



Medical Interpreter Services in the
Commonwealth of Massachusetts

Standards, Certification, and Financing

Findings and Recommendations of the
Massachusetts Disparities Council
Interpreter Services Working Group

Fall 2010

Acknowledgements

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Executive Summary

In May 2009, the Massachusetts Health Disparities Council convened an expert Interpreter Services Working Group (ISWG) to develop recommendations to enhance the provision of medical interpretation in the Commonwealth. This report represents an extensive body of work conducted by the ISWG and the resulting set of recommendations.

Recognizing the critical importance of seamless communication between providers and patients in clinical settings, Massachusetts requires by law (under Chapter 66 of the Acts of 2000, the Emergency Room Interpreters Law or ERIL), that its 72 acute care hospitals provide competent interpreter services at no cost to all non-English speaking patients who seek emergency care or treatment, 24 hours per day, seven days per week. In crafting the existing mandate, the legislature defined “non-English speakers” as persons who cannot speak or understand, or have difficulty with speaking or understanding the English language because the speaker primarily or only uses a spoken language other than English.

Massachusetts has long been at the forefront of providing medical interpreters services. Of the nearly 6,900 languages spoken in the world, 224 are spoken daily in the United States, and more than 100 are spoken daily in Massachusetts.¹ In 2007, more than 20% of Commonwealth residents at least five years old spoke a language other than English in their home.² In Fiscal Year 2007, MDPH documented that in MA 2,256 trained interpreters completed 1,202,031 sessions.³

Significant challenges have been encountered across the nation regarding state-specific regulations to certify medical interpreters, financing of these services, and development of and adherence to uniform standards of practice. Several professional organizations and coalitions have been established to represent the interests of medical interpreters and to advocate for continued development and validation of the relatively nascent field. The Massachusetts Medical Interpreters Association, now known as the International Medical Interpreters Association (IMIA), the National Council on Interpreting in Health Care (NCIHC), and the California Healthcare Interpreting Association (CHIA) are among the more notable.

The CHIA and IMIA have developed Standards of Practice and a Code of Ethics specific to their states, and in 2005 the National Standards of Practice for Interpreters in Health Care were

established, and framed around a National Code of Ethics. In 1993, the Washington Department of Social and Human Services began certifying medical interpreters. The IMIA, CHIA, and the NCIHC have tried to follow suit by piloting a tool for certification of medical interpreters. In November 2009, the first national certification was launched by the National Board of Certification for Medical Interpreters, an entity founded by the IMIA and Language Line University (LLU).

Reimbursement for medical interpreter services is possible through Medicaid and State Children's Health Insurance Program (SCHIP) funding, and is provided in twelve states and the District of Columbia. Massachusetts has not separately funded medical interpreters through SCHIP or Medicaid since Fiscal Year 2005 when interpreter services funding streams were bundled into provider payment rates under Chapter 58 reform. Similar to the public payer approach, many private payers in Massachusetts include interpreter services funding in the overall provider payment negotiated rates. Many managed care and private insurance vendors recommend, if not mandate, access to interpreter services, but few provide direct reimbursement for these services. Many hospitals recuperate the costs associated with the provision of medical interpreter services in the negotiated or contracted rate. This could be accomplished through administrative overhead or negotiated payment structures with both public and private payers.

Recommendations of the Interpreter Services Working Group

I. Develop Uniform Standards of Practice

Strengthen the Massachusetts Department of Public Health's Best Practices Recommendations for Hospital-based Interpreter Services Guidance (2001) and issue an MDPH circular letter to all hospitals and affiliated health clinics regarding use of uniform standards for training and evaluation of medical interpreters.

II. Achieve Certification of Medical Interpreters

Issue an MDPH circular letter to all hospitals and affiliated health clinics, further defining the qualifications and training for "competent interpreter services" and issue a strong recommendation for the use of certified medical interpreter services.

