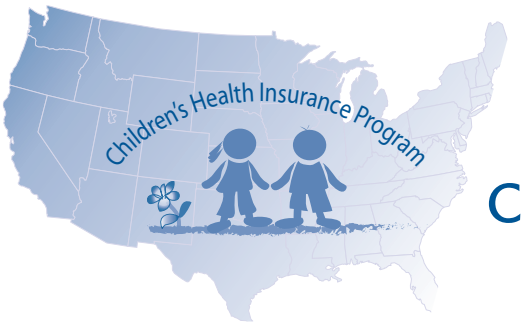

Improving Lanuage Access: CHIPRA Provides Increased Funding For Language Services

The Children's Health Insurance Program (CHIP) was created in 1997 to provide affordable health coverage to low-income children in working families who make too much money to be eligible for Medicaid but not enough to afford private coverage. The program currently covers more than 7 million children. In February 2009, after a protracted political fight, Congress enacted, and President Obama signed, legislation that renewed CHIP through the end of 2013 and expanded its scope. This series of issue briefs examines the new provisions that were included in the reauthorization and how they will affect implementation in the coming months.

In 2007, more than 55 million people in the United States (19.7 percent of the population that was five years old or older) spoke a language other than English at home.[1] Of those, almost half reported that they spoke English less than "very well." Individuals who are unable to communicate effectively because of a limited ability to speak, read, write, or understand the English language are referred to as being limited English proficient, or LEP.[2]

Close to 9 percent of the overall U.S. population has limited English proficiency, but across the country, many states report significantly higher percentages of people who are LEP. For example, in 2007, 20 percent of California residents were considered LEP, while approximately 15 percent of Texans, and 13 percent of individuals living in Arizona, Nevada, or New York were considered LEP.[3] Given the shifting demographics of the United States, the number of languages that are spoken across the nation is expected to rise, and the percentage of people who are LEP is expected to rise as well.

If health care providers and patients are not able to communicate with each other effectively, the quality of health care for people who are LEP, including some minorities, suffers. As the United States becomes more racially and ethnically diverse, addressing language access issues will play a significant role in helping eliminate disparities in health coverage, access, and quality for some racial and ethnic minorities.

The CHIP reauthorization law includes additional funding for states to cover interpretation and translation services that are provided in health care settings. CHIPRA therefore has tremendous potential to address some of the disparities that are particularly problematic for low-income children and pregnant women.

CHIPRA Provides Increased Funding for Interpretation and Translation Services

Language access services, or language assistance services, refer to translation (written) and interpretation (spoken) services that are provided in a health care setting.[4] Providing language assistance services is one way to help ensure that quality health care is available to everyone in the United States, including those for whom English is not the primary language. Research has shown that language barriers affect the quality of care by increasing the incidence of medical errors and patient noncompliance, as well as decreasing patients' trust of and satisfaction with their health care providers.[5]

To encourage more states to offer language services, CHIPRA increased the federal match that is available for interpretation and translation services to either 75 percent or the state's usual federal medical assistance percentage (FMAP) plus 5 percentage points (whichever is higher) for all CHIP enrollees and for children enrolled in Medicaid. The higher matching rate is also available for activities associated with language assistance, including translating documents (such as outreach and enrollment forms, health information brochures, and informed consent documents), and for the use of interpreters to facilitate the enrollment process. The higher matching rates are an incentive for states to provide culturally and linguistically appropriate outreach, enrollment, and care to the growing number of individuals in the United States who have a limited ability to read, write, speak, or understand English.

According to Federal Law, Patients Have a Right to Language Assistance Services

Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, or national origin by any entity that receives federal financial assistance. In accordance with this law, health care providers that receive federal funding are legally required to provide language assistance services to LEP patients.[6] In August 2000, President Clinton issued Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency," which reinforced that patients have a right to language access services and requires all federal agencies to draft guidance for funding recipients.[7] The executive order was reaffirmed by President Bush in October 2001.

In response to President Clinton's executive order, the Department of Health and Human Services (HHS) Office for Civil Rights issued guidance on how recipients of federal funds should provide meaningful language access. The HHS Office of Minority Health also developed 14 standards for culturally and linguistically appropriate services (CLAS). The four CLAS standards that are related to language are mandated, while the rest are recommendations. In order to ensure language access, these standards require that health care organizations provide meaningful language assistance services through trained medical interpreters and the translation of written materials. In addition, patients cannot be charged for these services.[8]

Federal Funding for Language Access Services

Although the federal government has mandated the implementation of language assistance services to help health care providers and LEP patients communicate more effectively, not all states provide these services.

