Including Language Access into Medicaid ACO Design

Rachel Gershon, Lisa Morris, and Warren Ferguson

I. Background

A. Language Access in Health Care

System-wide access to care and language services is crucial to providing quality care across the population and reducing health disparities. LEP[1] and deaf[2] patients generally fare better when provided with language services. Better comprehension, patient satisfaction, and treatment outcomes result.[3] Without appropriate language services, health care becomes less useful or even harmful to individuals.[4] For some, the experience of seeking care without access to language is traumatic, triggering memories of powerlessness and fear.[5]

An individual's language need determines what language services are appropriate. In this paper, we discuss language access for both LEP and deaf individuals. LEP individuals comprise approximately 9% of the nation's population and 12% of the Medicaid population.[6] LEP patients may need a range of language services, including bilingual medical providers (whose fluency has been verified), qualified interpreters, and document translation.[7] Conversational English does not preclude the need for language services. LEP patients who speak English conversationally may prefer to receive medical care facilitated by an interpreter due to unfamiliarity with medical terminology in English and due to lower language proficiency when stressed by illness or worry.

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Like the LEP population, there is broad diversity of language needs within the deaf population.[8] Some deaf individuals speak a signed language such as American Sign Language (ASL) and may consider themselves to be part of a linguistic minority.[9] Due to limited or no exposure to ASL, some deaf individuals do not speak any language, including ASL, very well.[10] Other deaf individuals became deaf later in life, and as a result may rely more on written English than ASL to communicate.[11] Immigrant populations may utilize other signed languages, such as Spanish or British Sign Language. Reflecting this diversity, deaf patients require a range of language services. Services include medical providers fluent in the patient's preferred signed language, certified interpreters trained in the patient's preferred signed language, translation of written materials into a patient's language, and Certified Deaf Interpreters.[12]

Deaf and LEP Medicaid members should have access to an adequate array of trained interpreters, translated materials, and bilingual providers. Quality health care services requires quality language services, where individuals are able to accurately communicate information about their condition, understand questions fromhealth care staff and receive accurate information regarding their condition and plan for care.[13] These elements of care are critical to accurate diagnosis, patient understanding, and shared decision-making, and are also essential to a positive patient experience.[14]

Patients and providers approach health care in the context of their own culture and communication styles (for example, in Deaf culture, conversations tend to include a lot of context). While this paper focuses on the language access aspect of health care, we acknowledge that there are additional factors that can influ-

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ence the provision of quality health care and should be addressed by the health care system.

B. Availability of Health Care and Language Services

Health care providers (including Medicaid providers) are not allowed to deny care on the basis of LEP or deaf status. Title VI of the Civil Rights Act of 1964 (as interpreted by federal regulations and the United States Department of Health and Human Services) requires almost all providers to offer care regardless of a patient's ethnicity.[15] The Americans with Disabilities Act and Rehabilitation Act both prohibit discrimination on the basis of deafness by health care providers.[16] Despite federal law banning discrimination, LEP and deaf patients experience reduced access to health care.[17] One study found that survey respondents who primarily spoke Spanish were significantly less likely to have had a physician visit, mental health visit, or influenza vaccination.[18] Another found that individuals who were born deaf or became deaf early in life were less likely to have visited a physician and less likely to have received a mammogram.[19] Though these results do not directly implicate providers for discriminatory practice, they do point to systematic barriers to health care access.

Both LEP and deaf individuals have a legal right to language services in health care, including when receiving care from Medicaid providers. Title IV (as interpreted by federal regulations and the United States Department of Health and Human Services) requires almost all providers to offer language access to any LEP patient free of cost.[20] The Americans with Disabilities Act requires any provider serving members of the public to provide free language services to deaf individuals.[21] Medicaid managed care regulations (which apply to some Medicaid ACOs) require Medicaid managed care programs to offer oral interpretation and translation free of charge.[22] Even with these language requirements, deaf and LEP individuals face barriers to quality language services.[23] For example, 80% of pediatrician respondents to a 2012 survey reported that they saw LEP patients, but a majority reported using a family member rather than a professional interpreter, despite the fact that using family members as interpreters is correlated with medical error.[24] A number of civil legal cases allege that professionals failed to provide deaf patients with language services.[25]

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Though the available health care and language access research includes LEP and deaf individuals on Medicaid, research studies almost always group those Medicaid members with individuals on other health insurance. We only found a few studies that looked at language barriers specifically for Medicaid members.[26] One study found that, of rehabilitation providers that accepted children with traumatic brain injuries on Medicaid in Washington State, only 45% offered language services.[27] Another found that when California started reimbursing for Vietnamese, Cantonese, Hmong, and Cambodian language services, affected individuals accessed more mental health services.[28] More research should be done regarding the access issues deaf and LEP Medicaid members in particular face, in order to inform Medicaid policymakers of their population's experience.

