Improving Access to Care Among Medicare Beneficiaries with Limited English Proficiency: Can Medicare Do More?

Language barriers prevent thousands of Medicare beneficiaries from communicating effectively with their health care providers. Communication failures in health care settings can lead to poor health outcomes, medical errors and increased costs. Medicare is doing some things to address the problem, but more can be done.

Introduction

Patient-provider communication is essential for effective management of chronic illness. Language barriers between patients and providers can lead to substandard care and medical errors. Federal policies that address language access have resulted in improvements in the availability of services for people with no or limited English skills; however, these policies have suffered from limited enforcement. This paper, which focuses on the Medicare population, examines problems associated with language barriers in health care settings, describes federal efforts to address the barriers, and makes policy recommendations. Communication barriers exist in many forms; this paper focuses on those that arise when providers and patients speak different languages.

Limited English Proficiency Among Older Americans

People for whom English is not their primary language or who have limited ability to read, write, speak, or understand English are defined as limited English proficient (LEP).

According to the American Community Survey, in 2006, 13.9 percent of Americans age 65 and older spoke a language other than English at home, and a sizable share of those older Americans (5.3%) reported having limited English proficiency. These numbers are up from 12.3 percent and 4.0 percent, respectively, just six years ago, and are expected to grow as the number of minority Medicare beneficiaries increases.

The U.S. Census Bureau projects that from 2005 to 2030, the proportion of the U.S. population that is Hispanic will increase from 14 percent to 20 percent, and the proportion that is Asian will increase from 4.3 percent to 6.2 percent. It is not unreasonable to expect that a significant number of these future Medicare beneficiaries will require interpreter services in health care settings.

Impact of Limited English Proficiency on Health Care and Health Outcomes

Many racial and ethnic minority Americans have limited or no English proficiency. Language barriers create challenges to effective communication
between patients and providers, and put patients at risk for receipt of substandard care and medical errors. LEP Medicare beneficiaries may have difficulty understanding how the program works and, therefore, not access the services they need. Among those who are able to access services, their limited ability to communicate with providers and other health professionals can affect the quality of the care they receive and their satisfaction with their care. People with limited English skills who have one or more chronic illnesses can experience a number of problems as they seek to navigate a complex U.S. health care system.

A 2006 study found that LEP Medicare beneficiaries had less access to a usual source of health care and to preventive cancer screenings than beneficiaries who were not LEP. Other studies have found that—

- Patients who face language barriers are less likely than others to have a usual source of medical care, are less likely to receive preventive services, and may be less likely to adhere to medication instructions.
- When Spanish-speaking patients are discharged from emergency rooms, they are less likely to understand their diagnosis or follow-up instructions, including how to properly take their medications.
- When Spanish-speaking patients have doctors who do not speak their language, they are more likely to not take their medications as instructed, miss their scheduled doctor appointments, and use emergency

Figure 1
Percentage of Population Age 65+ That Speaks a Language Other Than English at Home, 2000–2006

rooms for care than those with Spanish-speaking physicians.  
- When Spanish-speaking patients are seen by Spanish-speaking physicians, they ask more questions and understand their medical conditions better than when they are seen by physicians who do not speak Spanish.
- LEP patients who have physicians who do not speak their language have more medication-related problems.
- Chinese and Vietnamese LEP patients whose providers do not speak their languages are less likely to receive education about their conditions and treatments compared with those who have providers who speak their languages. They are also less satisfied with their care and experience worse interpersonal relationships with their providers.
- Patients with diabetes and hypertension report better health outcomes when their physicians speak their native language.
- Effective patient-provider communication is essential for adequate care of diabetes and other chronic illnesses.

Communication problems in health settings can pose significant barriers to receipt of high-quality health care. The problems that are likely to arise include the following:

- Inability of providers to take accurate medical and social histories, to assess patients’ beliefs about health and illness, and to establish empathetic relationships with patients.
Inability to reach agreement on treatment decisions and a course of treatment.\(^\text{17}\)

Provider misunderstandings of patients’ concerns, misdiagnoses, and inefficient use of resources (e.g., unnecessary tests and invasive procedures), leading to increased costs.\(^\text{18}\)

Inability of patients to understand informed consent and other legal documents.\(^\text{19}\)

Increased possibility of medical errors.\(^\text{20}\)

Inability of patients to understand treatment and prescription instructions and effectively self-manage their illnesses.\(^\text{21}\)

Poor patient compliance with treatment plans, inappropriate follow-up, and less patient satisfaction.\(^\text{22}\)

Increased likelihood of unnecessary emergency room use and inpatient hospitalizations.\(^\text{23}\)

Poorer patient outcomes.\(^\text{24}\)

Better communication between LEP patients and providers may help alleviate the problem of health care disparities.\(^\text{25}\) The ability to understand directions from health care providers is key to effective participation in the management of chronic illness. Minorities—especially Asian Americans and Hispanics—are less able to understand doctors’ orders (figure 3) or prescription drug labels (figure 4) and experience more difficulties during doctor visits (figure 5) than their white counterparts. Cultural and linguistic barriers create multiple opportunities for people to fall through the cracks in the health care system. They may avoid or delay care; fail to follow through

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**Figure 3**

Asian Americans and Hispanics Are Less Likely to Understand Instructions from a Doctor’s Office

Percentage of adults reporting it very easy to understand information from doctor’s office

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<thead>
<tr>
<th></th>
<th>Total</th>
<th>White</th>
<th>African American</th>
<th>Hispanic</th>
<th>Asian American</th>
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<tr>
<td>Percentage</td>
<td>57%</td>
<td>59%</td>
<td>55%</td>
<td>45%</td>
<td>44%</td>
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with recommended care, testing, or medications; or become confused trying to comply with treatment regimens.

