

***PAYING FOR LANGUAGE  
SERVICES IN MEDICARE:  
Preliminary Options and  
Recommendations***

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# Help LEP Patients and Physicians/Caregivers Communicate

- Language problems create barriers to care and compromise the quality of services for limited English proficient (LEP) patients.
- **Improve quality of health care**
  - Language services improve care, reduce medical errors and help patients take care of themselves
- **Reduce racial & ethnic disparities in health**
  - Federal civil rights policies

# But Payment Is a Stumbling Block

- HRET: Though most hospitals provide some language aid, they are paid only 3% of the time
- Creates disincentive to offer language services
- About 1/4<sup>th</sup> of state Medicaid programs pay
- **Medicare does not pay**
- Private insurance usually does not
- Recommendations for insurance reimbursement: Institute of Medicine, HHS Office of Minority Health, medical and hospital associations

# Why Medicare?

- Seniors who are LEP: 2.3 million and growing
- Language barriers reduce access. May reduce use of preventive and other key services
- Medicare policy is set by federal government
- Medicare payment policies influence private and state Medicaid payment policies

# If Willing, How to Pay?

- Medicare payment policy is already complex and controversial
- Many types of language services:
  - In-person interpreters
  - Telephone interpretation (language lines)
  - Bilingual/multilingual clinicians
- **Goal is to begin discussion of options, not to be final word**

# Hospital Payment: Inpatient & Outpatient Services

- **Phase I. Transitional hospital-specific adjustments**
  - Could use Census data on LEP populations
  - Require more uniform collection of primary language information & develop more refined system
- **Phase II. Claim-specific adjustments to DRG or APC payments**
  - Can be integrated with usual Medicare claims system
  - Based on patient's LEP status or use of language services
- Gives hospitals flexibility in how to arrange services

# Physician Services

- **Reimburse interpreters used in physicians' offices.**
  - Can develop fee schedule as for other services
- **Develop federal contracts for telephone language services that can be directly billed**
  - Physicians can use these contracted services
- Lets physicians use/prescribe either service, but does not make them fiscal intermediaries

# Managed Care

- Medicare managed care plans **already** agree in their contracts to provide language services
- Presumably built into their capitation rates
- Need for additional managed care payments not clear, but federal government should do more to monitor adequacy of language aid
- Changes in FFS reimbursements may ultimately increase capitation payments anyway

# Grants to Build Supply & Skills

- Develop grants to stimulate supply and skills of interpreters and bilingual clinicians
- Hospitals, health schools, community groups

# Cost Sharing

- Simply increasing Medicare payment levels would increase copayments for LEP Medicare beneficiaries.
- But federal civil rights policy specifies cannot charge for language assistance
- LEP patients tend to be poorer. Charges hurt the poor and create disincentives.
- Should exempt language services from cost-sharing

# Conclusions

- Federal policy helps reduce language barriers in health care in many ways
- Medicare policy is glaring omission
- We spend billions of dollars on high-tech medical interventions in Medicare, like implantable cardioverter defibrillators
- Shouldn't we also be willing to pay to help patients and caregivers communicate?