POLICY BRIEF

Improving Access to Language Services in Health Care: A Look at National and State Efforts

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Melanie Au

Erin Fries Taylor

Marsha Gold

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Policy Research, Inc.

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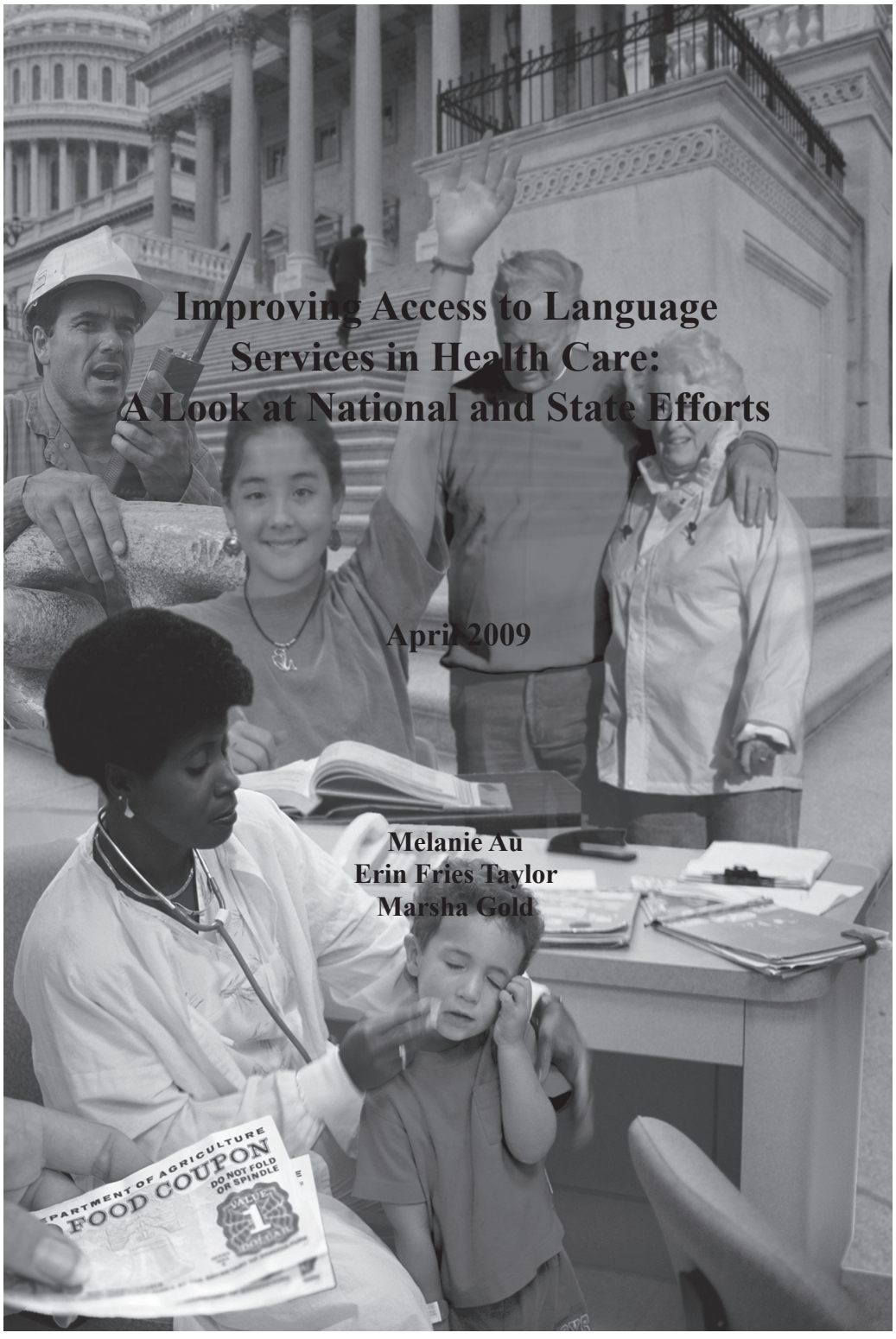

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Interest in providing access to language services in health care has increased in the past several years. This is particularly evident in recent state legislation that emphasizes health plan responsibility in promoting language services. This brief assesses emerging national efforts and profiles work in three leading states—California, Minnesota, and New York—to highlight challenges, successes, and implications for future policy and activities related to language services. The experiences of these states impart lessons to others looking to provide language services and ultimately improve health care for patients with limited English proficiency.

