

# The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond

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Over the past few decades, the number and diversity of limited English speakers in the USA has burgeoned. With this increased diversity has come increased pressure—including new legal requirements—on healthcare systems and clinicians to ensure equal treatment of limited English speakers. Healthcare providers are often unclear about their legal obligations to provide language services. In this article, we describe the federal mandates for language rights in health care, provide a broad overview of existing state laws and describe recent legal developments in addressing language barriers. We conclude with an analysis of key policy initiatives that would substantively improve health care for LEP patients.

**KEY WORDS:** language rights; language barriers; limited English proficient; health policy; interpreter.

J Gen Intern Med 22(Suppl 2):362–7

DOI: 10.1007/s11606-007-0366-2

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## THE LEGAL RIGHT TO LANGUAGE ACCESS IN HEALTHCARE SETTINGS

Thirteen-year-old Gricelda Zamora was like many children whose parents speak limited English: she served as her family's interpreter. When she developed severe abdominal pain, her parents took her to the hospital. Unfortunately, Gricelda was too sick to interpret for herself, and the hospital did not provide an interpreter. After a night of observation, her Spanish-speaking parents were told, without the aid of an interpreter, to bring her back immediately if her symptoms worsened, and otherwise to follow up with a doctor in three days. However, what her parents understood from the conversation was that they should wait three days to see the doctor. After two days, with Gricelda's condition deteriorating, they felt they could no longer wait, and rushed her back to the emergency department. Doctors discovered she had a ruptured appendix. She was airlifted to a nearby medical center in Phoenix, where she died a few hours later.<sup>1</sup>

Whereas stories like Gricelda Zamora's are fortunately rare, miscommunications due to language barriers are all too common in healthcare settings across the nation.<sup>2,3</sup> Few

debate that language assistance services are central to access and quality of care for limited English proficient (LEP) patients. But what legal right did Gricelda Zamora's parents have to an interpreter, and what responsibility did healthcare providers have to ensure communication in her case?

In the federal arena, the 1964 Civil Rights Act continues to be the single most important piece of legislation for providing LEP individuals a legal right to language assistance services. Over the ensuing 43 years, the linguistic diversity of the USA has burgeoned, with more than 200 different languages now spoken across the country.<sup>4</sup> With this increased diversity has come increased pressure—including new legal requirements—on healthcare systems and clinicians to ensure equal treatment of limited English speakers.

We begin by describing the federal landscape for language rights in health care: the Civil Rights Act, the role of the Department of Health and Human Services Office for Civil Rights in upholding this law, and policy developments in the last decade that have focused attention on the issue of language access in healthcare settings. We then provide a broad overview of existing state laws and describe recent legal developments in addressing language barriers. We conclude with an analysis of what needs to happen to ensure that cases like Gricelda Zamora's are a thing of the past.

## FEDERAL LANDSCAPE FOR LANGUAGE RIGHTS IN HEALTH CARE

### The Civil Rights Act

The legal foundation for language access lies in Title VI of the 1964 Civil Rights Act, which states:

No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.<sup>5</sup>

Congress passed the Civil Rights Act to ensure that federal money was not used to support discriminatory programs or activities. In interpreting Title VI, the Supreme Court has treated discrimination based on language as equivalent to national origin discrimination.<sup>6</sup> Similarly, the federal government in its regulations and policies has treated language as a proxy for national origin; therefore, in federally funded programs and activities, people who speak a language other than

English are entitled to treatment equal to that of English speakers. Title VI applies across all federal agencies, from the Department of Justice to the Department of Transportation; the Department of Health and Human Services (HHS) has further expounded these requirements for the healthcare arena. In 1980, it issued a notice stating, “No person may be subjected to discrimination on the basis of national origin in health and human services programs because they have a primary language other than English.”<sup>7</sup> In health care, the term “federal financial assistance” refers to federal funding such as (but not limited to) Medicaid, SCHIP and Medicare payments, NIH grants, and CDC monies.