III. Finance Medical Interpreter Services

Medical interpretation services should be taken into consideration as the Commonwealth moves away from a fee-for-service payment model and develops Accountable Care Organizations (ACOs) and global payment methods. The cost of interpreter services should be considered in the development of payments.

Introduction

In 2007 the Massachusetts Legislative Commission to End Racial and Ethnic Health Disparities, under Chapter 65 of the Acts of 2004, put forth three recommendations pertaining to access to and quality of **medical interpreter services** as part of its final report and blueprint:

1. Develop and implement statewide regulations to certify medical interpreters.
2. Develop uniform standards for delivering interpreter services in all health care settings. Standards should be modeled after the national standards developed through the National Council on Interpreting in Health Care (NCIHC).
3. Develop and implement procedures for reimbursement for interpreter services by all payers, public and private. The Department of Public Health should review the procedures used in other states including the model programs in the states of Maine and Washington and make recommendations for implementing programs in Massachusetts.

The Massachusetts Secretary of Health and Human Services and in consultation with the Massachusetts Health Disparities Council and the Office of Health Equity of the Massachusetts Department of Public Health facilitated an Interpreter Services Working Group that has contributed to the following report and promulgated a set of recommendations to enhance the practice and delivery of medical interpretation. This work is also responsive to recommendations from the 2007 Commission to End Racial and Ethnic Health Disparities report.

Medical Interpretation and Linguistically Appropriate Services

Despite long-standing recognition of the significant disparities that exist in healthcare access and outcomes for racial and ethnic minorities, non-English speaking and limited English proficient speakers continue to represent a disproportionate fraction of the negative health quality metric.^{4, 5} Minorities represent 30% of the United States populations and are the fastest growing segment, projected to exceed 50% by the year 2056.⁶ More than 46 million Americans designate a native language other than English, and estimates suggest that there are nearly 6,900 languages spoken in the world - 224 spoken daily in the U.S.¹ Increased emphasis on culturally and linguistically appropriate services is thus vital for the success of the U.S. healthcare system. Title VI of the Civil Rights Act of 1964 states that “no person in the United States shall, on the ground of race, color, and or national origin, be excluded from participation in, be denied benefits of, or be subjected to under any program or activity receiving federal financial assistance.”^{7, 8} Lau v Nichols (1974) stipulates that Title VI protect discrimination

based on language as indistinguishable from national origin. Additional state and federal legislation further stipulate that patients (or clients) be treated in their preferred language.^{7,8,9}

Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency of 2000, requires all federal agencies to examine the services they provide, identify any need for services to those with limited English proficiency (LEP), and develop and implement a system to provide those services so LEP person can have meaningful access to them. In 2002, the U.S. Department of Health and Human Services (DHHS) revised the infrastructure for such protections, designating responsibility to the Office of Civil Rights. This LEP guidance document established the **four-factor analysis** for consideration when designing systems for the provision of language access services:

1. The number or proportion of LEP persons eligible to be served by the program or likely to be encountered,
2. The frequency of contact persons who are LEP might have with the program,
3. The nature and importance of the service provided,
4. The resources available to the grantee/recipient and costs.

Furthermore, protections were provided such that “No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.”

Medical Interpretation in Massachusetts

Massachusetts has long been at the forefront for high-volume medical interpretation. Foreign-born persons, many of whom are of limited English proficiency (LEP) account for more than 14% of the Commonwealth’s population and represent the fastest growing demographic, having increased by 18% between 2000 and 2008. According to the 2005 American Community Survey, “more than 20% of the Commonwealth’s residents five years of age and older spoke a language other than English at home; of this population, 44% spoke English less than *very well*.”

Over the past two decades, Massachusetts has provided high quality culturally and linguistically appropriate care to its highly diverse LEP population, the need for which has been rigorously demonstrated. As previously described, patients who need interpretation but do not receive

adequate services have decreased health outcomes, are less likely to seek care in the future, and incur more cost to the system. Providing appropriate high-quality interpreter services is an imperative for all clinicians and access must be so protected by federal and state legislation, as Massachusetts has demonstrated.

