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policy brief

EXECUTIVE SUMMARY

New legislation could eliminate barriers to high-quality health care for Medicaid recipients who speak limited English.

New legislation makes medical interpreters available to Connecticut Medicaid recipients with Limited English Proficiency (LEP). Medical interpretation will eliminate the language barriers that have contributed to racial and ethnic disparities in health and facilitate accurate diagnosis, treatment and follow-up.

Legislation enacted on June 19, 2007 (Public Act No. 07-185) gives the state great flexibility in providing interpreters, leaving many questions unanswered.

Answers to these questions, as well as available options, are based on the experiences of the 12 states and the District of Columbia already reimbursing for medical interpreters in Medicaid, and supports implementation of the Recommended Action list.

RECOMMENDED ACTION

- Ensure Department of Social Services (DSS) pays for medical interpreters for all in-patient/outpatient care in fee-for-service and managed care.
- Pay for in-person medical interpreters for all Medicaid-covered services, and establish protocols for telephone language-line interpreters or other technologies as an alternative (when necessary) or as a guarantee of full coverage, 24/7.
- Reimburse providers for staff medical interpreters. (Does not include bilingual staff members without medical terminology and other interpreter training, i.e., receptionists.) Make payment directly to medical interpreters and language agencies when providers use non-staff interpreters. Eliminate payment when family members, friends or others interpret, except in state-specified situations.
- Establish a minimum state per-unit charge for providers with on-staff medical interpreters and language agencies. Allow independent interpreters to submit reasonable costs to DSS. Pay for travel and waiting time for language agencies and independent interpreters.
- Require that all medical interpreters follow the National Council on Interpreting in Health Care (NCIHC) code of ethics and standards of practice. Require that language agencies providing interpreters document their training and agree to follow the NCIHC code and standards. Once medical interpreter standards are adopted, DSS needs to evaluate their implementation and establish a phase-in process to meet those standards.

COVERED SERVICE AND ADMINISTRATIVE EXPENSE

Legislation enacted last year requires that Connecticut provide interpreters as a covered service (typically, all mandatory and optional Medicaid services, such as physician and hospital services, laboratory tests, X-rays and prescriptions). This would guarantee that services will be provided.

States also have the option of paying for them as an administrative expense (includes costs incurred by the state to operate the program, such as staff, computer systems and other related operating costs). But this may require new legislative approval because the existing law requires a covered service.

The distinction between covered and administrative services affects how DSS submits costs to the federal Centers for Medicare & Medicaid Services (CMS). In Connecticut, since federal payment is the same for covered and administrative services, there is no financial benefit to adopting language services as a covered service.[i] (*See following chart.*)

Nine of the states already providing reimbursement categorize medical interpreter costs as administrative instead of covered. A difference may arise in payments to managed care organizations if the costs of interpreters are included in the managed care organization's administrative overhead or capitation rate*. Then, there will not be separate bills for interpreter services, making it difficult to track the provision of the interpreters.

QUESTION	COVERED SERVICE	ADMINISTRATIVE EXPENSE	INCLUDED IN MANAGED CARE CAPITATION RATE*
How much would CT receive from CMS for language services?	50% of its costs	50% of its costs	50% of its costs
Would DSS have to submit a state plan amendment to CMS?	Yes	No	No
Could DSS utilize a separate billing code for language services?	Yes	Yes	No
Could DSS set the payment rate for medical interpreters?	Yes	Yes	No
Could DSS require submission of specific claims for medical interpreter services?	Yes	Yes	No
Could DSS decide in which settings and for which services to pay for language services?	Yes	Yes	No
Could DSS carve out language services from managed care rates and pay separately to ensure equal access between managed care and fee-for-service enrollees?	Yes	Yes	N/A
Could DSS require medical interpreters to be competent or meet certain standards?	Yes	Yes	Yes
Could DSS terminate medical interpretation without legislative approval?	No *(as long as Public Act No. 07-185 remains in effect)*	Yes	N/A

*(*Capitation is the system of payment for each customer served, rather than by service performed. Both are used in various ways in U.S. medical care.)*

TYPES OF MEDICAL INTERPRETATION SERVICES

States have significant latitude in determining which language services Medicaid will reimburse.

Some of the issues facing DSS are listed in the following chart:

ISSUE	OPTIONS	RECOMMENDATIONS
Which providers/services need to be covered?	Fee-for-service, managed care; in-patient and outpatient.	Provide medical interpreters to all Medicaid providers and all Medicaid services. Carve out language services from managed care capitation rate.
Which types of medical interpreter services need to be covered?	In-person interpreters, telephone/video interpreters. .	In-person interpreters preferred; alternative coverage acceptable. If DSS adopts new technology (i.e., video-conferencing), it must pay provider and start-up costs, and service use.
To whom would payments be made?	Medicaid providers, medical interpreters, language agencies, broker.	Pay providers for their staff interpreters. Pay interpreters/language agencies for contracted services.
How much should DSS pay for medical interpreter services?	Per unit v. per encounter v. percentage add-on to existing payment rate. Set rate v. reasonable rate; travel time, waiting time.	Establish per unit (per quarter hour or hour) rate for language agencies and providers with staff interpreters. Allow contract interpreters to charge reasonable rates. Pay travel and waiting time for contract interpreters and language agencies.
Should DSS implement requirements for medical interpreter competency and training?	No standards v. minimal standards v. implement competency standards prior to initiating reimbursement.	Initially require interpreters to abide by national code of ethics and standards of practice. Revisit issue if state or national medical interpreter standards are developed.

CONCLUSION

Although this summary provides information on many issues relevant to developing Medicaid medical interpreter payments, states have tremendous flexibility and are not limited by other states' actions. Factors affecting reimbursement will vary by facility, community and state. DSS needs to work with interested stakeholders to determine the methods and procedures that will best ensure timely access to competent medical interpreters for all Medicaid enrollees.

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REFERENCES

i Except for SCHIP enrollees for whom the federal payment for covered services is 65 percent.

For more information on how other states pay for interpreters in Medicaid and SCHIP, see M. Youdelman, *Medicaid and SCHIP Reimbursement Models for Language Services*, July 2007 Update, available at http://www.healthlaw.org/library/item.142454.

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