Recent federal law and guidance expand and clarify language access protections. In September 2014, the United States Department of Health and Human Services (HHS) issued an updated National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards) that includes standards for providing language services.[29] Section 1557 of the Affordable Care Act extends the reach of Title VI to more health care providers and insurers.[30] In May 2016, HHS released a final nondiscrimination rule under the authority of Section 1557 that requires Medicaid providers (and other providers who accept federal financial assistance) to offer free,

accurate, and timely language services to LEP individuals in a manner that protects the privacy and independence of individuals needing those services.[31] The regulation describes what constitutes an interpreter qualified for medical settings and restricts the use of family, friends, and especially children as interpreters.[32] In May 2016, HHS released revised Medicaid managed care rules that now require states to consider provision of care to LEP patients when determining whether managed care programs offer an adequate provider network.[33] Federal law is moving in the direction of greater language access. However, these provisions do not offer additional funding for language services, which could reduce their effectiveness.

C. Cost of Language Services

Despite federal law requiring language access, access to language services is still lacking. One reason for this is limited funding for language services and other costs associated with treating LEP and deaf patients.[34] In a recent study, when pediatricians were reimbursed by Medicaid for language services, they were twice as likely to use professional interpreters.[35] However, as of 2009, only 13 states and the District of Columbia directly reimburse health care or language service providers for language services in Medicaid.[36] Generally, other insurance providers do not pay for language access.[37]

For each particular health care encounter, there are costs associated with language barriers.[38] Professional interpreters and translators must be paid. Appointments and hospital lengths of stay can be longer when treating across language barriers.[39] There is a greater risk of medical errors.[40] Medical errors associated with communication barriers lead to financial consequences for the provider, either through penalties by payers or medical malpractice suits by patients.[41]

The provision of quality language services may mitigate some of the higher encounter costs of treating LEP and deaf patients. Though LEP patients may have longer hospital lengths of stay, the use of qualified interpreters is associated with decreased hospital lengths of stay.[42] This would help an entity responsible for the total cost of care, such as an ACO, save money through decreased health care spending. Though LEP patients may have higher readmission rates, the use of trained interpreters is associated with reduced risk of readmission within 30 days of discharge.[43] Because readmission is viewed as a sign of low-quality care and triggers Medicare penalties, reducing readmission rates helps providers improve quality and avoid those penalties.[44] Even with steps taken to mitigate costs, however, the cost of care encounters with deaf and LEP individuals will likely cost more than other patients.[45]

Medicaid ACOs are paid in part based on the total cost of care (as compared to payment for particular services). When looking at a patient's total cost of care (as opposed to costs for a particular health care encounter), there is some evidence that LEP and deaf patients without access to appropriate language services currently *under-utilize* health services.[46] While the provision of language services may reduce hospital length of stay and reduce other costs, language services may also *increase* costs if language access leads to patients increasing the amount of health care services they use. This added level of uncertainty about effects on total cost of care may discourage ACOs from pursuing language access. If new Medicaid ACOs are going to achieve language access while meeting required cost targets, considerations for LEP members should be included into ACO design.

D. Medicaid ACO Initiatives

ACOs are taking hold in Medicare, Medicaid, and private markets.[47] Medicaid ACOs[48] offer states with an opportunity to address language access for members. Medicaid, jointly funded by Federal and state governments, currently provides health care to over 72 million low-income Americans.[49] State governments are given flexibility to administer Medicaid within federal requirements.[50] Part of this flexibility allows State Medicaid agencies to pursue ACO initiatives. Medicaid ACO initiatives in different states differ in structure, payment, and quality strategies.

In Medicaid ACO initiatives, ACOs are selected to care for an assigned patient population. These ACOs are expected to arrange for a large range of services, including medical services, behavioral health services, and sometimes long-term services and supports for that assigned patient population. Some ACOs restrict patient care to an ACO's network providers when seeking care.[51]

As part of their ACO models, Medicaid state agencies use alternative payment methods. Historically, Medicaid providers were paid fee-for-service, meaning that each service was separately billed. Alternative payment methods differ from fee-for-service by giving ACOs flexibility to pay for different kinds of services that address health outcomes and cost.[52] These payment methods also hold ACOs more accountable for managing the health of its population and the total cost of care.

