CULTURAL COMPETENCE AND LANGUAGE APPROPRIATENESS IN THE PROVISION OF MEDICARE SERVICES AND NOTICES

Cultural competence and language appropriateness are ingredients in closing the disparities gap in health care. They define how patients, clients, health care providers, and advocates can improve access to health care and the quality of that care by knowing something about the culture and the cultural values of the patient. It is a way to talk about health and advocacy concerns without cultural differences hindering the conversation, but instead enhancing the conversation. Quite simply, services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse people by knowing something about the culture and the cultural values of the patient can help bring about positive health outcomes.

**Cultural Competence**

Cultural competence “embraces the principle of equal access and non-discriminatory practice in service delivery”.\(^1\) Culture is learned. It is not genetic or racial. We are born into a culture and live in a society with a certain culture. Culture consists of, in part:

- Shared ideas; knowledge; and meanings
- Shared rules; customs; laws; traditions; rituals; and beliefs
- Shared diet; dress; concept of space and time; family structure; styles of communication; body image
- Shared behaviors; perceptions; emotions; attitudes toward health, illness and life experiences.

In other words, 'culture' refers to patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.\(^2\) Cultural competence is the ability of an organization or of an individual to respect and affirm cultural differences in order to serve diverse communities more effectively.

Cultural competence is something that social organizations should implement and observe in order to permit the organization to work effectively with the people of diverse cultures it serves.

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In order for the organization to act in a culturally competent fashion, the individuals within that organization should understand cultures other than their own and honor the values of those other cultures so that it can provide services effectively. Thus, a commitment by the organization and the individuals in the organization is required to make cultural competence a reality.

In the context of health care and health care advocacy, there are many organizations and individuals with whom a client or patient may interact. It could be a hospital, a clinic, a home health agency, or it could be a physician, a nurse, a physical therapist or a health care aide, an attorney, or a paralegal advocate. Knowing something about the culture and cultural values of the people with whom one interacts can help make service delivery more effective and efficient and can improve the health outcomes of the patients being treated by health care organizations.

Culture defines:

- How rights and protections are exercised;
- How health care information is received;
- How health problems are defined;
- How symptoms and concerns about problems are expressed;
- How appropriate service providers are determined; and
- How types of treatments and solutions are determined and provided.

The increasing population growth of racial and ethnic communities and linguistic groups, each with its own cultural traits and health profiles, presents a challenge to the health care delivery service industry in this country. The provider and the patient bring learned patterns of language and culture to the health care and or advocacy experience, all of which must be transcended to achieve equal access and quality health care.

Because health care is a cultural construct arising from beliefs about the nature of disease and the human body, cultural issues are central in the delivery of health services treatment and prevention. By understanding, valuing, and incorporating the cultural differences of America's diverse population and by examining one's own health-related values and beliefs, health care organizations, practitioners, and advocacy groups can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture.

**Culturally and Linguistically Appropriate Standards (CLAS)**

The Office of Minority Health of the U.S. Department of Health and Human Services has developed “National Standards on Culturally and Linguistically Appropriate Services” (CLAS).” The CLAS standards are intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001).

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The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Four (4) standards concern the provision by health care providers of services and written materials in the preferred language of the patient and are mandatory for all health care providers who are recipients of Federal funds.4

Between now and December 31, 2010, the Office of Minority Health – with an eye toward revising and improving the CLAS standards - is seeking public comment on the CLAS standards. Comments are invited on three areas: (1) the wording or content of the individual standard; (2) the purpose of the standards; and/or (3) the intended audience for the national standards. In addition, three meetings will be held around the country in Baltimore (October 22, 2010); San Francisco (November 4, 2010); and Chicago (November 15, 2010) to gather and solicit detailed input from interested individuals and organizations.5

Language Appropriateness and the CLAS Standards

Without effective health provider and patient communication in a language both can understand, there is an increased risk of misdiagnosis, misunderstanding about the proper course of treatment, and poorer adherence to medication and discharge instructions.6 Health care providers around the country have reported language difficulties and inadequate funding of language services as major barriers to access to health care for limited English proficiency individuals and as a serious threat to the quality of care they receive.7

