Interpreter Services for Limited English Speakers (ISLES)

Reconfiguration of the Department of Medical Assistance Service's Interpretation Reimbursement Model and Creation of Interpreter Qualifications to Strengthen Virginia's Compliance With Health Equity Standards Outlined in Title VI

The Greater Good Initiative
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POLICY BRIEF

Across the United States, one of the primary barriers preventing individuals with Limited English Proficiency (LEP) from accessing sufficient healthcare is a lack of interpreter services offered by medical providers. In 2018, an estimated one in fifteen people living in the United States had LEP, and this number is only projected to increase.[1] Come 2050, an estimated 67 million individuals living in the United States will have LEP, exacerbating the already-pressing demand for strengthened language services in healthcare settings.[2] Per Title VI of the Civil Rights Act of 1964, federally funded health institutions are required to provide interpreter services for LEP patients.[3] However, in Virginia--as it is in most states--medical providers are not reimbursed for sourcing interpreter services, financially disincentivizing, if not preventing, providers from upholding this requirement.[4] The consequences of a lack of language services are dire: among the general United States population, LEP individuals are the least likely to receive preventative care, have access to care, or be satisfied with their care; further, LEP individuals are significantly more likely to suffer adverse effects from drug complications, meager understanding of diagnoses, lower health literacy, and an increased risk of being misunderstood by their physicians.[5] Each of these factors contributes to a lower return rate for follow-up visits, which increases LEP individuals' propensity for poorer health outcomes.[6] Given that Northern

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[1] Neira, L. (2018, August 22). *The Importance of Addressing Language Barriers in the US Health System*. Duke Personalized Health Care. https://dukepersonalizedhealth.org/2018/07/the-importance-of-addressing-language-barriers-in-the-us-health-system/

[2] Ibid.

[3] Title VI Of The Civil Rights Act Of 1964 42 U.S.C. § 2000d Et Seq. (2020, June 26). Retrieved October 25, 2020, from https://www.justice.gov/crt/fcs/TitleVI-Overview

[4] Juckett, G., & Unger, K. (2014, October 1). *Appropriate Use of Medical Interpreters*. American Family Physician. https://www.aafp.org/afp/2014/1001/afp20141001p476.pdf

[5] Ibid.

[6] Neira, L. (2018, August 22). *The Importance of Addressing Language Barriers in the US Health System*. Duke Personalized Health Care. https://dukepersonalizedhealth.org/2018/07/the-importance-of-addressing-language-barriers-in-the-us-health-system/

Virginia has rapidly become one of the most ethnically and linguistically diverse regions in the nation, accounting for at least 40% of the state's population growth over the last decade, many residents of the Commonwealth intimately understand the threats of illness, grief, and loss a lack of proper interpretation services can impose.[7]

It is exceedingly clear that not only a lack of interpreter services, but a lack of trained and qualified interpreters can and will put the livelihood of LEP patients at stake. However, the current guidelines established within the contracts between DMAS and MCOs do not clarify which requirements providers' must identify in an interpreter beyond that they must be a "trained professional."[8]

To ensure full compliance with Title VI of the Civil Rights Act of 1964, we propose that the Department of Medical Assistance Services (DMAS), in their contracts with Managed Care Organizations (MCOs), establish standards that interpreters hired by MCOs must meet. We recommend that DMAS amend their contracts authorizing MCOs to administer Medallion 4.0[9] and Commonwealth Coordinated Care Plus[10] to require that MCOs only hire interpreters who "demonstrate competency and skills in medical interpretation techniques, ethics, and terminology,"[11] which constitute three of the main categories of the National Board of Certification for Medical Interpreters' oral and written exams.[12] Additionally, we advise DMAS

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[7] Language Diversity in Northern Virginia. (2020, April 14). Retrieved October 25, 2020, from https://pglsinc.com/language-diversity-in-northern-virginia/

[8] *Medallion 4.0 Managed Care Services Agreement*. Department of Medical Assistance Services. https://www.dmas.virginia.gov/files/links/5400/Medallion%204.0%20Contract%20SFY21v2.pdf

[9] Ibid.

[10] *COMMONWEALTH COORDINATED CARE PLUS MCO CONTRACT FOR MANAGED LONG TERM SERVICES AND SUPPORTS*. Department of Medical Assistance Services. https://www.dmas.virginia.gov/files/links/5384/FINAL%20CCC%20Plus%20Contract%20Effective%20July%202020.pdf

[11] (2012, October). *New York State Medicaid Update*. New York State Department of Health. https://www.health.ny.gov/health_care/medicaid/program/update/2012/oct12mu.pdf

[12] Candle, E. (2012, December). *New York Medicaid Coverage of Language Services & Medical Interpreter Qualification Requirements*. International Medical Interpreters Association. https://www.imiaweb.org/uploads/docs/Eric_Candle_IMIA_medicaid_coverage_presentation_12_14_2012_1.pdf

in their contracts to recommend, but not require, MCOs to hire interpreters who have passed a credible language proficiency exam or obtained certification as a medical interpreter. Among certifications DMAS may deem indicative of an interpreter's ability to work in a healthcare setting, we propose that DMAS recommend MCOs to hire interpreters who have been "recognized by the National Board of Certification for Medical Interpreters,"[13] although we also encourage DMAS to compile a list of other certifications that would affirm an interpreter's credibility.

Our policy also directs DMAS to create a mechanism by which MCOs can receive reimbursement from DMAS for the cost of language and translation services. By establishing a mechanism to reimburse MCOS for the cost of translation and interpretation services, we hope to reduce the financial burden they assume to cover patients with LEP and incentivize them to allocate more resources to high-quality language services. Virginia could claim the reimbursement costs as an administrative expense, allowing them to draw down matching funds from the federal government.

[13] Ibid.

PRELIMINARY REPORT

What is the problem that you're trying to fix?

In 2010, 14.8 [14] of Virginia's population were labeled as "non-english speakers," a percentage that has increased in the last ten years. Since such a large portion of Virginians have limited English proficiency (LEP), it can often be difficult for them to receive adequate health care that they properly understand. Currently, Virginia Managed Care Organizations (MCOs) do not have the ability to claim reimbursement from the Department of Medical Assistance Services (DMAS) for money spent on language translators. Claiming these refunds will assist MCOs in hiring an increased number of translators without straining financial resources, helping improve communication between Virginia providers and their Medicaid patients.

