Evaluation of the Current System of Providing Language Access for Medicaid Patients in Washington State

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Executive Summary

This report traces the development of Washington State's experience in funding spoken-language interpreter services for Medicaid patients,[1] describes how the current system works, reports how its stakeholders evaluate its effectiveness and efficiency, and introduces a number of alternatives that might provide improved services with no increase in cost.

Washington State currently uses a brokerage system to schedule and pay for interpreter services for patients receiving Medicaid-eligible out-patient healthcare services. Providers and interpreters are significantly dissatisfied with this system. Four proposed alternatives are discussed.

- A statewide interpreter registry is found to be inadequate to the task.

- The model currently used by Labor and Industries has less administrative and overhead cost although higher labor costs. If the current DSHS standard of $34 per hour limit for direct service cost for interpreter services were applied to the L&I model, this would represent a significant saving from the current system, however the system does not meet DSHS standards for avoiding fraud or vetting patient eligibility.

- A model based on direct reimbursement to providers, who would then be responsible for the provision of language access services, was found to potentially meet the needs of the State and of some providers, although the model by itself provided no improvement in the working conditions of the healthcare interpreters.

- A model featuring an on-line scheduling program with automated invoicing was found to hold the most potential to both improve the system for users and contain costs.

Four recommendations were made, based on the findings of the report.

1. **The system** to schedule and pay interpreters for Medicaid patients **should be reconfigured to remove the multiple layers of administration** that account for too large a percentage of total program costs. If possible, both the brokers and the interpreter agencies should be removed from the arrangement; however at least one of these two should certainly be removed.

2. An **Interpreter Services Advisory Group should be formed** to discuss the results of this report and recommend a system of reforms to the current system of scheduling and paying for interpreters for Medicaid patients. It is critical that this Advisory Group be comprised of individuals who are already familiar with the history of the current system

[1] Interpretation for the Deaf and Hard-of-Hearing is provided through a different mechanism in Washington State and is not addressed in this report.

and the issues involved in scheduling and paying for interpreters. The Advisory Group should certainly include healthcare administrators in charge of language access programs, private practice providers, administrators from the current contracted brokers, staff involved with interpreter services at HRSA, and interpreters themselves. The recommendations from the Advisory Committee must be accorded the weight of authority, and a change to the current system must be required by January 2011 at the very latest.

3. **The state should provide greater incentives and support for private entities working to recruit, train and encourage healthcare interpreters.** It is in the interest of the state to promote, at least temporarily, the development of this new category of professional, considering the large number of Washington residents who require interpreters to effectively access public services.

4. In the long term, the state consider the potential benefits of **consolidating into one office language services for all state-run services**. While differing funding streams and reporting requirements may make this move untenable, it might lower costs by eliminating duplicative administrative services and simplifying reporting and billing protocols.

Introduction

In 1991, the Washington State Department of Social and Health Services (DSHS) became the first state in the U.S. to use public funds to pay for interpreters for patients receiving Medicaid-funded services. This pioneering decision has led DSHS into almost two decades of experimentation to find the best and least-expensive way to support the use of interpreters in health care.

The current economic crisis, however, provides a valuable opportunity to reassess whether the approach now in use is serving Washington as well as it could. The system for scheduling and paying for interpreters for Medicaid patients has become so complex that a growing number of providers will not access it and many interpreters will not work in it, leading to a shortage of interpreters for Medicaid patients and increasing fiscal pressures on healthcare facilities. The present state budgetary crisis has led lawmakers to consider eliminating the program altogether, just at a time when the federal government is increasing the percentage of this program that it will reimburse. Private insurers are unwilling to pay for interpreters, and healthcare providers, also in fiscal jeopardy, cannot bear this burden alone.

This report will trace the development of Washington State's experience in funding spoken-language interpreter services for Medicaid patients,[2] describe how the current system works, report how its stakeholders evaluate its effectiveness and efficiency, and introduce a number of alternatives that might provide improved services with no increase in cost.

History of Washington's Publicly-funded Interpreter Service Program

Why was the program initiated?

Title VI of the 1964 Civil Rights Act prohibits any program receiving federal funding from administering its programs in such a way as to create discrimination on the basis of race, color or country of national origin. In 1974, the Supreme Court decision in Lau vs. Wade established language as an aspect of country of national origin. The implication in health care is that any facility accepting federal funding (such as Medicaid or Medicare) is required to provide language access to its services.

Washington State has been a pioneer in enforcing these language access requirements. In 1981, country-of-origin complaints were filed with the Office for Civil Rights of the Department of Health and Human Services (DHHS) on behalf of clients at three Seattle hospitals, alleging that by not providing patients with interpreters, the hospitals were violating their civil rights. These complaints, and several civil suits that followed, led to an acknowledgement of the facilities' responsibilities to provide language access. In 1989, the Region X office of the DHHS Office for Civil Rights released a letter to all recipients of federal funding, reminding them of their responsibility to provide language access. Washington State DSHS followed soon after with a similar letter to all its contracted healthcare providers.

The letter caused concern among Medicaid providers, who felt that they were already reimbursed at some of the lowest rates in the country. Members of the Washington State

[2] Interpretation for the Deaf and Hard-of-Hearing is provided through a different mechanism in Washington State and is not addressed in this report.

Medical Association threatened to stop seeing Medicaid patients at all, given this additional financial burden. Apprehensive about the potential impact on its provider network, DSHS agreed to pay for interpreters for Medicaid patients receiving outpatient services. A system was set up under which freelance interpreters and interpreter agencies could bill the DSHS directly for their services to Medicaid patients.

The growth of the program

The next biennium saw a rapid growth in Medicaid spending related to language access. All stakeholders had significantly underestimated the unmet need for interpreters extant in the health sector. In addition, the lack of regulation of the industry coupled with the dependence on freelance interpreters, many of whom were recent immigrants without a sense of business ethics in the U.S., led to an alarming amount of fraud. The interpreting program became much more expensive than had previously been forecast, and DSHS began to search for ways to contain the costs. The Medical Assistance Administration (MAA, now the Health and Recovery Services Administration, or HRSA) began to audit certain interpreters, interpreters were required to get provider numbers, and other fiscal safeguards were introduced.