### The HHS Office for Civil Rights

Each federal Department has a civil rights office that is charged with ensuring that its Department’s programs are free of discrimination. The HHS Office for Civil Rights (OCR) is no exception. Its responsibilities include enforcing the Civil Rights Act, the Americans with Disabilities Act, the Age Discrimination Act, the Hill-Burton Act, and the Health Insurance Portability and Accountability Act (HIPAA). Any organization or individual who receives monies through HHS—health departments, health plans, social service agencies, nonprofits, hospitals, clinics, and physicians—is subject to OCR oversight.

The OCR has the authority to investigate complaints related to linguistic barriers, to initiate its own reviews, and to withhold federal funds for noncompliance. OCR complaints have arguably been responsible for the inception and growth of many of the premier hospital-based interpreter services programs in the USA. Boston City Hospital (now Boston Medical Center) in Massachusetts, Harborview Medical Center in Washington State, and San Francisco General Hospital in California were all targets of OCR complaints filed on behalf of LEP patients, and developed or enhanced their language assistance services in response to these complaints (personal communication, Peter Chan, Gloria Garcia-Orme).<sup>8</sup>

### Executive Order 13166 and the OCR Policy Guidance

In August 2000, President Clinton drew national attention to the issue of limited English proficiency when he issued Executive Order (EO) 13166, *Improving Access to Services for Persons with Limited English Proficiency*.<sup>9</sup> EO 13166 reiterates Title VI requirements for federal fund recipients and directs all federal agencies to ensure that their own programs provide equal access to LEP individuals. In response to this, OCR issued an extensive Policy Guidance to assist healthcare providers and other federal fund recipients in meeting their obligations to LEP individuals.

Under the Bush Administration, the Executive Order was upheld, whereas the Policy Guidance was revised and reissued in August 2003.<sup>10</sup> The Guidance attempts to balance the requirement that federal fund recipients must take reasonable steps to ensure LEP people have meaningful access to programs and activities with the agency’s reluctance to impose undue burdens on small business, local governments, or small nonprofit organizations.

The Guidance outlines four factors that institutions, programs, and providers should consider in determining the extent

and types of language assistance that should be pursued. The first is the number or proportion of LEP persons served or eligible to be served: the greater the number or proportion of LEP persons, the more likely language services are needed. The second factor is frequency of contact: the more frequent the contact with a particular language group, the more likely that interpreting or translating services in that language are needed. The third consideration is the nature and importance of service provided: the more important the recipient’s service or program, the more likely language services are needed. The final consideration pertains to resources and costs. The Guidance states that “[s]maller recipients with more limited budgets are not expected to provide the same level of language services as larger recipients with larger budgets....Large entities and those entities serving a significant number or proportion of LEP persons should ensure that their resource limitations are well-substantiated before using this factor as a reason to limit language assistance.”<sup>11</sup>

### Implications for Healthcare Providers

The legal responsibility to provide language access applies across all federal program areas and activities, including health care. The third factor in the OCR Policy Guidance suggests that, given the nature and importance of healthcare services, healthcare providers have a special obligation to ensure language access for their patients. The fourth factor, related to resources and costs, suggests that among healthcare providers, large organizations such as hospitals, health plans, and health systems should universally be providing language assistance services. Additionally, once a healthcare provider accepts any federal funds (e.g., Medicaid payments), the provider is responsible for providing language access to all the provider’s patients.

Despite the federal right to language access for LEP patients in healthcare settings, the reality is that many healthcare providers are not aware of their responsibility, have not prioritized the issue, or have not been held accountable through consistent enforcement of these laws.