The Commonwealth has pioneered this field, as highlighted by the establishment of the first professional organization of medical interpreters, the International Medical Interpreters Association (IMIA) (formerly the Massachusetts Medical Interpreters Association). The IMIA was the first body to establish ethical guidelines and to publish evidence-based recommendations for best practices. Furthermore, Massachusetts has had the highest concentration of medical interpreters in the United States since 1989. For more than two decades, all Massachusetts hospitals transferring ownership or expanding capacity have been assessed for infrastructure for providing access to those of limited English proficiency under the innovative Determination of Need (DoN) program. In 2000, the Massachusetts Legislature enacted Chapter 66 of the Acts of 2000 – the Emergency Room Interpreters Law (ERIL). ERIL requires that “every acute care hospital...provide competent interpreter services in connection with all emergency room [and Mental Health] services provided to every non-English speaker who is a patient or who seeks appropriate emergency care or treatment.”

In November 2008, the Office of Health Equity (OHE) of the Massachusetts Department of Public Health (MDPH) published its first annual report of hospital interpreter services (HIS) in the 72 Massachusetts acute care hospitals. The Commonwealth provides high-volume, high-diversity interpreter services. During the Fiscal Year 2007 (FY07), 1,202,031 sessions were completed by 2,256 trained interpreters: 80% were face-to-face contacts, 20% were telephonic, and 15% were in Emergency Departments with a large seasonal volume shift in areas of LEP worker migration. Over 100 languages are translated in Massachusetts, with 94% of sessions being Spanish, Portuguese, Russian, Chinese, Haitian Creole, Cape Verdean, Vietnamese, Arabic, American Sign Language (ASL), and Albanian translations; 95% of Massachusetts hospitals use a combination of modes of interpretation to provide comprehensive services. All 72 hospitals contract with at least one telephonic vendor. *

*For detail on variation (regional, hospital size, community-type) see *Interpreter Services in Massachusetts Acute Care Hospitals Report* (www.mass.gov/dph/healthequity).

Existing State Law, Regulations, and Guidance

In 2001, Massachusetts Department of Public Health (MDPH) amended its hospital licensure regulations (105 CMR 130.1102–1108, to implement G.L. c.111 §25J) to improve interpreter services in the Commonwealth. The changes became effective July 2001. Concurrently, MDPH convened an expert panel to develop and issue a guidance document styled *Best Practice Recommendations for Hospital Based Interpreter Services*. The MDPH regulations and guidance outlined the essential structure and components for meeting both the spirit and letter of the law. Thus, all Massachusetts acute care hospitals must:

- Identify a coordinator for interpreter services.
- Have policies and procedures in place for the provision of interpreter services and update as needed.
- Conduct an annual language needs assessment.
- Have a quality assurance process for interpreter services.
- Post notices at key points of entry regarding the availability of interpreter services at no cost.
- Provide 24/7 access to interpreters.
- Refrain from using families and friends as interpreters and prohibit the use of minors.
- Assure the quality of interpretation services and offer ongoing training to interpreters (continuing education).
- Collect data on the language in which patients prefer to discuss their health-related concerns.
- Ensure the translation of vital documents.

The existing state statute and MDPH regulations require acute care hospitals to use "competent interpreter services" which the statute and regulations define as a person who is

- fluent in English and in the language of a non-English speaker,
- trained and proficient in the skill and ethics of interpreting, and
- knowledgeable about the specialized terms and concepts that need to be interpreted for purposes of receiving emergency care or treatment.

Presently, there is neither statutory nor regulatory requirement that hospitals use a person who is certified.