Medicaid ACO payments are based in part on ACO quality.[53] During the development of ACOs, advocates cautioned that ACOs might limit care in order to save money, similar to behavior previously seen in managed

care.[54] In response, ACO proponents point to enhanced ACO quality measurement as one way to prevent harmful service restrictions.[55] Quality-based payment has been presented as an important feature to encourage ACOs to save money by providing better care rather than limiting necessary care. Because of the reliance on quality-based payment to ensure adequate access and quality, the state's ACO quality design should be scrutinized to make sure they promote access and quality for deaf and LEP Medicaid members, along with their payment and provider policies.

When considering how language access should be encouraged, both the effects of a policy option at the ACO and provider level should be considered. ACO relationships with ACO network providers differ across Medicaid models.[56] While ACOs are paid based on the total cost of care, providers may be paid using a different model, including fee for service. Quality and payment features that encourage increased language services at the ACO level may not flow down to the individual provider level, where language access decisions tend to be made.[57]

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II. Including Language Access in Medicaid ACO Design

We reviewed six state ACO initiatives in Alabama, Colorado, Illinois, Maine, Minnesota, and Oregon in order to identify policy options that promote language and health access.[58] Emerging Medicaid ACO initiatives present both risks and opportunities for language access. On one hand, Medicaid ACO initiatives may give ACOs the incentives and flexibility to increase language services. ACOs are encouraged to pursue a medical home model, which will likely improve patient care and communication.[59] Alternative payment methods give ACOs flexibility to pay for more interpreters and other support services that increase quality of care.[60] Integrated systems may make it easier to provide language access through a team-based care approach.[61] Concerns exist, however, regarding the treatment of vulnerable populations (including deaf or LEP individuals) in ACO initiatives. Shifting financial risk for the cost of care could serve as a chilling effect for outreach activities aimed at more complex patients, including those who are deaf or LEP.[62] And, even though quality and performance measures were encouraged to prevent ACOs from skimping on quality care, ACOs who serve more deaf and LEP patients may find it harder to meet quality and performance measures that are tied to payment.[63]

This article explores several ways that state Medicaid programs should consider to incorporate language access into their Medicaid ACO initiative. We consider various approaches to ACO payments, quality incentives, and network adequacy requirements. First, states can risk-adjust ACO payments to reflect the language needs of each ACO's population. Second, states can pay network providers fee-for-service for language services as they happen. Third, a combination of quality measurement tools can be used to both level the playing field for accessible ACOs and pinpoint where disparities occur. Fourth, states can ensure that ACOs provide an adequate network of providers that address language need.

The costs of language services and resulting health care utilization once language access is achieved and the financial effect on both ACOs and network providers remain largely unknown. Given this uncertainty, paying network providers fee-for-service for language services (rather than relying on any estimates of cost savings) appears to be the simplest and most effective way to increase the use of language services in Medicaid ACOs. As Medicaid ACOs develop further, this hypothesis should be tested by observing results of different approaches to improving language access in Medicaid ACOs.

A. Risk Adjust ACO Payment Based on Language Needs

One potential way to encourage language access for deaf and LEP individuals is to risk adjust ACO payments based on language need. Two payment methods are prominent in Medicaid ACO initiatives: shared savings and global payments. In both methods, ACOs are paid a certain amount based on the population of individuals assigned to that ACO and the expected expenditures for that population.[64]

ACOs do not necessarily get paid more to serve patients who need language services. Methods for calculating global payments and shared savings rely on an estimate of how much medical care should cost for a patient population. If this estimate is not adjusted for language need, an organization that sees a lot of LEP or deaf patients may be at a financial disadvantage. Risk adjustment can address this issue and direct more money to ACOs that see deaf and LEP patients. Risk adjustment accounts for the characteristics of an ACO's patient population when determining payment. States can risk adjust expected expenditures to account for members with more language service need. Most of the state initiatives we reviewed risk adjust payment to account for the ACO population's health status.[65] In our review of publicly available documents, only Minnesota planned to risk adjust based on language need, and risk adjustment is not planned there until 2017.[66]

States that pay Medicaid ACOs globally give ACOs a sum to pay for a population's health care needs. Alabama, Illinois, and Oregon all pay or plan to pay Medicaid ACOs on a global basis.[67] These three states also risk adjust or plan to risk adjust on the basis of health status, but not on language need. States that use a shared savings model continue to pay ACOs fee-for-service throughout the year. At the end of each year, Medicaid determines whether the ACO's patient population was more or less costly than expected. Any health care cost savings is shared with the ACO. Maine, Illinois, and Minnesota use shared savings in their Medicaid ACO initiatives.[68] These states also risk adjust or plan to risk adjust based on health status, but (with the exception of Minnesota) not on language need.[69]