In one study, over 25% of limited English proficient patients who needed, but did not get, an interpreter reported that they did not understand their medication instructions, as compared with 2% of those who did not need an interpreter or those who needed and received the services of an interpreter.8 Language barriers are also access to care barriers. Non-English speaking patients, for example, are less likely to use primary and preventive care and public health services and are more likely to use emergency rooms. Once at the emergency room, they receive far fewer services than those provided to English speaking patients.9

The discussion of medical interpreter services is not merely a question of language; it can be a question of serious medical harm. A report in the New England Journal of Medicine found that

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4 The 14 standards can be viewed in the entirety at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15
5 See, 75 Fed. Reg. 57957 (September 23, 2010) for full information about this opportunity for public comment.
7 Kaiser Commission on Medicaid and the Uninsured, Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami and Houston at 11-111 (Feb. 2001). See also, Institute of Medicine, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health 71-72 (2002).
many hospital patients who have limited English proficiency and who do not receive the services of an interpreter are at risk for sometimes life-threatening medical care. In one case cited in this study, the misinterpretation of a single word led to a patient’s delayed care and preventable quadriplegia. Among patients with psychiatric conditions, those who encounter language barriers are more likely to receive a diagnosis of severe psychopathology and more likely to leave the hospital against medical advice.

In lieu of trained medical interpreters, patients are forced to resort to ad hoc interpreters, such as family members, friends, untrained members of a medical site’s support staff, and strangers found in waiting rooms. Aside from the obvious violation of privacy and confidentiality, these interpreters are considerably more likely than professional interpreters to commit errors that may have adverse clinical consequences. Moreover, the presence of ad hoc interpreters may inhibit a patient’s discussion of sensitive topics such as domestic violence, substance abuse, sexually transmitted disease, and psychiatric illness.

As mentioned, four of the CLAS standards, all four of which concern the provision by health care providers of services and written materials in the preferred language of the patient, are mandatory for all health care providers who are recipients of Federal funds. Those standards are:

1. **CLAS Standard 4**

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

2. **CLAS Standard 5**

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

3. **CLAS Standard 6**

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

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11 *Id.*
12 *Id.*
4. CLAS Standard 7

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Medicare Legal Requirements for Culturally and Linguistically Appropriate Services

As a threshold manner, there is currently no requirement under federal law for the provision of culturally competent care to Medicare beneficiaries. Fortunately, however, there are significant rules regarding the provision of linguistically appropriate care. U.S. Department of Health and Human Services regulations require that all recipients of federal financial assistance from HHS provide meaningful access to limited English proficiency persons. Federal financial assistance includes grants, training, use of equipment, donations of surplus property, and other assistance. Recipients of HHS assistance may include hospitals, nursing homes, home health agencies, and managed care organizations. A complaint with the HHS Office of Civil Rights can be filed if a person believes they have been discriminated against under these regulations.

There are a number of legal requirements relative to linguistic appropriateness that have application to Medicare beneficiaries and their health care providers. First, of course, because Medicare Part A certified providers are recipients of federal funds they are required to adhere to CLAS standards 4 through 7 regarding language appropriateness. These standards, and their mandatory nature, are based on Title VI of the Civil Rights Act of 1964 (Title VI) with respect to services for limited English proficient (LEP) individuals. In 2000, the U.S. Department of Health and Human Services, Office of Civil Rights issued guidance on Title VI with respect to services for LEP individuals. These were revised in 2004.

