



**Concerning the Elimination of Funding for  
Medical Interpreter Services under Medicaid**

**As Proposed by the Governor's Biennial Budget**

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**Testimony by:**

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Senator Harp, Representative Geragosian and members of the Appropriations Committee, thank you for the opportunity to address your Committee today in favor of the important issue of maintaining funding for medical interpretation services. My name is Brad Plebani and I am an attorney and the Deputy Director of the Center for Medicare Advocacy, Inc. (“the Center”). The Center for Medicare Advocacy, Inc. is a national non-profit, non-partisan organization headquartered in Mansfield, Connecticut, that provides education, advocacy, and legal assistance to help elders and people with disabilities obtain fair access to Medicare and necessary health care. Because our mission is to assure fair access to health care, we strongly oppose elimination of funding for medical interpretation under Medicaid. Elimination of this funding would harshly affect those people who are eligible for Medicaid, including some who are dually eligible for Medicare and Medicaid, and deny them fair access to needed health care services.

The medical literature is replete with evidence that the absence of medical interpretation has a harmful effect on both access to health care and delivery of high quality health care services for patients with limited English proficiency. This results in poorer health outcomes for those patients, less adequate treatment for chronic medical conditions and the necessity for more costly acute medical services. Elimination of funding for medical interpretation services exemplifies the proverbial “penny-wise, but pound foolish” policy.

In Connecticut, 65 different languages are spoken by low-income residents with limited English proficiency. An estimated 22, 000 Medicaid recipients in Connecticut have limited English proficiency.<sup>1</sup> These 22,000 Connecticut residents, who need health care, face medical hurdles that English proficient patients do not.

Without effective health provider and patient communication in a language both can understand, there is an increased risk of misdiagnosis, misunderstanding about the proper course of treatment and poorer adherence to medication and discharge instructions.<sup>2</sup> Many other states, including New Hampshire, Maine, Massachusetts, Hawaii, Washington, Utah, Montana, Idaho and California have – some for many years now – provided medical interpretation services to their Medicaid recipients with positive effects.<sup>3</sup> Surely Connecticut, with a tradition of providing excellent medical services to its Medicaid recipients, can afford – even in difficult economic times – to match these other states’ efforts. This is particularly so given that the federal government will match state dollars in the provision of these interpreter services.<sup>4</sup>

Health care providers from around the country have reported language difficulties and inadequate funding of language services to be major barriers to access to health care for

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<sup>1</sup> *Connecticut Health Foundation*, “Estimates for the Cost of Interpretation Services for Connecticut Medicaid Recipients”, p. 9, (August 2006).

<sup>2</sup> *The California Endowment, Health in Brief*, “Improving Access to Health Care for Limited English Proficient Health Care Consumers”, April 2003, Vo. 2, Issue 1 available at [www.calendow.org](http://www.calendow.org).

<sup>3</sup> *Id.*

<sup>4</sup> *Connecticut Health Foundation*, “Estimates for the Cost of Interpretation Services for Connecticut Medicaid Recipients”, pp. 6 and 11, (August 2006).

limited English proficiency individuals and a serious threat to the quality of care they receive.<sup>5</sup>

In one study, over one quarter of limited English proficient patients who needed, but did not get, an interpreter reported that they did not understand their medication instructions, compared with only 2 % of those who did not need an interpreter and those who needed and received one.<sup>6</sup> Language barriers also impact access to care – non-English speaking patients are less likely to use primary and preventive care and public health services and are more likely to use emergency rooms. Once at the emergency room, they receive far fewer services than do English speaking patients.<sup>7</sup>

The discussion of medical interpreter services is not merely a question of language; it can be a question of serious medical harm. A report in the *New England Journal of Medicine* found that many hospital patients who have limited English proficiency and who do not get an interpreter are at risk for sometimes life-threatening medical care.<sup>8</sup> In one case cited in this study, the misinterpretation of a single word led to a patient's delayed care and preventable quadriplegia. Among patients with psychiatric conditions, those who encounter language barriers are more likely to receive a diagnosis of severe psychopathology – but also are more likely to leave the hospital against medical advice. Among children with asthma, those who encounter language barriers have an increased risk of intubation.<sup>9</sup>

In lieu of trained medical interpreters, patients are forced to resort to ad hoc interpreters, such as family members, friends, untrained members of a medical site's support staff, and strangers found in waiting rooms. Aside from the obvious violation of privacy and confidentiality, these interpreters are considerably more likely than professional interpreters to commit errors that may have adverse clinical consequences. *Id.* Moreover, the presence of these ad hoc interpreters may inhibit a patient's discussion of sensitive topics such as domestic violence, substance abuse, sexually transmitted diseases, and psychiatric illnesses. In sum, the use of such ad hoc interpretation services is clearly inadequate and potentially dangerous.

Connecticut Medicaid recipients who have limited English proficiency deserve better than this. They deserve health care access and delivery on an equal footing with those

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<sup>5</sup> Kaiser Commission on Medicaid and the Uninsured, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami and Houston* at 11-111 (Feb. 2001). See also, Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 71-72 (2002).

<sup>6</sup> See, Dennis P. Andrulis, Nanette Goodman, and Carol Pryor, *What A Difference an Interpreter Can Make* at 7, *The Access Project* (Apr. 2002).

<sup>7</sup> Judith Bernstein, *et al.*, *Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges and Follow-up*, *J. of Immigrant Health*, Vol. 4 No. 4 (October 2002); I.S. Watt, *et al.*, *The Health Experience and Health Behavior of the Chinese*, 15 *J. Public Health Med.* 129 (1993); Sarah A. Fox and J.A. Stein, *The Effect of Physician-Patient Communication on Mammography Utilization by Different Ethnic Groups*, 29 *Med. Care* 1065 (1991).

<sup>8</sup> See, Glenn Flores, M.D. "Language Barriers to Health Care in the United States", *New England Journal of Medicine*, 355:3, p. 229, (July, 2006).

<sup>9</sup> *Id.*

who are proficient in English. For these reasons, the Center for Medicare Advocacy strongly opposes elimination of funding for medical interpretation under Medicaid.

Senator Harp, Representative Geragosian, and members of the committee, on my own behalf and on behalf of the Center for Medicare Advocacy I thank you for the opportunity to address you today and hope that you will support funding for medical interpretation services under Medicaid .

Respectfully submitted,

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