ACO rates are typically set, in part, based on history.[70] If an ACO has not provided adequate language services in the past, then the historical basis for global payments would be problematic because new payments would not take into account needed language services. Global payments can be risk adjusted up for populations with more language needs. Under a scheme where a state risk adjusts payment based on language and the risk adjustment results in higher payments for LEP and deaf patients, the ACO that sees more patients with language needs would be paid more.

If risk adjustment results in the ACO being paid more to make up for the extra cost of providing language services, risk adjusting alternative payment methods for language need would encourage ACOs to recruit network providers who see a high proportion of deaf and LEP patients. However, risk adjustment has the disadvantage of being more complicated and projecting less clear incentives than fee-for-service reimbursement. A state may struggle to show ACOs a clear line between risk adjusted payments to the provision of quality language services. Tying payment to an alternative payment method may make it hard for ACOs to recognize that they are being reimbursed for language services, which would lead to a less-developed language service infrastructure compared to a structure resulting from other payment tools. Individual providers may not experience increases in payment, since risk adjustment only affects ACO payment. Because risk adjustment and alternative payment methods involve collection and analysis of large amounts of data, payment connected to a population's language need may be provided much later than when language services are needed. And, if language barriers are leading to LEP and deaf patients under-utilizing services, risk adjustment on the basis of language (without accounting for historical language service gaps) might actually *lower* reimbursement for those patients. If risk adjustment is used, the state should monitor the size of the language adjustment, and the quality and quantity of language services provided. It should examine whether language risk adjustment encourages the inclusion of providers who see LEP and deaf patients, encourages increased use of language services, and ultimately decreases health disparities.

B. Pay Fee-for-Service for Language Services

To strengthen incentives to provide language services, states can pay for them fee-for-service as they occur. Though we did not find evidence of this payment tool specifically within the Medicaid ACO model,[71] many states currently pay for language services fee-for-service in their Medicaid program. Using fee-for-service payment, the cost of interpreter services would be kept out of calculations for alternative payment methods such as global payments or shared savings.[72]

Fee-for-service payment is helpful when there is a historic gap in a needed service, because they encourage providers to provide more services.[73] Paying for language services as they occur would generally increase the volume of language services. As long as payment is adequate and provided directly to provid-

ers, this payment tool would encourage access to care, because ACOs and network providers would no longer face unfunded responsibilities to secure language services when they serve populations with language needs. This method would also encourage ACOs to offer quality language services, if requirements for quality are attached to language service funding.

In many cases, an individual provider bears the cost for language services rather than the ACO. If language service payments flow directly from the Medicaid state agency to the provider (rather than to the ACO), then it would be clear to the network provider that she would be covered for those services. When a state pays ACO network providers fee-for-service for language services, the state is pushing funds directly to the place where language service decisions are being made.

C. Modify ACO Quality Incentives

Through the ACO model, state governments seek to contain costs through better delivery of care, not denial of necessary care or avoidance of costly populations. Quality monitoring and accountability serve as important safeguards against improper cost containment efforts such as limiting necessary care.[74] All of the states we researched tied quality metrics to payment.[75] Payment for quality is not always calibrated for deaf and LEP populations. We consider some modifications that might address the particular needs of this population.

States can translate patient experience surveys into other languages. Surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey ask patients to describe their experience receiving health care.[76] Questions cover communication with providers, timeliness of care, and the politeness of the staff. Minnesota and Oregon tie CAHPS measures to payment in their ACO initiative.[77] Patient experience measures can be helpful for language access assessment purposes because they ask for the patient's perspective in the care encounter. Communication and patient understanding, both important parts of quality care, are specifically measured. CAHPS is currently available in official English, Russian, Spanish, Chinese, and Vietnamese versions.[78] Policymakers should consider using translated surveys as appropriate.[79] Methodology can be adjusted from the beginning of the program to ensure that, to the extent possible, translated surveys are valid instruments.

States can also use quality measures that directly measure language access. The National Quality Forum (NQF) has endorsed a number of these measures, including "Screening for preferred spoken language" and "Patients receiving language services supported by qualified language service professionals."[80] The state can consider using some of these metrics and tying payment to them. Using language access quality measures allow states to institute a gradual approach to measuring quality, changing goals as health care providers improve.