Furthermore, contracts between DMAS and MCOs do not specify standards interpreters must meet in order to be deemed hirable by MCOs. Contracts between DMAS and MCOs establish that interpreters must be "trained professionals," but offer no further guidance about what qualifies an interpreter to work in a healthcare setting.[15] Bolstering interpreter standards could help improve the quality of translation and interpretation services in Virginia.

What is the solution proposed?

We propose that the DMAS amend each of their contracts with MCOs to establish standards that interpreters hired by MCOs must meet to ensure full compliance with Title VI of the 1964 Civil Rights Act. According to the "Medallion 4.0 Managed Care Services Agreement," contract amendments "are mutually agreed to in writing by the Contractor and the

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[14] *United States Census Bureau.* (2010). Retrieved October 22, 2020, from https://data.census.gov/cedsci/table?q=languages+spoken+in+virginia

[15] *Medallion 4.0 Managed Care Services Agreement*. Department of Medical Assistance Services. https://www.dmas.virginia.gov/files/links/5400/Medallion%204.0%20Contract%20SFY21v2.pdf

Department."[16] Our policy advises DMAS to create a standard that MCOs must hire interpreters who "demonstrate competency and skills in medical interpretation techniques, ethics, and terminology," three interpreter standards adopted by New York.[17] We also encourage DMAS to recommend that MCOs hire certified medical interpreters and compile a list of certifications and language proficiency exams that would affirm an interpreter's value to a MCO. New York, for example, recommends the use of interpreters who have been "recognized by the National Board of Certification for Medical Interpreters."[18]

In addition to raising standards that interpreters hired by MCOs must meet, our policy calls for DMAS to reimburse MCOs for costs related to translation and interpretation services. MCOs are financially disincentivized from offering high-quality language services since doing so could attract more patients with LEP who tend to cost more than patients who do not require medical interpreters.[19] Creating a mechanism of reimbursement for the cost of language services aims to remedy this financial disincentive. To help cover reimbursement costs, we recommend that the Commonwealth of Virginia draws down federal matching funds. By claiming translation and interpretation services as an administrative cost, Virginia can receive reimbursement from the federal government, either at the standard 50% federal matching rate[20] or at a 75% matching rate, which applies to language services offered to "'children of families for whom English is not their primary language,' and family members of these children."[21]

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[16] *Medallion 4.0 Managed Care Services Agreement*. Department of Medical Assistance Services. https://www.dmas.virginia.gov/files/links/5400/Medallion%204.0%20Contract%20SFY21v2.pdf
[17] (2012, October). *New York State Medicaid Update*. New York State Department of Health. https://www.health.ny.gov/health_care/medicaid/program/update/2012/oct12mu.pdf
[18] Ibid.
[19] Ku, L., & Flores, G. (2005, March). *Pay Now Or Pay Later: Providing Interpreter Services In Health Care*. Health Affairs. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.24.2.435
[20] *Translation and Interpretation Services*. Medicaid.gov: the official U.S. government site for Medicare. https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services/index.html
[21] Ibid.

Why was this specific issue chosen?

As linguistic demographics across the United States become increasingly diverse, a lack of language services offered by healthcare providers prevents a rising number of LEP individuals from receiving sufficient medical treatment. As of 2013, more than 350 million languages were spoken across the United States.[22] Within the last decade, the number of Spanish and Asian language-speaking individuals grew by 50%, and this figure is only projected to increase.[23] In Northern Virginia, linguistic diversity growth rates supersede the national average: In Fairfax County, 39.2% of residents are non-English, whereas the average percentage of non-English speakers per county across the United States is 21.9%.[24] An increasingly diverse linguistic demographic correlates with an increased number of LEP individuals, and several studies[25] have revealed that LEP individuals are frequently provided insufficient medical care.[26] Challenges LEP individuals experience when seeking healthcare include a "delay or denial of services, issues with medication management, and an underutilization of preventive services."[27] Further, the Institute of Medicine of the National Academies reports that individuals who do not receive effective health communication consequently "fail to enroll in health coverage programs, fail to

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[22] Rodriguez, C. (2013). *9 Language Access Assurances in Health and Human Services: Analysis of Existing Policy Options and Recommendations for Improvement* (Powerpoint Presentation). Retrieved from https://docs.google.com/document/d/1ZQgPdylunD-JQE3yQrdIK87j4G5Os2sXYckerjZuZIU .

[23] Ibid

[24] (n.d.). *Languages in Virginia (State)*. Statistical Atlas. Retrieved October 26, 2020, from https://statisticalatlas.com/state/Virginia/Languages

[25] Betancourt, J. R., Renfrew, M. R., Green, A. R., Lopez, L., & Wasserman, M. (2012, September). *Improving patient safety systems for patients with limited English proficiency: a guide for hospitals* (AHRQ Publication No. 12-0041). Agency for Healthcare Research and Quality. https://www.ahrq.gov/sites/default/files/publications/files/lepguide.pdf

[26] Moissac, D. D., & Bowen, S. (2018). Impact of Language Barriers on Quality of Care and Patient Safety for Official Language Minority Francophones in Canada. *Journal of Patient Experience, 6*(1), 24-32. doi:10.1177/2374373518769008

[27] Au, M., Taylor, E. F., & Gold, M. (2009, April). *Improving Access to Language Services in Health Care: A Look at National and State Efforts*. Mathematica. https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/factsheets/literacy/langserv/languageservicesbr.pdf

make certain that their dependents are covered, neglect to seek preventative care, and tend to make medication and treatment errors because they cannot follow patients' instructions."[28]

It is overwhelmingly apparent that not only a lack of interpreter services, but a lack of trained and qualified interpreters can and will put the lives of LEP patients at stake. However, the current guidelines established within the contracts between DMAS and MCOs do not clarify which requirements providers' must identify in an interpreter beyond that they must be a "trained professional," creating a concerning sense of ambiguity surrounding standards of interpretation services.[29] Understanding the consequences that LEP individuals suffer when provided a lack of quality interpreter service, our policy aims to tighten the restrictions concerning interpreters' qualifications.

In addition, our policy recognizes that in order to secure qualified interpreters, providers must be capable of financing interpretation services. To mitigate providers' current financial disincentive to expand language services, our policy proposes a reimbursement model that allows healthcare providers to bill DMAS to receive funding for their language service-related expenditures. Pairing a recommendation to expand interpreters' service qualifications with a reimbursement mechanism that expands providers' capacity to afford quality language services, our policy aims to counteract the unjust commonality of poor health outcomes for LEP patients.

What were the broad questions that guided research into this issue?

