4]

State/Jurisdiction	Population age 5 and older	Speak language other than English at home		Speak English very well or well		Speak English not well or not at all		Speak English not well		Speak English not at all	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Nebraska	1,594,700	125,524	7.9	93,162	5.8	32,362	2.0	22,568	1.4	9,794	0.6
Nevada	1,853,720	427,915	23.1	321,002	17.3	106,913	5.8	75,284	4.1	31,629	1.7
New Hampshire	1,160,340	96,080	8.3	85,657	7.4	10,423	0.9	9,092	0.8	1,331	0.1
New Jersey	7,856,268	2,001,055	25.5	1,575,066	20.0	425,989	5.4	310,490	4.0	115,499	1.5
New Mexico	1,689,911	616,428	36.5	531,891	31.5	84,537	5.0	58,175	3.4	26,362	1.6
New York	17,749,110	4,961,140	28.0	3,807,217	21.5	1,153,923	6.5	841,361	4.7	312,562	1.8
North Carolina	7,513,165	603,135	8.0	422,168	5.6	180,967	2.4	124,513	1.7	56,454	0.8
North Dakota	603,106	37,967	6.3	34,426	5.7	3,541	0.6	3,259	0.5	282	0.0
Ohio	10,599,968	648,074	6.1	553,838	5.2	94,236	0.9	81,170	0.8	13,066	0.1
Oklahoma	3,215,719	238,461	7.4	188,679	5.9	49,782	1.5	37,446	1.2	12,336	0.4
Oregon	3,199,323	388,434	12.1	284,123	8.9	104,311	3.3	74,273	2.3	30,038	0.9
Pennsylvania	11,555,538	972,177	8.4	814,067	7.0	158,110	1.4	127,147	1.1	30,963	0.3
Rhode Island	985,184	196,573	20.0	155,840	15.8	40,733	4.1	30,238	3.1	10,495	1.1
South Carolina	3,748,669	196,250	5.2	152,288	4.1	43,962	1.2	33,068	0.9	10,894	0.3
South Dakota	703,820	45,512	6.5	39,685	5.6	5,827	0.8	5,230	0.7	597	0.1
Tennessee	5,315,920	256,256	4.8	197,482	3.7	58,774	1.1	44,000	0.8	14,774	0.3
Texas	19,241,518	6,009,856	31.2	4,582,241	23.8	1,427,615	7.4	911,915	4.7	515,700	2.7
Utah	2,023,875	253,106	12.5	198,350	9.8	54,756	2.7	39,360	1.9	15,396	0.8
Vermont	574,842	34,068	5.9	30,874	5.4	3,194	0.6	2,970	0.5	224	0.0
Virginia	6,619,266	734,625	11.1	591,326	8.9	143,299	2.2	109,648	1.7	33,651	0.5
Washington	5,501,398	770,351	14.0	593,586	10.8	176,765	3.2	128,766	2.3	47,999	0.9
West Virginia	1,706,931	45,890	2.7	40,124	2.4	5,766	0.3	5,322	0.3	444	0.0
Wisconsin	5,022,073	368,661	7.3	297,542	5.9	71,119	1.4	55,101	1.1	16,018	0.3
Wyoming	462,809	29,484	6.4	25,506	5.5	3,978	0.9	3,324	0.7	654	0.1

Source: Census 2000 Summary File 3
(Table generated by the Migration Policy Institute)

Immigrant Children

Children in immigrant families are a large and fast-growing population. A significant percentage live in low-income families, lack health insurance (although many are eligible for Medicaid and SCHIP), and are more likely to be in fair or poor health. Their parents face language barriers and have difficulty communicating with physicians, which can lead to problems in diagnosing illnesses and following treatment procedures. The following statistics on demographics and access to care illustrate the challenge.

Demographics

- One of every five children in the United States in 1997 was a child of immigrants.
- Children of immigrants are the fastest growing segment of the U.S. population under age 18. Between 1990 and 1997, the number of children in immigrant families grew by 47 percent, compared to 7 percent for children in U.S.-born families. By 2030, children who are Hispanic, Black, Asian or other racial minority will constitute 50 percent of all children, up from 31 percent in 1990.[5]
- One in four low-income children in the United States is the child of an immigrant.[6]
- Three of four children in immigrant families are citizens.[7]
- The largest minority group of children in the country are Latinos (16 percent of all children).