Some interpreters were also being used so continuously by DSHS Community Service Offices and Medicaid providers that in 1994 the IRS and the Employment Security Department (ESD) began to investigate the contention that contract interpreters really qualified as employees. In an effort to clarify this ambiguity, the state attempted to form a brokerage system which would place some administrative distance between the DSHS and the contracted interpreters.[3] A legal challenge to this change by The American Cultural Exchange, an interpreter agency in Seattle, resulted in the brokerage process being suspended due to an error in the procurement process.

Although the initial effort to institute a brokerage system was blocked, DSHS still needed to control the costs of the interpreting program and assure that interpreters could continue to function as freelancers. In 1996, MAA terminated its contracts with individual interpreters and began to contract only with interpreter agencies. Fees dropped from $28/hour to $16.40/hour, and a good many skilled interpreters left the field.

Nonetheless, the costs continued to rise. In 1998, DSHS instituted another creative and pioneering change: by establishing interlocal agreements with public healthcare facilities (such as county health departments, the University of Washington Medical Center and Harborview Medical Center), the state was able to access a 50% administrative match from Federal Medicaid dollars, above and beyond the state's usual Medicaid grant. DSHS successfully argued that, since these were all publicly-funded health services, the state's 50% of the match was represented in the money that these facilities were already spending on interpreter services. In addition, the terms of the administrative match allowed the publicly-funded facilities to include not only the cost of interpreters themselves, but the cost of running their interpreter services, in the calculation of the amount the federal government was to match. The establishment of the interlocal agreements removed these institutions from the State's interpreter bill and helped contain costs.

[3] It should be noted that interpreters for the Deaf and Hard of Hearing were, and still are, contracted directly by the DSHS Office for the Dear and Hard of Hearing, as are interpreters for Labor and Industry. It is not clear why direct contracting posed a difficulty in the case of spoken-language interpreters but not in these other cases.

In addition, in 1999, DSHS unified the interpreting contracts of its various administrations under the Department of General Administration. The judge in the earlier brokerage case had ruled that the scope of the interpreter program required that interpreter services be procured as a purchased service contract as opposed to a client service contract. Legally, only the GA could handle purchased service contracts, so this shift both unified the manner in which DSHS administrations procured interpreters and laid the groundwork for additional subsequent changes.

The scope of the contracting required to successfully run the interpreter program, however, represented a significant burden for the GA. Staff of the MAA, with more experience in this area, felt that they could run the program more inexpensively from within their Administration. A recent shift to a brokerage system in administering the Medicaid transportation program had resulted in significant savings for that program, and MAA felt that running the interpreter program through regional brokers would have similar positive effects, by:

1. Removing any possibility that interpreters could be construed to be state employees.
2. Containing costs
3. Creating a gatekeeper to assure that patients were actually eligible for services at time of service and that only valid providers were booking interpreters.
4. Controlling fraud through auditing.

In 2001, then, both fiscal and administrative pressures led DSHS to eliminate the Medicaid interpreting program from the state budget altogether. Public pressure was put on the legislature to re-fund the program, so the lawmakers restored the funding and adopted legislation allowing MAA to manage this purchased service contract if they established it as a brokerage system.

In late 2002, MAA contacted its 13 regional transportation brokers, requiring them in a matter of months to put in place an interpreter program or lose their transportation funding. The brokers rose to the challenge, with varying degrees of success and with, predictably, a chaotic period at the beginning of 2003 when the program went live.

As might be predicted with any major change, many stakeholders were unhappy with the shift to a brokerage system. DSHS did, however, register significant financial savings, though whether this is due only to the containment of fraud or to a significant decrease in the number of patients being served is not clear. In the 2008 legislative session, the funding was challenged again, but significant community protest protected the program. In 2009, despite significant financial cut-backs in the state budget, the program was protected. In 2010, however, the Medical Interpreter program is once again being threatened with elimination. Here is the opportunity, then, to evaluate whether a significant overhaul in the system might be in order.

Washington's Brokered Interpreter Service Program: How does it work?

Description of the current system

Requests for an interpreter originate with the medical provider, who must fax a request to the regional broker's office. In King County, which experiences 38% of all the brokered interpreter requests in the state, requests must be received by the broker before 10:00 a.m., at least three days before the appointment. Requests must be submitted on the broker's form, and requests for multiple interpreters must be submitted at least five days in advance.

The broker starts processing the interpreter request by using the DSHS patient database at www.webmed.gov to verify that the specific patient will be eligible for Medicaid coverage of the planned medical service on the date that it is being scheduled. Once verified, the broker then sends the request to one of its contracted interpreter agencies. The agency sends the request to its interpreters and locates one who can take the appointment. The agency then confirms with the broker who then confirms with the provider. If the agency cannot find an interpreter, the broker sends the request to another agency, and the process repeats. If no interpreter can be found, the broker informs the provider who requested the interpreter.

Once the interpreter completes the assignment, he or she must fill out and get a confirmation signature on an encounter form, which is then submitted to the interpreter agency with an invoice. The agency then bills the broker, which reviews the billing for accuracy and bills DSHS. DSHS has 30 days to pay the broker, which then has 10 days to pay the agency, which must then pay the interpreter within 10 days. Altogether interpreters report often waiting three months to receive payment for work completed.

The broker bills DSHS only for the amount owed the agency. Agencies are paid up to $34/hour, based on a competitive bidding process. Interpreters generally receive between $20-$22/hour plus mileage and parking for appointments over 10 miles away; individual rates are set by the agencies. The broker is paid an average administrative fee of $7.63 per appointment booked, based on historic data of volume and pro-rated per month. The exact amount varies by broker between $2.93 and $13.99 but cannot be more than 15% of the total expenditure.

Public healthcare facilities that have an interlocal agreement with the state may not use the broker. In these cases, the facility maintains detailed records of all costs related to interpreter services to Medicaid patients. The facility reports these to DSHS, which reviews the expenses, pays the hospital a 47% match[4] and then submits the reports to CMS for payment. CMS reimburses the state 50%[5] of the costs. The 3% difference between what the State receives from CMS and what it pays the hospitals covers the costs to administer this program.

While the eligibility screening process employed by the broker is required only for Medicaid patients, the broker processes requests for interpreters for clients of all DSHS services. In these cases, the request for the interpreter originates in the CSO or other DSHS office.