Several questions guided our research about the use of medical interpretation and translation services in Virginia. Why should reform of language services in healthcare target

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[28] Rodriguez, C. (2013). *9 Language Access Assurances in Health and Human Services: Analysis of Existing Policy Options and Recommendations for Improvement* (Powerpoint Presentation). Retrieved from https://docs.google.com/document/d/1ZQgPdylunD-JQE3yQrdIK87j4G5Os2sXYckerjZuZIU .

[29] *Medallion 4.0 Managed Care Services Agreement*. Department of Medical Assistance Services. https://www.dmas.virginia.gov/files/links/5400/Medallion%204.0%20Contract%20SFY21v2.pdf

Medicaid, and what are the current language-related inequities in the healthcare system? Researching inequitable access to translation and interpretation services led us to identify "cost and lack of reimbursement" as major obstacles to "providing adequate language services for LEP patients."[30] How do language barriers between patients and providers affect care and treatment in a healthcare setting? What qualities qualify an interpreter to work with patients and providers? This guiding question led us to identify several examples of interpreter qualifications set by other states that could be incorporated into the contracts between DMAS and MCOs. What mechanisms do other states employ to reimburse providers or Managed Care Organizations for translation and interpretation services? What methods (telephonic, in-person, etc.) do healthcare providers use to communicate with non-English speaking patients? Are there other forms of discriminations against non-English speakers in the public health sector?

What is the relevance of the issues to the Commonwealth and its citizens?

According to data from the U.S. Census Bureau, over nearly 16.8% of Virginians speak a language other than English at home.[31] This number is a little over 2% higher than the reported 14.1% of Virginia residents who spoke a second language in 2010 [32], meaning that in the span of ten years, the number of bilingual Virginia occupants increased by approximately 240,043 [33] . This indicates that the population of second language speakers is increasing in Virginia. In order to keep up with the growing linguistic diversity in the Commonwealth, healthcare systems must

[30] Baruch, E. (2013, July). *How Language Access Issues Affect Patients, Policymakers and Health Care Providers*. The Colorado Trust. https://www.coloradotrust.org/sites/default/files/CT_LanguageAccessBrief_final-1.pdf

[31] *United States Census Bureau.* (2019). Retrieved October 22, 2020, from https://data.census.gov/cedsci/table?q=languages%20spoken%20in%20virginia&tid=ACSST1Y2019.S1601

[32] *United States Census Bureau.* (2010). Retrieved October 22, 2020, from https://data.census.gov/cedsci/table?q=languages%20spoken%20in%20virginia&tid=ACSST5Y2010.S1601

[33] Ibid.

adjust. Currently, MCOs are responsible for hiring interpreters in Virginia, but they do not receive reimbursement from DMAS for the cost of language services. This policy would allow MCOs to bill DMAS and request reimbursement for the cost of translation and interpretation services. In order to afford the growing costs of hiring interpreters due to increasing linguistic diversity in Virginia, DMAS can draw down matching funds from the federal government. Easing the process of attaining qualified translators will help Medicaid patients with LEP access more comprehensive healthcare.

Why is this an issue that requires governmental response?

Permitting MCOs to request reimbursement for language services and establishing standards that qualify an interpreter to work with Medicaid patients requires governmental response because both actions change how Medicaid is administered. DMAS, as the state Medicaid agency of Virginia, would be responsible for implementing our proposed changes. Guidelines that allow MCOs to request reimbursement from DMAS for language services will help MCOs afford qualified medical interpreters and avoid unnecessary mistakes caused by miscommunication between the provider and patient. Under Title VI of the Civil Rights Act, "recipients of Federal financial assistance [are required] to take reasonable steps to make their programs, services, and activities accessible by eligible persons with limited English proficiency"[34]. As a recipient of Federal financial assistance, DMAS is obligated to uphold the quality of translation and interpretation services and ensure that they are widely accessible.

[34] *Limited English Proficiency*. (n.d.). HHS. Retrieved October 24, 2020, from https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html#:~:text=Title%20VI%20of%20the%20Civil,persons%20with%20limited%20English%20proficiency

What are the arguments for the creation of the programmatic or policy response to issues that will be proposed?

The expanding number of languages spoken across Virginia, the significant increase in Medicaid enrollees in Virginia over the past four years, and the lack of accountability concerning Medicaid standards of linguistic equity as outlined in Title VI convergently illuminate a stark need for interpreter service reimbursement reform within Virginia's Medicaid framework. From January of 2016 to June of 2020, the number of Medicaid enrollees in Virginia increased by 56.85%, with the sharpest increase occurring in the initial months of the COVID-19 pandemic.[35] Given the consistent increase in Medicaid enrollees and the probable longevity of the effects of COVID-19, Medicaid enrollees will likely continue to rise.

In tandem with the growing number of individuals on Medicaid, the meager system of accountability upholding linguistic equity standards set by Title VI affirms the need to approach language service reimbursement reform through a Medicaid-focused approach. The lack of definitive linguistic equity standards upheld in the contracts between DMAS and MCOs challenges healthcare providers' abilities to adhere to equity standards defined in Title VI.[36] Under Title VI, "all providers who receive funds from HHS for the provision of Medicaid services are obligated to make language services available to those with limited English proficiency (LEP)."[37] However, language interpretation services are not classified as mandatory 1905 services, meaning that states are not required to reimburse providers for the cost of language services, nor are they required to claim reimbursement related costs to Medicaid

[35] Virginia | Data.Medicaid.gov. (2020). Retrieved October 25, 2020, from https://data.medicaid.gov/Enrollment/Virginia/gvkx-jbkx/data

[36] Rodriguez, C. (2013). *9 Language Access Assurances in Health and Human Services: Analysis of Existing Policy Options and Recommendations for Improvement* (Powerpoint Presentation). Retrieved from https://docs.google.com/document/d/1ZQgPdylunD-JQE3yQrdIK87j4G5Os2sXYckerjZuZIU .

[37] Title VI, Civil Rights Act of 1964. (2020). Retrieved October 25, 2020, from https://www.dol.gov/agencies/oasam/regulatory/statutes/title-vi-civil-rights-act-of-1964

(DMAS).[38] However, states may consider language service expenditures within the general rate of reimbursement "for the underlying direct service," mandating Medicaid providers to offer language services for LEP; yet, this provision must be offered at their own expense.[39] The financial burden imposed on healthcare providers seeking to reimburse interpreters disincentivizes the expansion of vital language services. Jointly considering Virginia's high volume of Medicaid enrollees with its minimal systemic accountability surrounding language services as dictated in the contracts between DMAS and MCOs, focusing our reimbursement reforms on the Medicaid system represents a high-need, high-impact policy route.