The Interpreter Services Working Group

In 2007 the Massachusetts Legislative Commission to End Racial and Health Disparities under Chapter 65 of the Acts of 2004 acted upon the recognition that Massachusetts could improve the quality, cost, and accessibility of language access services by calling for the Massachusetts Department of Public Health to recommend *public policy and best practices for the delivery of interpreter services to patients with Limited English Proficiency*. Under the direction of the Executive Office of Health and Human Services and the Health Disparities Council, the MDPH Office of Health Equity engaged an expert working group representing allied stakeholders from across the Commonwealth.

The Interpreter Services Working Group (ISWG) was tasked with promulgating recommendations to:

1. Develop **uniform standards** for delivering interpreter services in health care settings. These standards should be modeled after the national standards developed through the National Council on Interpreting in Health Care (NCIHC).
2. Develop and implement statewide regulations to **certify medical interpreters**.
3. Develop and implement procedures for **reimbursement for interpreter services** by all payers, public and private. The Department of Public Health should review the procedures used in other states including the model programs in the states of Maine and Washington and make recommendations for implementing programs in Massachusetts.

From September 2009 through April 2010, the ISWG held six full-panel meetings to review the state of medical interpretation both nationally and in the Commonwealth, to review current national standards and Massachusetts best practices, and hear from and discuss issues and process with representatives from the National Board of Certification for Medical Interpreters – the first national certification entity. Additional meetings and considerable work were divided among core staff of the MDPH Office of Health Equity as well as members of the ISWG, with monthly guidance provided by the Health Disparities Council.

Recommendations of the Interpreter Services Working Group

The ISWG offers the following recommendations intended to further the vision that every resident of the Commonwealth have access to high quality health care services irrespective of language proficiency. These recommendations were drafted to ensure that all patients are provided medical interpreter services that are of uniform excellence and subject to the rigor of analysis of best practices. This requires the development of a highly trained workforce capable of delivering high quality interpretation in a health care setting. Financial structures must not be an obstacle to the receipt of care, nor to interpreters' ability to develop a highly skilled sector reflective of patients' and providers' needs. We thus offer three recommendations to address **Uniform Standards of Practice, Certification of Medical Interpreters, and Financing of Medical Interpreter Services.**

Recommendation 1: Develop Uniform Standards of Practice

Strengthen the Massachusetts Department of Public Health's Best Practices Guidance and issue an MDPH circular letter to all hospitals and affiliated health clinics regarding use of uniform standards for training and evaluation of medical interpreters.

By July 1, 2011, institutions[†] required to provide medical interpretation in MA under G.L. c.111 §25J must train and evaluate the medical interpreter staff using one of the following nationally recognized standards: the California Healthcare Interpreters Association (CHIA), the International Medical Interpreters Association (IMIA), or the National Council on Interpreting in Health Care (NCIHC) or equivalent nationally recognized standards as approved by the Commissioner of Public Health.

Rationale

In developing recommendations regarding uniform standards of practice, the ISWG examined best practices, standards, and documents of ethical conduct developed by MDPH, CHIA, IMIA, and NCIHC. Furthermore, the ISWG had extensive discussions with the President of IMIA as well as a physician-member of that organization. The Massachusetts Department of Public

[†] Acute Care Hospital Emergency Departments, Hospitals with maternity and newborn services, and Limited Services Clinics

Health-Office of Health Equity (MDPH-OHE) currently applies the standards developed by the International Medical Interpreters Association. In addition, in 2001, Best Practices Recommendations were developed by MDPH under the direction of Brunilda Torres, LICSW, in consultation with experts and stakeholders from across the Commonwealth. In keeping with the understanding that each institution must design a program as appropriate to best serve its patient population, the recommendations are intended as broad-reaching perspectives – there are, however, five core characteristics necessary for successful program design and implementation:

1. The program is structured rather than ad hoc, with comprehensive written policies and procedures
2. The program includes regular, systematic assessment of the language needs of people in the service area;
3. The program uses the community needs assessment and an assessment of its own resources in determining what types of oral language assistance to include in its delivery system;
4. The program establishes specific training and competency protocols for both interpreters and providers; and
5. The program has a monitoring and evaluation system in place.