## OVERVIEW OF STATE ACTIVITIES ON LANGUAGE ACCESS

As of January 2006, at least 43 states—as demographically, geographically, and politically diverse as Alabama, California, Massachusetts, and Wisconsin—had enacted one or more laws addressing language access in healthcare settings. More than half of these states had between one and four laws, whereas most others had between five and ten laws. A smaller number had more than ten. California continues to have more laws addressing language access in health settings than any other state—over 70 to date.<sup>12</sup>

### A Patchwork Quilt: Variability in Scope and Impact

As a whole, state legal activity on language access in health care has been a valuable addition to LEP patients’ federal rights. At the same time, as described below, the result has been a somewhat haphazard patchwork of legal obligations which vary from state to state, from language to language,

from condition to condition, and from institution to institution. Whereas it is beyond the scope of this article to discuss the impetus behind each state's laws, the resultant heterogeneous legal landscape is the result of a legislative process driven variably by changing demographics, advocacy groups, adverse outcomes due to language barriers, the political climate of each state, and underlying political agenda. In aggregate these laws provide additional protection for LEP patients. However, individual laws vary tremendously in scope and impact, and together leave many important areas unprotected. Many focus exclusively on patient education, notification, or informed consent; some also target a specific healthcare setting, medical condition, or language.

For example, New Jersey requires its Department of Health to disseminate informational brochures on breast cancer in both English and Spanish, but not for other medical conditions, e.g., lung cancer, or in other languages.<sup>13</sup> Similarly, several of Michigan's laws address specific medical topics for specific languages: one mandates that abortion consent forms be printed in English, Aramaic, and Spanish; another requires that patients receiving HIV tests receive a pamphlet describing the test in English or Spanish; a third stipulates distribution of a pamphlet with information about prenatal care and parenting in English, Spanish, and other needed languages; and a fourth requires a pamphlet on abortion risks and alternatives to be printed in English, Arabic, and Spanish.<sup>14</sup> Clearly, these laws are concerned with specific medical conditions rather than with the larger issue of access to translated health information.

The political agenda driving state laws on language access is particularly notable with regard to reproductive rights. Besides Michigan, several other states—including Arkansas, Kansas, Louisiana, Minnesota, Nevada, North Dakota, Oklahoma, Texas, and Virginia—have passed "Women's Right to Know" Acts. These typically require information about adoption, fetal pain associated with abortion, and possible detrimental effects of abortion to be translated into non-English languages, often at a much lower threshold than required for other interpretation or translation services.<sup>15</sup>

### Mandating Language Assistance Services

Less commonly, states have enacted laws mandating provision of language assistance services, typically either through specific types of facilities, or as a condition of licensure. For example, Massachusetts requires all emergency departments and acute psychiatric facilities to provide access to trained interpreters for their patients at all times. A number of states have specific requirements regarding language access in mental health settings. For example, Illinois requires state mental health facilities to provide interpreters for their patients throughout the intake and evaluation process.<sup>16</sup> Other states such as Colorado, New Jersey, and Rhode Island have linked facility licensure to the provision of language services.<sup>17</sup>

A recent California law deserves special mention, as it is much broader in scope than previous laws. Passed in 2003, SB 853 requires that all private managed care plans as well as individual and group health insurers provide members/insureds with appropriate access to translated materials and language assistance when seeking care.<sup>18</sup> The health plans and insurers have until 2009 to comply. If fully implemented

and enforced, this law will provide a strong state-based right to language assistance services for all privately insured individuals in California.

## RECENT POLICY DEVELOPMENTS IN LANGUAGE ACCESS

Since the release of EO 13166 and the OCR Policy Guidance, there has been little movement on the federal front towards improving or increasing language access. As a result, most legislative and regulatory activity to address language barriers in healthcare settings has occurred at the state level. Notable state legislative initiatives have occurred in three broad areas:

- continuing education for health professionals,
- certification of healthcare interpreters,
- reimbursement for language services for Medicaid/SCHIP enrollees.

### Continuing Education for Health Professionals

Three states (New Jersey, California, Washington) have enacted requirements that physicians or other health professionals receive training or continuing education that addresses language access and/or cultural competency.<sup>19–21</sup> These laws share the goal of educating health professionals on how language barriers can impact access to and the quality of health care received, with the hope that this will increase clinician support and use of language access services for LEP patients. A number of other states are considering these types of laws as well.