States can publish existing quality measures, stratified according to patient LEP status. Stratification is a process of separating quality measure data by category, such as LEP status. Researchers have found that certain measures are "disparities-sensitive," meaning that the measure reflects different results for certain minority groups.[81] Disparities-sensitive measures can be useful in showcasing disparities in treatment for LEP and deaf individuals. States can collect, stratify, and publish ACO quality metrics. Oregon currently publishes data stratified by race, and Minnesota plans to.[82]

States can also use stratification by language to develop payment based on disparity performance. States can reward ACOs who achieve the highest quality scores for LEP and deaf patients, or ACOs with the least LEP disparities within its organization. Some caution is warranted here. Different calculation techniques may lead to different results, and so should be considered carefully before tying payment to disparity measures.[83]

Finally, states can risk adjust quality measure results based on language need (different from risk adjusting payment). Risk adjusting quality measures is a process of accounting for population differences when analyzing quality measure data. Quality measure risk adjustment addresses the concern that ACOs providing outreach to deaf and LEP communities may receive lower quality scores because of health effects beyond the ACO's control.[84] Rather than highlight disparities, risk adjusting quality measures *masks* disparities in order to protect ACOs who serve populations with high language need. However, because it is difficult to determine what quality disparities are within a safety net ACO's control, risk adjusting quality measures may mask disparities in ACO performance in addition to protecting ACOs who serve populations with high language need.[85]

With the development of pay for performance schemes, there is an increased interest in risk adjusting quality measures. In 2011, the American Hospital Association submitted a request to CMS asking the agency to risk adjust measures related to Medicare hospital readmission penalties on the basis of race and language.[86] Given the sensitive nature of adjusting quality measures based on patient characteristics, NQF developed guidance for appropriate times to risk adjust quality measures.[87]

These different approaches to quality will have different effects on access and quality. Translating surveys, using language access quality measures, and stratifying quality results all encourage the provision of quality language services. They highlight where health disparities are by language, and encourage ACOs to modify their care and meet patient needs. However, these three modifications do not necessarily encourage ACOs to engage in outreach to LEP and deaf populations. ACO leaders may even harbor concern that increased language needs in the ACO's population would bring down quality scores, causing a reduction in quality-based payments.

Like risk adjusting payment for language service need, modifying quality incentives for language becomes quite complicated quickly, and the resulting payment is likely to be delayed and diffuse. Though helpful in rewarding systems for quality care to LEP and deaf patients, these rewards are likely not going to be as direct and clear as paying for language services fee-for-service.

Risk adjusting quality measures may help level the playing field for ACOs who see many deaf and LEP patients, and thus may encourage outreach efforts and access to care. However, risk adjusting measures also masks disparities, and will not necessarily encourage ACOs to offer quality language services. Thus, if quality measures are risk adjusted, states should also find a way to highlight and correct disparities.[88]

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D. Ensure an Adequate Network of Providers

In an ACO model, individual patients are assigned, or "attributed," to an ACO. This attribution process determines an ACO's amount of payment and scope of responsibility. Depending on state policy, ACO attribution may have a small or large effect on an individual's access to providers. In Colorado and Maine, for example, individuals are allowed to see providers outside the ACO's network.[89] Alabama, Illinois, and Oregon limit which providers an attributed individual can see.[90]

Deaf and LEP patients may want to choose providers that offer appropriate language services to meet their needs. States can require ACOs to develop networks of providers that adequately meet the language needs of its membership.[91] Opportunities to seek care out of network can be made for LEP and deaf individuals when the network is inadequate.[92] This can be part of the larger policy response that encourages appropriate language access.

Many Medicaid ACO programs we reviewed do require ACOs to offer an adequate network of providers that includes linguistic and cultural access.[93] New Medicaid managed care regulations (which apply to some Medicaid ACOs) also require managed care programs to have an adequate network that includes language access.[94] Enforcement of network adequacy rules with regards to language access should be monitored. If enforcement is weak (as appears to be the case with enforcement of language service requirements in health care), network adequacy rules may not be enough to encourage treatment of LEP and deaf patients and provision of quality language services.

III. Action Steps

Policymakers considering ways to include language access financing in ACO policy can start by assessing the options with consideration for the state's specific circumstances. Factors include a state's patient population mix, data collection capacity, structure of the ACO initiative, and opportunities for federal funding. Various individuals and organizations can be engaged to help assess the impact of language access policy on different stakeholders.