While Executive Order 13166 requires federal fund recipients to provide meaningful language access (see "According to Federal Law, Patients Have a Right to Language Assistance Services" on page 2), the majority of states do not currently draw down federal funding for these services. States are not required—*but have the option*—to pay for language services in their Medicaid and CHIP programs for providers. Each state determines whether it will reimburse hospitals and other health care providers for the costs of providing language services to Medicaid and CHIP enrollees.[9] The federal government pays for interpreter services that are provided to people enrolled in Medicaid and CHIP, but only if states choose to include this service in their Medicaid and CHIP plans.

In 2000, the Centers for Medicare & Medicaid Services (CMS) sent a letter to state health officials, *Policy Guidance on Medicaid for Persons with Limited English Proficiency*, reminding the states that language services were reimbursable as an administrative or covered service under Medicaid and CHIP plans.[10] However, only 13 states plus the District of Columbia currently reimburse providers for language services.[11] A majority of these states pay for interpreters only in fee-for-service plans.[12]

All states that offer language assistance services to their Medicaid and CHIP enrollees receive federal funding to help pay for those services. However, states have different reimbursement structures for drawing down those funds (see the table on page 4).[13]

There are several reasons why states may not provide language assistance services. For many states, tightening budgets (particularly in the current recession) have made it difficult to set aside funds to pay for their portion of language access services, despite the federal matching funds available. Other states may not know that federal funding is available to help pay for these services under their state Medicaid or CHIP programs. Lastly, in some states, language services may already be considered part of providers' cost of doing business, so additional expenses that are incurred may be lumped into providers' general reimbursement rates, no matter how much these language services actually cost to provide.[14]

Despite the higher federal matching rates under CHIPRA and the availability of new federal funds, many states may not have the financial resources to take advantage of the higher matches. Nonetheless, small investments in addressing racial and ethnic disparities through eliminating language barriers can potentially lead to greater gains, not only in terms of improving the quality of health care, but also by reducing costs associated with medical errors and costly procedures. Investing in language assistance services improves communication between patients and health care professionals, helping to ensure that quality health care is provided and received. Increased federal funding for language assistance services is therefore an important new opportunity that will improve health care services for children and their families.

How Can States Cover Language Assistance Services for Medicaid and CHIP Enrollees?

	Covered Services*	Administrative Services*
How do these reimbursement structures differ?	This option allows states to cover language assistance services along with other required health services under their Medicaid and CHIP plans.	This option allows states to cover language assistance services as an associated administrative cost of their Medicaid or CHIP program.
Is CMS approval required?	Yes. States must submit to CMS a state plan amendment (SPA) that modifies the language of their Medicaid and CHIP plans. The SPA must be approved by CMS before matching dollars can be received for that service.	No.
Which states cover language services this way?	Currently, five states claim their federal match as a covered service: Hawaii, Idaho, Iowa, Maine, and Utah.	Currently, eight states plus the District of Columbia claim their federal matching funds as an administrative expense. The eight states are Kansas, Minnesota, Montana, New Hampshire, Vermont, Virginia, Washington, and Wyoming.
Is there a difference in matching rates?	Each state has a different matching rate for covered services under its Medicaid and CHIP programs. Currently, with a recent increase from the American Recovery and Reinvestment Act, Medicaid matching rates for adults range from 56.2 percent to 80.5 percent. For CHIP, matching rates range from 65 percent to 83.09 percent. States receive a 75 percent match or FMAP plus 5%, whichever is higher, for language assistance services for children in Medicaid and all CHIP enrollees.**	States receive a 75 percent match or FMAP plus 5%, whichever is higher, for language assistance services for children in Medicaid and all CHIP enrollees. (Prior to the increase in matching funds, these states received a 50 percent match.)
Is spending capped?	No.	Yes. States can spend only 10 percent of their total CHIP allotment on administrative expenses.

* Mara Youdelman, *Medicaid and SCHIP Reimbursement Models for Language Services: 2007 Update* (Washington: National Health Law Program, May 2007), available online at http://www.healthlaw.org/library/item.142454; The National Health Law Program and the Access Project, *Language Services Action Kit: Interpreter Services in Health Care Settings for People with Limited English Proficiency* (Washington: National Health Law Program, revised February 2004), available online at http://www.healthlaw.org/library/item.70355.

** Kaiser Family Foundation, Statehealthfacts.org, "Federal Matching Rate (FMAP) for Medicaid with American Recovery and Reinvestment Act (ARRA) Adjustments, FY2009," available online at http://www.statehealthfacts.org/comparemaptable.jsp?ind=695&cat=4, accessed on December 15, 2009; Kaiser Family Foundation, Statehealthfacts.org, "Federal Matching Rate (FMAP) for CHIP," available online at http://www.statehealthfacts.org/comparetable.jsp?ind=239&cat=4, accessed on December 15, 2009.