What is the basic form of your policy response?

Our policy directs DMAS to amend their contracts with MCOs to establish qualifications that interpreters hired by MCOs must meet. The policy we propose also calls for contracts between DMAS and MCOs to specify forms of certification that would affirm an interpreter's value to a Medicaid provider. For example, New York recommends, but does not require that their Medicaid providers use interpreters who are "recognized by the National Board of Certification for Medical Interpreters".[40] Although recommending that MCOs use interpreters who have passed a credible language proficiency exam or received certification as a medical interpreter would help MCOs improve the quality of their language services, requiring MCOs to only use nationally certified interpreters would be too restrictive, since only 47 interpreters in Virginia have been nationally certified by the National Board of Certification for Medical

[38] *Translation and Interpretation Services*. Medicaid.gov: the official U.S. government site for Medicare. https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services/index.htmll
[39] Ibid.
[40] (2012, October). *New York State Medicaid Update*. New York State Department of Health. https://www.health.ny.gov/health_care/medicaid/program/update/2012/oct12mu.pdf

Interpreters.[41] Our policy also calls for DMAS to reimburse MCOs for the cost of translation and interpretation services, following the example of 15 states that offer a direct form of reimbursement for language services. [42] By reimbursing providers for translation and interpretation services, Virginia could claim reimbursement costs as an administrative expense and draw down federal matching funds to help cover expenditures.

What ongoing questions do you have?

Several questions emerged from our research about the use of interpretation and translation services in Virginia's Medicaid healthcare system. For example, should contracts between DMAS and MCOs establish when in-person interpreting is appropriate as opposed to telephonic interpreting? Do Medicaid providers in Virginia receive training about how to work in a triadic model of care, or one that involves a patient and an interpreter? As we move forward with this policy, how can we uphold the quality of interpretation for less commonly spoken languages and ensure that they are widely accessible?

[41] *Search the CMI Registry*. The National Board of Certification for Medical Interpreters. https://www.certifiedmedicalinterpreters.org/search-cmi-registry

[42] Youdelman, M. (2017, February 7). *Medicaid and CHIP Reimbursement Models for Language Services*. National Health Law Program. https://healthlaw.org/wp-content/uploads/2017/02/Medicaid-CHIP-LEP-models-FINAL.pdf

Policy Proposal/Analysis

What is the programmatic or policy response to the problem that was chosen?

Our policy seeks to improve the quality of interpretation services available to Medicaid patients with LEP by establishing standards interpreters must meet in order to work with providers and patients. The standards for interpreters would be specified in the two contracts DMAS signs with MCOs authorizing their right to offer Medallion 4.0[43] and Commonwealth Coordinated Care Plus (CCC Plus)[44]. Our policy calls for DMAS to amend their contracts with MCOs by adding language that requires MCOs to only hire interpreters who "demonstrate competency and skills in medical interpretation techniques, ethics, and terminology."[45] We also recommend that DMAS provide MCOs with a list of language proficiency exams and certifications that affirm an interpreter's value to a Medicaid provider. MCOs would be encouraged by DMAS, but not required, to hire interpreters who have passed one of the designated language proficiency exams or received certification as a medical interpreter.

Additionally, our policy creates a mechanism for MCOs to be reimbursed by DMAS for the cost of translation and interpretation services. By reimbursing MCOs for the cost of language services provided to Medicaid patients, DMAS could draw down matching funds from the federal government to cover 75% of translation and interpretation costs generated by "'children of families for whom English is not their primary language,' and family members of these

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[43] *Medallion 4.0 Managed Care Services Agreement*. Department of Medical Assistance Services. https://www.dmas.virginia.gov/files/links/5400/Medallion%204.0%20Contract%20SFY21v2.pdf

[44] *COMMONWEALTH COORDINATED CARE PLUS MCO CONTRACT FOR MANAGED LONG TERM SERVICES AND SUPPORTS*. Department of Medical Assistance Services. https://www.dmas.virginia.gov/files/links/5384/FINAL%20CCC%20Plus%20Contract%20Effective%20July%202020 20.pdf

[45] (2012, October). *New York State Medicaid Update*. New York State Department of Health. https://www.health.ny.gov/health_care/medicaid/program/update/2012/oct12mu.pdf

children" and 50% of translation and interpretation costs generated by all other Medicaid patients.[46]

Outline the process your policy proposal will take once implemented. Explain any systems that will be in place, administrative changes, agency authority changes, etc.

After the contracts between DMAS and MCOs are amended to establish interpreter standards and create a mechanism of reimbursing MCOs for language services, MCOs would need to develop a method of tracking the cost of translation and interpretation services. In the "Medallion 4.0 Managed Care Services Agreement," a contract between DMAS and health plans, section 15.1.B titled "Financial Report to the Department" describes how contracted parties report expenditures to DMAS:

> "The Contractor shall agree to work with the Provider Reimbursement Division of the Department to develop a financial report that details medical expenditure categories, total member months related to the expenditures, Incurred but Not Reported (IBNR) amounts, and all administrative expenses associated with the Medallion 4.0 Program, to include Medicaid and FAMIS populations."[47]

By tracking the cost of translation and interpretation services, MCOs could report language service-related expenditures in their quarterly financial reports to DMAS and receive reimbursement from the Commonwealth.

Why is this something that should be addressed at the state level?

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[46] *Translation and Interpretation Services*. Medicaid.gov: the official U.S. government site for Medicare. https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services/index.html

[47] *Medallion 4.0 Managed Care Services Agreement*. Department of Medical Assistance Services. https://www.dmas.virginia.gov/files/links/5400/Medallion%204.0%20Contract%20SFY21v2.pdf

Changing policies about Medicaid reimbursement requires DMAS, Virginia's state Medicaid agency, to take action. The federal government can match a percentage of states' Medicaid costs, but deciding how providers and MCOs are reimbursed is left to the discretion of each state. Because Medicaid is a state-administered program, the responsibility to impose interpreter standards also lies with DMAS. We recommend establishing interpreter standards in the contracts agreed to by DMAS and MCOs because MCOs are the entities in Virginia that hire interpreters available for Medicaid patients' use.

Are there alternative responses that should be taken into account?

