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HOW CAN STATES GET FEDERAL FUNDS TO HELP PAY FOR LANGUAGE SERVICES FOR MEDICAID AND SCHIP ENROLLEES?

Federal funding to help states and health care providers pay for language services is primarily available through Medicaid and the State Children's Health Insurance Program (SCHIP).[1] This federal funding offers states a valuable opportunity to help providers ensure language access. However, the programs have technical requirements and vary from state to state. This document provides a brief overview to assist you in evaluating the best way for your state to offer language services reimbursement. For specific information on your state, *see* http://www.statehealthfacts.kff.org/.

What are Medicaid and SCHIP?

Medicaid and the State Children's Health Insurance Program (SCHIP) are health insurance programs for certain low-income individuals operated jointly by the federal and state governments.[2] Both programs operate as federal-state partnerships – they are jointly administered and jointly funded. Medicaid provides health insurance to over 44 million individuals, SCHIP to over 3 million.

To be eligible for Medicaid or SCHIP, you must be low-income and fit within an eligible group. Medicaid primarily serves four groups of low-income Americans: the elderly, people with disabilities, parents and children. Medicaid is an "entitlement" program – everyone who meets the eligibility requirements must be provided health care and has the right to obtain needed services in a timely manner. SCHIP primarily covers children and sometimes others. such as parents and pregnant women. SCHIP is not an entitlement – its funding is limited to pre-set amounts determined by Congress.

How does the federal government pay its share of Medicaid and SCHIP costs to the states?

The federal government pays states in three ways for their Medicaid and SCHIP expenses:

- ***Covered Service*** – States get federal reimbursement for "covered services" provided to enrollees, such as a visit to a doctor or in-patient hospital stay. States must cover certain "mandatory" services, but they also have the option of covering certain additional services, such as language services.
- ***Administrative Costs –*** States also get federal funds to assist with the administrative costs of the program (e.g. costs of staff to determine eligibility and oversee contracts, and computer costs).
- ***Disproportionate Share Hospitals –*** States also get federal funding for payments made to "disproportionate share hospitals" – hospitals that serve a disproportionate share of Medicaid and uninsured patients.[3]

Why can states get (draw down) federal reimbursement for language services?

In 2000, the Centers for Medicare & Medicaid Services (CMS), a part of the federal Department of Health and Human Services and the agency overseeing Medicaid and SCHIP, reminded states that they could obtain federal "matching" funds for language services provided to Medicaid and SCHIP enrollees. In a letter to state health officials, CMS reminded states that

> Federal matching funds are available for states' expenditures related to the provision of oral and written translation administrative activities and services provided for SCHIP or Medicaid recipients. Federal financial participation is available in State expenditures for such activities or services whether provided by staff interpreters, contract interpreters, or through a telephone service. [4]

Why don't all states cover language services for Medicaid/SCHIP enrollees?

While each healthcare *provider* who receives federal funds must provide meaningful language access, *states* do not have to reimburse providers for these expenses. Each state determines if and how it will provide reimbursement for interpreters. Individual providers cannot seek reimbursement unless their state has set up a mechanism to do so. Only twelve states and the District of Columbia directly reimburse providers for language services.[5] States have an obligation, however, to ensure language access at Medicaid and SCHIP eligibility offices.

The reasons states do not offer direct reimbursement vary, and you may need to take different steps to educate policymakers depending on the reason in your state. For example, some state officials do not know that federal funding is available. Informing them may be sufficient to build their interest in offering reimbursement. Faced with tight budgets, some states may not designate state funds to pay their share of the Medicaid/SCHIP match. In these states, you may want to educate policy makers about the costs of non-compliance with federal requirements (such as Title VI), and the indirect costs of not providing language assistance to LEP patients (such as more medical errors, reduced quality of care, and unnecessary diagnostic testing). Finally, some states view language services as part of providers' costs of doing business, and bundle the cost of language services into the providers' general reimbursement rates, regardless of providers' actual costs. In these states, changing state policies may require providing information about the utilization of language services, the actual costs of interpreters, and why a bundled payment rate is insufficient to cover these costs.

How much would my state get from the federal government for language services?

This depends on the state, the program, and how the state chooses to be reimbursed.