Federal policies addressing language access have helped improve the availability of LEP services in health care settings; however, these policies have suffered from limited enforcement. The Office of Civil Rights in the U.S. Department of Health and Human Services (HHS) has the authority to take a much stronger stance on enforcement of Title VI compliance in Medicare, but the agency is chronically underfunded and understaffed.

In the face of evidence that people who are LEP receive worse health care, it is useful to identify policy options and other actions that address this disparity. At one end of the spectrum are federal laws and regulations that bar discrimination and may require health care providers or plans to provide interpreter services. If they were strongly enforced, providers would furnish interpretation services to avoid being sued or losing federal funding. At the other end of the spectrum are federal guidelines and quality measures designed to encourage health plans and providers to close the gap in quality and satisfaction by sharing best practices and making improvements. Other policy options would have health plans or government programs pay for or furnish interpretation services directly or would require such services as a condition of participation. In addition to federal policies, census data predicting the continued increase in the proportion of Asians and Hispanics in the U.S. population create a business imperative for providing language access.

Figure 4
Hispanics and Asian Americans Are Less Likely to Understand Instructions in Prescription Bottles

Percentage of adults reporting it very easy to understand prescription bottle

<table>
<thead>
<tr>
<th>Total</th>
<th>White</th>
<th>African American</th>
<th>Hispanic</th>
<th>Asian American</th>
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</thead>
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<tr>
<td>79%</td>
<td>82%</td>
<td>79%</td>
<td>64%</td>
<td>66%</td>
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Federal Laws and Policies Establishing the Right to Language Access

Federal policies that can be used to create a legal basis for the right to adequate language access to health care include Title VI of the Civil Rights Act of 1964; federal regulations implementing Title VI; Supreme Court decisions defining the scope of the Title VI implementing regulation; an Executive Order requiring all grantmaking federal agencies to provide guidance on how fund recipients can comply with LEP policy guidance; the adoption of national standards for providing culturally and linguistically appropriate services (CLAS); and Medicare policies related to reimbursement for interpreter services provided by participating hospital providers.

Title VI of the Civil Rights Act and Implementing Regulation

Congress enacted the Civil Rights Act in 1964. Title VI of the Act forbids providers who receive federal funds, directly or indirectly, from discriminating on the basis of race, color, or national origin. The HHS Office of Civil Rights (OCR) issued a regulation implementing Title VI shortly after it was enacted. The regulatory language specifically prohibits entities that receive federal funds from:

- Denying a person any service, financial aid, or other benefit provided under the program.
- Providing any service, financial aid, or other benefit to a person that is different, or is provided in a different manner, from that provided to others under the program.
- Subjecting a person to segregation or separate treatment in any matter.

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**Figure 5**

Hispanics and Asian Americans Experience More Communication Difficulties During Doctor Visits

- Felt Doctor Listened to Everything They Said
- Understood Everything Doctor Said

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<thead>
<tr>
<th></th>
<th>Total</th>
<th>White</th>
<th>African American</th>
<th>Hispanic</th>
<th>Asian American</th>
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<tbody>
<tr>
<td></td>
<td>66%</td>
<td>68%</td>
<td>69%</td>
<td>68%</td>
<td>57%</td>
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<tr>
<td>Felt Doctor</td>
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<td>Listened</td>
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<td>They Said</td>
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<td>Understood</td>
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<td>Everything</td>
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<td>Doctor Said</td>
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<td></td>
<td>56%</td>
<td>61%</td>
<td></td>
<td>61%</td>
<td>49%</td>
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<tr>
<td>Felt Doctor</td>
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<td>Doctor Said</td>
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Base: Adults with health care visit in past two years.
related to his or her receipt of any service, financial aid, or other benefit under the program.

- Restricting a person in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program.
- Treating a person differently from others in determining whether he or she satisfies any admission, enrollment, quota, eligibility, membership, or other requirement or condition that persons must meet to be provided any service, financial aid, or other benefit provided under the program;
- Denying a person an opportunity to participate in the program through the provision of services or otherwise, or affording him or her opportunity to do so that is different from that provided to others under the program.
- Denying a person the opportunity to participate as a member of a planning or advisory body that is an integral part of the program.\textsuperscript{30}

**Supreme Court Cases**

In 1974, the U.S. Supreme Court ruled in \textit{Lau v. Nichols} that discrimination on the basis of language is a form of discrimination based on national origin, in violation of Title VI.\textsuperscript{31} Although the case dealt with the right to language access to public education, it has been cited as establishing a right to language access to health services. However, a 2001 Supreme Court case, \textit{Alexander v. Sandoval},\textsuperscript{32} had a chilling effect on the earlier case in several ways.