More than 23 million Americans have limited English proficiency.

The Issues at a Glance

More than 23 million Americans have limited English proficiency (LEP), which complicates their ability to obtain quality health care (Youdelman 2008; Flores et al. 2008). Language barriers in the health care setting can lead to problems such as delay or denial of services, issues with medication management, and underutilization of preventive services (Green et al. 2005; Jacobs et al. 2004; Gandhi et al. 2000). Difficulty in communication also may limit clinicians' ability to understand patient symptoms and effectively provide treatment (Karliner et al. 2004). Moreover, existing research suggests the quality of communication between patients and providers is strongly associated with providers' ability to deliver better and safer care for LEP patients (Ponce et al. 2006). Language services, such as translation and interpretation, can facilitate this communication and thus improve health care quality, the patient experience, adherence to recommended care, and ultimately health outcomes (Flores 2005; Jacobs et al. 2006; Karliner et al. 2007).

National interest in providing access to language services is increasing, and several states are promoting the use of such services in health care settings. As interest in language services grows, the experiences of states that are forerunners in operationalizing and funding language services may guide other states' future activities.[1] Hence, more states may require health care organizations such as health plans to ensure access to language services.

National Awareness and Activity

. . . awareness of the need to provide language services in health care has increased in recent years . . .

Although Title VI of the Civil Rights Act of 1964 always has required that entities receiving federal funds provide language services to those with LEP, the law has not often been enforced in health care settings (Jacobs et al. 2006). However, awareness of the need to provide language services in health care has increased in recent years, with activity in language services spanning policy, research, and practice settings. The country's changing demographics—with an increasing number of foreign-born Americans and a growing number of immigrants moving to areas that traditionally have lacked large minority populations—has driven some of this activity (Youdelman and Perkins 2002). At the same time, the Institute of Medicine's (IOM's) 2003 *Unequal Treatment* report and other studies have highlighted disparities in health care for minority groups and the need for interventions such as language services (Institute of Medicine 2003).

New federal policies and guidelines on access to language services in recent years reflect a growing recognition of the need for language services in health care. In 2000, President Clinton's executive order reaffirmed Title VI and instructed federal agencies to draft guidance on access to language services for federally funded health care services (Youdelman 2007). In compliance with this executive order, in 2000 the Office of Civil Rights of the U.S. Department of Health and Human Services issued guidance on language services for health care entities receiving federal funds (for example, state public health agencies, entities funded by Medicaid and the Children's Health Insurance Program [CHIP]) (USDHHS 2003). Shortly thereafter, the Centers for Medicare & Medicaid Services (CMS) released final Medicaid managed care regulations requiring state Medicaid agencies to provide access to language services (National Health Law Program 2003). CMS also issued a letter clarifying that states could draw down federal matching funds for language services in Medicaid and CHIP. The CHIP Reauthorization Act signed by President Obama in February 2009 increased federal matching for language services in these programs from 50 percent to 75 percent (H.R. 2).

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At the same time, national accrediting organizations are establishing requirements for language services. For example, the National Committee for Quality Assurance (NCQA) and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) are increasingly recognizing language services as an important component of quality health care. In December 2008, NCQA, which accredits health plans, released for public comment a set of standards for assessing the quality of culturally and linguistically appropriate services in health care organizations, and will consider incorporating a subset of these standards into its core accreditation programs in the future (NCQA 2008).

In addition, several national programs are providing research and tools to promote access to language services. In 2006, NCQA created the annual Recognizing Innovation in Multicultural Health Care award program to recognize health plans that have made "exemplary efforts and demonstrated effectiveness" to improve culturally and linguistically appropriate services and reduce health care disparities. The National Health Plan Collaborative (NHPC), a group of national and regional health plans created in 2004 with the goal of reducing racial and ethnic disparities among plan membership, recently created a toolkit of strategies for plans interested in providing language services.[2] Other national programs aimed more generally at providers have produced information applicable for health plans as well. The Health Research and Education Trust (HRET) developed a toolkit for collecting race, ethnicity, and language data from patients to better target language services. Health plans have used the HRET toolkit to guide their data collection. In addition, the National Coalition on Health Care Interpreter Certification (NCC) is developing national certification standards for medical interpreters, which may help health plans set criteria for qualified, reimbursable services.