Including deaf and LEP stakeholders in the design, quality measure selection, interactions with the federal government, and implementation are opportunities to ensure consumer input. Development of interpreter service infrastructure may be needed to meet new language service demands, and potential providers of those services should be consulted. Medical providers should be trained to understand and provide culturally and linguistically competent care.

Virtually any method of encouraging language services requires the collection of data on limited English status of members. If language preference information is not in the medical chart or shared with other providers involved in a patient's care, then a provider

cannot plan for language needs in upcoming appointments. If the Medicaid agency does not have access to language preference data for its members, then it cannot track language health disparities or pay providers appropriately for language services. Data collection efforts should be coordinated with ongoing collection activities.

Once a policy is implemented, it should be monitored for compliance and evaluated for effects. Given the limited data available for cost implications around language access, the state should collect data on any costs and cost savings that language access provides due to better communication and better care. Though it is our belief that paying fee-for-service to network providers for language services will be the simplest and most effective method for encouraging language access, more data is needed to test this hypothesis.

IV. Conclusion

Medicaid ACO initiatives offer the opportunity for more efficient and effective care. Numerous options are available to financially reward ACOs for welcoming deaf and LEP patients and providing appropriate services. Increased financial pressure on the ACO, however, can lead to unintended consequences.

Paying network providers fee-for-service for language services appears to be the simplest and most effective way to increase the use of language services in Medicaid ACOs. State policymakers should include language access elements into Medicaid ACOs in order to improve the quality of care for deaf and LEP members. Ensuring increased language access will result in better access to safer and more efficient health care for patients. As Medicaid ACOs develop further, the results of various approaches should be tested by observing results of different approaches to improving language access in Medicaid ACOs.

