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Before the Committee on Health,
Council of the District of Columbia

Public Hearing on the "Fiscal Year 2011 Budget Request Act of 2010"
Budget for the Department of Health Care Finance

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Introduction

At the May 3, 2010 budget hearing for the Department of Health Care Finance (DHCF), my colleague, Andrew Patterson, testified on several items in the Mayor's proposed budget for DHCF, including the budget for language access. I am submitting this written testimony to supplement his testimony on the need for increases to DHCF's language access budget.

The Legal Aid Society serves a diverse group of clients, many of whom are limited English proficient (LEP) or no-English proficient (NEP). In partnership with the DC Language Access Coalition, we have advocated for improved language services at DHCF for years. Under Dr. Julie Hudman's leadership, DHCF has made good policy changes and availed itself of additional federal funding for the provision of language services. Yet, a large number of DC Health Care Alliance (Alliance) beneficiaries, many of whom are LEP/NEP, soon will transition to Medicaid and the Children's Health Insurance Program (CHIP). And, even before this transition takes place, a number of challenges in coordinating language services at DHCF persist.

In these tough economic times, we appreciate the challenges that District agencies face. Cuts across all agencies will result in cuts in critical services. And, we know that the provision of language services in health care can be expensive. Yet, the Mayor's proposed budget allocates only $45,000 for language access, which represents less than one full-time equivalent staff position and a $14,000 cut from last year's budget. The task of coordinating the provision of language services within an agency that serves over 200,000 District residents is enormous. The proposed budget for language services is grossly disproportionate to the number of beneficiaries who need these services and the resources required to provide these services.

A. Ongoing challenges to providing language accessible services

To appreciate the need for language access funding at DHCF requires an understanding of the complex web of DHCF's legal responsibilities to provide language services.

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[1] The Legal Aid Society was formed in 1932 to "provide legal aid and counsel to indigent persons in civil law matters and to encourage measures by which the law may better protect and serve their needs." Legal Aid provides assistance in public benefits, housing, family, and consumer law matters.

1. DHCF's legal obligations to provide language access

As a District agency, DHCF is covered by the DC Language Access Act of 2004. The Language Access Act requires that District agencies provide free oral interpreter services to all LEP/NEP individuals who seek to access or participate in the agencies' services, activities, or programs; it also requires free translation of vital documents to LEP/NEP individuals who speak a "prevalent language."[2] And, as a recipient of federal funds, it is covered by Title VI of the Civil Rights Act.[3] Title VI prohibits DHCF and other recipients of federal funds from discriminating on the basis of national origin, which includes limited English proficiency, as interpreted by the courts and federal agency guidance.[4] Guidance from the Department of Justice (DOJ) outlines four factors that federal fund recipients should use to determine the steps they need to take to serve LEP/NEP beneficiaries.[5] The District is among the states that elect to pay the costs of language services incurred by certain health care providers serving Medicaid and SCHIP enrollees.[6] Further, the Medicaid managed care regulations require that the state and the managed care organizations (MCOs) provide oral interpretation and written translations for enrollees and potential enrollees.[7] The MCOs must require this of their providers as well.

In order to comply with local and federal language access laws, DHCF must have adequate funding to do, at a minimum, the following:

- Provide free oral interpreter services to any LEP/NEP individual who seeks to access DHCF's services.
- Provide free written translation of vital documents to LEP/NEP individuals who speak one of the prevalent languages designated by DHCF.
- After balancing the four factors in the DOJ guidance, DHCF should determine which documents should be translated, when oral interpretation is required, and when such services should be provided.
- Pay the costs of language services incurred by certain health care providers serving fee-for-service Medicaid patients.
- Identify the major languages spoken by Medicaid managed care enrollees or potential enrollees and provide them with oral interpretation and written translations.
- Monitor the MCOs' compliance with the language access provisions of the Medicaid managed care regulations and the MCOs' contracts with the District.

Put simply, DHCF's obligations are to provide free oral interpreter services to all LEP/NEP individuals seeking its services, provide free translations of vital documents to LEP/NEP individuals who speak a prevalent language, coordinate payment for costs of language services incurred by certain Medicaid fee-for-service providers, identify the spoken language of Medicaid

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[2] D.C. Code § 2-1931(6) – (7).
[3] See 42 U.S.C. § 2000d-4a.
[4] Id.
[5] See 65 Fed. Reg. 50123 (Aug. 16, 2000).
[6] The District currently pays for the costs of language services incurred by Medicaid fee-for-service providers as an administrative cost.
[7] See 42 C.F.R. § 438.10. These regulations also require that managed care providers to make free oral interpretation available to enrollees, as well as notifying enrollees of their language access rights and conducting community outreach. See id.

managed care enrollees or potential enrollees, and monitor the MCOs' compliance with their language access obligations.