Covered Services -- For covered services, the state pays part of the costs and the federal government pays the remainder. Each state has a different federal "matching" rate – that is, the percentage of the provider reimbursement for which the federal government is responsible. The federal contribution varies from 50% to 83%, depending upon a state's per capita income (states

with higher per capita income receive less federal funding). States also have different matching rates for Medicaid and SCHIP; SCHIP services are reimbursed at a higher rate. For example, Iowa receives a 63.50% federal match for Medicaid services and 74.45% for SCHIP services. For information on your state, *see* Kaiser Family Foundation's State Health Facts Online, http://www.statehealthfacts.kff.org/.

Administrative Costs **--** Some states may choose to cover the costs of language services as an administrative expense, rather than as a covered service. For administrative expenses, all states receive a 50% federal match for both Medicaid and SCHIP.[6] In SCHIP, however, states can only spend 10% of their total federal allotment on administrative expenses. For states that are at or near their 10% administrative cap, it may thus be preferable to consider language services as a "covered service" rather than as an administration expense.

How does my state start drawing down federal reimbursement for language services?

Covered Services **--** States that wish to get federal funding as a "covered service" must add language services to their Medicaid "state plan." The state plan is the document that outlines how each state's Medicaid program works, including what services it covers. The state must submit this request – a "state plan amendment" or "SPA" – to CMS. Until a service is added to the "state plan" and approved by CMS, the state cannot receive federal reimbursement. In many states, because of the financial costs of covering a new service, the state legislature must approve the SPA prior to submission to CMS.

Administrative Costs **--** States that seek reimbursement for language services as an administrative expense do not need prior CMS approval. Thus, while the federal matching rate for administrative expenses may not be as high as the rate for covered services (e.g. 50% as opposed to 63.5% for Medicaid covered services in Iowa), a state may choose this option because it is easier to implement. However, this decision is also affected by the differing matching rates for Medicaid and SCHIP. In some states, the federal matching rate for Medicaid covered services is 50%, the same as for administrative expenses. In these cases, the state does not have a financial incentive to add a covered service to its Medicaid state plan. But while a state's Medicaid matching rate might be 50%, its SCHIP rate is always higher, at least 65%. In addition, states are not allowed to spend more than 10% of their SCHIP allotment on administrative expenses. So deciding to cover language services as an administrative expense in SCHIP may produce fewer federal dollars, and also create conflicts with other administrative priorities.

Disproportionate Share Hospital Costs **--** States can also use federal funding available for "disproportionate share hospitals" (DSH) – that is, hospitals that serve a disproportionate share of Medicaid and uninsured patients – to help pay for language services. States determine which hospitals are considered DSH and how much funding to distribute to them. States could consider a hospital's language services expenses in determining the allocations of DSH money.

Which providers can get reimbursed for language services?

Each state determines which Medicaid and SCHIP providers can obtain reimbursement. States may choose to reimburse all providers or only some —for example, only "fee-for-service"[7] providers, or hospitals, or managed care organizations. Most states that provide reimbursement do so for fee-for-service providers. Two states reimburse hospitals. One state has added money to the "capitation rate" it pays to managed care organizations for each enrolled patient to cover the costs of providing interpreter services.[8]

The decision of which providers to reimburse will vary state by state. Factors to consider include whether a provider uses a staff member or contract interpreter, whether staff interpreters interpret full-time or have other job responsibilities, and whether bilingual providers are competent to provide services in a non-English language and should be compensated for their language skills.

How can my state reimburse providers who receive pre-set rates for services?

Some states set payment rates that "bundle" all of the costs of providing services to a patient into a single fee; the fee includes the costs of medical tests or procedures, as well as of other services and items – for example, consultation, medical supplies and medications. The payment rate also includes reimbursement for a share of the facility's overhead costs – salaries, utilities, maintenance of physical plant, etc. Such bundling is particularly common for inpatient hospital services. The federal Medicare program bundles fees into "diagnosis related groups," or DRGs. Some states pay for inpatient hospital stays based on DRGs, while others pay on a per-case or per-diem basis. The cost of language services is implicitly included in whatever bundling method a state employs. For other health care providers, such as doctors operating small group practices, many states include all administrative and overhead costs – including language services – in the provider's payment rate. Federally qualified health centers receive bundled payments through a "prospective payment system," an advance payment that estimates the health centers' costs.

Since states set the Medicaid/SCHIP payment rates for each service, states can modify the rates to add on direct reimbursement for interpreters when they are used.[9] States can have a separate "billing code" with a payment rate specifically for interpreters – each time a provider uses an interpreter, the provider receives both the payment rates for the covered service and for the interpreter. States can also add a "modifier" for an existing rate – each time a provider uses an interpreter, the modifier increases the payment rate by either a percentage or a specific amount. The rates or modifiers can vary by language (frequently encountered versus less frequently encountered), type of interpreter (staff interpreter, contract interpreter, bilingual provider, telephone language line), or other factors.