Access to Health Care

- Minorities are much more likely to lack health insurance: 27 percent of Latinos lack insurance, 18 percent of blacks, 17 percent of Asian/Pacific Islanders, and 9 percent of whites. Approximately 3.2 million Latinos lack health insurance.[8]
- One in three poor Latino children is uninsured, despite eligibility of most for Medicaid and SCHIP.[9]
- Noncitizen children are twice as likely to be without health insurance as children who are U.S. citizens.[10]
- Of all children eligible but not enrolled in Medicaid, 36 percent live in immigrant families. Children of immigrants are more than twice as likely to be in fair or poor health than are children of native-born Americans (9 percent vs. 4 percent).[11]
- Within the low-income population, 12 percent of immigrant children vs. 5 percent of natives are in fair or poor health (age 5 and under); for those age 12 to 17, the figures are 19 percent vs. 9 percent.[12]

The Commonwealth Fund, in its 2001 Health Care Quality Survey, found that "African Americans, Asian Americans and Hispanics are more likely than whites to experience difficulty communicating with their physician … and to experience barriers to care, including lack of insurance or a regular doctor."[13]

Language barriers vary across populations. English is the primary language spoken at home by 59 percent of Hispanics and 92 percent of Asian Americans. Within those populations, the percentages are 89 percent for Puerto Ricans, 54 percent for Mexican-Americans and 40 percent for Central Americans; 66 percent for Koreans, 71 percent for Vietnamese and 80 percent for Chinese.[14]

Patient-physician communication varies among racial and ethnic groups. Minorities reported greater difficulty in communicating with physicians: 19 percent of all adults reported one or more communication problems, rising to 33 percent for Hispanics and 27 percent for Asian Americans. Of those families where English is not the primary language spoken at home, the percent that reported it very easy to understand instructions from doctor's office included:

- 51 percent of Hispanic English speakers,
- 37 percent of Hispanic Spanish speakers,
- 47 percent of Asian American English speakers, and
- 16 percent of Asian American non-English speakers.[15]

Of those who needed an interpreter, only half said they always or usually received one. When an interpreter was provided, usually it was a family member or friend (43 percent) or a staff person (53 percent) at the health care facility. Only 1 percent reported that they received a trained interpreter.[16]

Patients who need but do not receive interpreters often do not understand instructions for taking medications and seldom are asked if they need assistance to pay for medications or for general medical care.[17]

Federal Civil Rights Law and Enforcement

"No person shall on the ground of race, color, or national origin, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Title VI of the Civil Rights Law of 1964

Access to Services for Limited English Proficient Persons

What is "LEP?" Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English are considered limited English proficient, or "LEP." In other words, LEP individuals speak very little or no English.

Executive Order 13166 issued on August 11, 2000, instructed federal agencies to improve accessibility to their programs for those who are limited in English proficiency. Federal guidelines issued in 2002 reiterate civil rights law that, to avoid discrimination against people with limited English proficiency on the grounds of national origin, recipients of federal funds must provide "meaningful access" to their services. The Department of Justice was given responsibility to provide guidance to other federal agencies and to ensure consistency. Approximately 30 federal agencies have issued or are preparing language access guidance.

Within the health and human services field, the Office for Civil Rights in HHS has issued guidance specifically for HHS-funded activities. Affected organizations include state and local health and welfare agencies, hospitals and clinics, managed care organizations, nursing homes, mental health centers, senior citizen centers, Head Start programs and contractors.

Language services must be free of charge. Recipients of federal funds may provide language services by oral interpretation in person or via telephone and/or by written transla-

tion. Options for providing competent interpretation include hiring bilingual staff; hiring staff interpreters; contracting for interpreters; using telephone interpreter services; using community volunteers; and using family members or friends, if desired by the limited English proficient individual. However, the guidance notes that the use of friends and family members, particularly children, raises issues of competency, confidentiality, privacy or conflict of interest.

To determine what language assistance services are appropriate, the Department of Justice provides a four-factor analysis:

1. The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee;
2. The frequency with which LEP individuals come in contact with the program;
3. The nature and importance of the program, activity or service provided by the program to people's lives; and
4. The resources available to the grantee/recipient and costs.

The guidance further suggests five steps that are part of an effective implementation plan:

1. Identify individuals who need language assistance.
2. Offer information on ways in which language assistance will be provided.
3. Train staff.
4. Provide notice to limited English proficient persons.
5. Monitor and update the implementation plan.

Compliance. The goal is voluntary compliance. Federal procedures include complaint investigations, compliance review, efforts to secure voluntary compliance and technical assistance. Recipients that are found noncompliant are subject to loss of federal funds.