Movement at the State Level

In 2008, all 50 states had at least two laws in place on language services in health care settings . . .

As the country's demographics and immigration patterns change, more states are establishing regulations and policies to promote access to language services in health care (Perkins and Youdelman 2008). In 2008, all 50 states had at least two laws in place on language services in health care settings, up from 43 states in 2006 and 40 states in 2003 that had one or more laws (Perkins and Youdelman 2008; Perkins 2005; Perkins et al. 2003). For example, some states have passed laws mandating that Medicaid managed care organizations (MCOs) provide translated documents in prevalent non-English languages; others have passed laws requiring that MCOs create plans to address the needs of members with LEP. Although all

states now have some legislation in place, these laws vary greatly in terms of breadth, depth, and oversight.

California, Minnesota, and New York have been particularly active in legislating access to language services in health care. Although these states are at different stages, they generally are considered leaders in language services and are likely to provide insights for other states. California has the most comprehensive provisions in the nation on access to language services and is the only state that has passed regulations mandating that commercial health plans make available to and reimburse providers for language services. Minnesota has some regulations in place on language services, including regulations targeting Medicaid health plans, and has proposed legislation directed at commercial health plans. New York's efforts on language services have been focused on New York City, but there also are efforts to develop statewide legislation. Experts we interviewed indicated that some states are watching California and other leaders in language services closely to determine how policies might be adopted in their own states.

California

California has the most comprehensive legislation on language services of any state and continues to lead the nation . . .

California's status as the "majority minority state," with active consumer advocacy groups and awareness among policy leaders of the issues for individuals with LEP, has led to a number of legislative provisions on language services. California has the most comprehensive legislation on language services of any state and continues to lead the nation (Perkins and Youdelman 2008).

Legislation Targeting Commercial Health Plans. In 2003, the California legislature passed Senate Bill 853, which mandated that all commercial health plans provide language services for their enrollees and charged the state's Department of Managed Health Care (DMHC) with formulating regulations to ensure health plan and provider compliance. DMHC held multiple hearings with health plans, providers, interpreter agencies, and trade organizations in an attempt to ensure that the language needs of consumers were met in a way that worked within the constraints of health plan business operations. DMHC and the California Department of Insurance (CDI) finalized regulations on language services in 2008.

The regulations mandate that health plans provide enrollees with translated vital documents (for example, explanations of benefits) and ensure the availability of interpreter services at all points of patient contact, including clinical encounters (DrTango Inc. n.d.). Services must be provided at no cost to the enrollee. To guide the development of these services, plans must collect patient demographic data, including language information gathered through a patient survey.[3] Health plans also must monitor their language service programs to track plan and provider compliance.[4] Although providing some guidance on what elements the programs should include, the regulations gave health plans flexibility regarding program design and implementation. The health plans were required to submit their program plans for approval by July 1, 2008 and implement programs by January 1, 2009.

Regulations Allow for Variation in Language Service Programs. In response to the flexibility of the regulations, health plans in California have designed programs with varying characteristics, depending on their existing internal infrastructure and knowledge regarding how to support language services. All plans are required to translate vital documents into appropriate threshold languages (that is, languages used by enough health plan members to warrant translation), but the threshold languages can differ somewhat by plan (DrTango Inc. n.d.). For interpreter services, some plans will rely solely on bilingual staff and telephone interpreter

services through language lines; others will use a mix of language lines, face-to-face interpreter services, and community member telephone services.

To monitor provider use of language services, health plans are requiring that providers follow plan-specific processes to obtain language services, such as calling an 800 number to receive telephonic interpretation. However, it is unclear how plans will monitor providers to determine if they are using these services when appropriate. Staff at one health plan indicated that enrollee grievance filings will be the plan's primary method for monitoring compliance.

Collaboration between stakeholders has been essential in California.

Importance of Collaboration Between Stakeholders. Collaboration between stakeholders has been essential to this effort. Contacts involved in the regulations and/or designing language service programs specifically noted the importance of state agency efforts in working with health plans, providers, and consumer advocates to develop regulations. This helped ensure that the regulations met the needs of patients but also made sense from a business perspective. Collaboration also helped health plans to implement the regulations. DMHC worked with consumer advocates such as the California Pan-Ethnic Health Network to coordinate training sessions utilizing expert guest speakers to assist plans with their program design and planning processes.

