PAYING FOR LANGUAGE SERVICES IN MEDICARE: Preliminary Options and Recommendations

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Executive Summary

To improve access to health care, advance the quality of care and reduce the risk of medical errors, many organizations have proposed that insurers, including the federal Medicare program, provide funding for language services, such as professional interpretation, for patients who are limited English proficient (LEP). Such a step would serve as a counterpart to current federal civil rights policies that interpreter services be made available for LEP patients, as well as to nationwide efforts to improve the quality of care, which suffers when patients and their doctors (or other caregivers) are unable to communicate because of language barriers. Although more than two million elderly people in the United States are LEP, Medicare does not provide funding for language assistance. Reducing language barriers could increase the quality of care for a growing group of Medicare patients and reduce racial and ethnic disparities in health care.

This report discusses how the federal government could design payment systems for language services in Medicare. Medicare has a number of complex payment systems for inpatient hospital care, outpatient hospital services, physician visits, managed care and other services. A method of paying for language services that works in one Medicare payment system may not be feasible or appropriate for another. This paper reviews information about current approaches to pay for language services, current Medicare payment systems and principles that could be considered in designing payment systems for language services. It then reviews a number of options for inpatient and outpatient hospital systems, physician services and managed care plans.

The report offers a number of preliminary recommendations, but these recommendations should be viewed as a starting point, not an ending point, for discussion of these complex issues. The five recommendations are:

- *Develop a flexible system of Medicare payment for language services in hospitals.* Evidence shows that hospitals frequently offer interpretation and other language services, but are rarely reimbursed for these expenses. This discourages broader availability of language assistance. A two-phase system for development of payments could provide immediate financing for language services in inpatient and outpatient settings and provide time to develop a more refined payment system.

  In the first phase, hospitals could receive additional Medicare payments based broadly on the volume of LEP patients, as measured by Census data on the LEP population in their service areas. This would provide funding for language services and give time for hospitals to implement more consistent methods of recording data about patients' primary languages and how their language needs are met.

  This information could be used to develop, in the second phase, a more refined system that adjusts individual inpatient and outpatient hospital payments (i.e., Diagnosis-Related Group-based and Ambulatory Payment Classification-based payments) on a claim-specific basis for LEP patients. It is important to develop a system that gives hospitals flexibility in determining how to provide language

services, e.g., through in-person professional interpreters, through telephone language services or through increased availability of bilingual and multilingual clinicians.

- *Offer grants to hospitals, schools that train health professionals and community groups to increase the recruitment and training of bilingual and multilingual medical interpreters and clinicians.* To improve services, it will be necessary to increase the stock of appropriately trained medical interpreters and bilingual or multilingual clinicians. This could benefit not only Medicare patients, but the Medicaid and privately insured patients who will receive care from the same health professionals.

- *To improve language services in physician settings, provide Medicare reimbursements to in-person interpreters and develop a system of federal contracts for telephone interpretation firms.* This will increase the availability of interpretation services in primary and specialty care settings, but avoids making physicians the financial intermediaries for these services. A reimbursement system for payment of interpreters could be developed, like the reimbursement systems that exist for many other health professionals. The federal government could also arrange to contract with a number of telephone interpretation firms that physicians could call to get telephonic interpretation for Medicare patients. These firms would directly bill the federal government. There are many circumstances in which it is not feasible to arrange for in-person interpretation and telephone interpretation is the appropriate option.

- *Improve monitoring and oversight of existing requirements to provide language services in Medicare managed care.* Medicare managed care contracts already require that the health plans provide language assistance to LEP patients, but there is no organized system of monitoring how or whether health plans meet these requirements.

- *Exempt language services from Medicare cost-sharing requirements.* If there was no exemption, Medicare beneficiaries would be required to pay for a portion of the costs of interpretation in physician and outpatient settings. This might actually create a disincentive to the use of interpreters, reduce the quality of care provided and create additional liability risks for health care providers. This exemption would be akin to existing Medicare policies that exempt clinical laboratory tests from cost-sharing. It would assure consistency with existing federal civil rights laws and avoid creating a disincentive to not use language services.

This report also examines a number of other options for Medicare funding of language services. It discusses, for example, the potential for including language service criteria as a component of "pay for performance" systems in Medicare, but concludes that it is too early to understand how such an approach could be implemented or what its effects might be.

Medicare is a constantly evolving program. As the proportion of Medicare beneficiaries who lack English proficiency grows, the federal government has the opportunity to consider how it can better address the health care needs of these patients. In a nation that pays for high-technology medical advances to help patients, it is regrettable that we stint on simple things like helping a patient and physician communicate.

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In a variety of ways, the federal government requires, encourages and pays for language services to help patients with limited English proficiency (LEP) communicate more effectively with their doctors or other health care providers. These policies are part of broader efforts to improve the quality of health care as well as to reduce health care disparities that affect racial or ethnic minorities. Under federal civil rights policy, health care providers that receive federal funds are obligated to offer free language interpretation to assist LEP patients in order to avoid discrimination on the basis of national origin.[1] The U.S. Department of Health and Human Services (HHS) has established national standards for culturally and linguistically appropriate services in health care. The U.S. Public Health Service supports a variety of projects to improve language access and to reduce health care disparities.[2] The federal government also makes federal matching funds available to state Medicaid and SCHIP programs in order to finance language services for LEP patients.[3]

A notable gap in these federal policies is the lack of Medicare reimbursement for language services, including interpretation. (In this report, "interpretation" refers to oral translation between an LEP patient and an English-speaking health care provider. Other language services include translation of written materials.) The lack of funding for language assistance discourages health care providers from actually providing these services for their patients. The lack of financial incentives is an important — though not the only — stumbling block to improved language access and coverage of language services by health insurers could improve the availability of these necessary and effective services.[4] A widely-cited Institute of Medicine report on reducing racial and ethnic disparities in health care found that, "As a result of the increasing linguistic diversity in the United States, professional interpretation services are increasingly needed to assist low English proficient racial and ethnic minority patients in healthcare settings." Therefore, the Institute recommended, "Greater resources should be made available by payors to provide coverage for interpretation services for limited English proficient patients and their families."[5]

Other organizations have made similar recommendations. The American College of Physicians, for example, has stated that "Reimbursement for interpreter services should be provided by Medicare and Medicaid." It went on to note that, "This should be provided either directly to interpreter providers or as a reimbursable expense that could be billed separately with payment for physician office visits."[6] The American Medical Association has said that it is "strongly opposed to allowing the burden of funding written and oral interpretation services for limited-English-proficiency patients to fall on physicians."[7] The National Association of Public Hospitals and Health Systems has noted the difficulties of providing adequate language services without additional funding.[8] The National Alliance for Hispanic Health has called for reimbursement for interpreters as well as for increased compensation for bilingual health care providers.[9] The HHS Office of Minority Health's report on culturally and linguistically appropriate services stated that "Federal and state policymakers should support and implement direct reimbursement of interpretation and translation costs in the Medicare and Medicaid programs, and private insurers should do the same for their commercial products."[10]

Language barriers can have a detrimental effect on the health care of a substantial share of patients, especially those in racial/ethnic minority groups and immigrants. For example, about a third of Latino patients report having communications problems with their physicians as do more than one-quarter of Asian Americans.[11] An ample body of research evidence and common sense indicate that when LEP patients and their caregivers cannot communicate, unnecessary and potentially dangerous problems may follow, reducing access to health care, compromising the quality of care, elevating the risk of medical errors, inducing unnecessary diagnostic testing and invasive procedures, and raising the risk that the patient will not understand how to follow medical advice or self-manage his or her disease.[12] A recent study of Medicare beneficiaries found that LEP beneficiaries had poorer access to a usual source of health care and to preventive cancer screenings than beneficiaries who were not LEP.[13] That is, even though all of those studied had insurance through Medicare, there were discrepancies in access to care that were related to language proficiency.