The National Standards for Culturally and Linguistically Appropriate Services in Health Care, as issued by the U.S. Department of Health and Human services, work to set guidelines and accommodations to manage language barriers.[48] Such arrangements include the incorporation of language-concordant providers free of cost provided by the U.S. Department of Health and Human Services. Another arrangement provides easily understood multimedia materials and signs in various languages to assist communication with LEP individuals. Perhaps the most current and applicable method would be the implementation of technological translation services. A more cost-friendly method, using technology and electronic devices could prove to be an easy way of breaking down language barriers, but the risk of misinterpreting various dialects and short-language terms is high. Another alternative method could alter the structure of Medicaid reimbursement in Virginia. Instead of tasking MCOs with the responsibility of hiring interpreters, DMAS could require providers to hire language services when appropriate. In this case, Medicaid providers, rather than MCOs in Virginia, would request reimbursement from

[48] MinorityHealth. "Culturally and Linguistically Appropriate Services." *Think Cultural Health*, thinkculturalhealth.hhs.gov/clas.

DMAS for the cost of translation and interpretation services. Finally, the responsibility of establishing standards that affirm an interpreter's ability to work in a healthcare setting could lie with MCOs instead of DMAS.

Why is the policy you have proposed the appropriate/best response to the problem you have identified?

Virginia healthcare systems, like every other United States healthcare system, are complex. However, in the State of Virginia the interpreter standards specified in contracts between DMAS and MCOs are insufficient. Contracts must be amended to ensure that interpreters hired by MCOs are qualified to work in a healthcare setting. Our policy attempts to appropriately address the common concern that lack of reimbursement serves a major barrier to providing adequate language services.[49] By enabling them to receive reimbursement for the cost of translation and interpretation services, we hope to financially incentivize MCOs to invest in high-quality language services. Additionally, in complementing our proposed reimbursement reform with a call to expand the qualifications medical interpreters must meet in order to serve, the policy approaches language service enhancement from both the angle of financial incentivization and the angle of quality assurance, ensuring that language services are not only financially feasible for providers serving LEP individuals, but that those services are proficient.

What are the resources that will be needed to carry out this programmatic or policy response?

In order to effectively administer this policy, DMAS will need to provide MCOs with a list of language proficiency exams and certifications that confirm the prospective interpreter's

[49] Baruch, E. (2013, July). *How Language Access Issues Affect Patients, Policymakers and Health Care Providers*. The Colorado Trust. https://www.coloradotrust.org/sites/default/files/CT_LanguageAccessBrief_final-1.pdf

competency in a medical setting. Additionally, the nature of our reimbursement mechanism requires that federal funds are drawn down by DMAS to cover 50-75% of the interpreter service expenses providers will bill DMAS, and DMAS will need to cover the respective 25-50% of reimbursement funds that cannot be drawn down from the federal Medicaid budget. Schewing focus away from fiscal resources, it is recommended that an efficient system is implemented to ensure MCOs can connect LEP individuals or families seeking interpreter service to a qualified interpreter. In order for MCOs to track expenses related to translation and interpretation, they will need to utilize contractual procedures establishing a reimbursement relationship between MCOs and DMAS. For Medallion 4.0 MCOs, it is recommended that contracted parties report expenditures to DMAS, as outlined in the "Medallion 4.0 Managed Care Services Agreement."[50]

What criteria are you using to determine if your policy is successful?

A cost-benefit analysis may be necessary to determine the efficacy of increased budgeting for language services. It is presumed that with a lack of language services in the public health sector, the efficiency of treatment, both in terms of time and cost, suffers. Error rate is also higher due to a lack of clarity in patient-provider communications. Misunderstanding pre-existing medical conditions or possible risks of procedures, for example, are often caused by communication errors.[51] DMAS and healthcare providers should look for an overall decrease in treatment errors caused by inadequate language services as well as increased efficiency of care to determine the efficacy of our policy recommendations.

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[50] *Medallion 4.0 Managed Care Services Agreement*. Department of Medical Assistance Services. https://www.dmas.virginia.gov/files/links/5400/Medallion%204.0%20Contract%20SFY21v2.pdf

[51] *How can states get federal funds to help pay for language services for Medicaid and CHIP enrollees?* (2010). Healthlaw. https://healthlaw.org/wp-content/uploads/2016/11/How-Can-States-Get-Medicaid-and-CHIP-for-Language-Services.pdf

What would happen with the problem if no action is taken and the problem were to continue on unchanged and undisturbed?

Miscommunication in the healthcare setting can have life-threatening implications: without proper communication of information about their treatment or conditions, "patients may fail to comply with instructions or elect not to have potentially life-saving treatment."[52] Miscommunication is "more likely to occur when clinicians use an inadequately mastered" second language because they may struggle to understand culturally-specific terms that patients use to describe pain.[53] Without adequate language services, Patients may not be able to explain the extent of their symptoms, medical history, or other concerns causing significant delays in treatment overall.[54] In the past ten years, Virginia has continued to become more linguistically diverse; in 2019, it boasted 1,352,586 bilingual residents[55]. As this number continues to grow, it becomes even more imperative that the Virginia healthcare system uphold the quality of language services. Reimbursing MCOs for translation and interpretation services and requiring higher standards for interpretation would help Virginia Medicaid providers avoid unnecessary errors and prevent miscommunication with patients about their condition or treatment.

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[52] Meuter, R. F., Gallois, C., Segalowitz, N. S., Ryder, A. G., & Hocking, J. (2015, September 10). *Overcoming language barriers in healthcare: A protocol for investigating safe and effective communication when patients or clinicians use a second language*. National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4566365/

[53] Ibid.

[54] Rice, S. (2014, August 30). *Hospitals often ignore policies on using qualified medical interpreters*. Modern Healthcare. https://www.modernhealthcare.com/article/20140830/MAGAZINE/308309945/hospitals-often-ignore-policies-on-using-qualified-medical-interpreters

[55] *United States Census Bureau.* (2019). Retrieved October 22, 2020, from https://data.census.gov/cedsci/table?q=languages%20spoken%20in%20virginia&tid=ACSST1Y2019.S1601

BUDGET ANALYSIS

Based on expenditures reported by other states that have established mechanisms of direct reimbursement for translation and interpretation services, we predict that our policy will cost Virginia between $5 and $10 million per year, although drawing down matching funds from the federal government to cover at least 50% of the cost would reduce the total annual expense to $2.5-$5 million. In 2006, the Connecticut Health Foundation estimated "the annual cost for providing interpreter services through Connecticut's Medicaid program" to be $4.7 million, resulting in a final annual expense of $2.35 million after drawing down federal matching funds.[56] Connecticut's LEP population of about 269,970 people represents slightly more than half of Virginia's LEP population of 474,360, according to data from 2016.[57] Minnesota, which allows "FFS providers to claim reimbursement for the use of interpreters when providing outpatient services," reported an expenditure of $2,853,177.20 for their reimbursement program in 2015.[58] Minnesota's LEP population, at around 240,114 people, is roughly half of Virginia's LEP population. In 2016, Utah reported spending $78,735.81 on reimbursing FFS providers for language services, although their LEP population at around 138,734 only represents about 30% of Virginia's LEP population.