Endnotes

[1] U.S. Census Bureau, American Community Survey 2007, Table S1601, "Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over," available online at http://factfinder.census.gov, accessed on May 13, 2009.

[2] U.S. Department of Health and Human Services, Office of Civil Rights, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons (Washington: HHS, February 2002), available online at http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html.

[3] U.S. Census Bureau, American Community Survey 2007, op. cit. State information for Arizona, California, Nevada, New York, and Texas is available online at http://factfinder.census.gov.

[4] Marjory Bancroft, *Overcoming Language Barriers in Health Care Best Practices* (Ellicot City, MD: Cross Cultural Communications, April 23, 2007), available online at http://www.dhmh.state.md.us/hd/presentations/pdf/24MarjorieBancroft.pdf.

[5] G. M. Flores et al., "Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters," *Pediatrics* 111, no. 1 (2003), available online at http://pediatrics.aappublications.org/cgi/reprint/111/1/6; Sharon M. Lee, *A Review of Language and Other Communication Barriers in Health Care* (Rockville, MD: Department of Health and Human Services, Office of Minority Health, April 2003), available online at http://www.hablamosjuntos.org/resources/pdf/SMLeeCommunication_and_Health.pdf.

[6] Alice Hm Chen et al., "The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond," *Journal of General Internal Medicine* 22 (November 2007): 362, available online at http://ukpmc.ac.uk/articlerender.cgi?artid=1221365.

[7] Mara K. Youdelman, "The Medical Tongue: U.S. Laws and Policies on Language Access," *Health Affairs* 27, no. 2 (March/April 2008): 425, available online at http://content.healthaffairs.org/cgi/content/full/27/2/424.

[8] U.S. Department of Health and Human Services, Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary* (Washington: HHS, March 2001), available online at http://minorityhealth.hhs.gov/assets/pdf/checked/executive.pdf.

[9] National Association of Public Hospitals and Health Systems, *Medicaid and SCHIP Funding for Language Services* (Washington: National Association of Public Hospitals and Health Systems, April 2007), available online at http://www.naph.org/Publications/medicaidandschipfundingforlanguageservices.aspx.

[10] The National Health Law Program and the Access Project, *Language Services Action Kit: Interpreter Services in Health Care Settings for People with Limited English Proficiency* (Washington: National Health Law Program, revised February 2004), available online at http://www.healthlaw.org/library/item.70355. The letter from CMS is available online at www.cms.hhs.gov/smdl/downloads/smd083100.pdf.

[11] Mara Youdelman, *Medicaid and SCHIP Reimbursement Models for Language Services: 2007 Update* (Washington: National Health Law Program, May 2007), available online at http://www.healthlaw.org/library/item.142454. The states that cover language assistance services under their Medicaid and CHIP plans are Hawaii, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Vermont, Virginia, Washington, and Wyoming (plus Washington, D.C.). On July 1, 2009, Iowa also began to reimburse Medicaid and CHIP providers for providing language assistance services. Personal communication between Sally Nadolsky, Medicaid Policy Specialist, Iowa Department of Human Services, and Sherice Perry, Families USA, November 3, 2009.

[12] Mara Youdelman, op. cit.

[13] The National Health Law Program and the Access Project, op. cit. In addition, a majority of states receive additional payments for hospitals that serve a large proportion of Medicaid and uninsured patients. States decide which hospitals are considered disproportionate share hospitals (DSH) and how much funding they should receive.

[14] The National Health Law Program and the Access Project, op. cit.

Acknowledgments

This brief was written by

Sherice Perry
Program Manager
Minority Health Initiatives, Families USA

with

Sabrina Aggarwal
2008 Wellstone Fellow, Families USA

Rachel Klein
Deputy Director of Health Policy, Families USA

Rea Pañares
Director of Minority Health Initiatives, Families USA

Jennifer Sullivan
Senior Health Policy Analyst, Families USA

Assistance was provided by the following Families USA staff:

Ingrid VanTuinen, Senior Editor

Nancy Magill, Senior Graphic Designer

Special thanks to

Mara Youdelman,
National Health Law Program

Sally Nadolsky
Iowa Department of Human Services

This brief is part of a series of issue briefs that examines the new provisions that were included in the reauthorization of CHIP in February 2009. The series is available online at www.familiesusa.org/issues/childrens-health/chipra-implementation-series.html.

FamiliesUSA
The Voice for Health Care Consumers

1201 New York Avenue NW, Suite 1100 ■ Washington, DC 20005 ■ Phone: 202-628-3030
E-mail: info@familiesusa.org ■ www.familiesusa.org