Concern about language barriers is not just an issue of civil rights or racial and ethnic disparities, but part of a broader concern about the quality and efficiency of health care. Effective patient communication is an essential part of any strategy to improve the quality of medical care and to prevent unnecessary or inappropriate care. Improving language services would not only improve LEP patients' access to care, but increase the likelihood that that their diseases are properly diagnosed, that they learn how to better care for themselves, and that they better manage their diabetes, heart disease or other chronic diseases. In turn, this can help reduce unnecessary hospitalizations and emergency room visits.

According to the Census Bureau's American Community Survey, in 2003 there were 2.5 million people over the age of 65 in the United States who were LEP, meaning that they spoke English less than very well or not at all. About half are Spanish-speaking. The number of LEP seniors has been rising over time and is likely to continue to climb. While the great majority of LEP seniors are immigrants (including both naturalized citizens and non-citizens), a large number are native-born American citizens who are primarily LEP. Of these elderly LEP people, a smaller, but sizable, number of Medicare beneficiaries need language assistance. Some LEP Medicare beneficiaries already have accommodations (e.g., they already have located some bilingual health care providers) and some immigrants over the age of 65 are not on Medicare (because they are not eligible or did not have sufficient work experience in the United States to quality for free Part A coverage). Finally, a large share of the LEP are American citizens: American Community Survey data show that about half (46 percent) of those who are LEP are U.S. citizens (naturalized or native-born).

Some may question whether it is appropriate to use federal funds to pay for interpretation or language services in Medicare. Since English is the dominant language in the United States, some may feel it is inappropriate to offer services in any other languages. Such a belief, however, runs contrary to existing civil rights policies which require language interpretation for LEP patients to reduce the risk of discrimination on the basis of race, ethnicity or national origin. Offering Medicare reimbursements for language services does not

Table 1. Number of People Over 65 With Limited English Proficiency

Primary Language Spoken	1,000s of Seniors
Spanish	1,178
Other Indo-European Language	700
Asian/Pacific Island Language	531
Other Language	71
Total	2,480

Source: 2003 American Community Survey

substantially modify the existing civil rights of beneficiaries, instead it offers payments to healthcare providers in order to help them afford the services that they are already supposed to be providing.

Some may believe that the use of other languages may discourage people from learning English. Acquisition of English proficiency can help immigrants integrate more fully into American society and improve their employment prospects. But there is no evidence that offering interpretation in health care settings discourages people from learning English. Because health problems and medical treatment are intensely personal and technically complex, it is medically appropriate to offer communications in the language in which patients are most proficient. Finally, Medicare beneficiaries are mostly elderly; if they have not gained English proficiency by this phase in their lives their English skills are unlikely to improve greatly no matter how strong their intent. The ability to learn a language decreases sharply with age.

Finally, some may be concerned that offering interpretation in Medicare might aid undocumented immigrants. But undocumented immigrants are not eligible for Medicare. In order to qualify for Medicare, a person must be a U.S. citizen or a legal non-citizen immigrant who has met other additional criteria. Most foreign-born Medicare beneficiaries had to work in the United States for more than 10 years in order to qualify (or their spouses had to work that long), just as citizens must.

While some have proposed that Medicare pay for interpretation or language services, there has been relatively little discussion of *how* to structure payments for these services. This is not a trivial issue. Medicare payment policy is complex and is one of the most important aspects of federal policy for Medicare. This paper offers a preliminary set of options and recommendations about how Medicare could pay for language services, focusing on payments for hospital (inpatient and outpatient) care, physician care and managed care. Because Medicare payment methods often influence state Medicaid programs and private health insurance companies, developing Medicare payment methods could have broader repercussions for other payors and insurance beneficiaries.

The Varying Modes and Contexts of Language Services

There are many ways to provide language assistance to LEP patients in health care settings:

- In-person professional interpreters.
- Bilingual or multilingual clinicians.
- Other bilingual or multilingual health care staff who serve as interpreters.
- Telephone interpretation services, in which the clinician and patient are at one site, but the interpreter is in a remote location and provides interpretation by telephone (e.g., using a speaker phone or dual headsets) or similar arrangements (e.g., videoconference).
- Informal interpreters (e.g., a friend or family members).
- Standard written translations of forms, educational materials, etc.
- Custom written translations (e.g., written instructions from physician to patient or caretakers, translated descriptions of how to take medications, etc.).

Each approach serves different needs and has different costs. For example, while in-person professional interpreters are probably the most appropriate in certain settings (e.g., hospitals or large clinics) or for certain languages (e.g., Spanish or languages common in an area), telephone interpretation may be more logistically feasible in health care sites that see fewer LEP patients, for patients who speak a less common language or in after-hours settings when fewer staff are working. Research

indicates that there is less potential for misunderstanding and consequent medical error with a professional interpreter than an informal interpreter.[14]

Language assistance may be needed in many settings or contexts. It may be required in direct contacts between the patient and the physician or other clinician, including nurses or other health professionals. It can also be required in other contacts with non-clinical parts of the medical system, such as receptionists, social workers or the billing office. Finally, language assistance may be required in many different part of the health system, including hospitals, clinics, physicians' offices, nursing homes and so on.

In some cases, language services can be scheduled in advance. In some cases, they are required for emergency or unscheduled walk-in visits. These logistical factors also influence the form and cost of assistance.

How Others Pay for Language Services

Under Medicaid and SCHIP, interpretation services can be covered by states as either administrative expenses or as medical benefits, so state expenses are eligible for federal matching payments of 50 percent or more. According to the National Health Law Program, as of 2005 thirteen states paid for interpreter services under Medicaid or SCHIP.[15] Varying approaches are used: some authorize reimbursement to interpreters for their services, while others contract with specific organizations to provide interpretation. This latter approach is particularly useful in outpatient or office settings. One state has separate payment rates for telephone and in-person interpretation. In some areas, hospitals may include interpretation costs as allowable expenses used to establish overall Medicaid payment rates. One state uses interpretation costs in computing Medicaid disproportionate share hospital (DSH) payments and allocates a special grant fund for language services.

A number of private agencies across the nation are vendors of language services and many offer specialized medical interpreters. Medical interpreters not only have language skills, but have additional training in medical terminology and professional behavior, including patient confidentiality. Typically, these organizations have internal training and testing standards to ensure the linguistic competence of their staff and often also ensure qualifications in medical interpretation. They offer in-person and telephone interpretation services, as well as written translation services. For example, the U.S. General Services Administration has a federal supply schedule for language services which gives insights into the types of services and prices available among a variety of contractors.[16] In-person interviewers are typically paid on an hourly or daily basis with a two-hour minimum. Rates may vary depending on the language involved and type of interpretation. Telephone interpretation services typically charge by the minute as well as having a charge for the phone connection. In addition to commercial sources, a number of community-based nonprofit agencies offer interpretation services to nearby health care providers or help translate written materials for use by patients.