Following are some statistics for the brokered interpreter services for state fiscal year 2009 (July 2008-June 2009)[6]

Cost of service		$12,337,180
Paid to agencies and sub-contracted interpreters	$8,809,309	
Mileage reimbursed to interpreters	$3,527,871	
Administrative costs (amount paid to broker)		$1,836,350
Total expenditure		$14,173,530
Total Encounters		240,765
Monthly encounters	approx. 20,064	
Average cost per encounter		$58.86

[4] 72% for services to children enrolled SCHIP or Medicaid.
[5] 75% for services to children enrolled in SCHIP or Medicaid.
[6] Source: *Interpreter Services Brokerage, Yearly View*, data provided by HRSA in response to Public Disclosure Request 70992.

Service *(approx $26.46 to interpreter and $16.37 to agency)*	$42.80	
Mileage	$8.43	
Administration (average cost for the brokers)	$7.63[7]	
Hours of service	302,989	
Average length of encounter *(total # encounters divided by total # hours)*		1.26 hours
Cost of service per hour *($42.79 divided by 1.26 hours per encounter)*		$33.96
Paid to interpreter	approx $21/hour	
Paid to agency	approx $13/hour	

Of particular interest is to note that, of the $58.86 average cost per encounter, approximately $24 (41%) is going to administration, either through the broker or the agency. Only $26.50 (45%) goes to pay the interpreter. The final 14% represents mileage.

Evaluation of current system

DSHS' feedback

Employees of HRSA interviewed for this report felt that the current brokerage system has had a number of very positive results. First, the brokerage system has eliminated much if not all of the fraud being perpetrated prior to its inception. Secondly, the brokerage has sheltered the State from the fiscal liability attached to treating freelancers as employees. And finally, the brokerage has allowed HRSA to continue to provide services while saving money. Whether these savings are the result of a more efficient use of resources, from a control of fraud, or from a decline in demand as providers give up on the system is not clear.

Providers' feedback

Providers interviewed for this report did not share HRSA's positive view of the brokerage system. They had a great many complaints about the brokerage system, although there seems to be little concrete data, and many of the complaints are intertwined with problems related to the Medicaid-funded transportation service also managed by the brokers. Specific complaints included the following:

- The brokerage system does not provide access to interpreters for Medicaid patients who need to be seen in less than 72 hours. Emergency Departments, same-day clinics and anyone booking an appointment in the next two days cannot access DSHS-funded interpreters, even if the patient is Medicaid eligible.
- The requirement to use specific broker forms to request an interpreter or lodge a complaint poses a burden in the busy healthcare arena.
- Requiring all providers in a busy region such as King County to submit interpreter requests by fax to a single fax machine leads to requests arriving too late to be honored.
- Too frequently, the broker is not able to provide any interpreter at all.
- Providers only learn that the broker cannot find an interpreter too late to book someone else. Patients are either seen with no interpreter, or the appointment has to be rescheduled.
- Providers must monitor the case to see if an interpreter had been procured yet, using up a great deal of staff time.
- The quality of interpreters has been poor, with many interpreter no-shows. The Medicaid interpreters have been significantly less professional than others sent by the interpreter agency. Some providers reported being sent interpreters who were not certified or

[7] The administrative rate for the 15 brokers varies between $2.93 in Region 15 and $13.99 in Region 10.

qualified, despite contractual agreements that they be so. This concern is reflected in this response from an interpreter interviewed for this report:

> *At that particular clinic, they no longer go through [the broker] to arrange to pay for an interpreter for any DSHS patients they may have because they do not know who they will get. I am there the whole day [for other patients] and even though they request me, other interpreters are often sent. So they pay me directly. It's worth it to them to have the interpreter they want. They don't want just anyone, especially since some of the interpreters that were sent did not work out very well.*

Repeatedly, administrators interviewed for this report indicated that they are so frustrated that they have chosen not to use the brokerage service any more. One respondent said,

> *We had to stop using the service because it was so onerous. We believe that the process was specifically designed to deter you from using it.*

When asked if they had reported their complaints to the brokers or to HRSA, those interviewed affirmed that they had done so when the system was first initiated. Some complaints were never addressed; many times they were told to contact the State, where they were referred back to the broker, or to contact the interpreter agency, where they were referred either to the broker or to the State. When they received no satisfactory resolution, they eventually gave up. This may explain HRSA's experience of a reduction in complaints.

Interpreters' feedback

Interpreters interviewed for this report expressed a general frustration with the brokerage system, to the point that many are refusing to take Medicaid patients at all. This corroborates complaints received for some time from the interpreter agencies that they cannot find certified interpreters to send to Medicaid appointments. As independent contractors, interpreters earn so little for services to Medicaid patients that many interviewed for this report indicated that it is not worth their time to take the appointments; although interpreter agencies are being paid $34/hour for Medicaid patients, most interpreters receive only $21 an hour, with a 1 hour minimum, paid at 15-minute increments after that. If the patient does not show, the interpreter is paid for only half an hour. If the provider books the interpreter for three hours but uses the interpreter for only one, the interpreter is paid only for the time he interprets. Mileage and parking are paid only for interpreters who travel more than 10 miles to their appointments; bus fare is not paid regardless of distance traveled. Appointments cancelled within four hours of the start time are not paid at all, even though it is unlikely at that point that the interpreter will be able to fill that time slot.

In the DSHS system, then, spoken language interpreters are receiving an average of $21/hour with a one hour minimum. These working conditions should be compared to those of community interpreters serving in other venues:

- King County Superior Court: $40/hour, 2 hour minimum
- Other courts participating in AoC's pilot program: $50/hour, 2 hour minimum
- Harborview's Mental Health Court: $60/hour, 2 hour minimum
- US District Court $208/half day, $384/full day
- Labor and Industry $0.88/minute ($52.80/hour)
- DSHS interpreters for the deaf $25-55/hour depending on level of certification, 2 hour minimum

Interpreters report other dissatisfactions with the brokerage system.