The Department of Health and Human Services is currently reviewing comments on its republished policy guidance of Feb. 1, 2002. Comments were sought on the experiences of individuals or providers about the benefits or challenges that resulted from its initial Aug. 30, 2000, guidance; examples of cost-effective ways to provide services; suggestions for technical assistance; and descriptions of the costs for providing translation, interpreter or other language services. Pending the review and publication of final guidance, the August 2000 guidance remains in effect.

OMB Cost-Benefit Study

Congress, concerned about the costs of implementing the executive order, required the Office of Management and Budget (OMB) to assess the costs and benefits of implementation. The March 14, 2002, OMB report noted a lack of baseline information on benefits and costs and "data gaps" on the number of LEP individuals served and costs or benefits. Instead, the report used assumptions about language assistance services and notes that possible additional costs could be attributed to translated documents, bilingual staff, contracts for oral interpreter services, telephone interpreters, capital investments, central planning and data collection, and additional staff time to serve LEP individuals.

OMB estimated an average of $856 per emergency room, inpatient, outpatient and dental visit. The possible cost to health care providers is up to $267.6 million for interpretation services for 66.1 million emergency room, inpatient, outpatient and dental visits by LEP

individuals. The additional cost, or "LEP premium" is about $4 per visit or 0.5 percent.

The OMB report suggested the following benefits of providing language access: Clear communication between doctor and patient can help provide cost-effective delivery of service, accurate diagnosis and treatment, quality of care, patient protection such as informed consent, and improved public health. (Appendix B provides additional information about the OMB report.)

The Financing Angle: Medicaid, SCHIP and TANF

To help offset the cost of interpreter services, states can draw down the federal match under Medicaid, SCHIP and TANF in one of two ways. They can bill for language assistance as part of another medical or social service, or they can bill for it as an administrative expense. The administrative match rate for Medicaid and SCHIP is 50 percent. For SCHIP, administrative expenses are capped at 10 percent of direct services billed under the program. In the TANF block grant to states, administrative expenses are capped at 15 percent.

Centers for Medicaid & Medicare Services (CMS)

On Aug. 31, 2000, the Health Care Financing Agency (now CMS) issued a letter to state Medicaid directors confirming that federal SCHIP and Medicaid matching funds are available for state expenditures on oral interpretation and written translation, whether staff interpreters, contractor interpreters, or telephone services are used.

States can obtain a federal match for language services under Medicaid and SCHIP in two ways.

1. As Part of a Service. Interpretation as a distinct service is not reimbursable, but it is reimbursable as a part of medical assistance or a service. For example, a state can set two different rates in its state plan: one payment for physician services and one payment for physician services with interpreter services.
2. As an Administrative Expense. A state agency pays interpreters/translators directly or has contracts with physicians, hospitals, MCOs, and so forth, and reimbursement can be claimed with other administrative service costs submitted to CMS. The administrative match rate for Medicaid and SCHIP is 50 percent; for SCHIP the administrative rate is capped at 10 percent.

U.S. Department of Health and Human Services: TANF and MOE

HHS, in its series of questions and answers on the TANF program issued in November 1999, confirmed that state TANF agencies may use federal TANF and state MOE funds to provide language services to applicants and recipients who are limited English proficient.

"Administrative costs" include the costs of general administration and coordination of programs, including contract costs and all indirect (or overhead) costs. Examples of allowable activities include the salaries and benefits of staff performing administrative and coordination functions; activities related to eligibility determinations, the preparation of budgets, program plans and schedules; and the monitoring of programs and projects.

Administrative costs are subject to the 15 percent cap for TANF and MOE. For example, the cost of an interpreter who provides program information or performs an employability assessment is not subject to the cap; however, the cost of an interpreter to elicit family information for an eligibility determination is an administrative cost subject to the limitations.

Excluded from administrative costs are the direct costs of providing program services such as providing program information, the development of employability plans, work activities, post-employment services, work supports and case management. TANF and MOE expenses that are not administrative costs are not subject to the 15 percent cost limitations.

States must follow cost allocation guidelines governing expenses for two or more federal programs. When LEP-related services are needed for TANF, Food Stamp, and Medicaid benefits, states must allocate the costs of those services among the programs.

Technical Assistance from the HHS Office for Civil Rights

The HHS Office for Civil Rights offers technical assistance to recipients or covered entities. Examples of promising practices include simultaneous interpretation (using off-site technology); community language banks; state-agency supported language offices; multicultural projects that use community outreach workers and interpreters to help navigate the health and social service system; translated printed and on-line documents; telephone information lines with frequently spoken languages for recorded messages; and signage and outreach. Says Deeana Jang of OCR, "HHS, including its component agencies and its Office for Civil Rights, is committed to assisting recipients of HHS financial assistance to comply with their obligations under Title VI. HHS will continue to provide information-sharing on resources, to promote best practices in language access, and to fund model demonstration programs in this area."