First, the 2001 case limits the right of individuals to enforce Title VI to situations in which intentional discrimination can be shown, leaving the right to enforce discriminatory or disparate impacts to OCR.\textsuperscript{33} Second, the 2001 case raised questions about the continued viability of the Title VI implementing regulation, with the Court \textit{hinting} that the regulation may be at odds with the statute. While the statute prohibits \textit{intentional discrimination}, the regulations speak to \textit{disparate impacts}. Finally, the ruling raised questions about whether the Title VI ban on national origin discrimination includes LEP persons, leaving the issue unresolved. For now, those who seek more legal access to language services will have to rely on OCR enforcement activities. Unfortunately, fiscal constraints and competing priorities have limited OCR’s enforcement capacity.\textsuperscript{34}

**Executive Order 13166 and Its Implementation**

Executive Order (EO) 13166, issued by President Bill Clinton on August 11, 2000, required all federal agencies providing financial assistance to nonfederal entities to publish guidance on how federal grant recipients could comply with the Title VI nondiscrimination requirement by December 11, 2000.\textsuperscript{35} The Executive Order designated the Department of Justice (DOJ) as the lead agency responsible for providing LEP guidance to other federal agencies and required other agencies to develop guidance consistent with that of the DOJ.\textsuperscript{36} The Bush administration has reaffirmed EO 13166.\textsuperscript{37}

On August 30, 2000, HHS published a Policy Guidance addressing the Title VI prohibition.\textsuperscript{38} The department issued a Revised Policy Guidance on August 8, 2003, in which a \textit{flexible and fact-dependent standard} was articulated for determining whether a person has meaningful language access to care. Under the standard, four factors should be considered in determining meaningful access: (1) the number or proportion of
LEP persons eligible or likely to be eligible for service, directly affected, or encountered by the program; (2) the frequency with which LEP persons have or should have contact with the program, activity, or service; (3) the nature and importance of the program or service to people’s lives; and (4) the resources available to the recipient of federal grant funds and costs of complying with the standard. The guidance relies on flexibility, voluntary compliance, and educational interventions.

Providers who receive federal payments under Medicare Part B are exempt from the requirements of the Revised Policy Guidance on the theory that Part B is a private contract of insurance between the individual and the federal government and not a direct grant of public funds. Although the same logic could apply to payments made under Part A, most institutional providers receive other types of federal grant funds, making it difficult (if not impossible) for them to argue that they are not subject to Title VI enforcement activities. As a practical matter, exempt Part B providers who receive other sources of federal funding for programs such as Medicaid, TRICARE, and the Federal Employees Health Benefits Plan (FEHBP), are subject to the requirements of the Revised Guidance.

National Standards on Culturally and Linguistically Appropriate Services

In support of legal and regulatory efforts to ensure access to language services, 14 national standards for culturally and linguistically appropriate services (CLAS) in health care were published in the Federal Register on December 22, 2000. The standards were developed by the HHS Office of Minority Health (OMH). CLAS standards are primarily directed at hospitals, health plans, and large physician groups; however, individual providers are encouraged to use them to make their practices more accessible. The goal of the standards is to promote the elimination of racial and ethnic health disparities and ultimately improve the health of all Americans.

The standards are grouped according to three major themes: (1) culturally competent care, (2) language access services, and (3) organizational supports for cultural competence. Within this framework, the standards vary by stringency. CLAS mandates are current federal requirements for all recipients of federal grant funds; CLAS guidelines are activities recommended for adoption as mandates by federal, state, and national accrediting agencies; and CLAS recommendations are suggested for voluntary adoption by health care organizations.

CLAS Standard 4 describes various ways in which interpreter services can be provided and sets forth preferences for which approach should be employed depending on the circumstances. Although CLAS standards are a useful guide for developing programs and services that are responsive to persons who are LEP, they are not legally enforceable.

Medicare Reimbursement Policy

The Centers for Medicare and Medicaid Services (CMS) has addressed linguistic accessibility in its Part A payment policy. Part A participating hospitals are encouraged to make multilingual services available to patients who need them and may count the costs of providing these services as reasonable costs following cost reporting rules. Medicare pays hospitals a per case rate that reflects the average costs of providing services, with the costs of providing multilingual services factored into the average. However, no
additional payments or adjustments are provided to increase the amount of the payment to reflect the higher costs associated with providing a particular patient with multilingual services. In addition, Medicare policy is silent on reimbursement for interpreter services provided to Part B beneficiaries even though many LEP Medicare beneficiaries receive services in outpatient settings.48

Providing Interpreter Services

Ideally, patients and providers speak the same language. LEP patients can be linked with providers who speak their language through directories listing the languages spoken by providers. When providers who speak the patient’s language are not available, interpretation services can be provided in a variety of ways. These include:

- Bilingual staff members;49
- salaried staff interpreters;50
- contracted interpreters;51
- informal interpreters (such as friends or family members);52
- untrained volunteers;53 and
- telephone interpreter services.54

Bilingual staff members are health professionals (e.g., doctors or nurses) or ancillary staff (e.g., receptionists, food service, or housekeeping staff) who are available to translate for LEP patients. When the need for interpreter services arises, these individuals are required to leave their primary job responsibilities in order to facilitate patient-provider communication. These types of arrangements work best when the supervisor of the translating staff member is supportive of the arrangement, the staff member receives appropriate training (e.g., training related to interpreting, medical terminology, and privacy and confidentiality), and the staff member providing translation services is compensated for providing a service that is outside of the scope of his or her normal job responsibilities.55

Salaried staff interpreters are employed by an institution to provide interpreter services. As staff members, they are likely to interact with the same physicians and patients on an ongoing basis thereby establishing trust and rapport, and fostering an environment that supports effective communication and improved patient outcomes. The hourly wage for full-time staff interpreters ranges from $10 to $32.56 CLAS standards list bilingual staff as the first preference.57

Well trained contracted interpreters, who work through agencies or on a freelance basis,58 can be very effective in patient care settings. Their use is not always feasible, especially in emergency situations, because they are required to travel to providers’ offices or other settings in order to provide interpreter services.59 Contracted interpreters would probably fall into the same category as salaried interpreters under CLAS.60,61

The use of informal interpreters (e.g., friends, family members, and volunteers) raises significant confidentiality issues. Because they often do not have adequate command of medical terminology, their use could also lead to communication errors. In many cultures, it is not acceptable for a child or a husband to discuss sensitive health matters (such as those dealing with psychiatric or sexual issues) with a mother or wife.62 Even if there are no cultural conflicts, privacy issues remain.63 CLAS standards do not recommend the use of untrained friends and family members unless the patient requests it. The DHHS Policy Guidance and the CLAS standards do not
recommend the use of family and friends to provide interpreter services.

If a trained professional is not available, the CLAS standards express a preference for the use of trained volunteers before resorting to telephone interpreter services. The latter is the least preferred alternative under CLAS because the physical barrier imposed by the telephone limits the interpreter’s ability to effectively assist practitioners with physical examinations because the interpreter is unable see where the patient is being touched and cannot pick up on important visual cues. CLAS recommends the use of telephone services only as a supplemental system, when translation services are needed instantly, or when they are needed for an infrequently encountered language. Emerging technological innovations, such as the combined use of visual and telephonic communication, may alleviate some of the problems associated with the use of telephone services alone.

Regardless of the kind of interpreter service used, the interpreter has to go back and forth between the patient and the doctor, repeating what each has said in the other’s language. This lengthens the visit and reduces physician productivity; however, the alternative is poor communication and poor patient outcomes.

What Is Medicare Doing to Address Language Access?

Currently, CMS addresses the issue of language access primarily through Quality Assessment and Performance Improvement (QAPI) projects and through demonstration projects that test and measure the effects of new methods and potential program changes.

Quality Assessment and Performance Improvement Projects

CMS requires Medicare Advantage plans to conduct QAPI projects on an ongoing basis with the goals of improving health outcomes and enrollee satisfaction. These projects are generally conducted over a three-year period. In 2003, CMS required Medicare Advantage plans to focus QAPI projects on addressing clinical disparities or culturally and linguistically appropriate services (CLAS). The QAPI projects that were focused on CLAS were required to address language access or organizational support for such access, and to conduct intervention and outcome analysis to determine whether the intervention resulted in measurable improvements.

To help the plans develop, implement, and evaluate CLAS-focused QAPI projects, CMS distributed a template with best practice examples of interventions. For example, the plans could provide 24-hour access to interpreter services; adapt educational materials for the targeted language or culture group; incorporate culturally appropriate material for plan members; or establish linguistic services committees to oversee language issues.

These projects were scheduled to end in 2006. Originally, the health plans were required to provide CMS with annual project evaluations; however, in January 2005, the agency excused the plans from reporting requirements on QAPI projects begun before January 1, 2006 (including the CLAS projects begun in 2003) in order to implement new reporting guidelines. Therefore, the plans did not have to submit final reports on their CLAS-related QAPI projects. Anecdotal information obtained from CMS indicates that while some health plans developed projects that made language
services available to their LEP clients, many chose strategies such as updating provider directories to reflect the languages spoken by their provider panels.75

**Demonstration Projects**

CMS sponsors demonstration projects to test and measure the effect of potential program changes. The demonstrations attempt to measure the impact of new methods of service delivery, coverage of new services, and new payment approaches on beneficiaries, providers, health plans, states, and the Medicare Trust Funds.76

The Medicare program has a vested interest in ensuring language access for the millions of beneficiaries who need it. To improve health outcomes and reduce health care costs, CMS launched a number of Medicare demonstrations aimed at helping beneficiaries better manage their chronic illnesses, including plans to ensure that patients understand what their health care providers say.77 Two demonstrations that include language access as a project component are the Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities and the Senior Risk Reduction Demonstration.