Health care facilities often have in-house staff who serves as interpreters; some are professionally-trained and some are not (e.g., clinical or non-clinical staff who happen to be bi- or multilingual). In addition, a number of staff and affiliated clinicians (e.g., doctors and nurses) may be bilingual or multi-lingual and an interpreter is not needed since the clinician and patient can community directly. In order to attract (and retain) appropriate staff, many organizations give special consideration to job applicants who are bilingual or offer higher wages to those who are bilingual. A recent survey conducted by the Health Research and Educational Trust and the American Hospital

Association shows that hospitals use a wide array of staff and approaches, including professional interpreters, hospital clinical and non-clinical staff and telephone services, to provide language assistance. However, hospitals rarely receive direct reimbursement for the work they do. Only 3 percent of hospitals reported receiving reimbursements for language services, and those were primarily through state Medicaid programs.[17]

Medicare Payment Systems

Understanding how to pay for language services in Medicare requires first understanding how Medicare pays for medical care in general. The program has multiple payment systems which evolve and change over time. The following are very simplified descriptions of some of the most relevant payment systems in Medicare:[18]

- *Inpatient hospital payments.* Acute care inpatient hospital care is paid under Medicare's Prospective Payment System. The Medicare reimbursement is based on a Diagnosis-Related Group (DRG), which corresponds to the estimated resource costs of treating a patient with a given discharge diagnosis and treatment procedure. The prospective payment is not based on the actual cost of the specific services provided to each individual patient and is designed to avoid reliance on inflationary cost-reimbursement systems. Payments for patients treated for a given diagnosis are similar, regardless of, for example, the number of days spent in the hospital. In many cases, there are alternative DRGs used when a patient has or does not have co-morbidities or complications that make treatments more difficult and expensive. There also are arrangements for so-called "outlier" payments. The Medicare payments cover the operational costs associated with care during an inpatient stay (e.g., nursing costs, other staff costs, supplies, meals, etc.).

  Additional hospital payments — calculated on a different basis— are available under Medicare to help finance indirect medical education or to assist "disproportionate share" hospitals that serve large numbers of Medicaid or Supplemental Security Income patients.

- *Physician payments.* Physician payments are based on the Resource-Based Relative Value Scale (RBRVS), which is essentially a fee schedule that is based on the approximate resource cost of different medical procedures. There are frequently variants based on individual patients' co-morbidities or characteristics in recognition of the greater complexity of treating certain kinds of patients. In addition, payment bonuses are available for physicians who practice in rural or urban health professional shortage areas.

- *Outpatient hospital payments.* Payments for outpatient hospital services are based on the medical procedures used in treatment. The payment system relies on Ambulatory Payment Classification groups (APCs). They cover the institutional capital and operating costs of the hospitals in which care is rendered, not the physician-related charges. Typical services covered by APCs include emergency room, clinic, radiology, laboratory, operating room, etc.

- *Nonphysican payments.* In general, institutional payments and physician payments include payment for services rendered by nurses, clerks or other medical staff. In some cases, however, nonphysician staff may bill and be paid separately, usually based on a Medicare fee schedule. Such payments are available for physician assistants, nurse practitioners, psychologists or social workers, physical or occupational therapists and others. In some cases, these services are performed

under a physician's supervision (e.g., physician assistants), while in other cases the professionals are largely independent (e.g., psychologists or physical therapists).

- *Managed care payments.* Under managed care, Medicare makes monthly capitation payments to private health plans**,** which are responsible for the delivery of and payment for medical care to those who join these plans, instead of remaining in fee-for-service Medicare. Capitation payments under Medicare managed care (now called Medicare Advantage) were modified substantially under the Medicare Modernization Act.[i] Historically, capitation payments were based on estimates of the cost of serving patients under fee-for-service Medicare, with adjustments to the capitation payment made based on the characteristics of individual members, so that payments for those who are older or sicker are higher than for those younger or healthier. Under the new legislation, private plans must bid capitation rates, which will be judged relative to benchmark estimates derived from estimates of the cost of care under fee-for-service.

Medicare also has payment systems for long term care hospitals, nursing homes, home health care and, most recently, prescription drugs. The need for language assistance might crop up in any of these settings as well, but this report is focused only on language services in the context of hospital (inpatient and outpatient) and physician settings and in Medicare Advantage (managed care).

Medicare Value-Based Purchasing. Recently, a major topic of discussion in Medicare payment policy is the concept of "pay for performance."[19] Broadly speaking, the pay for performance movement promotes giving bonus payments to providers who demonstrate better "quality of care," as measured by a variety of evidence-based quality indicators. One way in which this might be accomplished is to hold back a small percentage of current Medicare payments to create a fund for bonus payments that would be paid to providers who demonstrate that they meet the quality criteria. There is broad interest in this as a way to align financial incentives with better quality and the concept seems likely to spur future refinements to Medicare payment policies. Legislation approved by the Senate as part of its FY 2006 budget reconciliation package included provisions to initiate pay for performance systems in Medicare, but these provisions were not contained in the final legislation signed by the President.

Medicare cost-sharing. A final issue is that Medicare requires extensive beneficiary cost-sharing. For physician services, for example, beneficiaries must pay a deductible of $124 (in 2006) and pay an additional 20 percent of the approved amount above the deductible.[ii] For inpatient hospital care, there is a large deductible ($952 in 2006) and extensive copayments are required for care received after the 60th day in the hospital. Low-income beneficiaries are largely protected if they are full dual eligibles **(**i.e., also receiving Medicaid**)** or if they are Qualified Medicare Beneficiaries (QMBs) whose incomes fall below the federal poverty line. For these individuals, state Medicaid programs will pay Medicare cost-sharing amounts.

One of the side effects of providing Medicare reimbursement for language services is that

[i] Two key changes in Medicare managed care under the Medicare Modernization Act are that managed care plans will include prescription drugs and there can be regional preferred provider organizations.

[ii] Non-participating physicians may also "balance bill" and require that patients pay additional amounts beyond the approved Medicare amount. Non-participating physicians receive 95 percent of the standard Medicare payment.

patients could be required to pay a portion of those costs, depending on how the payments are structured. This could be contrary to current federal civil rights policies under which providers are obligated to provide free interpretation services.[iii]

Principles for Payment Methods for Language Services

Before beginning a more detailed analysis of options for Medicare payments, the following are principles that can be used to assess alternative approaches of paying for language services:

- *Provide financial incentives for reasonable and efficient provision of competent language assistance to LEP Medicare patients.* Because Medicare does not provide payments for language services and has no effective penalties for not offering language assistance, the current system creates disincentives for interpretation services and leads to over-reliance on informal (ad hoc) interpreters.

- *Facilitate timely use of language services by LEP patients and health care providers.* A system should not impose undue burdens upon either patients or providers. For example, a patient should not need to take an oral or written exam to document that he or she is LEP and a clinician should not need to provide excessive documentation that a patient requires interpretation services. Once it is determined that these services are needed, they should be available on a timely basis (e.g., no requirements for prior authorization, no long waits for service).

- *Offer flexibility for varying modes of language assistance.* At the very least, payment systems should allow for both in-person and telephone interpretation, as appropriate. It would also be desirable to develop incentives to increase the availability of bilingual or multilingual clinicians and allied health personnel.

- *Be consistent with broader Medicare payment methodologies.* Medicare already has a complex system of reimbursement methods. Adaptations for language services should be compatible with current approaches.

- *Be consistent with federal civil rights policies.* Federal civil rights policies require the availability of free interpretation services for LEP patients, within certain practical limits.

- *Provide for accountability of payment for language services and provision of language services.* To the extent that payments are made to promote language services, there should be documentation or accountability that services are rendered.