Health plans with Medicaid experience were positioned to respond more quickly than others to language service requirements. Their knowledge of language services, derived from responding to existing MediCal requirements and serving diverse populations, has provided a foundation for new efforts. This is less likely to be the case with commercial-only plans that face a steeper learning curve. Hence, commercial and Medicaid plans have been working collaboratively through the Industry Collaboration Effort (ICE), a nonprofit industry-based organization, to create and share materials for language service programs.[5] The collaboration of health plans under the direction of ICE has facilitated a pooling of resources and knowledge, enabling plans to advance more quickly with language service programs. Several organizations emphasized the importance of a third-party organization such as ICE—specifically one that is industry based—to promote collaboration between competing plans that otherwise would be less willing to share information.

Challenges in Implementation for Health Plans. Currently, California is the only state that has passed a law requiring that commercial health plans provide language services at all points of patient contact, including clinical encounters. For this reason, the challenges faced by California health plans and other stakeholders in implementing language service programs are informative for others looking to extend language services to patients in commercial plans.

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Health plan staff indicated that the greatest challenge so far has been setting up and reworking existing information technology (IT) systems to support the collection and management of data on members' primary written and spoken languages. Working through the IT challenge has taken a great deal of effort, often more than advocates and state agencies expected. Health plan staff suggested that close collaboration with other stakeholders has been important in communicating the effort required and creating realistic expectations.

As the programs begin in January 2009, health plan staff expect challenges related to physician confusion and burden regarding the varying health plans' processes for obtaining language services, which might hinder the use of services. Staff from plans with experience in providing language services through Medicaid have indicated that interpreter services often are underutilized because physicians find accessing them too burdensome. To alleviate this burden, ICE has put together a master document listing the language services contact person at each of the health

plans; ultimately, however, training for clinical staff on how and when to access services will be needed to promote their appropriate use during the medical encounter.

Minnesota

Minnesota is one of a number of states that reimburses Medicaid providers for language services and has in recent years considered methods for funding these services in commercial markets as well.

From 1990 to 2000, Minnesota's foreign-born population more than doubled (Singer 2004). This change has been accompanied by increasingly active efforts in legislation and private and community collaboratives to provide, fund, and improve the quality of language services in health care settings. A central issue in providing language services is determining how to pay for them. Minnesota is one of a number of states that reimburses Medicaid providers for language services and has in recent years considered methods for funding these services in commercial markets as well. It is also one of a handful of states developing certification standards for interpreter services to ensure quality of services purchased.

Legislation and Activities for Funding and Ensuring Quality of Language Services. In 2001, Minnesota developed a mechanism to draw down federal matching funds to pay for language services for Medicaid and CHIP managed care and fee-for-service (FFS) enrollees (Youdelman 2007). Although CMS allows states this option, only 12 states and the District of Columbia have taken advantage of this mechanism to develop a reimbursement system for language services. FFS providers submit claims directly to the state, and providers for Medicaid managed care patients arrange for these services through health plans, which in turn receive payment rates that take into account the cost of language services.

Developing a reimbursement system for language services in Medicaid/CHIP has been expedited because these large programs have administratively determined reimbursement rules. For this reason, although language services for Medicaid/CHIP populations are reimbursed in Minnesota, no similar reimbursement process is required for commercial health plans, and establishing such a process is more complex because of the way health plans are paid. Currently, the expense of language services for commercially insured populations falls on providers. In recent years, legislation mandating that commercial health plans provide and pay for interpreter services was introduced in two legislative sessions but failed to pass because of strong opposition from health plans and employers (Senate Bill 827, Senate Bill 3373) (Interpreter Services Work Group Report 2008). Nonetheless, staff at a state agency noted that discussions about health plan funding for language services are ongoing and likely will resurface in future legislative sessions.

Health plans in Minnesota have raised concerns about determining the quality of interpreter services because fluency in a language is not indicative of a person's ability to provide effective medical interpreting. To address these concerns, the state is developing a plan for interpreter certification. Although there is general recognition that being bilingual is not a sufficient qualification for a medical interpreter, no federal standards currently exist to guide appropriate interpreter certification (Chen et al. 2007). As a result, a handful of states began developing their own standards and are currently participating in NCC's efforts to create national standards. Responding to recommendations from a commissioned workgroup on interpreter services, the Minnesota legislature passed a bill in 2008 instructing the Commissioner of Health to establish a statewide roster of interpreters and develop a plan for creating a registry and a certification process. The web-based roster, first released in November 2008, is accepting applications and should be searchable by providers by early 2009. Staff from a state agency indicated that the department is exploring the possibility of having a private organization take over the roster and continue developing the registry and certification process.