- Rules for reporting and invoicing, as well as forms, vary between brokers and between agencies, causing confusion among interpreters who serve various regions and who contract with various agencies. Like providers, interpreters are spending an increasing amount of their unpaid time on managing paperwork.
- There is no mechanism for interpreters to respond when complaints are lodged against them. Interpreters can be suspended without ever being allowed to present their side of the story.
- Interpreters struggle with the problems of double-booking and no-shows.

One constant complaint among interpreters interviewed for this report is that, while interpreters are treated as independent contractors when it comes to paying self-employment taxes and maintaining a business license, they are not allowed the benefits that come with being independent business people. DSHS interpreters may not advertise their services to the providers who make the requests (so there is no way to build a clientele), and they may not negotiate a better pay rate commensurate with their skills and experience. Although providers are technically allowed to request a specific interpreter if that interpreter demonstrates superior skills or service, the brokers rarely honor the request. On the contrary, interpreters who are requested are often suspected of soliciting work and are booked less or even suspended. If the broker or the agency errs in sending interpreters to the wrong place or to a patient who does not speak their language, the interpreter does not get paid. Finally, the long delay (often three months) to receive payment, when the pay is so low anyway, constitutes a significant disincentive for interpreters to participate in this system.

The inflexibility of the restrictions put on interpreters have also led to frequent counterproductive situations. Interpreters may not communicate directly with provider organizations, not even to inform them if they are running a bit late or if they need directions to find the correct clinic inside a medical center. Interpreters who discover upon arriving at a clinic that their patient did not show for an appointment may not serve another Medicaid patient at the same clinic at the same time who does not have an interpreter, even though this results in the patient not getting service and the interpreter being paid for only ½ hour.

In addition, there is no motivation for interpreters to provide excellent service or to improve their skills. Appointments are assigned by the brokers randomly to language agencies. There is no mechanism for superior interpreters to increase their volume or to be paid more for the assignments they accept. Basic training is not required to get certified, and though continuing education is referenced in the DSHS Interpreter Code of Ethics, it is not required to maintain a certified status. As certified and qualified interpreters refuse to work under these conditions, DSHS has simply lowered the bar by allowing “authorized” and “provisionally authorized” interpreters to take appointments, instead of resolving the underlying issue of insufficient pay to maintain an adequate workforce.

Although some agencies are required under contract to provide interpreters who have received formal training, training is largely unavailable, principally because too few interpreters register for the classes to make them viable. With the high turn-over in the field, it becomes highly doubtful that interpreters currently serving Medicaid patients have actually been trained. The State requires interpreters serving Medicaid patients to be certified or qualified, but anecdotal evidence suggests that the shortage of interpreters willing to take Medicaid appointments has led to the growing use of uncertified interpreters as well. And finally, very little continuing education is available, again, largely because attendance is so low. Interpreters interviewed for

this report felt no motivation to take continuing education, as it is not required and improved skills will not lead to higher pay or more appointments.

In summary, the interviewed interpreters reported that the working conditions attendant on taking Medicaid assignments are confusing, constantly changing and highly demoralizing, and making it virtually impossible for interpreters to earn a living. For this reason, of the 8,000 interpreters certified by DSHS over the past 14 years, fewer than one out of five[8] are currently willing to accept DSHS patients.

As one interpreter put it,

> *Most of us are merely seeking some reasonable measure of financial predictability, job consistency (e.g, standards for mileage pay and no-shows), recognition of a "job well done," to be able pay our bills, afford E+O insurance and work permits, and to have some incentive for professional growth.*

Alternatives to the Brokerage System

For the past year, advocates in Puget Sound have been looking into possible alternatives to the brokerage system: alternatives that would improve the ease and efficiency of the scheduling/ payment system while improving working conditions for interpreters.

The following criteria were identified by stakeholders interviewed for this report (healthcare administrators and schedulers, interpreters, and DSHS) as necessary for any alternative to the brokerage to be acceptable and successful.

1. Interpreter schedulers[9] must be able to identify, schedule and receive a confirmation from qualified interpreters in a timely and efficient manner.

2. Healthcare institutions need to be assured that each interpreter has signed a HIPPA agreement and an acknowledgement of the Code of Ethics, that each has liability insurance, and that measures to assure competency are in place.

3. Healthcare institutions need to work through a secure portal so that any patient information that is transmitted will be secure.

4. Healthcare administrators need to be provided with utilization reports.

5. Interpreter schedulers must have a way to provide feedback about the quality of the interpreter's service (timeliness, no-show rate, quality of interpreting).

6. Interpreter schedulers must have a way to resolve issues with individual interpreters and must be able to track interpreters that are blacklisted.

[8] As of January 2010, there are 1596 "active" interpreters on the DSHS database, based on data provided by HRSA.

[9] Depending on the healthcare facility, these may be full-time scheduling staff, clinical staff or front desk staff.

7. Interpreters must be able to be scheduled and to receive instructions on when and where to arrive.

8. Interpreters must be able to document length of service.

9. Interpreters must earn a reasonable per-hour rate.

10. Interpreters must be able to build a provider clientele based on the quality of their service.

11. Interpreters must be paid within 30 days.

12. Interpreters must have incentives to seek out basic training, certification and continuing education.

13. DSHS must be able to assure that interpreter services are being billed to them **only** when the patient is eligible for the specific Medicaid health service at the time of service provision.

14. DSHS must be able to prevent the types of fraud that led to the establishment of the brokerage service.

15. DSHS must assure that interpreters cannot be construed to be employees of DSHS.

16. DSHS must be able to process invoices without undue administrative burden.

17. DSHS must be able to audit services and payment.

18. DSHS must be able to safeguard client information according to DSHS standards.

19. DSHS must be able to assure that interpreter services are being provided by certified/qualified interpreters who have passed a TB test and a background check. In addition, if mileage is being charged, DSHS must have proof that the interpreter has the appropriate car insurance.

20. DSHS must have a service that stays within its budget and, if possible, reduces costs to below the current average of $58.86 per encounter.