Acknowledgments

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References

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16. Americans with Disabilities Act, 42 USC §12182 (1990); Section 504 of the Rehabilitation Act of 1973, 29 USC §794 (2014). See S. Rosenbaum, "The Americans with Disabilities Act in a Health Care Context," in M. J. Field and A. M. Jette, eds., *The Future of Disability in America* (Washington, D.C.: National Academy Press, 2007).
17. K. Fiscella, P. Franks, M. P. Doescher, and B. G. Saver, "Disparities in Health Care by Race, Ethnicity, and Language among the Insured: Findings from a National Sample," *Medical Care* 40, no. 1 (2002): 52-59; L. R. DeCamp, H. Choi, and M. M. Davis, "Medical Home Disparities for Latino Children by Parental Language of Interview," *Journal of Health Care for the Poor and Underserved* 22, no. 4 (2011): 1151-1166; see Barnett, *supra* note 11.
18. See Fiscella, *supra* note 17 (sample included individuals with private insurance or Medicaid).
19. See Barnett, *supra* note 11.
20. 42 USC §§2000d - 2000d-7; 45 CFR Part 80.
21. Americans with Disabilities Act, 42 USC §12182.
22. 42 CFR §438.10(c). Some ACOs are considered to be subject to the Medicaid managed care regulations.
23. See G. Flores et al., "Access to Hospital Interpreter Services for Limited English Proficient Patients in New Jersey: A Statewide Evaluation," *Journal of Health Care for the Poor and Underserved* 19, no. 2 (2008): 391-415; D. W. Baker et al., "Use and Effectiveness of Interpreters in an Emergency Department," *Journal of the American Medical Association* 275, no. 10 (1996): 783-788; L. R. DeCamp et al., "Changes in Language Services Use by US Pediatricians," *Pediatrics* 132, no. 2 (2013): e396-406.
24. DeCamp, *supra* note 23; G. Flores, M. B. Laws, S. J. Mayo, B. Zuckerman, M. Abreu, L. Medina, and E. J. Hardt, "Errors in Medical Interpretation and their Potential Clinical Consequences in Pediatric Encounters," *Pediatrics* 111, no. 1 (2003): 6-14 (The use of untrained interpreters is associated with medical errors). The use of untrained interpreters is discouraged by the United State Department of Health and Human Services' National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.
25. See J. Teitelbaum, L. Cartwright-Smith, and S. Rosenbaum, "Translating Rights into Access: Language Access and the Affordable Care Act," *American Journal of Law and Medicine* 38, nos. 2-3 (2012): 348-373, at 361.
26. R. Weech-Maldonado et al., "Racial and Ethnic Differences in Parents' Assessments of Pediatric Care in Medicaid Managed Care," *Health Services Research* 36, no. 3 (2001): 575-594 (finding that, among a few Medicaid managed care plans, LEP status was associated with worse patient assessment of pediatric experience); L. R. Snowden et al., "Limited English Proficient Asian Americans: Threshold Language Policy and Access to Mental Health Treatment," *Social Science and Medicine* 72, no. 2 (2011): 230-237; M. Moore et al., "Availability of Outpatient Rehabilitation Services for Children After Traumatic Brain Injury," *American Journal of Physical Medicine and Rehabilitation* 95, no. 3 (2016): 204-213.
27. Moore, *supra* note 26.
28. Snowden, *supra* note 26.
29. United States Department of Health and Human Services, "National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care," 78 *Federal Register* 58539 (September 24, 2014).
30. 42 USC §18116.
31. 45 CFR §92.201.
32. *Id.* The regulations also require covered entities to provide taglines in significant mailings and translation. 45 CFR §92.8
33. 42 CFR §438.68. The new rule also requires the state to set language access rules based on the languages prevalent in each managed care program in addition to those prevalent statewide, which may have the effect of increasing the languages in which written documents have to be translated. 42 CFR §438.10(c). Written material that is required to be translated is identified and a new requirement regarding taglines added. 42 CFR §438.10(c). As was the case before the final rule, oral interpretation is required in all languages for enrollees; the rule clarifies that the state must make oral interpretation available to potential enrollees as well. 42 CFR §438.10(c). Provider directories must now include a provider's linguistic capabilities (this information was previously required to be provided by the state upon request). 42 CFR §438.10(h).
34. L. Ku and G. Flores, "Pay Now or Pay Later: Providing Interpreter Services in Health Care," *Health Affairs* 24, no. 2 (2005): 435-444 ("Although providers are obligated to offer these services to LEP patients, lack of payment deters their actual availability.")
35. DeCamp, *supra* note 23; see also Snowden, *supra* note 26 (Adding more Medicaid language assistance resulted in greater mental health care access by Asian LEP patients in California).
36. M. Youdelman, *Medicaid and SCHIP Reimbursement Models for Language Services (2009 update)* (National Health Law Program 2009).
37. Ku, *supra* note 34.
38. E. A. Jacobs, D. S. Shepard, J. A. Suaya, and E. L. Stone, "Overcoming Language Barriers in Health Care: Costs and Benefits of Interpreter Services," *American Journal of Public Health* 94, no. 5 (May 2004): 866-869; B. Blanchfield, S. Gazelle, M. Khaliif, I. Arocha, and K. Hacker, "A Framework to Identify the Costs of Providing Language Interpretation Services," *Journal of Health Care for the Poor and Underserved* 22, no. 2 (May 2011): 523-531.
39. See Karliner, *supra* note 3; A. John-Baptiste et al., "The Effect of English Language Proficiency on Length of Stay and In-Hospital Mortality," *Journal of General Internal Medicine* 19 (2004): 221-228; Blanchfield, *supra* note 38.
40. Flores, *supra* note 24.
41. See, e.g., National Health Law Program, *The High Costs of Language Barriers in Medical Malpractice* (2010).
42. M. Lindholm, J. L. Hargraves, W. J. Ferguson, and G. Reed, "Professional Language Interpretation and Inpatient Length of Stay and Readmission Rates," *Journal of General Internal Medicine* 27, no. 10 (2012): 1294-1299 (use of professional interpreters associated with a shorter length of stay (by one day)). LEP patients stay in the hospital longer than English-speaking patients with similar conditions. See John-Baptiste, *supra* note 39 (LEP patients stayed between 0.7 and 4.3 days longer than English-speaking patients).
43. *Id.* (Lindholm et al.). LEP patients have a higher rate of readmission within 30 days of discharge compared to their English-speaking counterparts. L. S. Karliner, S. E. Kim, D. O. Meltzer, and A. D. Auerbach, "Influence of Language Barriers on Outcomes of Hospital Care for General Medicine Inpatients," *Journal of Hospital Medicine* 5, no. 5 (2010): 276-282.
44. 42 USC §1395ww(q) (2015); see J. R. Betancourt, A. Tan-McGrory, and K.S. Kenst, "Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries," Prepared by the Disparities Solutions Center, Mongan Institute for Health Policy at Massachusetts General Hospital, Baltimore, MD, Centers for Medicare & Medicaid Services Office of Minority Health (September 2015) ("In FY 2016, as required by legislation, hospitals can now lose as much as three percent of their Medicare payments under the program."). Offsite interpreting, such as through telephonic and video remote interpreting, may also reduce the cost of language services. E. A. Jacobs et al., "Shared Networks of Interpreter Services, at Relatively Low Cost, Can Help Providers Serve Patients with Limited English Skills," *Health Affairs* 30, no. 10 (2011): 1930-1938. Such technology should be used with caution, however, because there are situations where an in-person interpreter leads to a better outcome. See, e.g., National Association of the Deaf, *Advocacy Statement: Use of VRI in the Medical Setting* (2008).
45. See Jacobs, *supra* note 38; Blanchfield, *supra* note 38.
46. E. A. Jacobs et al., "Impact of Interpreter Services on Delivery of Health Care to Limited-English Proficient Patients," *Journal of General Internal Medicine* 16, no. 7 (2001): 468-74 ;