2. Practical implications of DHCF's legal obligations

On their face, DHCF's legal obligations are substantial and require significant resources to meet. The practical implications of implementing and complying with the federal and local law, however, are even larger. A few examples include:

- In order to know which LEP/NEP individuals and language groups require interpreter or translation services, DHCF needs to collect language data and transmit this data to the Income Maintenance Administration (IMA), the enrollment broker, and the MCOs effectively. Thus, DHCF not only needs to collect and manage its own data about the LEP/NEP population, but it also needs to receive and share this kind of information with other entities—a task that requires significant resources.
- Until DHCF is able to collect information about LEP/NEP individuals effectively, it will have no way of knowing who needs language services. This makes the task of determining which language groups rise to the level of "prevalent" nearly impossible and thus hinders the process of identifying which documents need to be translated into various languages.
- DHCF has the responsibility of monitoring the MCOs' compliance with their language access obligations, which requires collecting and reviewing reports, monitoring the outreach and enrollment materials that the MCOs send to enrollees or potential enrollees, and generally holding MCOs accountable. In order to secure compliance, it is likely that DHCF needs to train MCOs and providers on how to provide language services to managed care enrollees and equip them with the resources to provide those services.
- DHCF needs to continue to pursue additional federal funds for language services that are available. We hope that DHCF soon will amend the Medicaid State Plan to add language services as a Medicaid "covered service," which would entitle it to an 84 percent federal share of payments for language services under CHIP. Implementing policy changes, though, requires local funding.

Although the provision of language services in the health care system can be costly, it is essential for providing quality care. Providing interpreters at medical visits allows for effective communication between doctors and patients, enabling physicians to identify health problems early on, to ensure that patients understand their treatment options, care instructions, and medication management, to obtain consent, to promote the use of primary and preventative care, and to reduce patients' reliance on emergency care. Securing professional interpreters, instead of forcing patients to rely on family members or friends, protects patients' confidentiality and ensures accurate and efficient interpretation. Providing interpreter and translation services when beneficiaries contact DHCF enables them to access information about coverage or troubleshoot language access problems with their providers. Communication breakdowns in any of these contexts, and many more, can significantly delay access to quality health care or, in some cases, preclude access altogether.

B. Current and emerging coordination challenges

DHCF is doing its best to coordinate this wide array of responsibilities with its current funding levels, but additional local funding is needed. In the past year, Dr. Hudman has designated a member of her staff as the agency's point person for language services, and we have seen several improvements in the delivery of language services as a result. For example, DHCF created a language field in its new management information system that will help them identify individuals who need language services and language groups that are entitled to free translations. Also, DHCF is working on an outreach campaign to inform LEP/NEP beneficiaries of their language access rights, as well as educating providers about their obligations to provide language services.

However, despite this progress, more coordination is needed to meet current and future challenges, and this coordination requires local dollars. For example, one of the great successes of the past year was DHCF's election to use federal funds to cover lawfully residing immigrant children and pregnant women in Medicaid and the Children's Health Insurance Program (CHIP) without the five-year waiting period.[8] By transitioning this group of people from the DC Health Care Alliance to Medicaid and CHIP, the District is not only maximizing federal dollars for health care but also federal dollars for language services. Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the District will not only save local dollars by transitioning Alliance beneficiaries to Medicaid for health services, but the District also will receive an enhanced federal match for its expenditures on language services for a group of people that formerly received language services exclusively through local dollars.

Electing to receive these funds, though, is just the first step. Major coordination will be required to implement this change. Not only does the agency need to identify the individuals eligible for transition, the agency needs to notify these individuals properly. Not surprisingly, a large number of these individuals will be LEP/NEP, and DHCF will need to communicate with them in their language about this transition. Similarly, in implementing the federal health reform law, DHCF will need to devote significant resources toward transitioning yet another large segment of the Alliance population to Medicaid.

Yet, seeking federal reimbursement for language services, while important, cannot fund the enormous coordination effort that is required to make health care accessible to the LEP/NEP population. Because DHCF's ability to use federal dollars to fund the agency's coordination of these efforts is limited,[9] and because it cannot receive federal funding for providing the language services that it is required to provide under local law, it needs significant local funds to meet its legal obligations.

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[8] Previously, certain categories of lawfully residing residents could only become eligible for Medicaid after waiting five years from the date that they became a "qualified immigrant" under Medicaid's eligibility criteria for non-US citizens. During the five-year waiting period, these individuals would be in the Alliance. Now that these groups will be able to get Medicaid without first being in the Alliance for five years, the District will save money on the costs of health care for these individuals, as well as the costs of interpreter and translation services.

[9] States that cover the costs of language services as an administrative expense cannot spend more than ten percent of their SCHIP allotment on administrative expenses.

Conclusion

Fundamentally, language-accessible health care is a quality of care issue. At a time when many Alliance beneficiaries will transition to Medicaid, and when many of these individuals are LEP/NEP, funding for language services is all the more critical to ensure that individuals are getting the health care to which they are entitled. The public health is served by making sure that all individuals, regardless of spoken language, get quality health care. This can be accomplished only when DHCF, MCOs, and providers communicate effectively with the LEP/NEP population. We urge the Council to devote funding to language services that is commensurate with the overwhelming need.

Thank you for the opportunity to present this testimony, and please do not hesitate to contact me for further information or with any questions or concerns.