An important issue in all the following discussions is the competency of interpretation and language services. It is critical that interpreters be competent, both with respect to language proficiency as well as issues specific to the medical context (e.g., understanding medical terminology, confidentiality, etc.) However, there is no commonly accepted national standard for the competency of interpreters, although some states have established standards. It is likely that Medicare payments would create a stronger need for methods to assess both language proficiency

[iii] Federal civil rights policy establishes that health care providers must offer language assistance to LEP patients if the providers receive federal funds, but some guidance notes that this does not apply to physicians who only receive payments under Medicare Part B. Relatively few physicians, however, receive only Medicare Part B funds and do not receive funding from other federal programs such as Medicaid, other HHS programs, or other federal insurance programs such as the Federal Employees Health Benefits or TRICARE programs. Moreover, when the physicians operate under the auspices of hospitals, clinics or managed care plans that receive federal funding, these requirements still convey to the physicians.

and professional skills for interpreters, perhaps developed by a national professional association. This issue may be the most visible if Medicare payments are made directly to interpreters, because it would raise the issue of who is a qualified interpreter eligible for such reimbursement. The National Council on Interpreting in Health Care recently released its "National Standards of Practice for Interpreting in Health Care," which discusses a number of professional and ethical practice issues, and has been striving towards development of other competency standards.[20] While this is a critical issue, the nature and development of competency standards is well beyond the scope of this report.

Options to Pay for Language Services in Medicare

This section describes six basic strategies for paying for language services in Medicare. They are not mutually exclusive and could, in some cases, complement one another. In the sections following this one, we discuss how these options might be applied to hospitals, physicians and managed care plans. The six options discussed are:

1. Direct reimbursement for in-person interpreters
2. Contracting for telephone interpretation services
3. LEP adjustments for individual claims or payments (e.g., DRG or RBRVS payments)
4. LEP payments for hospitals on a facility-specific basis
5. Pay for performance quality adjustments
6. Grant programs to promote language services

1. ***Direct reimbursement for in-person interpreters***. In-person interpretation is often considered the most appropriate way to provide language services in many cases. An in-person interpreter can establish better rapport between the patient and physician and help disentangle cultural differences that may impede communication. They can provide not only oral interpretation, but can help translate written documents (e.g., writing down the physician's instructions in the patient's language). They can provide other advice to help a patient navigate the complex medical system. By being physically present, interpreters can also accompany patients through stages of medical care, e.g., they can accompany the patient from the physician's examining room to the radiology department where an x-ray is done.

This option would adopt a fee schedule for in-person interpreters who could directly bill Medicare for services. CMS could develop a fee schedule, based on surveys of prevailing payment rates for interpreters and other information about geographic variations in wage rates or costs. In order to participate, interpreters would need to establish their professional qualifications and agree to contractual elements, such as payment rates. They should also document that each claim being submitted is related to ("incident to") a medical contact for an LEP Medicare patient such as a physician visit, hospital interview, etc. By their nature, interpreters do not function independently, but act in conjunction with other medical care.

This approach is comparable to Medicare payments for certain other nonphysician professionals who can bill independently. It is relatively straightforward and permits clear linkages between the patient, the interpreter and the health care provider. Many interpreters would probably

develop preferred affiliations with certain health care providers, while others would be available on a more freelance basis and work with multiple providers.

This approach does not require that an interpreter have only that role or be a full-time interpreter. For example, if a lab technician or nurse is also qualified as an interpreter, that person could bill for the time in which he or she serves as an interpreter, but otherwise be paid for the other functions. There would need to be rules that assure, of course, that there is no double-billing and that this person is qualified.

Some have noted that it may take physicians more time when they must communicate with patients through an interpreter. Current Medicare payment methods already have an option that physicians could use to seek higher reimbursement when time spent with a patient is higher than average. For evaluation and management (E/M) services, there are codes that are used for increased reimbursements for longer amounts of time spent with a patient coordinating care or counseling, particularly when the time spent with a patient in an outpatient setting exceeds 30 minutes.[21]

2. ***Contracting for telephone interpretation services.*** Telephone interpretation services are necessary and appropriate in a wide variety of circumstances, particularly when it is difficult to locate an in-person interpreter, when a patient speaks a less common language, when the practitioner is located in an area with few LEP patients or when the visit was unscheduled or after hours and it is not possible to locate an in-person interpreter.

Telephone interpretation typically involves larger firms. These firms must employ a number of interpreters and usually cover a variety of languages, although some may specialize in a few languages (e.g. Spanish). Many, but not all, of these firms have the capability of 7 day/24 hour service. They must have administrative and technology systems to ensure that they can provide relevant language, communication and billing services.

Unlike an in-person interpreter, a telephone interpreter does not need to be located in the same locale as the clinician (and does not even need to be located in the United States). Thus, the federal government could play a different role by establishing direct contracts with telephone interpreter firms for Medicare. Federal contracts could be established with multiple telephone interpreter agencies with varying rates for different types of calls (scheduled, unscheduled, emergency, in Spanish, Mandarin or Serbian, etc.). The federal government could negotiate with the firms to find the best offers or accept all offers that meet certain qualifications and price levels. The availability of multiple contracts could help establish market competition that could lead to improved and more efficient services.

CMS could then make available to Medicare providers the names of the contracted firms, describe the services offered and list the phone numbers. A Medicare provider could select which telephone contractor to use, arrange for the telephone call, and provide information about the Medicare contact (e.g., both the patients' and providers' Medicare numbers). After the service is

provided, the telephone interpretation contractor could directly bill Medicare.

Because of the organizational nature of telephone services, it makes more sense to pay the telephone contractor rather than the individual interpreter. As part of the contracting process, telephone firms would have to explain and demonstrate the diversity of languages and services they can accommodate and how they assure the competency of their interpreters.

In this report we discuss telephone interpretation, but acknowledge that other types of remote interpretation are possible and may become more feasible as technology improves, such as videoconferencing, wireless remote interpretation or computer-assisted interpretation, and as providers begin to adopt newer technologies.

3. ***LEP adjustments for individual claims or payments.*** This option would modify existing Medicare payment systems by using adjustments (e.g., multipliers or add-ons) when a patient is LEP or receives language assistance. For example, a DRG-based inpatient hospital payment, an APC-based outpatient hospital payment, or a managed care capitation payment could be increased by some amount or some percentage to account for the additional costs of language services needed for LEP patients. Such an adjustment might be triggered by either the identification of a patient as being LEP or the provision of language services to an LEP patient. That is, the standard payment to the provider would be increased when there is an LEP patient — because LEP patients need additional services — or when additional services are rendered.

Approaches like these have parallels within Medicare payment systems. For example, being LEP could be considered a risk factor that that signals the need for more complex care that must be provided, akin to a higher level of severity of an illness or a co-morbidity factor. There are parallels to this in the current DRG payment system as well as in modifications of the inpatient hospital payment system that CMS proposed to increase the extent to which there are severity-based adjustments to hospital payments.

Alternatively, payments could be adjusted based on the actual language services that are appropriately rendered for an LEP patient. If the payment adjustment is based on the service utilization, they could be differentiated by the type of language service rendered (i.e., one amount for an in-person professional interviewer, another for telephone interpretation, yet another for use of a bilingual clinician.) There are parallels in the Medicare payments for evaluation and management (E/M) services for outpatient hospital services, which offer varying levels of payment depending on the intensity of services actually delivered in care for a specific patient. In fact, the American Hospital Association and the American Health Information Management Associations had earlier recommended that factors like language proficiency be considered as factors in determining outpatient hospital payments for E/M services.[22] The specifics for such an LEP adjustment could be designed by HHS or by the Medicare Payment Advisory Commission (MedPAC).