State Programs and Promising Practices

New policies, programs and funding mechanisms to provide language access have been established nationwide. The National Health Law Program in its May 2002 publication, Providing Language Interpretation Services in Health Care Settings, cites examples from states, managed care organizations, hospitals, community-based organizations, and educational models. According to the report, "In most instances, these efforts represent partnerships between government, providers, and communities, and they hold great potential to be replicated elsewhere."

States have developed a number of methods to provide interpretation services, including salary premiums for bilingual medical staff; language classes for medical staff specific to a medical setting; nonprofit language banks that recruit, train and schedule interpreters; volunteer interpreter services; and remote simultaneous interpretation. Rates for interpretation services can range from $25 to $60 per hour for staff interpreters and language banks, and up to $132 per hour for telephone language lines (these vary by contract and usage). States have also developed innovative practices in outreach, application and enrollment to diverse ethnic populations that include translated materials, interpreter banks, use of ethnic media and bilingual health volunteers.

In 2001, the New Jersey legislature renamed the New Jersey Office on Minority Health as the Office on Minority and Multicultural Health and added $1.5 million to address racial and ethnic health disparities. New responsibilities include development of culturally appropriate health education materials and cultural and language competency courses designed to address disparities in health care access, utilization, treatment decisions, quality and outcomes. The office is charged with developing a statewide plan to increase the number of racial and ethnic minority health care professionals, make recommendations for outreach to minority communities, and evaluate multicultural programs in other states for potential replication in New Jersey. The law establishes a New Jersey Office on Minority and Multicultural Health Advisory commission (Chapter 205 amending P.L. 1991, c.401).

States are just beginning to tap federal funds for language services in health and human services. Despite a lack of written federal guidelines on how to apply for the match, at least nine states – Hawaii, Idaho, Maine, Massachusetts, Minnesota, Montana, New Hampshire, Utah and Washington – have managed to obtain federal matching payments from Medicaid and SCHIP for language interpretation.

Washington

Nearly one in five of Washington's 900,000 Medicaid clients is considered limited English proficient. Like other states, Washington has been sued under Title VI to provide effective communication between patients and health providers. As part of a consent decree issued more than 10 years ago, Washington established language support services and launched a certification program for interpreters. No civil suits have been filed since the programs began. Washington was also the first state to use the Medicaid match to help offset the expense of interpretation services.

The state uses two contracting structures for Medicaid clients. For public hospitals and public health departments, it enters into "interlocal agreements," reimbursing 50 percent of the cost of hiring interpreters. This cost is offset by the state's 50 percent federal administrative match under Medicaid (approximately $3 million in 2002). No state money is involved: the remaining 50 percent is provided by locally generated matching funds that meet federal funding requirements. Examples of acceptable costs are interpretation for dental, inpatient and outpatient care and administration of interpreting services. For private physicians, clinics and outpatient services at hospitals, Washington pays interpreter agencies directly, spending approximately $10 million annually in federal and state Medicaid dollars.

For better quality control, accountability and efficiency, the state is moving to a "broker" system that uses intermediaries between providers and interpreter agencies to improve scheduling and payment processes. The change is expected to save $2.6 million in federal and state funds from January to June 2003. According to Tom Gray, section manager for transportation and interpreter services in the Medical Assistance Administration, the state is not supplanting the legal responsibility of medical providers to provide medical interpreters. Instead, the state's interpreter service assists the provider in assuring equal access and effective communication. For example, if the broker does not have a medical inter-

Since the 1980s, New Hampshire has had policies to reimburse sign language and foreign language interpreters. Interpreters must enroll as Medicaid providers in New Hampshire and bill the state for language services. The state reimburses interpreters as an administrative cost at the rate of $15 for the first hour and $2.25 for each subsequent quarter hour. The Department of Health and Human Services purchases Spanish and Serbo-Croation interpretation and translation support. The state website lists a telephone number for the English for Speakers of Other Languages program (ESOL) and an on-line list of interpreters compiled by the state Department of Education. New Spanish language versions of Family Assistance, employment, TANF, Medicaid and SCHIP forms were released in 2002.

preter available, the provider must still adhere to the letter and intent of federal law by finding another qualified person to do the job.

