Medicaid Interpreter Services Pilot: Report on Program Effectiveness and Feasibility of Statewide Expansion

Pursuant to S.B. 376, 79th Legislature, Regular Session, 2005

Submitted by the
Health and Human Services Commission

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Executive Summary

S.B. 376, 79th Legislature, Regular Session, 2005, directs the Health and Human Services Commission (HHSC) to establish a pilot program to provide Medicaid recipients with oral and written language interpreter services. S.B. 376 further requires the language interpreter pilot program to be established through local governmental entities, with first priority given to the following: (1) Harris County Hospital District; (2) Bexar County Hospital District; (3) El Paso County Hospital District; (4) Tarrant County Hospital District; and (5) Parkland Health and Hospital System.

S.B. 376 specifies that funding for the pilot program will be provided by participating local governmental entities, in order to maximize the availability of federal Medicaid matching funds. S.B. 376 directed HHSC to evaluate the pilot program and report to the 80th Legislature no later than January 1, 2007, on its effectiveness, as well as the feasibility of statewide expansion.

HHSC's research revealed that 12 states directly reimburse Medicaid providers for interpreter services. In most states, language service costs are generally regarded as part of the provider's overhead or administrative expenses. Although traditionally it is the provider's responsibility to arrange and pay for any language interpreter services, Texas does pay for language interpreter services rendered to clients under the two Medicaid managed care models [health maintenance organization (HMO) and Primary Care Case Management (PCCM)]. Texas has greater Medicaid managed care enrollment than most other states, with 65 percent of Medicaid clients enrolled in either an HMO or PCCM. As of October 2006, over a million Texans (1,010,054) were enrolled in the Texas Medicaid managed care program, the State of Texas Access Reform (STAR).

To avoid duplication of services rendered to Medicaid managed care clients, HHSC determined that only fee-for-service populations would be considered under the pilot. HHSC communicated this finding to the hospitals named in the S.B. 376 legislation, and asked the hospitals if they wanted to pursue a pilot only for fee-for-service populations. The hospitals confirmed their continued interest in the pilot, but have requested that HHSC look at the possibility of utilizing a more simple documentation method called a random moment time study (RMTS) approach. HHSC is in the process of seeking approval for this approach with the federal Centers for Medicare and Medicaid Services (CMS).

While the pilot remains feasible, it has not yet been implemented pending negotiation with CMS and the development of contracts between HHSC and the hospitals. The estimated date of program implementation is dependent on CMS direction and contract negotiation. A follow-up report will be provided to the Legislature after the pilot has been in operation for approximately six months, so that HHSC can provide an analysis related to its effectiveness and potential for statewide expansion.

Background

Current Legislation

S.B. 376, 79th Legislature, Regular Session, 2005, requires the Health and Human Services Commission (HHSC) to establish a pilot program to provide Medicaid recipients with oral and written language interpreter services. It further directs HHSC to conduct a study to determine the effectiveness of the program and feasibility of expanding the program statewide.

The pilot program is to be established through local governmental entities, with first priority given to the following entities.

- Harris County Hospital District
- Bexar County Hospital District
- El Paso County Hospital District
- Tarrant County Hospital District
- Parkland Health and Hospital System

S.B. 376 assumes that the pilot will be funded utilizing funds provided to HHSC by participating local governmental entities in order to maximize the availability of federal Medicaid matching funds. A local hospital district can provide funds to HHSC via fund certification or intergovernmental transfer.

Related Texas Legislation

H.B. 3235, 79th Legislature, Regular Session, 2005, requires HHSC to provide interpreter services as requested when providing Medicaid services to Medicaid recipients who are deaf or hard of hearing, or to the parent or guardian of a person receiving Medicaid, if the parent or guardian is deaf or hard of hearing. Provisions of this bill are subject to available funds. HHSC has received verbal guidance from the Centers for Medicare and Medicaid Services (CMS) that a state plan change is not necessary and a billing code already exists that can be used for these services. HHSC is working to implement H.B. 3235, and under the planned program, only physicians with 14 or fewer employees will be allowed to bill for this service. Hospitals will be prohibited from billing for these interpreter services.

Medicaid Program Overview

Medicaid is an entitlement program established under Title XIX of the Social Security Act of 1965. The program is financed by a combination of state and federal funds. Currently, for every dollar spent on the Medicaid program in Texas, approximately $0.60 is paid by the federal government.