13 Although not strictly applicable to the Medicare program, the recently enacted health care reform law – the Patient Protection and Affordable Care Act (PPACA) has important requirements requiring group health plans and health insurers offering group or individual coverage to implement an appeals process that provides notices to enrollees “in a culturally and linguistically appropriate manner”. PPACA § 1001 [amending the Public Health Services Act by adding § 2719]. In addition in August 2010, the Joint Commission – which provides accreditation to hospitals – announced a new initiative to evaluate hospital compliance with its Patient Centered Communication Standards. These Standards include provisions for providing culturally competent, as well as language appropriate care. See, http://www.jointcommission.org/NR/rdonlyres/26D4ABD6-3489-4101-B397-56C9EF7CC7FB/0/Post_PatientCenteredCareStandardsEPs_20100609.pdf to view these standards. See, in particular, Standard R1.01.01.01. Noteworthy, however, is that non-compliance with these standards currently will not affect actual hospital accreditation, meaning that the standards are currently advisory, rather than mandatory.

14 42 CFR §80.3(b)(2); see, also, 45 CFR Part 80, Appendix A which includes a listing of federal financial assistance to which the regulations apply.

15 42 CFR § 80.2

16 45 CFR §§ 80.6 through 80.11; see, also, http://www.hhs.gov/ocr/civilrights/complaints/index.html

17 In fact, prior to obtaining Medicare certification, a potential Part A provider is required to obtain a civil rights clearance from HHS, which requires providers to state their procedures for effectively communicating with limited English proficient persons. See, http://www.hhs.gov/ocr/civilrights/Clearance%20for%20Medicare%20Provider%20Applicants/index.html

Under the provisions of this guidance, language services must be made available to each individual who cannot speak, read, or understand the English language at a level that permits him or her to interact effectively with clinical or nonclinical staff at a health care organization. These services must be made available regardless of the size of the person’s language group in the community. Health care organizations may use a wide variety of strategies for overcoming linguistic barriers to health care. These include the use of bilingual providers, bilingual/bicultural community health workers, and interpreters (onsite and telephone).  

Moreover, Medicare Advantage plans and Medicare Prescription Drug plans are required by regulations and policy to adhere to certain language requirements. For example, the marketing regulations for Medicare Advantage (Medicare Part C) plans require that marketing materials and election forms be provided in the language of individuals residing in “markets with a significant non-English speaking population.” These materials include: (1) written descriptions of rules (including limitations on providers from whom services can be received), procedures, basic benefits and services and fees and other charges; (2) written descriptions of any supplemental benefits and services; (3) written explanations of grievance and appeal procedures, including the difference between the two and when it is appropriate to use which procedure; and (4) any other information necessary to enable beneficiaries to make an informed choice about enrollment. 

Medicare Prescription Drug (Medicare Part D) plans are required to adhere to similar requirements in markets with “a significant non-English speaking population”. As with Part C plans, these rules apply to Medicare Prescription Drug (Medicare Part D) plans with respect to their marketing materials and enrollment forms, including (1) written descriptions of rules (including limitations on providers from whom services can be received), procedures, basic benefits and services and fees and other charges; (2) written descriptions of any supplemental benefits and services; (3) written explanations of grievance and appeal procedures, including the difference between the two and when it is appropriate to use which procedure; and (4) any other information necessary to enable beneficiaries to make an informed choice about enrollment. 

Of course, as noted, a significant caveat is that these regulations apply to plans in markets with a significant non-English speaking population. The regulations themselves do not define the term “significant”. However, through guidance the Centers for Medicare & Medicaid Services (CMS) has defined this requirement as applying to any language that is the primary language of more than ten percent (10%) of a plan’s (i.e., plan benefit package) geographic service area. “CMS expects plans operating in areas where the ten percent language requirement threshold is met will provide non-English materials upon beneficiary request. Regardless of the percentage of non-English speakers in a service area, all plan sponsors’ call centers must be able to accommodate non-English providers who receive only Medicare Part B payments. The regulations do not apply to any federal financial assistance by way of insurance or guaranty contracts. 45 CFR 80.2.


For an overview of strategies to overcome linguistic and cultural barriers, see “Overview of Models and Strategies for Overcoming Linguistic and Cultural Barriers to Health Care”, www.diversityrx.org/html/models.htm

19 42 CFR § 422.2264(e)
20 42 CFR § 422.2264(a)-(d)
21 42 CFR § 423.2264(e)
22 42 CFR § 423.2264(a)-(d)
speaking/reading beneficiaries. Plan sponsors must have appropriate interpreter services available to call center personnel to answer questions from non-English speaking beneficiaries.”  