Many states include requirements to provide access to language services in their contracts with managed care organizations. If a state chooses to directly pay managed care organizations for the costs of these language services, they have two options – pay for language services separately from the managed care capitation rate[10] (i.e. "carve out" language services from the

set of services the managed care organization must provide) or increase the capitation rate to include language services.

How much should the state pay for interpreters?

When a state decides to reimburse providers for language services, it determines the payment rate. Those currently in use vary from $12 to $190 per hour. The rates should reflect labor costs in the state and consider training or certification requirements. When setting the payment rate, the state should also consider travel time, waiting time, and other activities associated with providing interpretation; these circumstances vary by state, and often by region. For example, in rural areas where travel times can be lengthy, a state should evaluate whether the interpreter can receive reimbursement for travel time. (A state also needs to determine if and what to pay in a variety of circumstances: for example, what happens if the interpreter arrives but the provider or patient cancels the appointment.) To encourage the use of interpreters, it is important that states set a rate that will cover at least the interpreter's actual costs. The state should also set an adequate reimbursement rate to ensure that a sufficient number of interpreters to meet the needs of its LEP population are willing to participate in the program.

How can states offer reimbursement?

Currently, states that provide reimbursement for language services use four payment models:

- require providers to hire interpreters and submit for reimbursement
- pay interpreters directly
- use "brokers" or language agencies – providers can call these designated organizations to schedule an interpreter; the state reimburses the broker/agency which in turn pays the interpreter
- provide access to a telephone language line for providers.

For more information on these models, see *Medicaid/SCHIP Reimbursement Models for Language Services: 2007 Update*, available at www.healthlaw.org.

What about language services for individuals <u>not</u> enrolled in Medicaid/SCHIP?

Federal funding is only available for language services for Medicaid and SCHIP enrollees (or to parents of Medicaid/SCHIP enrolled children). It is also available for patients who receive Medicaid-covered emergency services.

Health care providers who receive federal funds, however, must ensure language access for *all* of their patients, not just Medicaid and SCHIP enrollees. Thus, a gap exists between existing federal funding and the need for services. States could use state funds to provide language services for other individuals. Once a state has established a language assistance program for its Medicaid and SCHIP beneficiaries and invested the initial resources necessary to implement it, the additional costs to expand the program to other LEP patients would probably be minimal.

[1] The Community Health Centers Reauthorization Act includes language services demonstration programs but funding has not yet been provided.

[2] For more information on these programs, *see* www.healthlaw.org, http://www.kff.org/content/2001/2248/2248.pdf (*Medicaid: A Primer*) or http://cms.hhs.gov/medicaid/mover.asp (*Medicaid: An Overview)*.

[3] Currently, hospitals that serve a "disproportionate share" of Medicaid and uninsured patients are eligible to receive supplemental Medicaid payments through the Disproportionate Share Hospital (DSH) program. In many states the DSH program represents one of the most significant sources of federal funding to support health care for the uninsured and Medicaid beneficiaries. More than 10% of all Medicaid funding is through DSH, amounting to more than $15.8 billion combined federal and state spending in 2001.

[4] This letter is available at http://www.cms.hhs.gov/smdl/downloads/smd083100.pdf.

[5] These are the District of Columbia, Hawaii, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Vermont, Virginia, Washington and Wyoming. For more information on the models these states are using, *see Medicaid/SCHIP Reimbursement Models for Language Services: 2007 Update*, available at www.healthlaw.org.

[6] Limited exceptions exist to the administrative matching rate. For example, states can receive 90% federal funding for upgrading computer systems or providing family planning services and supplies; 75% federal funding to cover the costs of medical and utilization review; and 100% for expenses in implementing and operating an immigration status verification system.

[7] "Fee-for-service" generally refers to services not provided through a hospital, managed care organization, or community health center. Providers agree to accept a state-set fee for the specific service provided to a Medicaid/SCHIP enrollee.

[8] For more information on the models these states are using, *see Medicaid/SCHIP Reimbursement Models for Language Services: 2007 Update*, available at www.healthlaw.org..

[9] States cannot, however, increase their Medicaid/SCHIP reimbursement rates above Medicare reimbursement rates.

[10] The "capitation rate" is the amount a state pays the managed care organization for each enrollee per month, which compensates the managed care organization for all the services covered by the contract. It is a set amount that does not vary depending on how many or few services the enrollee utilizes.