An unusual aspect of Washington's program is that the state agreed to test and certify individuals for language proficiency. Washington currently certifies interpreters and translators in Spanish, Vietnamese, Russian, Cambodian, Laotian, Mandarin Chinese, Cantonese Chinese and Korean. Interpreters for other languages must undergo an assessment to determine their competency. Contractors that request a federal match for interpreters must use state-certified interpreters, bilingual employees that have passed the state test, or contractor-certified interpreters for whom the contractor accepts full responsibility.

Compliance. A client can call the DHS customer service line (available during normal business hours, five days per week) to register a complaint of discrimination. The state is usually able to resolve the problem. However, if the client remains unsatisfied, the complaint can then be submitted to OCR; if voluntary compliance is unsuccessful, the matter can be referred to the Department of Justice.

Minnesota

In Minnesota, languages now spoken– Amharic, Arabic, Cambodian, Chinese, Croatian, Hmong, Korean, Lao, Liberian, Oromo, Russian, Somali, Spanish, Sudanese and Vietnamese – reflect the estimated 225,000 immigrants and refugees who have settled there during the past 20 years.

In its efforts to improve language access, the Minnesota Department of Health has developed a wealth of information, including a spoken language resource guide; professional standards for interpreters; contact information for language contractors and payment rates; a translation protocol for written materials with answers to frequently asked questions about choosing and evaluating a translation agency; a translators' code of conduct, and examples of new software to aid translation.

In 2001, the Legislature approved a two-year, $4.3 million initiative (including $1.9 million in federal matching funds) to improve access to medical services by reimbursing providers for interpreter services for limited English proficient clients in the state's Medicaid and SCHIP program.

Hawaii spends about $144,000 per year for interpreter services and is reimbursed for language services as a covered service under Medicaid (59 percent rate) and SCHIP (71 percent rate). The state Medicaid managed care program includes the cost of translation services in its capitated rate.

Hennepin County, Minnesota's largest county, has an estimated LEP population of more than 100,000, or 10 percent of the county's population. In 1999, the county established a project for multicultural services to provide a central point of access for refugees, immigrants and other new American populations. The Office of Multi-Cultural Services seeks to coordinate existing services across departments and partner with the community; to enhance access to culturally and linguistically appropriate services; and to improve staff cultural competency and expand bilingual-bicultural employment opportunities.

The county has developed an extensive LEP plan for its Health and Human Services departments. The plan includes language assistance resources; the process for accessing language assistance, including rules governing interpreters, an LEP Individual Bill of Rights, draft standards for ethics and competency standards for interpreters; training; and monitoring. The county's 1996 Language Assistance Protocol directs county departments to attempt to schedule bilingual county staff or county staff interpreters before using contracted vendors. The county's on-line plan lists all contracted vendors for telephone and on-site interpreters, languages and available hours, contact information, and contracted rates. In 2001, the county spent an estimated $1.6 million for contracted services.

In addition, the county's Office of Multicultural Service, which has a budget of $1.8 million, employs 10 interpreters and 32 cultural liaisons at community centers to improve access to county services and to conduct community outreach. Bilingual county staff are certified and receive a pay differential. The county partners with VISTA to link ethnic community organizations with county services.

The county's future goals include developing a common pool of interpreters; developing skills, training, and curriculum for interpreters; and employing bilingual and bicultural staff in various county positions. In the long run, says Vinodh Kutty, Hennepin County Office of Multicultural Services, "the cheapest, easiest way to address language access will be to increase the diversity of the workforce." However, training will still be needed in order for bilingual staff to competently understand and explain medical and legal terminology to non-English speakers.

In 2001, Rhode Island enacted legislation that requires hospitals, as part of licensing requirements, to provide non-English speaking patients with a state-certified interpreter if a bilingual clinician is not available. The hospital may use a qualified interpreter if a state-certified interpreter is not available. The Department of Health must review annually each licensed hospital's level of performance in providing interpreter services. Hospitals that fail to comply are subject to suspension or revocation of their license or a fine of $1,000. The Department of Education must issue regulations establishing standards, criteria, and testing methods for interpreter certification (Chapter 23-17.20 of the General Laws entitled Health and Safety).

Massachusetts

In 2000, the Massachusetts legislature enacted H. 4917, the Emergency Room Interpreter Bill. The law, effective July 1, 2001, requires all acute care hospitals to use competent interpreter services for emergency room services when serving non-English speakers. State payers of medical care reimburse hospitals for the costs of providing competent interpreter services. The 2002 state budget appropriated $1 million for language services in hospitals and acute psychiatric facilities. Recently, Massachusetts received approval for three state plan amendments that will allow the state to draw down federal matching funds.