Medicare appeal regulations and policy also require adherence to certain language requirements. The Medicare regulations require consideration of a beneficiary’s “linguistic limitations (including any lack of facility with the English language)” in determining whether good cause exists for a late filing of a request for a redetermination, reconsideration, administrative law judge hearing or appeal to the Medicare Appeals Council. These regulations also apply to beneficiary appeals regarding issues relative to Medicare Advantage plans and Medicare Prescription Drug plans

Additionally, Medicare policy requires that advanced beneficiary notices (ABNs) meet certain language requirements. Medicare beneficiaries are required by law to know, or to reasonably be deemed to know, when services that they are receiving from a provider will not be covered by Medicare. If they do not have this requisite knowledge, their financial liability for the cost of the services will be waived. One of the ways that this requisite knowledge can be demonstrated is by reference to a written notice of non-coverage, known as an advanced beneficiary notice or “ABN”. This notice is to be delivered to the beneficiary, or an authorized representative, by the provider of the services who has made the determination that – in its opinion - the services will not be covered by Medicare.

The Medicare policy manual contains a number of provisions that speak to this issue. The Medicare Claims Processing Manual (CMS Pub.100-4), Chapter 30 states:

“An ABN must: be written in lay language” §40.3.1.2

“An ABN is not acceptable evidence [of notice] if: The notice is unreadable, illegible, or otherwise incomprehensible, or the individual beneficiary (or authorized representative) is incapable of understanding the notice due to the particular circumstances (even if others may understand).” §40.3.1.3 (Emphasis added)

“Delivery of a notice occurs when the beneficiary (or authorized representative) both has received the notice and can comprehend its contents.” §40.3.4.1 (Emphasis added)

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26 See, 42 CFR § 405.942(b)(2) [redeterminations]; 42 CFR § 405.962(b)(3) [reconsiderations]; 42 CFR §405.1052(a)(2)(iv) [administrative law judge appeals]; 42 CFR § 405.1102(b)(3) [Medicare Appeals Council appeals].
27 42 CFR §422.562(d)
28 42 CFR §423.562(e)
29 42 U.S.C. Sec. 1395pp
“A person who does not read the language in which the notice is written….or could not ask questions about the printed word without the aid of a translator, is a person for whom receipt of the usual written notice in English may not constitute having received notice at all…This may be remedied when an authorized representative has no barrier to receiving notice. However, in the absence of an authorized representative, the notifier must take other steps to overcome the difficulty of notification. These may include providing notice in the language of the beneficiary (or authorized representative)….or by getting an interpreter to translate the notice, in accordance with the needs of the beneficiary or authorized representative to act in an informed manner.” §40.3.4.3

These provisions apply to ALL notices required to be delivered in various care settings. When a beneficiary receives an ABN in a language that s/he cannot understand and no translation is provided, an argument can be made that the beneficiary’s liability for the cost of the Medicare services in question should be waived, as the beneficiary did not know or could not reasonably be deemed to know that the services would not be covered by Medicare. 30

Conclusion

Although much remains to be done to assure that Medicare beneficiaries obtain adequate access to and receipt of culturally competent and linguistically appropriate services, there exist rights and remedies to address health disparities based on racial and ethnic differences. Awareness of the need for culturally competent and linguistically appropriate care is the first step in eliminating cultural and linguistic barriers to health care. Knowledge of one’s rights and remedies is a second step. Enforcement and expansion of those rights are the next steps – steps that the Medicare advocacy community is well suited and well positioned to achieve.

See, 42 USC 1395pp; CMS Ruling 95-1, [(CMS) Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. CMS Rulings are binding on all CMS components, Medicare contractors, the Provider Reimbursement Review Board, the Medicare Geographic Classification Review Board, and Administrative Law Judges (ALJs). CMS Ruling 95-1 is available on-line at: http://www.cms.gov/Rulings/CMSR/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS026534&intNumPerPage=10 ]