A recent review of the evidence suggests that while the literature in this area is overall of poor quality, continuing medical education (CME) appears to be effective to some degree in the acquisition and retention of knowledge, attitudes, skills, behaviors and clinical practice outcomes.<sup>22</sup> Importantly, multiple exposures were more effective than a single exposure. This suggests that other states considering similar legislation targeting physician CME may want to consider a model that integrates cultural and linguistic competency across clinical topics and over time rather than instituting a one-time requirement.

### Certification of Healthcare Interpreters

Whereas there is general agreement that being bilingual is necessary but not sufficient to serve as a medical interpreter, there are no federal standards governing certification of healthcare interpreters. Most states that have established or are in the process of establishing Medicaid reimbursement for language assistance services have not addressed the issue of certification. While certification is not a prerequisite for reimbursement, addressing the qualifications and competency of medical interpreters and translators—whether through the establishment of training, assessment, and/or certification standards—is essential to ensuring the quality of services provided. The National Council on Interpreting in Health Care has developed National Standards of Practice for Interpreters in Health Care<sup>23</sup>, but these have not been universally adopted. Given the lack of

federally recognized standards, individual states have begun addressing interpreter competency.

Washington was the first state to establish a healthcare interpreter certification program. In the 1980s and early 1990s, its Department of Social and Health Services (DSHS) entered into an agreement with the Office for Civil Rights to ensure that LEP clients received equal access to DSHS services. As a result, the Language Interpreter Services and Translations (LIST) was formed in 1991 to oversee language testing and certification of Department bilingual staff, contracted interpreters, and translators.<sup>24</sup>

More recently, other states have begun developing their own healthcare interpreter certification standards. In 2006, in response to a legislative mandate, the Oregon Office of Multicultural Health released Standards for Registration, Qualification and Certification of Health Care Interpreters.<sup>25</sup> Similarly, the Indiana legislature has charged an independent commission with developing standards for training and practice for health interpreters and translators.<sup>26</sup> North Carolina's Department of Health and Human Services is working with the Center for New North Carolinians to develop credentialing for interpreters as a pre-condition for initiating Medicaid reimbursement (personal communication M. Terry Hodges, Raleigh Bailey).

### Reimbursement for Language Services for Medicaid/SCHIP Enrollees

Arguably, the single biggest barrier to language access for LEP patients is the lack of widespread reimbursement for healthcare interpreting and translation services. Fortunately, Medicaid and the State Children's Health Insurance Program (SCHIP) have indicated that language services are eligible for federal matching funds.<sup>27</sup> However, each state determines whether and how its Medicaid program will provide reimbursement for interpreting, and providers cannot receive payments for these services unless the state chooses to provide them.

Currently, the District of Columbia and 12 states are explicitly paying for interpreter services under their Medicaid/SCHIP programs (Table 1). Most states primarily or exclusively target fee-for-service outpatient visits, although three states also pay for interpreting for inpatient and managed care encounters, and Kansas provides reimbursement only for interpreter services related to Medicaid managed care. The states vary significantly in their reimbursement rates, as well as who is reimbursed. Some contract with interpreters or language agencies directly, whereas others pay the provider, who then pays the interpreter. Only two states—Virginia and Washington—have specific provisions for interpreter competency.<sup>28</sup> Two additional states are close to instituting a reimbursement system for interpreter services: Connecticut enacted a law in June 2007 to allow reimbursement<sup>29</sup>, and as mentioned above, North Carolina is developing state-based interpreter certification as a precursor to reimbursement.

What is most notable about the states that are paying for interpreting for their Medicaid and SCHIP patients is that—with the exception of Hawaii—they all have small LEP populations. According to the 2000 Census, the percentage of LEP persons residing in these continental states ranged from 1.5% for Montana to 7.4% for Connecticut, with the US average

being 8.1%.<sup>30</sup> Among the states with the highest concentration of LEP residents—California (20%), Texas (13.9%), New York (13%), Hawaii (12.7%)—only Hawaii is currently paying for interpreter services. Whereas the need for language assistance is greatest in these states, the challenge is the commensurately high cost of providing these services.