Interpreter registry model

One model that has been suggested to replace the brokerage system is a statewide on-line tiered interpreter registry such as the one being currently developed by the Washington State Coalition for Language Access (WASCLA). A registry of this sort is an on-line searchable database in which schedulers for legal, medical, social service and educational settings can search for an interpreter. Schedulers first input the preferred language, gender and location of the interpreter. The service would then provide information on all interpreters who meet the criteria, providing first information on “first tier” interpreters, or rather, those interpreters with federal court, state court **and** DSHS certification/qualification. If there are no first-tier interpreters available, the service will then provide the names of second-tier interpreters (those with either a federal court, a state court, or a DSHS certification/ qualification) and then third tier interpreters

(those with no certification). Schedulers would then have to contact their chosen interpreter by telephone, and wait for a response if the interpreter is not immediately available. The scheduler's institution would be responsible for contracting and paying the interpreter. This service does provide access to interpreters, but it is so unwieldy that it would be unlikely to be used by healthcare facilities booking more than a few patients a week. Schedulers would likely have to contact multiple interpreters in order to book even one appointment. The institution would then have to sign a contract with every interpreter it schedules or limit schedulers to searching only among interpreters with whom they already have a contract. There would be no way to provide feedback on the quality of the interpreter's services, and no method for DSHS to pre-screen patients for Medicaid eligibility or to assure that interpreters meet legal standards of any sort. Auditing would have to be done institution by institution, creating a significant administrative burden for DSHS employees. This service also provides no incentive for interpreters to get basic training or continuing education. In short, dependence on a simple interpreter registry is unlikely to lower costs or improve interpreter services.

A similar if more sophisticated registry was implemented in 2006 in California by the California Healthcare Interpreter Association (CHIA). To date, only 250 interpreters have registered, and the system is vastly underused by organizations searching for interpreters. CHIA executives believe that the system does not match well with the manner in which healthcare facilities search for and schedule interpreters. Most either hire interpreters onto staff, contract with agencies or use telephonic interpreters. When they do use the registry, it is to fill occasional gaps either in languages or in coverage.

CHIA identifies other barriers to the success of its registry:

- Interpreters' qualifications listed on the registry are self-reported and are not verified, leading to questions of veracity.
- Interpreters feel intimidated by the long registration survey and so do not participate.
- Interpreters feel uneasy about listing all their contact information in such a publicly accessible venue.
- CHIA lacks the resources to adequately maintain the registry's list of trainings and certifications up-to-date.
- Because clinical interpreters are not certified in California, it is easier for healthcare providers to find interpreters through means other than the registry.

A registry system does seem to be working for California's Workers' Compensation system, perhaps the overall volume of demand is lower and interpreters in this sector must be certified.

While not a solution for the problem being considered by this report, an up-to-date state-wide registry of active DSHS-certified/qualified interpreters could be useful for providers seeking interpreters on a sporadic basis.

Model currently used by Labor and Industry

Labor and Industry uses a modified interpreter registry model for its interpreter scheduling. In this system, both interpreters and interpreter agencies can contract directly with L&I to become "authorized providers." When approved medical providers schedule a limited-English-proficient patient, they also request an interpreter from L&I. L&I approves or denies the requested service. The provider then goes on-line to the L&I registry and searches for an authorized interpreting provider: either a freelance interpreter or an interpreter agency. The scheduled interpreter arrives at the appointment and has the authorized medical provider fill out the necessary

paperwork confirming the time he worked and services rendered. The interpreter invoices according to minutes worked. The interpreter and provider must submit the paperwork to L&I, which then pays the interpreter directly. In the case of an interpreter agency, L&I pays the agency directly, which in turn pays the interpreter. Most interpreters get paid in three to four weeks (as opposed to three months in the DSHS system) and, unless the claim is denied, they are paid for all services performed. Generally the initial interpreter will follow a patient through all aspects of the care, e,g. occupational therapy, physical therapy, medical appointments, dental appointments, etc.

In this system, interpreters are paid $0.88 per minute ($52.80/hour) with no minimum, up to eight hours a day. Interpreters cannot self-refer, but they can advertise their services to providers, who may request specific interpreters.

Interpreters working for L&I do run a risk though. If the patient's claim is rejected, the interpreter (as well as other service providers) do not get paid at all. Overall, fewer than 5% of claims are rejected, however, there is insufficient data to determine whether this number is higher for limited-English-proficient patients.

L&I covers about 124,560 interpreted appointments a year, a little over half of DSHS' volume. Interpreters receive a provider number, just as other healthcare providers do and just as interpreters used to receive from DSHS. It is not clear why this practice put DSHS at legal risk but does not seem to concern L&I. This direct billing does cause extra work for L&I staff; they are currently training interpreters to bill electronically. Billing fraud is a concern in the L&I system, just as it was for DSHS before instituting the brokerage system.

Quality control in the L&I system is limited to requiring proof of certification from interpreters seeking a provider number. There have been complaints of poor interpreting, though there is no evidence of any subsequent legal action.

SFY 2008 is the most recent fiscal year for which data could be obtained from L&I. Table 1 shows a comparison of approximate costs for the provision of interpreter services through L&I and DSHS brokered services for that year.

	DSHS[10]	L&I[11]
Total expenditure, SFY 2008	$12,905,630	$11,104,461
Total number of encounters, SFY 2008	221,781	124,563[12]
Cost per encounter	$58.19	$89.18
Approximate % expenditure paid to interpreter (not including mileage)	45%	Cannot be determined, as invoices from interpreters and from language agencies are reported in aggregate.

Table 1: Cost Comparison, Provision of Interpreter Services
by Labor and Industries and by DSHS for SFY 2008

[10] Source: *Interpreter Services Brokerage, Yearly View*, data provided by HRSA in response to Public Disclosure Request 70992.

[11] Source: WA Dept of Labor and Industries Red Brick Data Warehouse, specifically the Claim_Info and Med_Item tables, provided in response to Public Disclosure Request 70992.

[12] The total number of times that billing codes 9988M, 9989M, 9996M and 9997M were submitted in FY2008. These correspond to group interpretation, individual interpretation, IME no-show and document translation at an insurance company.

Anecdotal evidence supports the claim that interpreters earn a better wage from, and therefore are more willing to work for L&I. It does not appear, however, that the system is cheaper or that it meets various criteria for success required by DSHS.