**Cancer Prevention and Treatment Demonstration**

The Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA) required CMS to enter into at least nine cooperative agreements to implement and operate demonstration projects under the Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities.78 The three- to five-year projects, which began in 2006, were required to target American Indian (including Alaskan Native, Eskimo, and Aleut), Asian American and Pacific Islander, Black, and Hispanic Medicare beneficiaries.79 The projects aim to identify methods to reduce disparities in early cancer screening, diagnosis, and treatment among the target populations.80 Project designs had to include services that enable minority Medicare beneficiaries to effectively navigate the health care system, including the provision of interpreter services.81

On April 3, 2006, CMS awarded four-year cooperative agreements to six demonstration sites that will serve a total of 7,000 minority Medicare beneficiaries in seven states—Hawaii, Maryland, Michigan, Montana, New Jersey, Texas, and Utah. In September 2006, the demonstration sites began recruiting people in their communities who did and did not have cancer.

Each of the sites uses patient navigators as the primary means of facilitating services. Patient navigation in cancer care refers to the assistance offered to patients, cancer survivors, families, and caregivers to help them navigate the complexities of the health care system and overcome barriers to the receipt of high quality care. Examples of navigation services include scheduling appointments with culturally sensitive caregivers and arranging for interpreter services.82 People who do not have cancer are offered patient navigator services to help them access screening and diagnostic services. Those with a cancer diagnosis receive assistance in obtaining appropriate treatment and follow-up services.83

Demonstration sites that have made culturally and linguistically competent patient navigators available include the Hawaii, New Jersey and Texas sites.84
Senior Risk Reduction Demonstration

In April 2008, CMS initiated the three-year Senior Risk Reduction Demonstration (SRRD). According to persons involved with the Demonstration, the goal of the SRRD is to determine whether risk reduction programs (also referred to as health promotion, health management, disease management, and disease prevention programs) that have been developed and tested in the private sector can be applied to Medicare beneficiaries to improve health outcomes and reduce avoidable health care utilization.85 Rather than taking a single-risk-factor approach to health management, the SRRD addresses multiple risks that contribute to disease, including physical inactivity; obesity; smoking; depression; high blood pressure, cholesterol, and glucose; and inappropriate use of preventive services. The SRRD addresses the needs of LEP participants by including language accommodations in recruiting materials, information-gathering materials, and feedback.86 A secondary goal of the SRRD is to determine whether seniors from communities with strong information, referral, and assistance (I&R/A) programs will show even greater gains in health and decreased inappropriate use compared with seniors from communities that do not have strong referral programs.87 Ten communities with exemplary I&R/A programs have been selected to participate in this aspect of the demonstration, and all are required to provide language access.88

What More Can Medicare Do?

CMS could extend reimbursement for interpreter services to fee-for-service Medicare, include questions about language access in Consumer Assessment of Health Plans Surveys (CAHPS), and pursue a number of other policy options to improve access to language services for Medicare beneficiaries.

Reimburse for Interpreter Services in Fee-for-Service Medicare

Medicaid and the State Children’s Health Insurance Program (SCHIP), allow (although they do not require) states to receive federal matching funds for providing oral and written interpreter services to beneficiaries. As of 2005, at least 13 states covered these services.89 In contrast, traditional fee-for-service Medicare Part B does not require providers to make language services available to beneficiaries and does not reimburse for interpreter services even if they are provided voluntarily.90 Medicare managed care plans (Medicare Advantage) are required to provide culturally competent services, including language and reading services, to LEP enrollees.91 It is unclear how closely CMS monitors and enforces this requirement, if at all.92 Some health plans may simply pass the requirement on to their participating providers without ensuring that they are in compliance.93

According to the Office of Management and Budget (OMB),94 the cost of providing interpreter services to fee-for-service Medicare beneficiaries is minimal—an estimated $4.04 per visit, or about 0.5 percent of the cost of an average visit.95,96 According to the OMB, the cost would be offset by the savings generated though avoidance of unnecessary emergency room use, avoidance of unnecessary tests and procedures, and improved patient understanding of and adherence to treatment regimens. Medicare could develop a payment system for language services provided in hospitals97 and outpatient settings, and could exempt
low-income beneficiaries from cost-sharing for language services.  

**Include Questions About Language Access in the CAHPS Health Plan Survey**

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a group of standardized surveys that ask patients to evaluate consumer’s experiences with health care providers. The surveys cover topics of importance to consumers, such as the provider communication skills and the accessibility of services. CAHPS is administered for hospitals, fee-for-service Medicare, and Medicare Advantage plans. Because the surveys are only administered in English and Spanish, the ability of researchers to investigate questions of language access among all Medicare beneficiaries is limited.