Nonetheless, there appears to be some movement towards reimbursement in both California and Texas. In December 2006, California's Department of Health Services convened a Medi-Cal (Medicaid) Language Access Taskforce charged with developing and presenting recommendations on the delivery and reimbursement of language services. Over the course of 1 year, the Taskforce will evaluate models used in other states, examine the various options California has in drawing down federal funds for language services, and develop a cost analysis for each option based on Medi-Cal LEP utilization data. The final report, due on December 31, 2007, will include a recommended system, interpreting and translation quality standards, and an implementation plan with proposed timeline.<sup>31</sup> In 2005, Texas enacted legislation directing its Health and Human Services Commission (HHSC) to establish a pilot project for Medicaid reimbursement for language services in five hospital districts. HHSC is exploring specific cost allocation methodologies with the Centers for Medicare and Medicaid Services, and will implement and report on the pilot when this is resolved.<sup>32</sup>

### WHERE DO WE GO FROM HERE?

Shortly after Gricelda Zamora's death, the hospital system responsible for her care announced that it was expanding its fledgling medical interpreter program to all its hospitals. The hospital where she was treated retrained its staff on how to use its telephone interpreter service, and the Arizona Hospital and Healthcare Association formed a partnership with CyraCom to encourage hospitals to use two-way handsets to facilitate telephonic interpretation. Despite these positive changes, a reporter covering the issue of language barriers in health care found that other hospitals in the area continued to make do with providers' broken Spanish, a posted list of basic Spanish words, or pulling any available bilingual staff member to interpret.<sup>33</sup>

Unfortunately, a high-profile case like Gricelda Zamora's—or an OCR complaint against a specific institution—is often the impetus for substantive improvements in language assistance services. Whereas these improvements clearly benefit the institution's patients, they can also increase disparities across institutions, as the availability and quality of language assistance become increasingly institution (and language) specific.

Whereas there is a well-founded legal right to language access, with more specific rights in certain settings, for certain languages, and in certain states, there has been a low level of awareness as well as inconsistent enforcement of these legal rights. To create a more consistent, comprehensive system for language assistance services, four fundamental changes need to occur.

First, we need a financing mechanism for language assistance services across payors, which would lessen the extreme institutional variability in services that currently exists. Ideally, insurers would contract with and pay medical interpreters or language agencies directly to serve their patients rather

Table 1. District/State Methods for Reimbursing Interpreters in Medicaid/SCHIP

State or District	Entities reimbursed	Types of providers			Amounts paid	Interpreter competency requirements
		FFS	MCOs	Inpatient		
DC	Language agencies <sup>a</sup>	√ <sup>b</sup>			\$135–\$190/h (in-person) \$1.60/min (telephonic)	No
HI	Language agencies	√			\$36/h (in 15 min increments)	Language agencies monitor quality and assess the qualifications of interpreters
ID	Providers	√			\$12.16/h	Provider determines competency
KS	Medicaid fiscal agent administers language line		√		Spanish—\$1.10/min other languages—\$2.04/min	No
ME	Providers	√			Reasonable costs reimbursed	Provider determines competency; interpreter must sign Code of Ethics
MN	Providers	√			Lesser of \$50/h (in 15 min increments) or usual and customary fee	Provider determines competency
MT	Interpreters	√	√	√	Lesser of 25/h (in 15 min increments) or usual and customary fee	Provider must hire a “qualified” interpreter (no definition)
NH	Interpreters	√			\$15/h \$2.25/15 min after first hour	No although interpreters must enroll as Medicaid providers
UT	Language agencies	√			\$28–35/h (in-person) \$1.10/min (telephonic)	Language agencies monitor quality and assess the qualifications of interpreters
VA	Area Health Education Center & 3 public health departments	√			Reasonable costs reimbursed	Interpreters must meet proficiency standards, including a minimum 40-h training
VT	Language agency	√	√	√	\$60/h (in 15 min increments)	No
WA—non-public entities	Brokers; language agencies	√	√	√	Brokers receive administrative fee Language agencies receive \$33/h (\$34 as of 7/1/07)	State agency certifies interpreters
WA—public entities	Public entities	√	√	√	50% allowable expenses	State agency certifies interpreters
WY	Interpreters	√			\$45/h (in 15 min increments)	Interpreters must abide by NCIHC Code of Ethics