For this system to meet the 20 criteria listed at the beginning of this section, authorized Medicaid providers needing an interpreter would be required to fax an approval request to DSHS, wait for DSHS staff to verify patient eligibility, and then book a DSHS-vetted interpreter directly. Interpreters would need to qualify for vetting by DSHS, perhaps by showing not only certification but also basic training and continuing education. The interpreters would bill DSHS electronically at the currently-approved rate of $34/hour, which would represent a sufficient pay increase to motivate them to pursue the training and CEUs necessary to maintain their provider status with DSHS. Providers, however, will likely balk at the additional cost of scheduling their own interpreters, and DSHS would need to increase staff to handle verifying appointment eligibility and auditing of invoices.

Reimburse providers directly

A third model to improve quality and efficiency in a Medicaid-supported language access system is to reimburse healthcare providers at a higher rate for interpreted visits and then allow the providers themselves to decide how to most efficiently supply interpreter services.

This direct-reimbursement model could be done in a variety of ways. For example, providers could track the provision of services to Medicaid patients and bill DSHS quarterly. In a more elegant system, the Medicaid coding system could be adapted so that, for example, an X-ray for a patient requiring an interpreter would be billed to Medicaid with a different – or an extra – code than an X-ray for a patient who did not require an interpreter. The interpreted appointment would be reimbursed at a higher rate, providing the institution with funding to provide language access services in whatever way it found most efficient: e.g. bilingual providers, dual-role interpreters, staff interpreters, or agency interpreters.

This model has some attractive features. It would entirely remove the need for the brokerage system with its attendant costs and put the responsibility for providing interpreters back on the recipients of federal funds. Billing could be done electronically and be easily audited. Providers would be responsible for billing for interpreter services when they bill for medical services, having already verified the patient's Medicaid eligibility. Interpreters could in no way be considered employees of the state. Providers could choose to work with agencies that met their needs, or they could contract directly with interpreters, or even hire more staff interpreters. Facilities themselves would be left to audit the invoices from interpreters and agencies for fraud. And finally, DSHS could set the reimbursement rate at whatever fit its budget, running the same risk as always: that if reimbursement is too low, providers will stop seeing Medicaid patients.

There are also some drawbacks to this system. First of all, DSHS would have to create a new electronic billing code, with all the attendant technology and training costs. Small healthcare providers with limited expertise in language access programs would be at a disadvantage, both in finding interpreters and in having to front the cost of interpreter services while waiting for reimbursement. The principle drawback of this model, however, is that it does nothing to address the conditions that are causing a shortage of qualified interpreters willing to work for DSHS. It does not guarantee a living wage or better working conditions to interpreters. It creates

no incentives for improving the quality of interpreter services, unless the rigid rule set under with DSHS interpreters are forced to function is eradicated.

If measures to address these concerns were put in place together with a direct billing system, this model could succeed in meeting all stakeholders' needs as well as lowering costs to the State.

On-line scheduling

A fourth model for lowering costs and improving interpreter services is the establishment of an on-line interpreter scheduling system that could remove agencies and/or the brokers from the equation altogether.

Like an on-line registry, on-line scheduling systems allows those looking for interpreters to search a large interpreter database on the basis of multiple search parameters. So a scheduler might search, for example, for a female Somali interpreter, who is both trained and DSHS-qualified, and who is available on January 22nd at 2:00 for one hour in Redmond. The service brings up all the interpreters registered on the database who meet the criteria. The scheduler can then either send a text message to one specific interpreter or send an email "blast" to all interpreters who meet the criteria. Interpreters are linked to the service through their Blackberries, I-phones or other electronic communication devices, and so can respond rapidly to either accept or decline the offer of work. Once an interpreter accepts the appointment, the service no longer lists the interpreter as available for that time frame and her name would not come up if another scheduler tried to book a Somali interpreter at the same time.

Several such on-line booking services exist. Two were reviewed for this report:

- The Portal, developed and maintained by Fluency, Inc in Sacramento, California. The Portal is being used by many interpreter agencies around the country. It is also being piloted, with a grant from The California Endowment, as the regional interpreter scheduling system for healthcare facilities in Alameda County, California. More information is available at www.gofluently.com.

- Eduardo Zaldibar of e-interpreters.com in Everett, Washington has also developed on on-line scheduling system for interpreters. The service is currently being redesigned and should be ready for piloting in early 2010.

Both of these services are proprietary, and the developers would expect a minimal fee for each scheduled appointment. In return, they would manage and maintain the on-line service.

An on-line scheduling program is only part of an integrated system, requiring five components:

1. An organizational home, rather like an interpreter agency, that could be an independent non-profit organization or an initiative of a larger organization such as the Washington Federation of State Employees. It would require only a small local office in the region being served with perhaps two employees, a locked file cabinet and a computer,

2. An on-line scheduling system, such as the ones described above, customized, managed and maintained by the original designers. In return, these would receive a small fee per appointment booked.

3. Interpreters, who would apply to Interpreters Online to be registered in the service.

4. Medicaid providers, whose schedulers would use the on-line scheduling system to book interpreters.

5. DSHS, which would audit the whole process.

In this model, the organizational home for the program recruits, vets and registers interpreters on the service. For ease of discussion, this organization will be referred to in this report as "Interpreters Online." In one scenario, interpreters would need to meet certain criteria before they would be allowed into the program: they would be required to have basic training, be certified, and accrue a certain number of continuing education credits every year. In another scenario, any interpreter could be registered in the service, but interpreters who meet certain qualifying criteria would come up first in any search. Interpreters Online verifies interpreters' credentials, has them sign HIPPA compliance forms, and signs them to contracts. It also registers healthcare facilities that wish to use the service, training their schedulers on how to use it and providing problem-solving services.

When a scheduler is looking for an interpreter for a Medicaid patient then, she first accesses the on-line service. The scheduling interface asks the scheduler to enter the patient's DSHS Client Identification number (voucher number, medical coupon number), and the date and the type of the proposed service. The scheduling interface searches www.wawebmed.gov to see if the patient will be eligible for the proposed services at the proposed appointment date. If the answer is affirmative, a message shows on the interface informing the scheduler that Interpreters Online will bill DSHS for the interpreter for this patient. If the answer is negative, the scheduler will be informed that Interpreters Online will bill the facility for the interpreter. This allows the scheduler to cancel if she wishes to use another interpreting resource for this patient.

