



policy brief

MEDICAID PAYMENTS FOR MEDICAL INTERPRETATION: HOW IS MEDICAL INTERPRETER COMPETENCY ADDRESSED?

SUMMARY FINDINGS

- Currently, there are no federal standards to certify medical interpreters and no certification requirements to initiate Medicaid payments for language services.
- Among states receiving federal matching funds, Washington state is the only one that operates a comprehensive certification program for medical interpreters.
- A handful of other states have enacted laws or policies to ensure the competency or certification of medical interpreters.

BACKGROUND

While 12 states and the District of Columbia use Medicaid and State Children’s Health Insurance Program (SCHIP) funds to pay for medical interpreters to ensure health care access for enrollees, these states often do not specify standards for interpreter competency or certification. The federal Centers for Medicare & Medicaid Services (CMS) does not require states to establish interpreter certification as a condition of Medicaid reimbursement.

COMPETENCY ISSUES IN STATES PROVIDING MEDICAID PAYMENTS FOR INTERPRETERS

Only the state of Washington has a comprehensive “Language Testing and Certification program” for medical interpreters, which requires certification for any person interpreting for the Department of Social and Health Services or one of its contractors (including all Medicaid and SCHIP health care providers). The testing program certifies interpreters in its seven most prevalent foreign languages and assesses the quality of interpreters in all other languages. To date, the state has given tests for 88 languages plus major dialects.

In Virginia, interpreters are required to meet proficiency standards — including a minimum 40-hour training — in order to receive Medicaid reimbursement. North Carolina has chosen to develop an interpreter credentials program before initiating Medicaid reimbursement. The curriculum will start with two levels: a two-day introductory course followed by a one-day practicum that will incorporate the recently released National Standards of Practice and Code of Ethics from the National Council on Interpreting in Health Care (NCIHC). The program will assess an individual’s language competency and require a demonstration of interpreter competency. A basic credentialing process will be developed, followed by specialized credentialing in advanced areas, such as social service, public health, and mental health. Virginia’s Department of Health and Human Services would only reimburse interpreters who have credentials in the areas for which they interpret.

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The other states providing Medicaid reimbursement have few, if any, specific requirements regarding interpreter competency. The states that contract with language agencies (District of Columbia, Hawaii, Kansas, Utah and Vermont) delegate decisions about interpreter competency to those agencies. In the states where providers hire and pay for interpreters (Indiana, Maine and Minnesota), the provider determines competency. In Maine, providers are required to make sure interpreters protect patient confidentiality and have read and signed a code of ethics (the state provides a sample code of ethics as an appendix to its Medical Assistance Manual). Two of the states that directly pay interpreters have more explicit requirements. In Montana, the provider is responsible for hiring a “qualified” interpreter. In Wyoming interpreters are required to abide by the national standards developed by NCIHC.

OTHER STATE REQUIREMENTS FOR MEDICAL INTERPRETER COMPETENCY

While interpreter competency or certification are not required to initiate Medicaid payments or reimbursement, attention to the issue is growing. A handful of states have addressed the issue in state laws or policies. For example, Washington, D.C.’s Language Access Act requires “experienced and trained” interpreters and Hawaii’s Language Access Law specifically requires “competent” language services for operations conducted by state agencies. However, these standards may or may not apply to Medicaid providers. California, Indiana, Iowa, Massachusetts, Oklahoma, Oregon, and Washington all have or are exploring the development of statewide certification for health care interpreters. For example, Oregon’s Department of Human Services is required to “establish procedures for testing, qualification and certification of health care interpreters for persons with limited English proficiency.” These procedures will include: (1) minimum standards for qualification and certification as a health care interpreter, including formal education or training in medical terminology, anatomy and physiology, and medical ethics; and (2) requirements that the health care interpreter can fluently interpret slang or specialized vocabulary and has experience working as an intern with a practicing health care interpreter.

In addition to statewide efforts, a few states address interpreter competency in specific context. Massachusetts, for example, is implementing a law requiring interpreters in emergency rooms and in-patient psychiatric facilities. “Competent interpreter services” are required in these situations, with competency defined as having the “skills and ethics of interpreting, and knowledge in both languages regarding the specialized terms (e.g., medical terminology) and concepts relevant to clinical or non-clinical encounters.” Rhode Island also requires the use of “qualified interpreters,” as a condition of hospital licensure, and precludes the use of children under 16 as interpreters. New York recently implemented regulations requiring hospitals to develop a language assistance program, which must consider issues of interpreter competency and not utilize children younger than 16 except in emergencies.

Some states have addressed competency issues through agency policy. For example, Georgia’s Department of Human Resources offers a training program that includes: (1) an orientation to program benefits, (2) introduction to terminology used in departmental programs, (3) instruction on confidentiality and privacy standards, and (4) training on DHR’s Code of Professional Conduct. While the agency does not certify interpreters, it will include them on a list of qualified interpreters once they have completed the training program. Similarly, Maryland’s Department of Health and Mental Hygiene requires interpreters to: (1) demonstrate proficiency in both English and the language spoken by the LEP individual; (2) receive training in the ethics of interpreting; and (3) have fundamental knowledge in both languages of specialized terms and concepts used in the subject program.

CONCLUSION

No federal medical interpreter certification standards and no requirements for certification are used to initiate Medicaid payment for language services. And only a few states have, or are establishing, statewide medical interpreter certification standards. Yet many states, recognizing that interpreter competency is critical for accurate communications between patients and health care providers, have begun to address the issue.



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