Sources: Youdelman M. *Medicaid and SCHIP reimbursement models for language services*. Washington, DC: National Health Law Program; May 2007. Bau I, Chen A. *Improving access to health care for limited English proficient health care consumers: options for federal funding for language assistance services*. Woodland Hills, CA: The California Endowment; April 2003

SCHIP State Children's Health Insurance Program, FFS fee-for-service, MCO managed care organization, NCIHC National Council of Interpreting in Health Care

<sup>a</sup>Language agencies are organizations that contract with and schedule interpreters. They may also oversee assessment and/or training

<sup>b</sup>Limited to fee-for-service practices with fewer than 15 employees

than having the providers involved in screening, selecting, and paying the interpreter. All states need to include language assistance services as a Medicaid covered benefit, and other states should follow California's lead in extending requirements to provide language assistance services to private health plans and insurers. Perhaps even more importantly, Medicare should begin paying for language assistance services; a recent brief published by the Center on Budget and Policy Priorities and the National Health Law Program provides a broad overview of some possible options in this area.<sup>34</sup>

Second, we need a significant investment in developing our medical interpreter workforce, in terms of increasing both the number and quality of trained medical interpreters. Certification, which has gained traction in a number of states, is a critical part of assuring the quality of interpreting and would benefit from coordination and standardization across states. However, without widespread reimbursement for language access services in health care, it will ultimately be difficult to

attract qualified individuals into the medical interpreter workforce.

Third, we need healthcare providers to understand the deleterious effects of language barriers and the benefits of working with trained medical interpreters, so that they advocate for language assistance services for their LEP patients in the same way they would advocate for any important diagnostic test or therapeutic agent. States should examine the impact of recent educational legislation in New Jersey, California, and Washington, and tailor their approach to minimize the burden on providers while maximizing the effectiveness of any new educational requirements.

Finally, we need LEP patients to be aware of their legal rights. Given the relatively disempowered status LEP patients have in our healthcare system, increased patient awareness alone is clearly not sufficient to improve language access.<sup>35</sup> At the same time, LEP patient and community advocacy in filing OCR complaints has been critical to improving access to

language assistance services across the country and remains an important driver for legislative change.

While we have come a long way since the passage of the 1964 Civil Rights Act, much more remains to be done to ensure that the language one speaks does not diminish the quality of health care one receives. As our nation continues to become more culturally and linguistically diverse, we owe it to Gricelda Zamora and all our LEP patients to ensure that communication is not an impediment to health.