The Massachusetts Department of Public Health (MDPH) regulations require hospitals to:

1. Designate a coordinator of interpreter services.
2. Post notices and signage informing emergency room patients of their right to interpreter services. (Note: MDPH provides a poster available online that translates the following into 30 different languages: "You have the right to a medical interpreter at no cost to you. Please point to the language and wait."
3. Perform an annual language needs assessment in their service areas.
4. Assure that interpreters have received appropriate training.
5. Refrain from encouraging the use of family members to interpret and prohibit the use of minor children to interpret.

A unique aspect of this legislation is inclusion of a private right of action: under sections 1 and 5, an individual can sue the hospital if the hospital did not exercise reasonable judgment in making competent interpreter services available.[18]

MDPH has also developed Best Practice Recommendations for Hospital Based Interpreter Services. The document discusses publicizing the availability of interpreters, telephone communication and translation of written materials, developing needs assessment, training, and monitoring. Also included are descriptions of oral language assistance models: staff interpreters, contract interpreters, employee language banks, community interpreter banks, telephonic service, and remote simultaneous translation. Sample costs are $15 to $45 per hour for freelance interpreters and $12 to $20 per hour plus benefits for staff interpreters.

Oregon created a 25-member Oregon Council on Health Care Interpreters in the Department of Human Services to develop testing, qualification and certification standards for health care interpreters for LEP clients, to coordinate with other states on educational and testing programs, and to examine operational and funding issues. SB 790, approved by Governor Kitzhaber on Aug. 2, 2001, appropriated $50,000 for the biennium.

The Office of Minority Health and the Office of Refugee and Immigrant Health recently merged into the state Office of Multicultural Health, with the goal of promoting the optimal health and well-being of immigrant, refugee, and racial and ethnic minority communities statewide.

In Utah, medical interpreter services are available free of charge to clients in Medicaid, SCHIP and the Utah Medical Assistance Program as a covered service in the state plan. For fee-for-service clients, the state contracts with five interpreter services agencies that cover 27 languages. Managed care plans in the state must include interpretation services as part of their state contracts. The Utah Medicaid Provider Manual, updated in January 2001, includes an on-line two-page Guide to Medical Interpretive Services that lists available languages and contractors. Utah pays about $35 per hour for on-site interpretation and $22 per encounter for phone interpretation. The state is reimbursed at the 70 percent federal match.

Maine

In Maine, interest in adding sign language as a reimbursable service under Medicaid paved the way for adding foreign language interpreters. After convening public hearings and inviting public comment, the program agency revised its manual to add interpreters for sign language and foreign languages as covered services and, in January 2001, MaineCare (formerly Medicaid) began reimbursing physicians for part of the costs they incur in hiring interpreters (up to $30 per hour, about half the going rate.) Hospitals cannot bill separately for interpreter services, but the costs are allowable as part of their Medicaid reimbursement rates. The state estimates that interpreter costs are not significant in the overall Medicaid budget – perhaps $100,000 in a total budget of $1.4 billion – but they are likely to increase in the future.

Providers are being creative in locating interpreters. For example, they may link with a local college or university that has language resources, locate individuals in the medical community, or use a telephone-based language interpreter service. The state requires providers to ensure that interpreters protect patient confidentiality. Interpreters and translators who serve Medicaid clients must also read and sign a code of ethics, which is included in The Maine Medical Assistance Manual. However, the lack of standardization and lack of licensing for foreign language interpreters is of continuing concern.

Although the system is not perfect, Meryl Troop, director of multicultural services in the Department of Behavioral and Developmental Services, said providers in general "are less reluctant" to make interpretive services available than in the past. And although some providers resent having to pay the difference between Medicaid and the cost of the interpreters, many acknowledge they might otherwise be liable for the full cost and are glad for the help.

Next Steps

At a time when nearly every state is facing budget shortfalls and increasing costs in Medicaid programs, cost will continue to be a critical factor as states attempt to serve non-English-speaking clients. Some options for states are to review Medicaid, SCHIP and

TANF programs to maximize available federal dollars for language services; coordinate with other states to share promising practices; and, within states or localities, share pools of qualified interpreters. Two primary ways the federal government could lessen the costs of implementing language access requirements, according to OMB, are to: 1) create uniformity among federal programs and activities with those of the recipients of federal funds in providing LEP services, while recognizing the need for flexibility to address local circumstances, and 2) facilitate telephonic interpretation services through improved availability and access. The Department of Justice has taken the first step toward uniformity by creating "template" LEP guidance that all federal departments and agencies will use. For example, bulk purchases of language services could increase efficiency and achieve economies of scale, particularly for less often encountered languages.