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[56] Bagchi, A., & Stevens, B. (2006, August). *Interpretation: Estimates for the Cost of Interpretation Services for Connecticut Medicaid Recipients*. Connecticut Health Foundation. http://www.hartfordinfo.org/issues/wsd/health/est_cost_interpreter_services.pdf

[57] Scamman, K. (2018, March 12). Limited-English Proficiency: LEP Populations by U.S. State (Infographic). *Telelanguage: Interpretation and Translation Services*. https://telelanguage.com/limited-english-proficiency-lep-populations-by-u-s-state/

[58] Youdelman, M. (2017, February 7). *Medicaid and CHIP Reimbursement Models for Language Services*. National Health Law Program. https://healthlaw.org/wp-content/uploads/2017/02/Medicaid-CHIP-LEP-models-FINAL.pdf

CONCLUSION

Title VI of the Civil Rights Act of 1964 "prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance."[59] Consequently, all Medicaid providers must utilize translation or interpretation services to communicate with limited English proficient patients. Virginia's Medicaid agency, the Department of Medical Assistance Services (DMAS), instructs Medicaid providers to use "trained professionals" when oral interpretation services are used to communicate "technical, medical, or treatment information" to "the member, a family member or a friend."[60] Managed Care Organizations, which contract with DMAS to administer Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus)--Virginia's two managed care programs--have the responsibility of hiring interpreters when Medicaid patients with limited English Proficiency (LEP) request them. Unlike the 15 states that directly reimburse Medicaid providers for language services,[61] Virginia, which declined to renew a pilot reimbursement program in 2009,[62] does not reimburse MCOs or other Medicaid providers for the cost of language services.

Our policy aims to tighten the compliance of Virginia's Medicaid program with Title VI. We recommend that DMAS amend their Medallion 4.0[63] and CCC Plus[64] contracts to establish standards that interpreters hired by MCOs must meet. Contractually requiring MCOs to hire

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[59] Title VI Of The Civil Rights Act Of 1964 42 U.S.C. § 2000d Et Seq. (2020, June 26). Retrieved October 25, 2020, from https://www.justice.gov/crt/fcs/TitleVI-Overview

[60] *Medallion 4.0 Managed Care Services Agreement*. Department of Medical Assistance Services. https://www.dmas.virginia.gov/files/links/5400/Medallion%204.0%20Contract%20SFY21v2.pdf

[61] Youdelman, M. (2017, February 7). *Medicaid and CHIP Reimbursement Models for Language Services*. National Health Law Program. https://healthlaw.org/wp-content/uploads/2017/02/Medicaid-CHIP-LEP-models-FINAL.pdf

[62] Youdelman, M. (2009). Medicaid and SCHIP Reimbursement Models for Language Services (2009 update). National Health Law Program. https://healthlaw.org/wp-content/uploads/2014/06/2009_Medicaid_SCHIP.pdf

[63] Ibid.

[64] *COMMONWEALTH COORDINATED CARE PLUS MCO CONTRACT FOR MANAGED LONG TERM SERVICES AND SUPPORTS*. Department of Medical Assistance Services. https://www.dmas.virginia.gov/files/links/5384/FINAL%20CCC%20Plus%20Contract%20Effective%20July%202020 20.pdf

interpreters who "demonstrate competency and skills in medical interpretation techniques, ethics and terminology" could uphold the quality of interpretation services utilized by Medicaid patients in Virginia.[65] Following New York's example, we also suggest that DMAS recommend to MCOs that they hire interpreters who are certified or have passed language proficiency exams deemed credible by DMAS. Furthermore, taking into account that "cost and lack of insurance reimbursement for interpreter services were identified as the biggest challenges hospitals face in providing adequate language services for LEP patients," we propose that DMAS establish a mechanism of reimbursing MCOs for the cost of interpretation and translation services.[66] By allowing MCOs to receive reimbursement for language services, our policy aims to ease the financial burden an MCO assumes by investing in high-quality interpretation and translation services.

[65] (2012, October). *New York State Medicaid Update*. New York State Department of Health. https://www.health.ny.gov/health_care/medicaid/program/update/2012/oct12mu.pdf
[66] Baruch, E. (2013, July). *How Language Access Issues Affect Patients, Policymakers and Health Care Providers*. The Colorado Trust. https://www.coloradotrust.org/sites/default/files/CT_LanguageAccessBrief_final-1.pdf

REFERENCES

Au, M., Taylor, E. F., & Gold, M. (2009, April). *Improving Access to Language Services in Health Care: A Look at National and State Efforts*. Mathematica. https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/factsheets/literacy/langserv/languageservicesbr.pdf

Bagchi, A., & Stevens, B. (2006, August). *Interpretation: Estimates for the Cost of Interpretation Services for Connecticut Medicaid Recipients*. Connecticut Health Foundation. http://www.hartfordinfo.org/issues/wsd/health/est_cost_interpreter_services.pdf

Baruch, E. (2013, July). *How Language Access Issues Affect Patients, Policymakers and Health Care Providers*. The Colorado Trust. https://www.coloradotrust.org/sites/default/files/CT_LanguageAccessBrief_final-1.pdf

Betancourt, J. R., Renfrew, M. R., Green, A. R., Lopez, L., & Wasserman, M. (2012, September). *Improving patient safety systems for patients with limited English proficiency: a guide for hospitals* (AHRQ Publication No. 12-0041). Agency for Healthcare Research and Quality. https://www.ahrq.gov/sites/default/files/publications/files/lepguide.pdf

Candle, E. (2012, December). *New York Medicaid Coverage of Language Services & Medical Interpreter Qualification Requirements*. International Medical Interpreters Association. https://www.imiaweb.org/uploads/docs/Eric_Candle_IMIA_medicaid_coverage_presentation_12_14_2012_1.pdf

COMMONWEALTH COORDINATED CARE PLUS MCO CONTRACT FOR MANAGED LONG TERM SERVICES AND SUPPORTS. Department of Medical Assistance Services.

https://www.dmas.virginia.gov/files/links/5384/FINAL%20CCC%20Plus%20Contract%20Effective%20July%202020.pdf

How can states get federal funds to help pay for language services for Medicaid and CHIP enrollees? (2010). Healthlaw. https://healthlaw.org/wp-content/uploads/2016/11/How-Can-States-Get-Medicaid-and-CHIP-for-Language-Services.pdf