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## REFERENCES

1. Ask Doctor Alice: Is the Doctor In? Not if You Don't Speak English. Asian Journal Publications. October 29–November 4, 2004; p. 23.
2. **Andrulis DP, Goodman N, Pryor C.** What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured With Limited English Proficiency. Boston, MA: The Access Project; 2002 (April).
3. **Crane JA.** Patient comprehension of doctor-patient communication on discharge from the emergency department. *J Emerg Med.* 1997;15:1–7.
4. **Gordon RG, ed.** *Ethnologue: Languages of the World*, 15th Edition. Dallas, TX: SIL International. Available at: <http://www.ethnologue.com/>. Accessed February 22, 2007. 2005.
5. 42 U.S.C. §2000d.
6. *Lau v. Nichols*, 414 U.S. 563 (1974).
7. 45 Fed. Reg. 82972 (Dec. 17, 1980) (Notice).
8. **Perkins J, Youdelman M, Wong D.** *Ensuring Linguistic Access in Health Care Settings: Legal Rights And Responsibilities*, 2nd Edition. Washington, DC: National Health Law Program; August 2003.
9. 65 Fed. Reg. 50121 (August 16, 2000).
10. 68 Fed. Reg. 47311 (August 8, 2003).
11. 68 Fed. Reg. 47311, 47315.
12. **Perkins J.** Summary of State Law Requirements Addressing Language Needs in Health Care. Washington, DC: National Health Law Program; updated 2006 (January).
13. N.J. Rev. Stat. §26:2–168.
14. Mich.Stat. Ann. §14.15(b) and (c); Mich.Stat. Ann. §33.5133; Mich.Stat. Ann. §333.9161; Mich.Stat. Ann. §333.17015.
15. Ark.Stat. §20-16-904; Kan.Stat. Ann. §65-6710; 40 La.Rev.Stat. Ann. §1299.35.6.B(2)(4); Minn. Stat. Ann. §145.4243; N.D. Cent. Code §14-02.1-02.1; Nev.Rev.Stat. §442.253(1) and (3); 63 Okl. St. §1-738.3; Tex. Health & Safety Code Ann. §245.023; Va. Code Ann. §18.2-76(D).
16. Mass. Ann. Laws Ch.111, §25J(b), Ch.123, §23A(b); Ill. Admin. Code tit. 59, §111.25.
17. 6 Colo. Code Regs. § 1011-1 12.1.6(4); N.J. Admin. Code tit. 8, § 36-4.15; N.J. Admin. Code tit. 8 § 43-4.17; R.I. Gen. Laws § 23-17-54.
18. Cal. Health & Safety Code § 1367, 1367.04, 1367.07; Cal. Insurance Code § 10133.8, 10133.9.
19. N.J. Rev. Stat. C.45:9-7.2-7.4.
20. Cal Bus & Prof Code § 2190.1.
21. Rev. Code Wash. (ARCW) § 43.70.615.
22. **Marinopoulos SM, Dorman T, Ratanawongsa N, et al.** Effectiveness of continuing medical education. Rockville, MD: Agency for Healthcare Research and Quality; January 2007. Available at: <http://www.ahrq.gov/clinic/tp/cmetsp.htm>. Accessed July 18, 2007.
23. National standards of practice for interpreters in health care. Santa Rosa, CA: National Council on Interpreting in Health Care; September 2005.
24. WAC (Washington Administrative Code) §§ 388-271-0010, 0020, and 0030.
25. Oregon Revised Stat. 409.615-625. Or. Admin. R. 333-002-0010-333-002-0230.
26. Ind. Code IC 16-18-2-62.
27. **Westmoreland TM.** SMD Letter—Policy guidance on Medicaid for persons with limited English proficiency. August 31, 2000. Available at <http://www.cms.hhs.gov/smdl/downloads/smd083100.pdf>. Accessed July 18, 2007.
28. **Youdelman M.** Medicaid and SCHIP Reimbursement Models for Language Services. Washington, DC: National Health Law Program; 2007 (May).
29. Connecticut Public Act No. 07–185.
30. **Shin HB, Bruno R.** Language Use and English Speaking Ability: 2000. Census 2000 Brief. Washington, DC: U.S. Census Bureau; 2003 (October).
31. Medi-Cal Language Access Services Taskforce Participation Agreement. Available at: [http://www.dhs.ca.gov/director/omh/PDFs/News%20Articles/Agenda\\_12-13-2006\\_Participation\\_Agreement.pdf](http://www.dhs.ca.gov/director/omh/PDFs/News%20Articles/Agenda_12-13-2006_Participation_Agreement.pdf). Accessed July 7, 2007.
32. Medicaid interpreter services pilot: report on program effectiveness and feasibility of statewide expansion. January 2007. Available at: <http://www.hhsc.state.tx.us/reports/RPCMemo121906LangInterpretPilotRept.pdf>. Accessed July 9, 2007.
33. **Scioscia A.** Critical connection. Phoenix New Times. July 29, 2000. Available at: <http://www.phoenixnewtimes.com/2000-06-29/news/critical-connection/>. Accessed July 7, 2007.
34. **Ku L.** Paying for Language Services in Medicare: Preliminary Options and Recommendations. Washington, DC: Center on Budget and Policy Priorities; 2006 (October).
35. **Grubbs V, Chen A, Bindman A, Vittinghoff E, Fernandez A.** Effect of awareness of language law on language access in the health care setting. *J Gen Intern Med.* 2006; 21(7):683–88.