The supply and availability of interpreters and translators are also a long-term challenge. Many communities report shortages of qualified medical interpreters. "The most cost-effective solution for states is to support outreach and hire bilingual staff, rather than depend on telephone interpretation services." says Kathy Poulos of the National LEP Advocacy Task Force. Telemedicine may also provide some additional options for states that lack on-site bilingual staff.

Health care organizations have begun developing the business case for providing linguistic and cultural access, analyzing the demographics of minority patients, their health care needs and desires, and their buying power. In the long run, the changing demographics of minority consumers may lead private organizations to explore ways to enlarge market share by providing enhanced bilingual and bicultural services. Racial and ethnic minorities comprised 70 percent of the total population growth between 1988 and 1998, and will only increase given the census 2000 reports on immigrant and minority growth. As an example of hospitals adapting to their clients, the New York Hospital Medical Center of Queens found that those of Korean and Chinese descent comprise 50% of the community. The Center launched a series of visits with Asian physicians, community and religious leaders to establish personal relationships and improve hospital services. After noticing Korean mothers did not return to the facility for care after birth of their child, they discovered a simple problem: seaweed soup is a tradition believed to help with postpartum recovery, and has since been added to the hospital menu.

Although it will take time to demonstrate results, language access may also improve cost-effective delivery of services. Health care plans with capitated payments have an incentive to reduce the future costs of care – linguistic access and cultural competence could reduce unnecessary diagnostic tests, provide more accurate medical histories, and help people obtain preventive treatment.

Appendix A. Federal Law and Policy

Under Title VI of the Civil Rights Act of 1964, "No person shall on the ground of race, color, or national origin, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

In August 2000, President Clinton issued an executive order requiring federal agencies to publish guidance on how federally-conducted programs and federally-funded programs could provide meaningful access to limited English proficient persons. This Executive Order was reaffirmed by the current administration. Approximately 30 federal agencies, including the Department of Health and Human Services (HHS) and the Department of Justice (DOJ), issued guidance in 2000. In 2001, the Bush administration reaffirmed the executive order and directed federal agencies to reissue the language access guidance in order to obtain public comment. The Department of Justice issued final guidance on June 18, 2002; HHS' final guidance is still pending. The Office of Management and Budget (OMB), which was required to assess the costs and benefits of the executive order, submitted its report to Congress in March 2002.

The Executive Order

On Aug. 11, 2000, President Clinton issued Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency,'' 65 FR 50121 (August 16, 2000). Every federal agency that provides financial assistance to non-federal entities was required to publish guidance on how their recipients can provide meaningful access to LEP persons. The executive order also, for the first time, required federal agencies to ensure meaningful access to their own programs and activities. Finally, the order gave DOJ the responsibility for providing LEP guidance to other federal agencies and for ensuring consistency among each agency-specific guidance.

Guidance from HHS and DOJ

HHS Guidance

On Aug. 30, 2000, HHS issued policy guidance on language access for providers of health-related services and social service programs. The guidance applies to state-administered, private and nonprofit facilities and programs that receive HHS funds. This guidance provides "additional clarification of existing responsibilities" under Title VI, describes the legal responsibilities of providers to assist people with limited English skills, and provides a range of options for providers to meet the language needs of the nation's increasingly diverse populations.

The federal guidelines reiterate that, to avoid discrimination against LEP persons on the ground of national origin, health providers must take reasonable steps to provide "meaningful access" to their services. In addition, these services must be free of charge. The guidance applies to all recipients of federal funds: state, county and local health and welfare agencies; hospitals and clinics; managed care organizations; nursing homes; mental health centers; senior citizen centers; Head Start programs; and contractors.

Options for providing interpreters include bilingual staff, interpreters, and telephone interpreter services. The HHS guidance discourages the use of friends and family members, particularly children, as interpreters.

DOJ Guidance

The DOJ guidance notes that language can be a barrier to accessing important benefits or services, understanding and exercising rights, complying with responsibilities, or understanding information provided by federally-funded programs and activities. The guidance reaffirms the federal government commitment to improving language accessibility to these progams and to promoting programs and activities to help individuals learn English.

DOJ issued final guidance on June 18, 2002, and the assistant attorney general has asked all federal agencies to create plans to ensure meaningful access, using the DOJ LEP guidance as the model. Final HHS guidance is expected in early 2003.

The DOJ final guidance reiterates four factors to be considered in an individualized assessment of obligation, with the goal of voluntary compliance:

1. The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee;
2. The frequency with which LEP individuals come in contact with the program;
3. The nature and importance of the program, activity or service provided by the program to people's lives; and
4. The resources available to the grantee or recipient and costs.