Importance of Collaboration Among Stakeholders for Advancing Access to Language Services. Minnesota has a number of collaborative groups that encompass health industry and community organizations working on access to language services. Several organizations indicated that these collaborations help ensure that the issue receives continued attention, and that future legislation and regulation will include stakeholder input. Groups such as the Interpreter Stakeholders Group, a multistakeholder collaborative that has been involved in discussions on funding language services, drafting legislation on language services, and helping develop the interpreter roster/registry, is viewed by stakeholders as playing an important and constructive role in facilitating improvements in access to language services.

Despite growing awareness and support in Minnesota for language services, policymakers still are debating how to provide and fund services effectively, particularly in the commercial market.

Challenges Ahead. Despite growing awareness and support in Minnesota for language services, policymakers still are debating how to provide and fund services effectively, particularly in the commercial market. One key issue is finding a funding mechanism that allows for equitable access by insured Minnesotans and equitable sharing of responsibility for funding language services. Paying for language services is of primary concern. Providers, in particular, are concerned about costs they might not recoup in payments from health plans/insurers, with the latter similarly interested in ensuring that costs are shared among stakeholders (providers, plans, and purchasers). Another issue is the lack of information on the quality of interpreter services, although the ongoing work on the interpreter registry and a mechanism for certification will help address this.

New York

New York is a large state with a sizeable immigrant population (21 percent of its population is foreign born) (Singer 2004). That population is concentrated primarily in and around New York City, where immigrants comprise 37 percent of the city's residents (Kallick 2007). New York City, therefore, has a history of focused advocacy efforts, community activities, and regulation on language services. In contrast, immigrants account for only 5 percent of upstate New York's population. Hence, statewide efforts to promote language services have been more limited; however, examples of viable efforts to provide language services in other states and the growth in refugee and migrant worker populations in areas outside of New York City have contributed to recent statewide activity.

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Legislation and Activities on Language Services. Looking to examples from other states, advocacy groups in New York City and state legislators have been working on statewide legislation to reimburse language services in Medicaid. In 2007 and 2008, bills were introduced in the State Assembly and Senate mandating that Medicaid provide reimbursement for interpreter services in health care settings (Assembly Bill A-733, Senate Bill 7059).[6] In addition, the governor's 2007 budget earmarked money for Medicaid reimbursement of interpreter services provided by hospitals, but only in New York City. Advocacy organizations and the New York State Department of Health have discussed the possibility of expanding this budgetary allocation to include outpatient facilities statewide. Contacts indicated that that the future of the two bills and the budgetary allocation is uncertain, given the state's current budget deficit. Even so, advocates expressed optimism about the prospects for the bills given the new CHIP Reauthorization Act, which raises federal matching for language services in Medicaid and CHIP.

Although the fate of legislation requiring Medicaid reimbursement of language services remains uncertain, other statewide and local efforts on language services have gained momentum. The New York State Attorney General recently announced a settlement agreement requiring statewide provision of translation and interpreter services by pharmacies, which resulted from a civil

rights complaint filed by advocacy organizations against pharmacies. The agreement requires CVS and Rite-Aid pharmacies across the state to make translated prescription labels available in the six languages most commonly spoken in the state and ensure that customers receive medication counseling in their primary language (Office of Attorney General 2008).

In addition, in July 2008, Mayor Michael Bloomberg signed New York City's first Language Access Executive Order, requiring city agencies to provide interpreter services and oral and written translation services for the six languages most commonly spoken by New York City residents (Mayor Bloomberg Executive Order 120 2008). Although the order applies only to New York City, staff at an advocacy organization indicated that there have been discussions with and among state agencies about creating a similar statewide executive order.

Activity on Language Services Might Continue to Grow. Staff at several organizations suggested that legislation and activities on language services in New York City and State might continue to grow for several reasons. First, efforts in other states to provide and fund language services have spurred progress by advocates and legislative leaders in furthering similar activities in New York. According to organizations involved in the Medicaid reimbursement legislation, other states' endeavors to develop Medicaid reimbursement for interpreter services helped to advance discussions in New York. Examples of other states' efforts to expand access to language services (for example, California's SB853) could have similar effects. Second, increasing awareness statewide of the need for language services might add momentum to language service activities as immigrant populations grow in areas outside of metropolitan New York City.