If the scheduler wishes to continue, a series of query screens lead the scheduler through the processes of designating search parameters. When submitted for search, the parameters will result in a list of interpreters who meet the search criteria. Clicking on an interpreter's name will produce the interpreter's entire profile. Or a scheduler can search for a specific interpreter, perhaps one who has provided superior service in the past. If the interpreter is already booked for that time period or has blocked out that time on the schedule, his or her name will not appear.

Once the search has been completed, the scheduler can send out an offer of work to either one or multiple interpreters. This invitation is sent as a text message to the interpreters' electronic messaging service (I-phone, Blackberry, etc.), through which they will be able to rapidly respond directly to the scheduler. The interpreter can also use the booking service to check his or her appointments and to download directions to the hospital, or even directions within the hospital to the exact clinic where he or she needs to go.

When the interpreter completes the encounter, the interpreter can use the same I-phone or Blackberry to register a confirmatory signature and time stamp from the healthcare facility. This will automatically trigger the release of an electronic invoice to Interpreters Online. Interpreters Online uses the electronic invoices to create weekly billings to either the hospital or DSHS. Payments to Interpreters Online are transferred electronically into interpreters' bank accounts, speeding up the payment process.

A service such as the one described above can only work if a critical mass of its users find that it meets their needs. Earlier in this report, we reported 20 criteria identified by various stakeholders as requisite for their participation. A review will show how well the service described above meets their needs.

1. Interpreter schedulers must be able to identify, schedule and receive a confirmation from qualified interpreters in a timely and efficient manner.
   The on-line scheduling system linked to I-phones and Blackberries significantly speeds up the identification of and communication with interpreters. By vetting interpreters before they are allowed to register, the service assures that any interpreter found on the service will be qualified.

   Facilities that are do not currently schedule their own interpreters, but that instead depend on agencies to locate and book them, will find that this system places a large demand on their internal staff. One administrator interviewed for this report felt this would make the system too onerous for them to use.

2. Interpreter schedulers must have a way to provide feedback about the quality of the interpreter's service (timeliness, no-show rate, quality of interpreting).
   The on-line scheduling system can be set up with a feedback option such as those found on E-bay. Users can rate the interpreters whose services they have utilized; users can even customize their preferences so that the system will routinely exclude interpreters with whom they have had a negative experience.

3. Healthcare institutions need to be assured that each interpreter has signed a HIPPA agreement and an acknowledgement of the Code of Ethics, that each has liability insurance, and that measures to assure competency are in place.
   Interpreters Online would have the responsibility of vetting each interpreter and keeping copies of key documents in their locked files.

4. Healthcare institutions need to work through a secure portal so that any patient information that is transmitted will be secure.
   Both of the on-line scheduling programs reviewed for this report utilized high-level encryption to ensure the security of patient information.

5. Healthcare administrators need to be provided with utilization reports.
   The electronic nature of the booking service makes it easy to generate utilization reports.

6. Interpreter schedulers must have a way to resolve issues with individual interpreters and must be able to track interpreters who have been blacklisted.
   Interpreters Online could potentially work with interpreters who have received complaints to help them improve. As mentioned above, facilities could adjust their search preferences to eliminate interpreters who they feel have acted unprofessionally.

7. Interpreters must be able to be scheduled and to receive instructions on when and where to arrive.
   The on-line scheduling system makes it easy for interpreters to be found, to be scheduled, to respond to job offers and to find directions to the appointments.

8. Interpreters must be able to document length of service.
   The electronic signature feature allows easy electronic documentation of length of service.

9. Interpreters must earn a reasonable per-hour rate.
   Regarding pay rates, please see the financial analysis at the end of this section.

10. Interpreters must be able to build a provider clientele based on the quality of their service.
    The electronic scheduling system allows providers to ask for specific interpreters if they have been particularly skillful. However, only providers' offices can book interpreters, so neither patients nor interpreters themselves can manipulate the service. It is true that in the past there have been examples of interpreters convincing schedulers to give them preference in booking, and this service would not prevent that problem.

11. Interpreters must be paid within 30 days.
    As long as DSHS requires 30 days to pay on invoices once they are submitted, it will not be possible to guarantee payment to interpreters within 30 days. However, if an electronic invoice is generated as soon as the service is provided, and if Interpreters Online invoices DSHS weekly and pays through electronic deposit as soon as payment is received from the State, the current delays in payment could be significantly reduced.

12. Interpreters must have incentives to seek out basic training, certification and continuing education.
    The service described above includes various mechanisms to motive interpreters to take basic training, get certified/qualified and pursue continuing education. First, the service could be set up so that only interpreters who meet these criteria will be allowed to register. Or the service could be set up so that interpreters who meet these criteria appear first in a search. Also, the inclusion of a vetted profile on-line and a feedback option for the schedulers creates motivation for interpreters to continue to improve their skills and provide better service.

13. DSHS must be able to assure that interpreter services are being provided **only** to patients who are eligible for the specific Medicaid health service at the time of service provision.
    Theoretically, this service could be tied into www.wawebmed.gov, just as the brokers currently are, to assess electronically whether or not a patient is eligible for particular service at a particular time. Whether this is technically possible is a question for the DSHS Information Technology experts and the programmers for the chosen on-line scheduling system.

14. DSHS must be able to prevent the types of fraud that led to the establishment of the brokerage service.
    This service precludes many types of fraud, however, no service will completely eliminate the threat of fraud. The service will eliminate double billing, interpreters booking for patients, and interpreters billing for non-existent patients.

15. DSHS must assure that interpreters cannot be construed to be employees of DSHS.

Under the service described above, interpreters would certainly not be considered employees of the state. It would be the responsibility of Interpreters Online to assure that interpreters are not construed to be its employees.

16. DSHS must be able to process invoices without undue administrative burden.
    DSHS would receive and pay one invoice per week from each regional office of Interpreters Online.

17. DSHS must be able to audit services and payment.
    Auditing with this service could be done in person at the Interpreters Online office, or electronically through the on-line service.

18. DSHS must be able to safeguard client information according to DSHS standards.
    The encryption programs utilized by both on-line scheduling systems reviewed for this report were quite robust and would most probably meet, or could be upgraded to meet, DSHS standards.