Policies and Procedures Pertaining to Interpreter Training and Competence

“The best way to ensure competent interpretation is through standardized interpreter training and evaluation. This will help minimize the risk of error that may occur with ad hoc interpretation, such as deletions, additions, inaccuracies, misrepresentations and distortions of the intended message, which can be complicated by the fact that neither the patient nor the provider is able to judge the quality of interpretation. Competent interpreter services can help avoid unneeded testing, misdiagnosis, and inappropriate treatment for the patient, liability for the provider, and increase access to care, patient satisfaction, and patient follow-up.”¹⁰ Massachusetts requires all hospital interpreters to undergo 54 hours of training prior to being employed as such, as per ERIL (Chapter 66 of the Acts of 2000). Training should include: the impact of language barriers, procedures surrounding the request of interpreter services, skills for providers on working effectively with interpreters (on-site and telephonic), the challenges of interpretation and the dynamics of such a triadic relationship, legal and ethical issues, and integration of skills in cross-cultural competency.

ISWG Consensus

Consensus among ISWG members was to support the use of currently available, professionally and nationally recognized standards put forth by the California Healthcare Interpreting Association, the IMIA, and the National Council on Interpreting in Health Care.

Consensus among ISWG members was professional standards and codes are best promulgated and monitored through established professional associations, similar to other allied medical professions and that state government should not develop its own professional standards or codes of ethic for medical interpreters. At the time of the writing of this report, there were three nationally recognized organizations that have put forth standards of practice and codes of ethic for medical interpretation: CHIA, IMIA, and NCIHC.

A side-by-side comparison of the standards showed that all three associations have very similar, if not overlapping, principles – and hence, are uniform in practice and embody the principles put forth by the MDPH in 2001 – Best Practices Recommendations for Hospital-based Interpreter Services (www.mass.gov/dph/healthequity). They also provide similar core competency expectations only differing in the level of explanation, discussion, or the format in which they are presented. In addition, it was recognized by ISWG members that over two decades of work by experts and professionals in the area of language access has resulted in the promulgation of these commonly referenced and adopted standards.

The language in the recommendation explicitly names the three national organizations. The recommendation also recognizes that other national groups may evolve and produce their own standards. Appropriate development and application of such documents may lead to the future expansion of these recommendations.

These standards [noted above] should be identified in policy and procedural documents established by each institution. Current DPH hospital licensure regulations require each acute care hospital to develop written policies and procedures for interpreter services (105 CMR 130.1102) and to provide ongoing training and education (105 CMR 130.1106), but do not mention CHIA, IMIA, and the NCIHC. DPH is poised to issue a circular letter clarifying its requirements to bring more uniformity and high quality to the training component, with giving adequate flexibility to institutions.

Recommendation 2: Achieve Certification of Medical Interpreters

Issue an MDPH circular letter to all hospitals and affiliated health clinics, further defining the qualifications and training for “competent interpreter services” and issue a strong recommendation for the use of certified medical interpreters.

By January 1, 2013, it is expected that institutions required to provide medical interpretation in MA under G.L. c.111 §25J will have voluntarily integrated certified medical interpreters whether employed, contracted or used, whether full-time or part-time, whether paid or unpaid volunteers, and whether on-site or via remote telephonic into their practices and certified by the National Board of Certification of Medical Interpreters (NBCMI) or equivalent certification body as approved by the Commissioner of Public Health in consultation with the Office of Health Equity and the Division of Health Care Quality.

By January 1, 2015, these institutions must ensure that individuals who interpret for the deaf and hard of hearing are certified by the National Registry of Interpreters for the Deaf or an equivalent body as approved by the Commissioner of the Department of Public Health, in consultation with the Commissioner for the Commission for the Deaf and Hard of Hearing.

To be approved as being “equivalent” the standards and processes used by another board for certification must be as stringent and as precise as the standards and processes for certification used by the entities specified above.