CAHPS was launched in October 1995 by the Agency for Healthcare Research and Quality (AHRQ) in response to concerns about the lack of reliable information on the quality of health plans from the enrollees’ perspective. CMS now fields the survey in fee-for-service Medicare and Medicare Advantage,\(^99, 100\) and has the authority to add supplemental questions to gather consumer information on issues of concern to the Medicare or Medicaid programs.\(^101, 102\)

CAHPS is a valuable tool for learning about care from the consumer perspective, but the Medicare survey does not ask questions about primary language or language access.\(^103\) A CMS representative said that because the survey is administered only in English and Spanish, questions about language access would not reflect the needs among other LEP racial/ethnic groups, and that there has not been much demand for the inclusion of these kinds of questions.\(^104\) According to the representative, CMS is open to adding supplemental questions about limited English proficiency and its effect on care to the survey.\(^105\) Useful questions would probe beneficiaries on issues such as whether language barriers prevent them from communicating symptoms, understanding prescribed treatments, and medication and follow-up instructions.

The CAHPS Hospital Survey (Hospital CAHPS or H-CAHPS), initiated in October 2006, seeks to understand the experience of adults with inpatient hospital care and services. Hospitals across the country use the H-CAHPS on a voluntary basis and the resulting data are reported quarterly to CMS.\(^106\) The survey is currently conducted in English, Spanish, and Chinese; however, CMS is considering expanding it to other languages, although these have not been identified.\(^107\)

The H-CHAPS asks respondents to identify the language primarily spoken at home. This information is used as a patient mix adjuster that adjusts hospital scores for purposes of public reporting and comparison. It could also be used to identify hospital inpatients who are LEP,\(^108\) to identify needs for inpatient interpreter services among Medicare beneficiaries, to identify barriers to quality inpatient hospital care from the patient perspective, and to get a sense of whether and to what extent hospitals are in compliance with the requirements of Title VI, its implementing regulation, and federal guidance. A representative from CMS said that the agency would consider such uses of LEP information from the H-CAHPS survey.\(^109\)

**Other Policy Options**

Recent research has identified some policy options CMS could pursue to improve access to language services for Medicare beneficiaries.\(^110\) These options include the following:
Increase language options on the CMS website. Currently, CMS presents information primarily in English and Spanish. Improve Medicare data on race and ethnicity, including working with the Social Security Administration (SSA) to develop a program to collect data on race, ethnicity, and socioeconomic status at the time of enrollment in Medicare and for current beneficiaries. SSA is the primary source of race and ethnicity information; however, the usefulness of the information is limited by three main factors: (1) the fact that until 1980 SSA used only three racial designations (white, black, and other); (2) the voluntary nature of reporting race; and (3) the difficulty of making systematic corrections to the data.

Require the uniform collection of race and ethnicity data by health plans.

Provide grants to hospitals and health professional training programs to increase the number of minority physicians and other practitioners.

Provide grants to community-based organizations to train bilingual interpreters.

Initiate federal contracts for telephone interpreter services.

Improve oversight of existing requirements to provide culturally and linguistically appropriate (CLAS) services in Medicare Advantage.

Develop and distribute model contract language related to the provision of interpreter services for government contracts with health plans.

Require Medicare Advantage plans to undertake more QAPI projects focused on CLAS, especially among plans in areas with large numbers of LEP persons, and widely disseminate project results. CLAS projects could be required to use templates developed by CMS.

Add supplemental questions to the health plan CAHPS to determine the extent to which LEP persons are unable to communicate effectively with providers and the extent to which this affects their satisfaction with care.

Use the financial clout of the Medicare program to require medical residency and nursing programs to incorporate education about the importance of language access and its role in reducing health disparities and medical errors in their curriculums.

Engage in outreach and education activities to inform persons with low English proficiency about their legal rights with regard to language services.

View language and cultural access as important quality measures and making sustained efforts to ensure language access at every level of care.

Conclusion

Language barriers make it hard for people who have no or limited English skills to effectively participate in their own health care. The problem is especially acute for Medicare beneficiaries, among whom the prevalence of chronic disease is highest. Recent federal demonstration projects have included activities designed to overcome these language barriers. The projects may identify promising strategies for responding to the needs of LEP persons. But demonstration projects are frequently discontinued or their findings are not incorporated throughout the Medicare program. Thus, despite the cautious promise of some of these
Improving Access to Care Among Medicare Beneficiaries with Limited English Proficiency: Can Medicare Do More?

projects, much remains to be done. Reducing language barriers in Medicare supports two important national goals: reducing racial and ethnic disparities in health care and improving the quality of care received by Medicare beneficiaries.

Congress has recognized that one of the most promising strategies to ensure access to language services is to provide reimbursement for translation. H.R. 3014—introduced in July 2007 and endorsed by the Congressional Black Caucus, the Hispanic Caucus, and the Asian Pacific American Caucus—would establish a center for remote translation and incorporate the four factors of the HHS revised Policy Guidance into law. It also would establish 30 demonstration sites to evaluate the impact on costs and health outcomes of providing reimbursement for interpreters for LEP beneficiaries. The bill has been referred to a number of committees.123

Another measure—the Children’s Health and Medicare Protection Act (CHAMP), H.R. 3162—was passed by the House on August 1, 2007 but failed in the Senate. CHAMP would have (1) collected primary language information on Medicare beneficiaries and Social Security applicants; (2) conducted a study to determine how Medicare could develop payment systems for language services; (3) awarded demonstration grants to Medicare service providers to improve communication between providers and Medicare beneficiaries in underserved racial and ethnic minority communities where many people face language barriers; (4) required an Inspector General report on Medicare’s compliance with the CLAS standards; and (5) required an Institute of Medicine report on the impact of language access services on the health and health care of LEP populations. Many House members continue to support the CHAMP provisions, even though they did not become law.