19. DSHS must be able to assure that interpreter services are being provided by certified/qualified interpreters who have passed a TB test and a background check. In addition, if mileage is being charged, DSHS must have proof that the interpreter has the appropriate car insurance.
    As mentioned above, Interpreters Online would have the responsibility of vetting each interpreter's documentation, including TB tests, background checks, and car insurance.

21. DSHS must have a service that stays within its budget and, if possible, reduces costs to below the current average of $58.86 per encounter.
    At this time, DSHS pays $34/hour to the interpreter agencies, an average of about $8 per appointment to the brokers and about $8 per appointment to reimburse for mileage. The average encounter runs 1.25 hours, meaning that a typical appointment costs DSHS about $59. About $51 is paid to the interpreter agency, of which about $34 ($26 fee plus $8 in mileage) goes to the interpreter.

    In the system described above, costs break down as follows for a **pilot program in the busiest region (King County),** which could expect about 105,373 hours of interpreting, or about 83,629 encounters per year, based on demand in SFY 2009.[13]

Billing entity	Description of Fee	Cost per encounter
On-line scheduling system	The Portal, for example, has a standard billing service that results in a fee of about $.75 - $1.40 per appointment booked, depending on volume. At the volume calculated above, the fee would be $0.75 per encounter.	$0.75
Interpreters Online	Based on an annual budget of about $500,000 to establish and maintain Interpreters Online, the	$6.00

[13] Source: *Regional Cost Report by Hours Served,* data provided by HRSA in response to Public Disclosure Request 70992.

	organization would need to charge a $6 fee per encounter.	
Interpreters	Mileage (at current average) Fee ($34.30/hour, assuming an average length of encounter of 1.26 hours)	$8.00 $43.22
TOTAL		**$57.97**

In this scenario, interpreters could be paid an hourly rate of around $34/hour without raising costs for the State. While still lower than the rates paid to interpreters by the courts or by Labor and Industry, this is a significant increase for Medicaid interpreters, one which would lead to a more stable and more qualified pool of interpreters willing to serve Medicaid patients and to invest in basic training, certification and continuing education in order to be able to participate in the on-line scheduling system.

In summary, a service such as the one described above has the potential to meet almost all of the requirements identified by interpreter schedulers, by interpreters and by DSHS as necessary for success. The service would improve the quality of interpreting by paying a wage to freelance interpreters that will attract the best interpreters and that will motivate interpreters to get trained and certified and to take continuing education. The service would cost no more that the State is currently paying. By lowering the interpreter fee, for example from $34/hour to $32/hour, the State could save over $607,000, based on SFY 2009 volumes. .

The initial establishment of such a service would not be expensive, since the greatest cost – the development of the on-line scheduling system – has already been paid by the system designers and would be paid over time through their fees.

Recommendations

It is clear that the current system for scheduling and paying for interpreters for Medicaid patients has become so unwieldy that many of the end players (providers and interpreters) are opting out of participation. While this result may contain costs for the state, it does not bode well for the quality of communication and care being provided to Medicaid patients or for the future of the program if the labor pool becomes too unstable.

Stakeholders from all the interest groups in this discussion have valid concerns, and any viable modification to the current system must address these concerns. The goal is to implement a stable and sustainable program to provide interpreters to Medicaid patients at a reasonable cost. In the exploratory research conducted for this report, the last two models discussed above (direct reimbursement to providers who manage their own interpreter services, and the direct contracting of interpreters by the brokers using an on-line scheduling system) show promise in meeting more of the stakeholders' needs than the current program. More extensive consultation between stakeholder groups is needed, however, to assure that a system based on these or any new model would be workable, sustainable and cost-effective.

It is this report's primary recommendation, then, that **the system to schedule and pay interpreters for Medicaid patients be reconfigured so as to remove the multiple layers of administration** that account for too large a percentage of total program costs. If possible, both the brokers and the interpreter agencies should be removed from the arrangement; however at

least one of these two should certainly be removed. Currently, the brokers verify patient eligibility and audit billing, while agencies schedule interpreters. Direct contracting of interpreters by DSHS (the current model employed by L&I) while maintaining the current rate to interpreters of $34/hour could contain costs by shifting the scheduling function onto providers. Safeguards to avoid fraud, however, would have to put in place by the State, potentially raising personnel costs. Eliminating interpreter agencies could contain costs and increase pay to interpreters by shifting the scheduling function to the brokers, while on-line scheduling and billing could allow these to conduct this function with little increase in personnel. In either case, the end result must be to contain costs and create working conditions that will assure an adequate and stable pool of qualified interpreters.

This report's second recommendation is that an **Interpreter Services Advisory Group be formed** that involves members of key stakeholder groups to discuss the results of this report and recommend a system of reforms to the current system of scheduling and paying for interpreters for Medicaid patients. It is critical that this Advisory Group be comprised of individuals who are already familiar with the history of the current system and the issues involved in scheduling and paying for interpreters. The Advisory Group should certainly include healthcare administrators in charge of language access programs, private practice providers, administrators from the current contracted brokers, staff involved with interpreter services at HRSA, and interpreters themselves. The recommendations from the Advisory Committee must be accorded the weight of authority, and a change to the current system must be required by January 2011 at the latest.

A third recommendation of this report is that the **state provide greater incentives and support for private entities working to recruit, train and encourage healthcare interpreters.** It is in the interest of the state to promote, at least temporarily, the development of this new category of professional, considering the large number of Washington residents who require interpreters to effectively access public services.

The fourth and final recommendation of this report is that, in the long term, the state consider the potential benefits of **consolidating into one office language services for all state-run services**. While differing funding streams and reporting requirements may make this move untenable, it might lower costs by eliminating duplicative administrative services and simplifying reporting and billing protocols.

Summary

The current system being used to schedule interpreters for Medicaid patients is resulting in a shortage of qualified interpreters and intense frustration among providers trying to schedule interpreters. In order to simplify the system, make it more efficient, and at the same time increase interpreter pay and control overall costs, the system should be reconfigured to eliminate the multiple intermediaries between the payor (the State) and the service providers (the interpreters). The efficacy of technological advances such as an online scheduling service or of direct reimbursement to providers need to be evaluated as possible options. In order to do this, an Advisory Group should be formed from system stakeholders to make firm recommendations as to system renovation.