In addition, the state should consider periodic review the national certification and ensure it is keeping pace with MA-specific language needs and the MA workforce of nationally certified medical interpreters.

MDPH will monitor for a two year period, ending January 2013, through the Office of Health Equity, the rate of adoption of the use of certified medical interpreters by hospitals and affiliated health centers. In the event low adoption occurs, where adoption of the use of certified Medical Interpreters by hospital is not in proportion to the rate of certification in the state, MDPH may amend its hospital licensure regulations to require all hospitals and affiliated health centers to use certified medical interpreters.

Rationale

In developing recommendations regarding certification of medical interpreters, the ISWG examined a detailed history of pertinent initiatives. Certification of interpreters has been extensively explored and systems developed in the courts (federal and state), including the National Center for State Courts' National Consortium for State Court Interpreter Certification (NCSCIC), and the certification of the National Association of Judiciary Interpreters and Translators (NAJIT). The ISWG then explored the certification programs of the Registry of Interpreters for the Deaf (RID), which has long offered *Generalist* and field-specific *National Interpreter Certifications*. Furthermore, the ISWG detailed a for-profit model of private medical interpreter certification (Language Line LLC), as well as the one existing model of public medical interpreter certification (Washington State Department of Social and Health).

Each of the aforementioned four models was investigated through archival information and telephone conversations. These investigations had seven primary components: certifying body, fields of certification, regulation, certification process, overview of the examination, validity, and potential deficits. Cost and other pertinent perspectives were shared where available. Knowledge of previous attempts in various local environments, with additional timing, resource, motivation, and outcome information, enabled a deeper level of evaluation by the ISWG. Finally, the ISWG met with leaders of the National Board of Certification for Medical Interpreters (NBCMI), the first validated and piloted certification program, which began testing in Fall 2009.

Similar to the process undertaken to develop standards for medical interpreters/interpretation, many years and involvement by numerous experts in the field has resulted in NBCMI's release of standards for its board certification program. It has been reported that the NBCMI board certification program has undergone rigorous psychometric analysis and field piloting.[‡] Alternate pathways such as 'Grandfathering' (certification by virtue of practice experience) of currently practicing medical interpreters will be at the prerogative of NBCMI. In addition, and at present, this certification process ensures the availability of mechanisms to "screen" interpreters of languages of lesser diffusion (languages not frequently encountered) thereby assuring a level of proficiency in those languages as well.

[‡] Psychometrics: The branch of psychology that deals with the design, administration, and interpretation of quantitative tests for the measurement of psychological variables such as intelligence, aptitude, and personality traits. Also called *psychometry*

Massachusetts recognizes the opportunity to glean pertinent information from the national certification and the process. The Commonwealth is also committed to ensuring the delivery of quality medical interpretation by qualified, trained and certified individuals. The MDPH will closely monitor the rate at which medical interpreters are being certified in the state as well as the rate at which interpreter services departments in Massachusetts-based hospitals are integrating certified medical interpreters into their practices. A 2-year look, ending January 2013, will allow the Department to determine whether voluntary adoption has been reasonable and should continue or whether more stringent requirements need to be put in place through amended hospital regulations.

ISWG Consensus

ISWG consensus is that it is not necessary for Massachusetts to develop a professional licensure/certification process that is different than the national process. Firstly, it would take several years for MA to develop and test prior to launching. Secondly, there is the investment of human and financial resources that is not warranted at this time to duplicate an already well-documented process. Thirdly, prior experience with state-developed efforts suggest that housing this process in a state agency or creating a new MA professional licensure board is an inappropriate utilization of resources and will hinder efforts to improve quality and competence of our medical interpreter workforce.

For the same reasons and after consultation with the Commission for the Deaf and Hard of Hearing, the ISWG is recommending that hospitals hire interpreters with certification from either NBCMI or the National Registry of Interpreters for the Deaf.