To participate in the Medicaid program, the federal government mandates certain benefits that states must provide and optional benefits that states may choose to provide. States have the option to add additional services as well as eligibility categories. There are three primary

categories of Medicaid eligibles in Texas: Families and Children, Cash Assistance Recipients, and Aged and Disabled.

In Texas, Medicaid acute care health benefits are delivered through three primary delivery models: fee-for-service, health maintenance organization (HMO)-provided managed care, and Primary Care Case Management (PCCM)-provided managed care.

With fee-for-service reimbursement, providers receive a payment for each unit of service provided. With an HMO arrangement, the state contracts with the HMO to provide services to certain beneficiaries. The HMO is paid a monthly premium for each person enrolled, based on a projection of what the typical patient will cost. This arrangement is known as a "risk-based" arrangement, meaning that if the cost of care for an enrollee is higher, the HMO may suffer losses, while the HMO profits if the enrollee costs are less. In a PCCM model, each participant is assigned to a primary care provider who must authorize most other services, such as specialty care, before those services are reimbursed under Medicaid. Primary care providers are reimbursed on a fee-for-service basis and also receive an approximately $3 per member per month case management fee.

Interpreter Services in Texas Medicaid

Currently, in Texas, interpreter services are not considered a Medicaid covered service and are not reimbursable as a Medicaid fee-for-service benefit. When a health care professional enrolls as a Medicaid provider, he or she agrees to adhere to the program's federal and state requirements. Specifically, providers must ensure meaningful access to programs and services by ensuring effective communication, including the provision of interpreter services. As a result, it is the provider's responsibility to arrange and pay for interpreter services.

However, under the two managed care models, the state does pay for interpreter services. The state's contracted Medicaid and Children's Health Insurance Program (CHIP) HMOs, as well as the PCCM administrator, are contractually obligated to offer interpreter services for clients who are seeking medical services. These services are incorporated into rates paid by the state to these contractors.

HHSC requires specific language interpreter services from the HMOs in their state contract, the Uniform Managed Care Contract. This contract is available online at www.hhsc.state.tx.us/medicaid/FY2007ManagedCare_1.pdf. Specifically, per the 2007 contract HHSC holds with the HMOs, the HMOs must provide language interpreter services for their member services and hotlines. The HMOs also must provide information on how to obtain interpreter services in the member handbook and provider manual.

PCCM does not have an explicit contract reference addressing the availability of interpreter services for client visits to a provider. However, the PCCM contractor must comply with applicable federal and state law, including provisions specific to managed care organizations participating in the Medicaid program.

The PCCM Member Bill of Rights language mirrors the Texas Administrative Code (TAC), which specifically addresses interpreter services in a provider office setting. TAC Rule 353.202, Member Bill of Rights, states that each managed care organization participating in the state's Medicaid program shall provide to each member an easy to read, written document describing the member's rights, which must include the right to have interpreters, if needed, during appointments with providers and when talking to a health plan. Accordingly, the PCCM member handbook, under "What are my Rights in PCCM?," reads: "You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to... have interpreters, if needed, during appointments with your providers and when talking to your health plan." The member handbook also contains specific information under the heading: "How Do I Get Interpreter Services?"

Health plans, including PCCM, provide information on how to access interpreter services within their provider manuals and member handbooks.

Relevant Federal Requirements and Legislation

Medicaid providers in Texas are subject to Title VI of the *Civil Rights Act of 1964* (Public Law 88-352), Section 504 of the *Rehabilitation Act of 1973* (Public Law 93-112), the *Americans with Disabilities Act (ADA) of 1990* (Public Law 101-336). Title VI of the Civil Rights Act prohibits entities receiving federal funds from discriminating against persons on the basis of race, color or national origin, and requires that "recipients take reasonable steps to ensure meaningful access to their programs and activities by limited English proficient persons." The Rehabilitation Act and the ADA prohibit discrimination against qualified individuals with disabilities, and require providers to offer "auxiliary aids" (including interpreter services) to ensure effective communication.

In addition, the federal Department of Health and Human Services issued "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" on August 8, 2003. This guidance applies to the state and Medicaid health care providers, and reaffirms the requirement to ensure meaningful access to programs and services. It further provides options on how providers should approach offering interpreter services, and delineates how a determination of discrimination will be made by the federal Office of Civil Rights.