The virtue of this approach is that it makes the payment to the main medical provider (e.g., the hospital) and offers flexibility to the providers about how to

arrange and pay for language services. Each provider could decide whether it is more sensible or appropriate to contract with interpreters, to hire interpreters directly or to increase the number of bilingual or multilingual clinical staff. In contrast, if a payment system only pays for interpreters, there is no incentive to increase the number of bilingual clinicians or to develop other ways of providing the needed services.

This approach assumes, however, that the provider wants to be responsible for arranging for the language service and for being the financial intermediary. The American Medical Association and the American College of Physicians have stated, for example, that they would prefer direct reimbursement of interpreters, so that physicians do not become middlemen responsible for their payment. This is less likely to be a concern for larger facilities, such as hospitals, that already employ and contract with a wide variety of health care personnel.

If the additional payment is triggered only by a patient's LEP status (and not the service rendered), then there might not be any guarantee that language services are actually delivered. That is, additional payments may be triggered even if an LEP patient's family member or a bilingual clinician provides interpretation and no additional interpreter resources are provided. This is not necessarily an issue, however, if the assumption is that the average cost of care increases when LEP patients are served and that providers will make appropriate service decisions about how to meet the patient's individual needs.

If the additional payment is based on the service rendered, there may be concerns that this creates incentives to use more expensive services. That is, if use of an in-person interpreter costs more than telephone interpretation, providers may choose the more expensive option. But that is often a concern in medical care reimbursement because the determination of the proper course of treatment and intensity of care is judgment-based and there need to be other methods of reviewing whether decisions made are clinically appropriate.

An impediment to immediate use of this option is that hospitals and other health care providers do not currently collect consistent information about the language proficiency of their patients or about the language services provided. This gap could make it difficult to establish coding systems and reimbursement rates initially, but requiring the use of these data to support claims for reimbursement would surely spur the collection of these data in a more consistent fashion.

4. ***LEP payments for hospitals on a facility-specific basis.*** Rather than individually determining whether each claim requires an LEP adjustment (as described in #3 above), an alternative is to create an LEP adjustment factor on the overall volume of care to LEP patients provided by each hospital. These could be applied as percentage increases to the DRG or APC payments that are otherwise paid for that facility. To qualify for these LEP payments, hospitals could be required to use these funds for language services for their patients or related purposes, such as training in using language services for medical personnel, and to submit reports to CMS documenting how the funds are used.

For example, a hospital for which 10 percent of its patients are LEP might receive a certain percentage increase in its Medicare payments for inpatient and outpatient claims, while a hospital with 20 percent LEP volume could receive twice that percentage increase.[iv] These LEP payments would be targeted based on documentation that the providers serve more LEP patients or are located in areas with high concentrations of LEP populations. A more sophisticated version of this approach could permit different adjustments for different languages. For example, it may be relatively more expensive to arrange services for Cambodian-speaking patients than for Spanish-speaking patients, and a higher payment adjustment may be appropriate.

HHS or MedPAC could design a formula to establish LEP adjustment levels after examining, as a benchmark, the cost of language services at a number of hospitals that are known to offer strong interpretation and language services. Such payments should be available to all hospitals (i.e., not to just those with a high volume of LEP patients), because hospitals with a lower volume of LEP patients need additional encouragement and funding to develop language services. While hospitals with more LEP patients bear higher burdens and costs, they are also more likely to have already developed assistance programs than hospitals with less LEP volume.

This approach would provide discrete funding for language services in hospitals, but also give them flexibility about how they implement those services, e.g., whether they use these funds to pay for interpreters or to increase the number of bilingual or multilingual clinicians. It would also give them flexibility as to whether to use employed staff or contracted services. In reality, a large hospital probably needs to use a mixture of bilingual clinicians, in-person interpreters and telephone services to meet the diverse needs encountered over a large patient caseload and a variety of inpatient and outpatient services. This option also includes a reporting requirement in order to assure that there is accountability for the use of these funds. That is, hospitals would need to provide brief reports that these funds are used for language services and that describe the allocation of those funds.

Although there is substantial interest in improving the collection of information about the primary language spoken by patients in health care settings, consistent data for every hospital are not yet available. Thus, an interim alternative is to use data already collected by the Census Bureau to estimate the percentage of people in hospitals' service areas who are LEP. While this does not directly measure the number of LEP patients actually served by each hospital, it measures the level of need in the area served by a hospital, which should provide a reasonable approximation of service needs. The decennial Census provides detailed information about language skills of populations in very fine geographic detail (e.g.,. down to the Census tract level). These data could be adjusted to account for population shifts by using data from the more frequently collected American Community Survey which

[iv] This is analogous to Medicare Indirect Medical Education (IME) payments in which the payments are made based on the number of interns per hospital bed. The higher the ratio of interns, the greater the payment increase.

can produce estimates on a community-specific level. Such a Census-based estimate of the percent of the population in a local area that is LEP could be multiplied by data about each hospital's inpatient and outpatient caseloads to estimate the number of LEP patients seen.

If such an approach is used for a longer time period, there ought to be a transition plan to develop consistent counts of the number of LEP patients seen in each hospital as a more accurate measure of LEP volume. Currently, there are no federal requirements for collection of data about hospital patients' language status. However, a recent survey by the National Public Health and Hospital Institute (NPHHI) found that 50 percent of all acute care hospitals already routinely collect data about the language spoken by their patients, although they do not routinely use these data to assess or improve the quality of care and the types of questions asked vary.[23] Using these data as part of a Medicare payment mechanism would spur hospitals to do a better job collecting these data. A recent report noted that one of the greatest barriers to hospitals' collection of data on race, ethnicity and language was the perception that these data are not used.[24]

There is growing momentum to collect data about primary language status as a standard component of medical records, so that it may be feasible in the next few years to ascertain the percentage of a hospital's patients that are LEP. The National Committee on Vital Health and Statistics, a federal advisory group, has recommended that HHS require that health plans collect data on primary language spoken and facilitate more complete data collection by health care providers.[25] The Joint Commission on Accreditation for Healthcare Organizations (JCAHO), the primary accreditation organization for hospitals and related health care providers, has recently added a standard to collect information on each patient's language status.[26] Also, the Health Research and Educational Trust (HRET) — the research and education affiliate of the American Hospital Association (AHA) — has developed a toolkit to encourage and support hospital efforts to collect data on patients' race, ethnicity, and primary language. This toolkit is based on their work with a consortium of six major hospitals and health systems to develop ways to eliminate disparities.[27]

5. ***Pay for Performance Quality Adjustments***. Many policy experts are discussing modifying Medicare payment methods to "pay for performance," so that providers who meet certain quality criteria receive quality bonuses. While the most active discussions concern physician payments, the concept has also been discussed for other payment systems (e.g., hospital care or managed care capitation payments). It could be possible to include the provision of language services as one of the quality indicators used to modify Medicare payments.

   It is a little difficult to assess this concept thoroughly at this time because the basic frameworks for Medicare pay for performance systems have yet to be established. Nonetheless, the federal government is supporting a number of Medicare demonstration projects and a large number of private initiatives are also underway that could form the basis for a future system.