For future consideration, the Council and Commonwealth could explore the potential for instituting a state registration process for medical interpreters. Registration would facilitate the development of a State-domain repository of all certified medical interpreters who are practicing in MA, similar to the registry within the Commission for Deaf and Hard of Hearing (see, G.L. c.6 s.196). Registration could entail requiring practicing medical interpreters to produce a certificate along with other required documents, such as proof of a minimum number of hours of cultural competency training, a minimum number of Continuing Education Units annually, etc. Interpreters not residing in Massachusetts (telephonic) would also be held subject to requirements of MA registration.

Recommendation 3: Finance Medical Interpreter Services

Medical interpretation services should be taken into consideration as the Commonwealth moves away from a fee-for-service payment model and develops Accountable Care Organizations (ACOs) and global payment methods. Separate and full reimbursement for this service should be analyzed by the Division of Health Care Finance and Policy for the financial impact and efficacy of such a mandate.

Rationale

In developing recommendations regarding the reimbursement for medical interpreter services, the ISWG examined existing research on the use of interpreter services, including reports conducted by the Centers for Medicare and Medicaid (CMS), the American Academy of Family Physicians, and the American Medical Association. In addition, the ISWG received input from both public and private payers regarding how reimbursement for interpreter services is currently treated by payers operating in Massachusetts. A summary of the existing research follows; however, the ISWG's recommendations are based on the current landscape in Massachusetts and with deference to the state's payment reform efforts, which include the development of ACOs and moving to global payment methods. Additionally, based on the ISWG's research, the ISWG learned that both public and private payers include reimbursement for interpreter services in the negotiated rate paid to contracted providers and hospitals.

Existing Research

In 2000, the Centers for Medicare and Medicaid (CMS) renewed their commitment to funding interpreter services as an administrative cost or elective covered service under Medicaid and State Children's Health Insurance Program (SCHIP) funding streams. Currently, twelve states (Hawaii, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Vermont, Virginia, Washington, and Wyoming) provide reimbursement, along with the District of Columbia. Texas, North Carolina, and California are in discussions (all have established working groups or task forces) of reimbursement programs coupled with certification or standardization of interpreter services.

From 2002-2005, Massachusetts directly reimbursed language services for Medicaid patients in emergency departments and in-patient psychiatric facilities. This service was not protected by Chapter 58 reform, with interpreter services funding streams bundled into provider payment rates ("considered part of doing business"). Disproportionate Share Hospital funds (formerly

covered interpreter services) were transitioned into the Health Safety Net. For uncompensated care, hospitals can currently include interpreter services as a metric for determination of Medicaid rates. In FY2005, the last year of Medicaid interpreter fund disbursement, \$1.1million was appropriated for emergency room and in-patient psychiatry interpreter services.¹¹

According to the American Academy of Family Physicians, “payment for interpreter services in both publicly- and privately- funded health care systems must be the responsibility of the insuring or purchasing entity...both public and private HMOs and health plans should be asked to take explicit responsibility for paying and arranging for interpreter services as a covered benefit for members with the caveat that such services are the responsibility of the primary financial entity (HMO or purchaser) and are not to be born by fiscal intermediaries such as local medical groups or physicians and other health professionals, unless they have explicitly contracted for the provision of such interpreter services.”

The American Medical Association holds similar views. The American College of Physicians asserts, “[comprehensive] coverage under Medicaid, Medicare, and SCHIP is particularly warranted.” Currently more than 2.4 million Medicare- enrollees are of LEP, but Medicare does not reimburse for language services. The results of this are three fold: 1) other insurers are less likely to cover interpreter services (Medicare, not Medicaid, is considered a high-quality government insurance program and is often used as a heuristic method for payment structures); 2) a disparity gap may be perpetuated for seniors who are of LEP, and 3) this may undercut enforcement of Title VI of the Civil Rights Act.