Regardless of the outcome of these federal legislative proposals, CMS currently has the authority to take steps to ensure that a growing LEP Medicare population has access to the language services.

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Ibid.

Ibid.


Ibid.

Ibid.

Ibid.

Supra, note 1.

Supra, note 4.

Ibid.

Ibid.

Ibid.

Ibid.

Supra, note 7.

Supra, note 4.

Supra, note 7.


Supra, note 5.

Ibid.

Supra, note 24.

Ibid.

The purpose of this part is to effectuate the provisions of title VI of the Civil Rights Act of 1964 (hereafter referred to as the Act) to the end that 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 otherwise subjected to discrimination under any program or activity receiving Federal financial assistance from the Department of Health and Human Services. 45 C.F.R., section 80.3(b).


Supra, note 24.

Ibid.


Supra, note 24.


The guidance was originally published on August 30, 2000, and included a 60-day comment period. See 65 FR 52762. It was republished for additional comment on February 1, 2002, pursuant to a memorandum issued by the U.S. Department of Justice on October 26, 2001. See 67 FR 4968. On March 14, 2002, OMB issued a report to Congress on costs and benefits of improving access to services for LEP persons. OMB recommended the adoption of uniform guidelines across all federal agencies. Consistent with this recommendation, DOJ published LEP Guidance for DOJ grant recipients, which were drafted as a model for all federal grantmaking agencies. See 67 FR 41455. The revised LEP Guidance of August 8, 2003, reflects comments
received by the agency as well as the DOJ Guidance. 68 FR 47311.

39 Supra, note 24.

40 According to language in the Revised Guidance, this emphasis reflects a desire not to overburden small businesses, small local governments, and small nonprofits (supra, note 5).

41 In 1946, Congress passed the Hospital Survey and Construction Act (Hill-Burton Act), which gave hospitals, nursing homes, and other health care facilities federal grants and guaranteed loans for construction and modernization. In return, they agreed to provide a reasonable volume of services to persons unable to pay and to make their services available to all persons residing in the facility’s area. The program stopped providing funds in 1997, but about 300 health care facilities nationwide are still obligated to provide free or reduced-cost care.

42 Infected Judgment: Legal Responses to Physician Bias, 48 Vill. L. Rev. 195 (2003), citing Smith, D.B, Health Care Divided: Race and Healing a Nation (Ann Arbor, MI, University of Michigan Press, 1999). Smith views the Part B exemption as a product of the political realities of the time that made it unrealistic and administratively burdensome to enforce Title VI against large numbers of individual physicians. In addition, local medical societies, state societies, and the American Medical Association were political forces and were reluctant, if not hostile, participants in the Medicare program, making it politically untenable to attempt to enforce Title VI.

43 Medicaid is a joint state and federally funded program that pays qualifying medical expenses for eligible people under age 65 who are indigent and meet certain other criteria. TRICARE is the Department of Defense’s health care program for members of the uniformed services, their families and survivors. The Federal Employees Health Benefits Program is a health insurance program that provides coverage for federal employees and retirees.


45 Ibid.

46 Ibid.

47 E-mail communication with Jane Perkins, Legal Director, National Health Law Program, Chapel Hill, NC, July 2008.

48 E-mail communication with Jane Perkins, Legal Director, National Health Law Program, Chapel Hill, NC, August 2008.

49 Ibid.


51 Ibid.

52 Ibid.

53 Supra, note 7.

54 Ibid.

55 Supra, note 45.

56 Ibid.

57 Supra, note 42.

58 Supra, note 45.

59 Supra, note 42.

60 Supra, note 42.

61 Using contracted interpreter services may raise important privacy considerations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Public Law 104-191. Under HIPPA a covered entity (such as a hospital) must enter into a written agreement with its business associates (such as brokers/consultants) where the business associates promise to properly protect the use and disclosure of personal health information received from the "covered entity". A "business associate" is a person or entity that performs or assists in the performance of a function or activity on behalf of a covered entity and uses PHI in the process of performing that function or activity. Cigna, HIPAA Frequently Asked Questions assessed at www.cigna.com/customer.

62 Ibid.

63 Supra, note 8.

64 Supra, note 42.

65 Supra, note 45.

66 Ibid.

67 Supra, note 42.

68 CMS, Quality Improvement Organization Manual, Chapter 6: Medicare + Choice Organizations (Baltimore, MD, CMS, Rev. 11, 10-3-03), accessed at www.cms.hhs.gov/manuals.
Improving Access to Care Among Medicare Beneficiaries with Limited English Proficiency: Can Medicare Do More?