Juckett, G., & Unger, K. (2014, October 1). *Appropriate Use of Medical Interpreters*. American Family Physician. https://www.aafp.org/afp/2014/1001/afp20141001p476.pdf

Ku, L., & Flores, G. (2005, March). *Pay Now Or Pay Later: Providing Interpreter Services In Health Care*. Health Affairs. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.24.2.435

Labaf, A., Shahvaraninasab, A., Baradaran, H., Seyedhosseini, J., & Jahanshir, A. (2019, June 2). *The Effect of Language Barrier and Non-professional Interpreters on the Accuracy of Patient-physician Communication in Emergency Department*. NCBI. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6789075/

Language Diversity in Northern Virginia. (2020, April 14). Retrieved October 25, 2020, from https://pglsinc.com/language-diversity-in-northern-virginia/

(n.d.). *Languages in Virginia (State)*. Statistical Atlas. Retrieved October 26, 2020, from https://statisticalatlas.com/state/Virginia/Languages

Limited English Proficiency. (n.d.). HHS. Retrieved October 24, 2020, from https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html#:~:text=Title%20VI%20of%20the%20Civil,persons%20with%20limited%20English%20proficiency

Medallion 4.0 Managed Care Services Agreement. Department of Medical Assistance Services. https://www.dmas.virginia.gov/files/links/5400/Medallion%204.0%20Contract%20SFY21v2.pdf

Meuter, R. F., Gallois, C., Segalowitz, N. S., Ryder, A. G., & Hocking, J. (2015, September 10). *Overcoming language barriers in healthcare: A protocol for investigating safe and effective communication when patients or clinicians use a second language*. National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4566365/

MinorityHealth. "Culturally and Linguistically Appropriate Services." *Think Cultural Health*, thinkculturalhealth.hhs.gov/clas

Moissac, D. D., & Bowen, S. (2018). Impact of Language Barriers on Quality of Care and Patient Safety for Official Language Minority Francophones in Canada. *Journal of Patient Experience*, 6(1), 24-32. doi:10.1177/2374373518769008

Neira, L. (2018, August 22). *The Importance of Addressing Language Barriers in the US Health System*. Duke Personalized Health Care. https://dukepersonalizedhealth.org/2018/07/the-importance-of-addressing-language-barriers-in-the-us-health-system/

(2012, October). *New York State Medicaid Update*. New York State Department of Health. https://www.health.ny.gov/health_care/medicaid/program/update/2012/oct12mu.pdf

Rice, S. (2014, August 30). *Hospitals often ignore policies on using qualified medical interpreters*. Modern Healthcare. https://www.modernhealthcare.com/article/20140830/MAGAZINE/308309945/

Rodriguez, C. (2013). *9 Language Access Assurances in Health and Human Services: Analysis of Existing Policy Options and Recommendations for Improvement* (Powerpoint Presentation). Retrieved from https://docs.google.com/document/d/1ZQgPdylunD-JQE3yQrdIK87j4G5Os2sXYckerjZuZIU.

Scamman, K. (2018, March 12). Limited-English Proficiency: LEP Populations by U.S. State (Infographic). *Telelanguage: Interpretation and Translation Services*. https://telelanguage.com/limited-english-proficiency-lep-populations-by-u-s-state/

Search the CMI Registry. The National Board of Certification for Medical Interpreters. https://www.certifiedmedicalinterpreters.org/search-cmi-registry

Title VI Of The Civil Rights Act Of 1964 42 U.S.C. § 2000d Et Seq. (2020, June 26). Retrieved October 25, 2020, from https://www.justice.gov/crt/fcs/TitleVI-Overview

Translation and Interpretation Services. Medicaid.gov: the official U.S. government site for Medicare. https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services/index.html

United States Census Bureau. (2019). Retrieved October 22, 2020, from https://data.census.gov/cedsci/table?q=languages%20spoken%20in%20virginia&tid=ACSST1Y2019.S1601

United States Census Bureau. (2010). Retrieved October 22, 2020, from https://data.census.gov/cedsci/table?q=languages%20spoken%20in%20virginia&tid=ASST1Y2010.S1601

Virginia | Data.Medicaid.gov. (2020). Retrieved October 25, 2020, from https://data.medicaid.gov/Enrollment/Virginia/gvkx-jbkx/data

Youdelman, M. (2017, February 7). *Medicaid and CHIP Reimbursement Models for Language Services*. National Health Law Program. https://healthlaw.org/wp-content/uploads/2017/02/Medicaid-CHIP-LEP-models-FINAL.pdf

Youdelman, M. (2009). Medicaid and SCHIP Reimbursement Models for Language Services (2009 update). National Health Law Program. https://healthlaw.org/wp-content/uploads/2014/06/2009_Medicaid_SCHIP.pdf

APPENDIX

A. Press Release

THE GREATER
GOOD INITIATIVE

The Greater Good Initiative: Reconfiguring Language Service Reimbursement Opportunities for Medicaid Providers and Expanding Qualifications for Medical Interpreters in the Commonwealth

October 26th, 2020 - With the presence of COVID-19 still looming large, many Americans continue to hold their health and well-being at the top of mind. Now more than ever, people want to feel secure when seeking medical assistance, hoping their healthcare provider can remediate any health-related anxieties that have arisen amid this precarious time. Trust in one's healthcare provider is of paramount value. However, for many individuals with Limited English Proficiency (LEP), it doesn't even take a global pandemic to question their trust in the medical personnel who care for them. Historically and presently, individuals with LEP disproportionately suffer from adverse health outcomes when seeking care from their provider. From failed health literacy to misdiagnoses, the communication barriers between English-speaking providers and LEP patients can lead to fatal consequences. One of the most prominent barriers preventing individuals with LEP from accessing proper healthcare is a lack of sufficient language and interpretive services.

Aiming to expand language and interpretive services within the state of Virginia, The Greater Good Initiative has released a policy that proposes reforms to both the language service reimbursement model and the qualifications medical interpreters must meet in order to serve. Channeling reforms within the Medicaid System, the policy proposes that the Department of Medical Assistance Services (DMAS), the state agency who administers Medicaid throughout the Commonwealth, provides Managed Care Organizations (MCOs) with reimbursement funds for the costs of language services, incentivizing providers to provide high-quality interpreters for their LEP patients. Additionally, the policy proposes the expansion of qualifications medical interpreters must meet. Presently, as per the contracts between DMAS and MCOs, the only guiding qualification offered to providers seeking to hire interpreters is that they must be "trained professionals." In order to strengthen the standard of interpretive services, the policy offers a series of specific qualifications interpreters must meet in order to affirm their capacity to serve.