In November 2005, the U.S. Senate passed budget reconciliation legislation that included a "value-based" purchasing system for Medicare that would require HHS to develop a system of bonus payments to be allocated to physicians, hospitals, nursing homes, etc. who have met quality criteria or whose performance has improved. The funds for these quality payments would come from a two percent reduction in regular provider payments. This provision was not contained in the final budget reconciliation bill, so these issues remain unresolved.

While measures of the quality of LEP services are possible, such measures do not exist yet and, thus, could not be implemented in the immediate future. The Joint Commission on Accreditation of Healthcare Organizations has standards regarding language services, but they are fairly broad and do not readily lend themselves to rigorous quantitative measurement; the organization is conducting further work to see how to further improve standards and improve hospital services.[28] The National Committee for Quality Assurance is also considering quality standards related to language assistance for health plans.[29] One promising approach was recently developed by child health researchers in Florida.[30] That effort developed a survey that can be asked of parents of recently hospitalized children about a number of communications issues and examined other quality measurement approaches that have been used.

Another approach may be to adapt the Consumer Assessment of Health Plan and Systems (CAHPS) — a set of surveys and data analysis tools developed by the Agency for Healthcare Research and Quality and researchers — to better measure quality related to language services and cultural competency. Versions of CAHPS already exist that apply to Medicare managed care plans and versions for hospitals and physicians are in planning.

Another concern is that the effect of including language services as one of several quality indicators could make financial incentives for LEP services quite small. For example, if two percent of Medicare physician compensation is set aside for quality bonuses and language services are one of ten quality criteria used to determine those bonuses, the relative impact of language services is likely to be small (2 percent divided by 10 is 0.2 percent) and the amount of the LEP-related bonuses may be less than the cost of providing additional services. In and of itself, this probably would not provide enough of an incentive for physicians to pay for substantially more language services.

6. ***Grant programs to promote language services***. A final option is to establish special grant programs that would foster greater availability of language services. While such grants are not normally associated with Medicare, CMS or another agency in the Public Health Service, such as the Office of Minority Health or the Health Resources and Services Administration, could develop grant programs to improve the supply of bilingual or multilingual clinicians or of trained interpreters. For example, a program could offer grants to health care providers or teaching institutions to encourage training of bilingual clinicians, whether by increasing the number of bilingual students entering medical or nursing schools or other programs or by facilitating language

training of health students. Alternatively, grants could be provided to community agencies to offer training in medical interpretation to those who are already bilingual or multilingual, to boost the supply of trained interpreters.

While we discuss this option in the context of Medicare, it would have broader repercussions. To the extent that it increases the number of trained interpreters or bilingual providers or improves the quality of their linguistic abilities, it could also improve services for Medicaid, privately insured and uninsured patients who receive care from the same practitioners.

Paying for Language Services in Hospitals

Evidence suggests that hospitals and medical centers, particularly safety net facilities, are the health care settings most likely to offer language assistance. Many hospitals across the nation have implemented innovative approaches to try to reduce language barriers that might be faced by their patients.[31] A national survey by the National Public Health and Hospitals Institute found that a majority of hospitals have some language assistance policies: 38.5 percent have paid staff interpreters, 42.6 percent use contracted interpreters, 64.9 percent use telephone language services and almost one-third use a combination of all services (these amounts total over 100 percent because a facility may use multiple methods).[32] Because of their size, hospitals are better able to employ interpreters and bilingual health staff and to make arrangements to facilitate language assistance (e.g., creating directories of languages spoken by hospital staff, having contracts with telephone interpretation services, or making arrangements with community groups for interpretation, conducting multilingual outreach, etc.). Some hospitals have helped support community "language banks" that recruit and train interpreters and make them available for use at local hospitals and other medical facilities.

Although many hospitals provide language services, they rarely receive any direct reimbursement from insurers for these services, which discourages wider availability of language assistance.[33] The lack of funding means that facilities that provide these services bear higher, unreimbursed costs than those that provide little language assistance.

A 2002 report examined the experience of thousands of uninsured patients in a number of urban safety net hospitals across the U.S. Of the 15 percent of patients who required an interpreter, 7 percent found such aid available but 8 percent did not.[34] Those who needed, but did not receive, interpretation services not only reported greater barriers to and frustration with medical care, but also received less help regarding financial assistance about paying their bills, with the likely result that the LEP were less likely to get help paying for their medical care. These findings are consistent with prior research that large numbers of LEP patients in hospitals do not receive interpreter assistance.[35]

In addition to serving current patients' needs, an important reason to encourage language services in hospitals is that most health professionals receive a substantial amount of their early professional training and experience in hospitals. Thus, encouraging the hiring and/or training of bilingual clinicians in hospitals should eventually increase their availability in other community settings. In addition, monolingual clinicians can become more familiar working with interpreters in serving LEP patients in hospitals, which should improve their skills in the community.

Any of the six basic payment options listed above could be applied to promote language services for inpatient or outpatient hospital care under Medicare. The options that are most appropriate for hospital care are #3, *LEP adjustments for individual claims or payments* or # 4,

LEP adjustment payments on a facility-specific basis. Both approaches would essentially augment regular Medicare payments to hospitals and give facilities some flexibility in how to use these funds through a mixture of in-person interpreters, telephone interpreters, bilingual or multilingual staff, etc. These funds could be used to help pay for existing language services as well as to boost services.

But the approaches differ in some significant ways, too. Creating LEP adjustments for individual claims is, in the long run, more consistent with the way hospitals are paid and could be implemented with the addition of simple coding adjustments to standard claims forms. On the other hand, determining the proper reimbursement levels and coding categories and then educating providers on their use would take time. Providing facility-level payment adjustments would be easier to implement initially, since it just requires information on the general volume of LEP patients seen at the hospital. On the other hand, a special pool of funds for language services may not be viable on a long-term basis. Experience suggests that similar payment adjustments (e.g., Indirect Medical Education or Disproportionate Share Hospital payments) are often viewed as politically vulnerable.

We recommend considering a two-phase approach. The first phase would create facility-specific payment adjustments based on the overall volume of LEP patients in a hospital. On an interim basis, hospitals would receive these facility-specific payments and help generate information that could be used to develop claims-level adjustments for LEP services. The second phase would be to create payment adjustments for individual claims for LEP patients and services.

Phase 1: hospital-specific payment adjustments. As an approach to rapidly encourage improvement of language assistance in hospital settings and to pay hospitals for language services that are being provided, this would develop a transitional payment method. The simplest way to expedite payments is to use Census data about the percentage of the population that is LEP in each hospital's service area. These factors would be used to create proportionate adjustments to regular Medicare payments. For example, hospitals located in areas with higher density of LEP population would receive a higher percentage adjustment to regular DRG-based or APC-based payments than hospitals in areas with lower LEP density. The transitional period would serve two purposes. First, it would begin to provide additional revenue to hospitals offering more care to LEP patients and create an incentive for these facilities to upgrade their efforts on a short-term basis. Second, during this interim period, hospitals and HHS could begin to require consistent collection of data about Medicare patients' primary languages and the language services rendered (e.g., how often are interpreters used, telephone language services, bilingual clinics, informal interpreters, etc.). This information could be used to develop a more refined approach to fine-tune hospital payments for LEP services.

Phase 2: LEP payment adjustments for individual claims. An eventual goal would be to develop a system that adjusts the amount paid for hospital services on a per claim basis. There are at least two ways in which such adjustments could be made:

- Based on a patient's status as being LEP. This might simply note if a patient is LEP or not. Or it could be more sophisticated, based on the primarily language spoken by a patient. It is probably less expensive to help a Spanish-speaking patient than one who speaks Cambodian because Spanish is more common and it is easier to find Spanish interpreters.