70 Ibid. QAPI efforts are mandated as a condition of participation in Medicare Advantage plans and Medicaid managed care plans. These mandates also apply to hospitals, rural health clinics, federally qualified health clinics, and nonmedical religious health care institutions that accept Medicare and Medicaid.

71 Ibid. CMS provided technical support to plans opting for CLAS initiatives.

72 Supra, note 5.


74 CMS changed project evaluation time frames and reporting format. Letter to Medicare Advantage Organizations from Cynthia Moreno, acting director, Quality Assessment Performance Improvement (QAPI) Projects after January 1, 2006 (Baltimore, MD, CMS, January 12, 2005).

75 Telephone conversation with Michelle Turano, CMS health insurance specialist, April 11, 2008.


77 Two examples of these initiatives are the Coordinated Care Demonstration authorized by the Balanced Budget Act of 1997 to examine whether private sector case management tools adopted by health maintenance organizations could be applied to fee-for-service beneficiaries, and the Benefits Improvement and Protection Act Disease Management Demonstration, which is designed to determine whether disease management services provided to Medicare beneficiaries with certain chronic diseases can yield better patient outcomes without increasing program costs (HHS, Statement by Stuart Guterman on Eliminating Barriers to Chronic Care Management in Medicare before the House Ways and Means Subcommittee on Health, February 25, 2003).

78 Public Law 106-554, sections 122(a) and (b).

79 CMS, Solicitation for Proposals for the Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities, Solicitation No. 5036-N (CMS, Baltimore, MD).

80 Ibid.

81 CMS, Office of Public Affairs, CMS Announces Demonstration Project to Reduce Disparities in Cancer Prevention and Treatment (Baltimore, MD, December 14, 2004).

82 Navigation services might also include arranging financial support; arranging for transportation to and from diagnosis and treatment appointments, and child care during appointments; coordinating care among providers (such as screening clinics, diagnosis centers, and treatment facilities); ensuring coordination of services among medical personnel; ensuring that medical records are available at each scheduled appointment; and coordinating other services to overcome access barriers encountered during the cancer care process. National Institutes of Health, National Cancer Center (NCI), NCI’s Patient Navigation Research Program: Fact Sheet (Bethesda, MD).

83 Supra, note 76.

84 E-mail communication with Pauline Lapin, CMS Office of Research, Development, and Information, Baltimore, MD, April 29, 2008.


86 E-mail communication with Jennie Bowen, senior research analyst, Thomson-Reuters, April 28, 2008.

87 Ibid.

88 Ibid.

89 Supra, note 7.

90 Ibid.

91 Ibid.

92 Supra, note 7.

93 Ibid.

94 OMB oversees the preparation of the federal budget and supervises Executive Branch agencies. In helping to formulate the budget, OMB evaluates the effectiveness of agency programs, policies, and procedures.


96 Provider and physician groups cite much higher costs of providing interpreter services. E-mail communication from Timothy Jost, Saturday, May 24, 2008.
Improving Access to Care Among Medicare Beneficiaries with Limited English Proficiency: Can Medicare Do More?

97 Supra, note 7. This report provides an extensive discussion of how Medicare reimbursement policies could be modified to pay for language services.

98 Ibid.

99 Telephone interview with Elizabeth Goldstein, director, CMS Division of Consumer Assessment and Healthcare Survey, April 22, 2008.

100 CAHPS originally stood for Consumer Assessment of Health Plans Study, but the products have evolved beyond health plans so the name was changed. The CAHPS program is funded and administered by the U.S. Agency for Healthcare Research and Quality (AHRQ), which works closely with a consortium of public and private organizations. HHS, Agency for Healthcare Research and Quality, CAHPS Overview, accessed at www.cahps.ahrq.gov.

101 Supra, note 95.

102 The CAHPS Health Plan Survey is administered to commercial, Medicaid, Medicare, and SCHIP plans representing more than 120 million enrollees. HHS, Agency for Healthcare Research and Quality, CAHPS Overview, accessed at www.cahps.ahrq.gov.

103 E-mail communications with Michael S. Hornbostel, NCBD1@WESAT.com, April 8 and April 10, 2008.

104 Supra, note 95.

105 Ibid.

106 The initial phase of data collection will last nine months. Hospital-level results will be publicly reported in early 2008 on the Hospital Compare Web site (www.hospitalcompare.hhs.gov), which is also available through a link at www.medicare.gov. After the initial phase, the data will be updated quarterly. HHS, Agency for Healthcare Research and Quality, CAHPS Hospital Survey (H-CAHPS), accessed at www.cahps.ahrq.gov/content/products/HOSP/PROD_HOSP_Intro.asp.

107 Supra, note 95.

108 Ibid.

109 Ibid.

110 This is not an exhaustive list.

111 E-Mail communication from Timothy Jost, Saturday, May 24, 2008.


113 Ibid.

114 Ibid.

115 In 2003, only 4 percent of physicians were African Americans and only 5 percent were Hispanic; only 11 percent of all medical school graduates were from minority groups (supra, note 5).

116 Supra, note 7.

117 Ibid.

118 Ibid.

119 Supra, note 48.

120 Supra, note 5.

121 Ibid.

122 Ibid.