Third-party reimbursement has been highly correlated with greater use of professional interpreters.¹² An encouraging 2002 report of the Office of Management and Budget (OMB) estimated that the added cost of interpreter services for all LEP persons would be only \$4.04 per visit (0.5% of the average cost of care in 2002).^{§13} This cost is significantly smaller than the racial and ethnic cost-gap disparity (estimated to be 20-60% between Latinos/Asians and non-Latino whites).¹⁴ The burden of cost must be shifted, especially off of out-patient primary care providers who do not have the overhead nor payment structure capability to absorb such expenses. This is particularly true in resource-poor settings and in small or solo practices.¹⁵

[§] This is based on an estimate of interpreter compensation of \$20-26/hour – in person, and \$132/hour – telephonic. The total annual budget would be \$268 million. This does not discount for services already provided.

ISWG Consensus

The landscape in Massachusetts differs from other states in terms of payment for interpreter services. ISWG members representing both public and private payers indicated that reimbursement for this service is generally included in the negotiated reimbursement rate with providers. Some hospitals integrate costs as a metric of determination of payment rates, however specific data is not readily available.

The ISWG also reviewed the following four models of payment structure that shaped the deliberations of the ISWG proposed by Ku and Flores (2005): 1) insurance payment directly to interpreters, 2) federal/state funding of community language banks (who would be contracted by insurers), 3) expansion of existing reimbursement infrastructure such that codification exists for LEP persons, and additional payment is required from insurer (federal, state, or private), or 4) insurance companies could contract with telephonic services for all their enrollees.

Since these services are included in provider reimbursement rates, ISWG members caution against pulling out this one specific service for separate reimbursement. Separate reimbursement would be at odds with the Commonwealth's view on payment reform which includes a move away from the fee-for-service model to a global budget model. To keep the recommendations in line with payment reform, the ISWG recommends that interpreter services be taken into consideration as the Commonwealth develops the global payment structure and the capabilities of ACOs.

To the extent that providers remain in fee-for-service payment structures, the ISWG recommends that any mandate to separately reimburse for this service be referred to the Division of Health Care Finance and Policy for financial analysis, efficacy review, and examination of how this service is reimbursed.

Conclusion

At the core of the work of the *2005 – 2007 Commission to End Racial and Ethnic Health Disparities* were three fundamental understandings:

- 1) Health disparities stem from social arrangements historically rooted in interpersonal and institutional racism. These arrangements have an active legacy in the present.
- 2) There are multiple causes of health disparities. Single sector approaches, whether aimed at larger social conditions, health care services, or patient education and behavior, will not suffice. Only a comprehensive approach can lead to the elimination of health disparities.
- 3) Eliminating health disparities requires political will and coordinated oversight to ensure that gains are both substantive and sustainable.¹⁶

These basic principles resulted in the Commission putting forth a comprehensive set of recommendations upon which to base subsequent work related to eliminating racial and ethnic disparities in health in the Commonwealth of Massachusetts. With this as the context, the Interpreter Services Working Group on behalf of the MA Health Disparities Council promulgated cogent, client-centered, industry efficient recommendations to guide the practice of medical interpretation in the state.

In addition to the Commission's report, the 1st Annual Hospital Interpreter Services (HIS) Report (Nov. 2008) produced by the MA Department of Public Health, Office of Health Equity, highlighted that Massachusetts hospitals have developed unique organizational structures to accommodate interpreter service departments and have made advancements in the area of interpreter services. The report concluded that the Commonwealth lacked the regulatory mandate to ensure competent training which can impact the effectiveness and quality of services. It recommends that measures and standards be adopted and appropriate oversight conducted that assures and improves the quality of language services.

As a result, the ISWG endeavored to ensure that its recommendations are **1) actionable, 2) achievable, 3) measurable, 4) equitable, and 5) cost-effective.** In addition, the recommendations account for the current environment in which medical interpretation is practiced, is in alignment with the advancements underway, and presents a method that provides sufficient flexibility for adoption. The ISWG's recommendations ultimately provide the mechanism for making the blueprint provided by the Commission to End Racial and Ethnic Health Disparities operational.

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