Virginia is home to one of the most linguistically diverse populations in the United States, and particularly within Northern Virginia, the population of LEP individuals is steadily increasing.

With the release of their policy, The Greater Good Initiative aims to ensure all Virginians, regardless of which language they speak, have access to sufficient healthcare services.

About The Greater Good Initiative: The Greater Good Initiative (GGI) is a youth-led, nonpartisan policy think tank working to create sustainable solutions to our nation's most pressing issues. Currently working in the Civil Rights, Economic, Education, Environmental, and Public Health Sectors, GGI has coordinated with local, state, and federal legislators, policy professionals, and community leaders to write and advocate for realistic and effective policies that actively respond to the public's greatest concerns.

B. Supplementary Materials

Table 1: Summary of States' Language Reimbursement Programs

State	Medicaid and CHIP providers who can submit reimbursement	Providers the state reimburses	Reimbursement rates for language services provided to Medicaid/CHIP enrollees	Administrative or Service Claims
CT	All providers	Providers	Not available	Administrative
DC	Fee for Service (FFS)	Language agency vendors	Not available	Administrative
IA	FFS providers who do not submit cost reports	Providers	$14.39/15 min. (oral); $1.63/min. (telephonic)	Service
ID	FFS and Primary Care Case Management programs	Providers	$3.04/15 min. (oral); $12.50/15 min. (sign language)	Service
KS*	Not applicable	Fiscal agent	Spanish: $1.10/min.; Other languages: $2.04/min.	Administrative
ME	FFS	Providers	Lesser of $20/15 min. or usual and customary fee	Service
MN	FFS	Providers	$12.50/15 min.	Administrative
MT	All	Interpreters	Lesser of usual and customary or $10/15 min. for sign language, $8.75/15 min. for in-person oral, and $6.25/15 min. for video/telephonic	Administrative
NH	FFS	Interpreters enrolled as	$90/event (up to two hours); $11.25 for each	Administrative

Table 1 (Cont.)

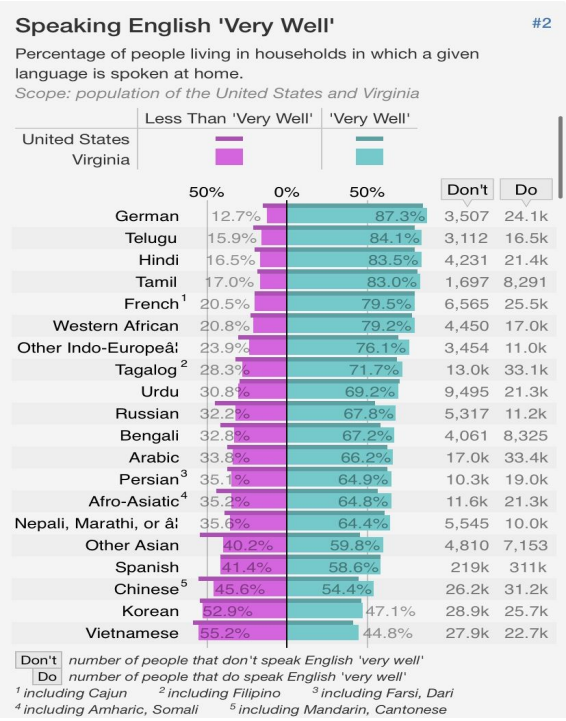
State	Medicaid and CHIP providers who can submit reimbursement	Providers the state reimburses	Reimbursement rates for language services provided to Medicaid/CHIP enrollees	Administrative or Service Claims
		Medicaid providers	additional 15 min.	
NY	FFS	Providers	$11/8-22 min.; $22/>23 min.	Administrative
NC	FFS	Counties	Varies by county	Administrative
TX	FFS providers in private or group practices with < 15 employees	Providers	$76.05 for first hour; $19.01 for each additional 15 min.	Service
UT	FFS	Language agencies	$30-66/hour	Administrative
VT	FFS	Providers	Less of $15/15 min. or usual and customary fee	Administrative
WA	Public entities	Public entities	50% for Medicaid; 75% for CHIP[30]	Administrative
	Non-public entities	CTS Language Link	$38/hour (oral); $.60/min. (telephonic); $80-125 (sign language)	Administrative
WY	FFS	Interpreters	$11.25/15 min.	Service

** State information current as of 2009.*

Source: *National Health Law Program*[67]

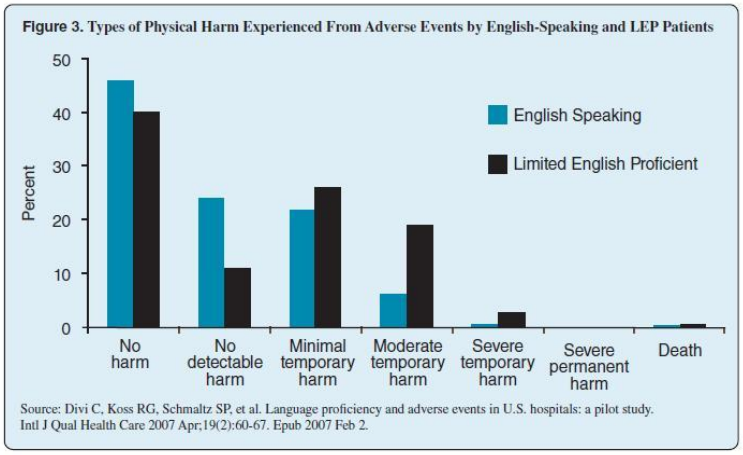
[67] Youdelman, M. (2017, February 7). *Medicaid and CHIP Reimbursement Models for Language Services*. National Health Law Program. https://healthlaw.org/wp-content/uploads/2017/02/Medicaid-CHIP-LEP-models-FINAL.pdf

Graph #1: Percentage of non-English speaking households who can or cannot communicate “very well” in English



Source:Statistical Atlas[68]

Graph #2:Comparing physical harm resulting from adverse events in a medical setting as experienced by LEP patients and English speaking patients



Source: Agency for Healthcare Research and Quality[69]

[68] Languages in Virginia (State). (2018). Retrieved October 26, 2020, from https://statisticalatlas.com/state/Virginia/Languages

[69] Chapter 1: Background on Patient Safety and LEP Populations. (2020, September). Retrieved October 26, 2020, from https://www.ahrq.gov/health-literacy/professional-training/lepguide/chapter1.html