- Based on the language services used for LEP patients. That is, the use of an in-person professional interpreter might receive one level of adjustment, but there

would be different adjustments when a telephone language line or bilingual clinician is used. And there might not be any payment at all if the hospital did not provide any formal language assistance (e.g., if a friend or family member of the patient provided interpretation.)

One concern is that there are differing methods used to establish hospital inpatient and outpatient services in Medicare. Inpatient services are paid primarily based on a patient's diagnosis, not the services actually rendered. This is designed to avoid creating an incentive for hospitals to do things in more expensive ways and to encourage greater efficiency. (Such a concern may be less severe for language assistance than for other inpatient services. Compared to the very large differences that might occur for alternative treatment options for certain diseases, the differences in costs for in-person interpretation vs. telephone interpretation vs. paying for bilingual clinicians are more modest.) Outpatient payments, on the other hand, are primarily determined based on the services or procedures actually rendered in patient care, although they too are prospectively set prices, based on the average cost of a bundle of services related to an outpatient encounter

Nonetheless, Medicare payment methods are not so monolithic as to have no exceptions. For example, Medicare inpatient payments may be adjusted when certain new technologies are used for care; this is commonly called the new technology add-on payment. And, as noted earlier, Medicare outpatient hospital payments permit adjustments of the evaluation and management services based on the types and complexity of types of services rendered to individual patient care episodes.

Under the two-phase approach developed, policy-makers would have time to consider how to develop claim-specific adjustments that are most appropriate in hospital settings and hospitals would have time to develop information systems that can accommodate such payments.

Other Options Considered. Option #6 (grants to promote language services) is worth considering too. The purpose of such grants, however, is not quite the same. The grants are not designed to pay for services on an ongoing basis, but to help fund recruitment and training of interpreters and develop the human capital resources needed. The grants need not be targeted to hospitals only, however, but could be directed to medical, nursing and other health professions schools or to community agencies. Such grants could be used to encourage the recruitment and training of bilingual clinicians or of professional interpreters, which ought to eventually increase the availability of bilingual clinicians in the community.

Options #1 (direct reimbursement of interpreters) and #2 (contracting with telephone interpretation firms) are feasible for hospitals, but have the disadvantage of offering somewhat less flexibility and offering no incentives for developing bilingual or multilingual clinicians or other health staff. We expect that the net result of option #4 would be to help increase the use of in-person and telephone interpreters for language services in hospitals.

It is hard to assess the appropriateness of Option #5 (pay for performance) at this time because the discussions about the broader structure of a pay for performance system for hospitals are still nascent. To the extent that pay for performance pilot or demonstration projects are being developed, it may be worthwhile considering whether language assistance should be added as a quality criterion, in addition to the other approaches, listed above.

Paying for Language Services in Physicians' Offices

Less is known about the availability of language services in physicians' offices. Physicians practice in a wide variety of settings; the most common are solo or small group practices. A variety of innovative ways to arrange language services have been developed in small group physician practices across the nation,[36] but it is likely that an LEP patient is less likely to receive language assistance in a solo or small group practice setting than in a larger clinic or at a hospital. The ability of physicians' offices to communicate with LEP patients probably varies widely across the nation. Areas like Los Angeles County or New York City probably have more capacity for LEP patients than other areas with fewer immigrants.

The recommended methods of increasing language services in physicians' offices in Medicare are options #1 (*direct reimbursements of in-person interpreters*) and #2 (*contracting for telephone language services).* These would let physicians arrange for in-person or telephone interpretation services, but would not require that they be fiscal intermediaries for the services. Making the payments based on services rendered by interpreters would guarantee that the services are used for their intended purpose. If interpreters had a better funding base and greater volume of use, they could more readily locate in or near physicians' offices. This would facilitate use of their services for all parties and may also make their services more efficient and less costly per encounter.

The direct reimbursement and contracting options could be limited to use in physicians' offices or other settings that do not have another language services payment method. That is, if LEP bonus payments (discussed above) are available for hospitals on an inpatient or outpatient basis, then it would be the responsibility of the hospital to arrange for interpretation services, not the physician, and the hospital would pay for it using its funds. Independent billing of interpreter services would not be permitted in conjunction with physician care in a hospital setting.

This option does not directly give financial incentives for bilingual clinicians, unless they are also certified as interpreters. But to the extent that there are other efforts that foster the training of bilingual clinicians, it may be less necessary to provide additional compensation to them. The availability of funds for in-person interpreters may spur physicians to hire nurses or other health staff who are or can be certified as interpreters, however.

Option #5, including language services as a pay for performance criterion for Medicare physician payment, might provide some additional, small incentives. But it is not yet clear how to create a quality indicator for language assistance and it is questionable whether a small quality adjustment would cover the costs of interpretation services. On the other hand, it should also be noted that language assistance may inevitably be related to quality measurement, even if it is not explicitly addressed. For example, if a performance measure for an internist is based on how often his female patients have mammograms or how often his diabetes patients have hemoglobin A1C tests, then a physician who cannot effectively communicate with his patients is likely to perform poorly. In that regard, pay for performance initiatives could indirectly improve language assistance.

Option #3, risk adjustments to RBRVS payments for LEP patients, would offer more flexibility in how to arrange for services in physicians' offices. But it would require that physicians become financially responsible for the costs of interpretation services, which would create administrative burdens. Finally, it would be difficult to ensure that payments made on behalf of LEP patients are actually used to provide language assistance.

Options #4 (bonus LEP payments) and #6 (grants) do not apply to physician office settings.

Paying for Language Services under Managed Care

Under the regulations for Medicare managed care (now called Medicare Advantage), managed care plans are required to "ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds."[37] Given this requirement and the fact that negotiated contractual agreements assume compliance with regulatory requirements, it is less clear that Medicare managed care organizations need additional payments to provide language services. Moreover, since the benchmark for managed care rates is based on fee-for-service payment levels, increases in Medicare fee-for-service payments for LEP patients ought to eventually influence managed care payments.

A number of managed care plans already do much to foster language services, but more could be done. (See, for example, Medicare-related assessments and recommendations by Ellen O'Brien and Timothy Jost[38] or general managed care reviews by Cindy Brach and her colleagues[39]). CMS published *Providing Oral Linguistic Services: A Guide for Managed Care Plans,* a report that offers practical suggestions for Medicare managed care plans.[40] Both the Joint Commission on Accreditation of Hospitals and Healthcare Organizations and the National Committee on Quality Assurance have sought to upgrade standards for language services in managed care settings. A key pitfall, however, is that it appears that most managed care plans do not directly reimburse for interpretation services or create incentives for bilingual clinicians, they merely pass along the requirement to their contracted providers without specific funding.[41] Thus, the managed care plans may have contractually agreed to offer language assistance, but their operational payment policies can create disincentives for service.

Of the six payment options, the only one that could readily be applied to managed care payments is option #3, risk adjustments for LEP patients to capitation payments. However, as noted above, it is not clear if such adjustments should be made. One particular concern is that it appears that immigrant patients have much lower per capita medical expenses than other patients. For example, a recent analysis of the Medical Expenditure Panel Survey found that, after statistical adjustments for a host of characteristics, including age, race/ethnicity, health status and insurance coverage, immigrants' medical expenditures were roughly half as high as those for non-immigrants.[42] These differences are probably attributable to a variety of health care barriers faced by immigrant patients, including language barriers, and to lower use of medical services under the status quo. Making risk adjustments to capitation payments based on LEP status based on historical data could inadvertently lock-in lower expenditures for LEP patients and thereby lower resources to pay for their care, rather than provide new resources for language assistance. Because of this concern, we do not recommend this option at this time.