HHS is currently reviewing comments on its republished policy guidance of Feb. 1, 2002, and expects to publish final guidance soon. Comments were sought on the experiences of individuals or providers on the benefits or challenges that resulted from the guidance; examples of cost-effective ways to provide services; suggestions for technical assistance; and descriptions of the costs for providing translation, interpreter or other language services. Pending the review and publication of final guidance, the Aug. 30, 2000, guidance remains in effect.

"Meaningful access," as described by HHS, means that language assistance should result in accurate and effective communication between provider and client, at no cost to the client. Effective programs usually have four elements: assessment of language needs of the population served; a written policy on language access; staff training; and vigilant monitoring.

The HHS Office for Civil Rights (OCR) will make assessments of compliance on a case-by-case basis based on the four DOJ factors. Compliance procedures include complaint investigations, compliance reviews, efforts to secure voluntary compliance and technical assistance. If voluntary compliance is unsuccessful, OCR can secure compliance through termination of federal assistance after the covered entity has been given the opportunity for an administrative hearing; referral to DOJ for injunctive relief or other enforcement proceedings; or any other means authorized by law.

Appendix B. OMB Report to Congress: Assessment of the Total Benefits and Costs of Implementing Executive Order #13166: Improving Access to Services for Persons with Limited English Proficiency Submitted March 14, 2002

OMB found that improved access to benefits can "substantially improve the health and quality of life of many LEP individuals and their families. Moreover, language-assistance services may increase the efficiency of distribution of government services to LEP individuals and may measurably increase the effectiveness of public health and safety programs." Benefits could include cheaper, targeted, early intervention. For example, preventive health care, early detection and treatment of disease could reduce the cost of late-stage disease treatment or emergency visits. In addition, efficiency gains may result from decreased staff time needed for an LEP individual; more standardized provision of language services; and reduced errors in eligibility and payments.

The report suggests that language services can increase access of LEP individuals to quality health care and can improve communication with health care professionals. Other benefits could include increased patient satisfaction; decreases in misdiagnoses or errors; decreased medical costs through decreased emergency room visits; improved health; more patient confidentiality and true "informed consent," and understanding of the legal issues.

OMB notes that there is a lack of baseline information about benefits and costs and "data gaps" on the number of LEP individuals served and the costs or benefits. Instead, the report used assumptions about language assistance services and notes that possible additional costs could be attributed to translated documents, bilingual staff, contracts for oral interpreter services, telephone interpreters, capital investments, central planning and data collection, and additional staff time to serve LEP individuals.

In its case study for the health care sector, OMB estimated costs of language services for emergency room visits, inpatient hospital visits and outpatient physician visits. For emergency room visits, OMB assumed the LEP population of 4.1 percent of the total population and usage at the same rate as English speakers, and that about 30 percent of the hours would be provided by staff interpreters, language bank and language line at a national estimate of $8.6 million in costs to hospitals. Using the same assumptions, inpatient visits would cost $78.2 million. Outpatient or office visits to community health centers were estimated at 15 percent of the total hours for interpreters, language bank and language line at $11.5 million; to hospitals (30 percent of total hours) at $12.4 million; and to private providers (50 percent of total hours) at $156.9 million. Finally, the report notes that it is difficult to assess the extra cost of providing adequate access to LEP persons, the "LEP premium." Using a top-down estimate, the report estimates an average $856 per emergency room, inpatient, outpatient and dental visit. Estimating up to $267.6 million on language services for 66.1 million visits by LEP persons, the additional cost is about $4 per visit or 0.5 percent.

Two primary ways the federal government could lessen the costs of implementing Executive Order 13166, according to OMB, are to: 1) create uniformity among federal pro-

grams and activities with those of the recipients of federal funds in providing LEP services, while recognizing the need for flexibility to address local circumstances; and 2) facilitate telephone interpretation services through improved availability and access. For example, bulk purchases of language services could increase efficiency and achieve economies of scale, particularly for less often encountered languages. The OMB report is available at http://www.whitehouse.gov/omb/inforeg/lepfinal3-14.pdf

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Other Resources

For a clearinghouse of information, tools and technical assistance on limited English proficiency and language services, visit "Let Everyone Participate," http://www.lep.gov.

State web sites:

Maine:	ftp://ftp.state.me.us/pub/sos/cec/rcn/apa/10/144/ch101/c1s.doc
Massachusetts:	http://www.state.ma.us/dph/bhqm/2bestpra.pdf http://www.state.ma.us/dph/orih/orih.htm http://www.state.ma.us/dph/omh/interp/interpreter.htm
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