Although attention to language services in health care has increased at the national level in recent years, concrete policies and activities have developed almost exclusively at the state and local levels.

Lessons Learned

Although attention to language services in health care has increased at the national level in recent years, concrete policies and activities have developed almost exclusively at the state and local levels. Examining activities in leading states highlights the successes and challenges of these efforts, while also providing an opportunity to see how other states might proceed as interest in language services grows.

Our examination of states at different stages in their language services activities identified three primary challenges for states and stakeholders looking to develop such services in the health care setting.

- ***Promoting Appropriate Use of Language Services.*** Clinical staff need training to help them determine when to request a medical interpreter because every health care interaction does not necessarily require a highly trained interpreter (Barrett et al. 2008). For example, advocates for language services believe that trained interpreters are most critical during the medical encounter and less so for administrative issues. As programs for language services are developed, particularly at the health plan level, evaluation research is needed to provide more information on what services (translated materials, interpreters, bilingual staff) are appropriate for different patient interfaces (administrative, medical), and whether such services can improve the quality of health care effectively. Moreover, health plans and other health care organizations need to estimate the demand for language services to plan their services accordingly.
- ***Ensuring Quality of Language Services.*** Unqualified interpreter services at the medical encounter—for example, interpretation by a bilingual relative of the patient—do not benefit the patient and, in fact, might result in increased medical errors and poor adherence to clinical instructions (Robert Wood Johnson Foundation 2008). Although there is general

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. . . as more states embark on activities related to language services, standards on the quality of such services should emerge to ensure their effectiveness.

agreement that providing qualified interpreter services is important, there currently are no federal standards, and only four states require or are developing state certification of interpreter services (Perkins and Youdelman 2008). Therefore, as more states embark on activities related to language services, standards on the quality of such services should emerge to ensure their effectiveness. Current efforts by the NCC to develop national standards are aimed at fulfilling this need.

- ***Developing Payment Mechanisms for Language Services.*** Determining how to pay for language services in health care is challenging, particularly for states working to extend services to LEP residents through health plans. In public programs such as Medicaid and CHIP, states have the option of drawing down federal matching funds to pay for services but only a handful have done so, perhaps because of the complexity involved in developing payment mechanisms. Creating payment mechanisms in the commercial health plan setting might prove even more complex. States considering extending language services in health care might benefit from examining payment mechanisms developed in states already active in language services.

Regardless of specific challenges, respondents from profiled states stressed the importance of collaboration and broad stakeholder involvement to address challenges and drive successful efforts to provide language services. Experts believe that disseminating lessons from the three states discussed here will help other states and health care organizations operating in diverse settings face the challenges of providing high-quality language services to LEP patients.

Endnotes

1. For the purpose of consistency, we use "language services" and "access to language services" throughout the text; however, we recognize that a variety of terms are used by different organizations (for instance, language assistance, language access, language access services, and linguistic services).
2. For more information, see the NHPC website, http://www.nationalhealthplancollaborative.org (accessed January 7, 2008).
3. Although the regulations require that language data be collected via patient survey, health plans were given flexibility on collecting race and ethnicity data. Proxy methods, such as geocoding and surname analysis, are permitted for collecting race and ethnicity data.
4. Title 28, California Code of Regulations, Section 1300.67.04 refers to language assistance programs but we use the term language service programs to be consistent with the rest of the text.
5. Materials include translated announcements to enrollees on availability of language services, examples of staff training programs, and tools and standard coding for collecting patient data.
6. Senate Bill 7059 was sponsored by Senator John Sabini, who has since left the Senate. Senator Thomas Duane is the sponsor of a similar bill (Senate Bill 3740) that was introduced and referred to the Committee on Health on March 30, 2009.

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This work was developed as part of a larger project funded by the Agency for Healthcare Research and Quality in which Mathematica evaluated the second phase of the National Health Plan Collaborative to reduce racial and ethnic disparities. We gratefully acknowledge the insights provided by national experts and representatives from state and private organizations contacted for this study. We also thank Judith Wooldridge at Mathematica for valuable input.

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