The other five options really do not apply to Medicare managed care payments.

However, HHS can and should do more to increase the quality of language services in Medicare managed care and to ensure that plans are meeting their contractual commitments. (For example, see the recommendations of Jost and O'Brien, *op cit.*) HHS can review and increase oversight over Medicare managed care plans to ensure that they are providing adequate language services. HHS could, for example, ensure that plans have

or require contractual arrangements for interpretation services (e.g., telephone services), that they pay for interpreters and could also heighten efforts to monitor the adequacy of language services provided. In this regard, quality measurement plans that are being developed by organizations like NCQA and JCAHO or similar to those developed by Florida researchers could be particularly important.

Cost-sharing

For those who do not also receive assistance under Medicaid (including QMB coverage), there can be substantial cost-sharing in Medicare.[v] Initiating payments for language services in Medicare has the potential to force beneficiaries to pay for language services, which could raise issues about a conflict with the current civil rights requirement that providers offers these services at no charge to LEP patients.

Unless there are exemptions for language services, as discussed below, the impact of our recommended LEP payment strategies could be as follows:

- *Inpatient hospital services.* Medicare deductibles and copayments (those which apply after the 60th day in a hospital) are fixed. A percentage increase in payments to hospitals for LEP patients would not increase beneficiary cost-sharing.

- *Outpatient hospital services* are subject to the Part B deductible ($124 in 2006) and coinsurance. The outpatient coinsurance level can be substantial, up to 40 percent, but is gradually being phased down to 20 percent. An LEP adjustment in the outpatient payment levels could lead to a slight increase in outpatient cost-sharing.

- *Physician services* are subject to the Part B deductible and 20 percent coinsurance. This report's recommendation would permit separate reimbursement for in-person and telephone interpretation. If these interpreter services are treated like physician services (or similar nonphysician services), then beneficiaries would be responsible for at least one-fifth of the cost.

- *Managed care.* Medicare permits greater flexibility in cost-sharing under managed care than under fee-for-service care. Our recommendation is to not make adjustments to Medicare capitation payments for LEP patients. However, managed care plans, to the extent that they pay for interpretation payments, could require beneficiary cost-sharing.

The most straightforward solution to this issue is to exempt language service payments from Medicare cost-sharing. This is comparable to the exemption from Medicare cost-sharing that now applies to clinical laboratory services like blood tests or urinanalysis. Language services are similar to these diagnostic services since good patient-physician communication is an essential component of making an accurate diagnosis of the patient's needs. Earlier research has shown that physicians often order more diagnostic tests for LEP patients in order to compensate for their inability to understand the oral description of the patients' symptoms and problems.[43]

Requiring cost-sharing for interpreters could increase barriers to the use of these services which could increase the risk of misdiagnoses and medical errors and undercut civil rights policies. In turn, these disincentives could create additional liability risks for health care providers who may be concerned about the risks for medical errors due to the lack of proper interpretation.

[v] Under Medicaid, dual eligibles may face "nominal" copayments.

Conclusions

This report lays out six options for ways by which the federal government could take further steps to reduce language barriers for Medicare beneficiaries with limited English proficiency, particularly through payment for such services. It includes recommendations for approaches to enhance language services in hospital, physician and managed care settings. These options are preliminary in nature and could certainly be refined.

The purpose of this report is to establish a starting point for discussion of these complex issues rather than determine a final end point. In addition to the options and recommendations, the report lays out some principles that could be used to assess the appropriateness of payment systems for language services. The recommendations do not say how much the payment increases should be, nor does this report estimate the cost of such changes. It simply attempts to suggest how relevant payment systems for Medicare could be designed. Even if Congress approved changes like these, further analytical work and refinement by HHS or the Medicare Payment Advisory Commission would be needed.

Briefly, this report makes five preliminary recommendations:

- A two-phase system for development of payments could provide immediate financing of language services in inpatient and outpatient hospital settings and provide time to develop a more refined payment system. In the first phase, hospitals could receive additional Medicare payments based broadly on the volume of LEP patients, as measured by Census data on the LEP population of their service areas. During this interim phase, hospitals would develop more consistent methods of recording data about patients' primary language and how their language needs are met. This information could be used to develop a more refined system that adjusts individual inpatient and outpatient hospital payments on a claim-specific basis for LEP patients. Both these approaches give hospitals flexibility in determining how to provide language services whether through in-person professional interpreters, through telephone language services or through increased availability of bilingual and multilingual clinicians.

- Consider grants to hospitals, medical and other health professions schools and community groups to increase the recruitment and training of bilingual or multilingual clinicians and professional interpreters. The purpose of these grants should be to broadly foster the training and hiring of bilingual and multilingual health care providers, including interpreters. While this report is focused on Medicare, these grants ought to be viewed in a broader perspective since health care providers serve multiple populations. That is, the internist or nurse who cares for Medicare patients is likely to also serve patients covered by Medicaid and other forms of insurance (including the uninsured).

- Provide direct reimbursement of in-person interpreters, telephone interpretation and qualified bilingual staff who serve as interpreters provided in physicians' offices. HHS could arrange for contracts for telephone interpretation firms that describe their operations and the training and competency standards for their medical interpreters. Medicare physicians could directly contact telephone firms for interpretation services and the firms would directly bill Medicare.

- At this time, we do not recommend directly adjusting the basis for Medicare managed care plans for LEP patients. Medicare health plans already contractually

agree to provide language services under the rate bidding system. Language-based adjustments to capitation rates could actually reduce resources available for LEP patients because immigrants have historically had poor access and low medical expenditures because of problems like language barriers. However, HHS should do more to strengthen oversight of managed care plans' language services.

- Exempt language services from Medicare cost-sharing requirements, akin to the exemption that already exists for clinical laboratory tests. This is consistent with existing federal civil rights policies and would avoid unnecessary barriers to the use of interpreters that could have the unintended result of compromising medical quality and increasing the risks of medical errors.

This report focuses on one specific issue concerning language services for LEP patients: how to pay for these services. There are a host of equally important issues which are beyond the scope of this report to address. More research is needed to examine modes and logistical approaches to provide language services, including examination of the cost-effectiveness of alternative approaches. Elements of language services could be addressed more explicitly in demonstration projects concerning disease management or quality improvement to attempt to examine the impact of language assistance on longer term health status and medical costs. As noted earlier in this report, a basic and fundamental need is better collection of data about patients' primary languages and their inclusion as a standard part of medical records. More consideration is needed of methods to determine the competency of medical interpreters and of bilingual or multilingual clinicians. More work is also needed to help design better performance or quality indicators concerning language assistance.

The federal government has made an important commitment to ensuring that barriers related to race, ethnicity or national origin, including the language a person speaks, do not create disparities in access to health care or to quality of care. One of the noteworthy exceptions to this commitment is the lack of financing for language services and interpretation in Medicare. This report discusses strategies that could reduce these gaps and improve the quality of care. Medicare is a program that is continually evolving. In a nation that can develop, pay for and implement high-technology medical advances, it is regrettable that we stint on simple things like language services to help patients communicate with their physicians and medical caregivers. For example, the Medicare program has agreed to pay for costly implantable defibrillators after determining that these devices were effective in improving health, despite the cost.[44] Surely, the nation could make similar reforms to Medicare to increase the quality of language services for LEP Medicare beneficiaries.

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