What Other States Are Doing

National Health Law has conducted extensive research on how states have utilized federal funds to pay for language services. Their findings are summarized in the document, *Language Services Action Kit: Interpreter Services in Health Care Settings for People with Limited English Proficiency*. The *Language Services Action Kit* contains a useful comparison chart of specific reimbursement models used by states.

The kit reports that 12 states directly reimburse providers for Medicaid interpreter services. In most states, such as Texas, language service costs for fee-for-service clients are considered part of the provider's overhead or administrative expenses. For Texas Medicaid clients in the

managed care programs, language interpreter services are included in the rates paid by the state to the contractors. Of the states that directly reimburse providers for interpreter services, all but two states pay for language services rendered solely to fee-for-service populations. Montana and Washington pay for language services to all populations.

Montana pays for interpreter services provided to Medicaid recipients if the medical service is medically necessary and a covered service. The interpretation service must be provided face-to-face, and the interpreter subsequently files a claim for direct reimbursement.

The State of Washington has built a system to provide interpreter services. Interpreter services are "carved out" from managed care, meaning that these services are not included in the monthly premium payment made by Medicaid to the managed care organizations. This allows the state to draw down federal match for this service across all Medicaid populations.

Implementation Efforts to Date

To develop recommendations for implementing S.B. 376, HHSC conducted research, including an examination of similar programs in other states. States primarily draw down federal matching funds to pay for interpreter services in Medicaid in one of two ways: adding interpreter services as a Medicaid benefit under their State Plan or treating interpreter services as an administrative expense. In consultation with the hospitals named in the legislation, HHSC plans to draw down federal funds as an administrative expense because it does not require CMS approval of a state plan amendment. Drawing down federal funds as an administrative expense allows the state to obtain a 50 percent federal match on the local funds provided by the hospital districts.

In addition, HHSC plans to utilize fund certification rather than intergovernmental transfers as a method of finance. The participating pilot hospitals expressed a preference for this approach. Fund certification, unlike intergovernmental transfers, does not involve the actual transfer of dollars.

States cover a variety of populations with interpreter services, ranging from fee-for-service only populations, to all Medicaid populations. Texas has greater enrollment in Medicaid managed care than most other states, and HHSC's Medicaid HMOs already have contract provisions related to the provision of interpreter services to their members in the 2007 Uniform Managed Care Contract. In addition, the PCCM contractor, the Texas Medicaid & Health Partnership (TMHP), has an obligation to offer members interpreter services when needed. Typically, these services are rendered via a language interpreter hotline.

To avoid duplication of services rendered to Medicaid managed care clients, HHSC determined that only fee-for-service populations would be considered under the pilot. HHSC communicated to the participating pilot hospitals the findings regarding each HMO's contractual obligations to provide its members with interpreter services, and confirmed that the hospitals were interested in pursuing the pilot only for the fee-for-service population.

At the hospitals' request, in June 2006 HHSC provided additional details on proposed documentation requirements. HHSC offered two cost allocation methodologies, each with

differing documentation requirements: 1) a direct charge allocation method, meaning that the contractor must document that the entire cost is completely related to the performance of an allowable activity, or 2) a Medicaid Eligibility Ratio (MER) allocation method. These are the two methods employed in the State of Washington.

Both the direct charge method and the MER approach were deemed administratively cumbersome by the hospitals. The hospitals have requested that HHSC explore the possibility of utilizing a more simple documentation method called a Random Moment Time Study (RMTS) approach.

CMS is in the process of reviewing and approving the RMTS approach for the Texas Medicaid Administrative Claiming (MAC) program. MAC is currently being utilized in Local Independent School Districts, Mental Health Mental Retardation Centers, Early Childhood Intervention Centers and local health departments. A request for offers (RFO) has been posted on the Electronic State Business Daily for potential vendors of the RMTS. Adding S.B. 376 capabilities to the RMTS vendor's responsibilities would constitute a change in the scope of services from the original RFO, and may need to occur via a contract amendment once the vendor contract has been executed, in order to prevent a delay in contract execution.

HHSC is exploring with CMS the possibility of utilizing an RMTS for the pilot. Once HHSC receives CMS guidance regarding the specific cost allocation method to be used, HHSC can proceed with the contract development process with each hospital named in the legislation.

Conclusion

In conclusion, the pilot implementation is feasible, but has not been implemented yet pending negotiation with CMS and contract development and execution between HHSC and participating hospital districts. A follow-up report will be provided to the Legislature once the pilot has been in operation for approximately six months so that HHSC can provide an analysis related to its effectiveness and potential for statewide expansion.