L. C. Hampers and J.E. McNulty, "Professional Interpreters and Bilingual Physicians in a Pediatric Department: Effect on Resource Utilization," *Archives of Pediatric and Adolescent Medicine* 156, no. 11 (2002): 1108-1113 (though other services were less likely for patients with interpreter services, the chances of being admitted were greater with an interpreter compared to the chances without an interpreter).

47. D. Muhlestein, "Continued Growth of Public and Private Accountable Care Organizations," *Health Affairs* blog (February 19, 2013).
48. The term ACO is evolving as Medicare, Medicaid, and commercial payers implement ACO initiatives. Throughout this paper, we use the term "ACO" to refer to a provider-led entity contracted with a payer to provide care for a population and that engages in some form of alternative payment method. Alternative payment methods include global payments, shared savings, and bundled payments.
49. 42 USC §1396b (2010); Centers for Medicare and Medicaid Services, *Medicaid & CHIP: February 2016 Monthly Applications, Eligibility Determinations and Enrollment Report* (April 26, 2016). This number is subject to change with the continued implementation of the ACA.
50. See, e.g., 42 USC §1315, 42 USC §1396n, and 42 USC §1396u-2.
51. S. L. Kocot, C. Dang-Vu, R. White, and M. McClellan, "Early Experiences with Accountable Care in Medicaid: Special Challenges, Big Opportunities," *Population Health Management* 16, Supplement 1 (2013): S-4-S-11.
52. See Kocot, *supra* note 51.
53. *Id.*
54. Families USA, *Accountable Care Organizations in Medicaid: Challenges and Opportunities for Advocates* (2013).
55. See E. J. Emanuel, "Why Accountable Care Organizations Are Not 1990s Managed Care Redux," *JAMA* 307, no. 21 (2012): 2263-2264.
56. Alabama's Regional Care Organizations must show that its payment method aligns with the program's incentives. Ala. Admin. Code 560-X-62.10. In Illinois, the ACO must share savings with primary care providers. Illinois Department of Healthcare and Family Services, Illinois Solicitation for Accountable Care Entities (2014) ("Illinois 2014 Solicitation") at 3.1.6.1. Oregon CCOs are required to provide patient-centered primary care homes with "training and tools necessary to communicate in a linguistically and culturally appropriate fashion with Members and their families." Oregon Health Authority, Request for Applications for Coordinated Care Organizations (2012)("Oregon 2012 RFA") at Appendix A, A.3.1.b.
57. For states whose Medicaid ACOs are subject to managed care regulations, states are restricted in how ACOs can direct payments and incentives to ACO providers. 42 CFR §438.6(c).
58. We reviewed publicly available state legislation, regulation, procurement documents, contracts, and other materials. Reviewed procurement materials included: Colorado Department of Health Care Policy and Financing, Request for Proposals: Regional Care Collaborative Organizations for the Accountable Care Collaborative Program 1 (August 2010) ("Colorado 2010 RFP"); Illinois 2014 Solicitation; Maine Accountable Care Communities State Plan Amendment (2014) ("Maine 2014 SPA"); Maine Department of Health and Human Services, Request for Applications: MaineCare Accountable Communities Initiative (2013)("Maine 2013 RFA"); Minnesota Department of Human Services Health Care Administration, Request for Proposals for Qualified Grantee(s) to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnership (IHP) Demonstration (2015)("Minnesota 2015 RFP"); Oregon 2012 RFA.
59. See Kocot, *supra* note 51.
60. *Id.*
61. See Agency for Healthcare Research and Quality 2012, *supra* note 13; Oregon 2012 RFA at Appendix F; A. Shih et al., *Organizing the U.S. Health Care Delivery System for High Performance* (Commonwealth Fund 2008).
62. C. E. Pollack and K. Armstrong, Commentary, "Accountable Care Organizations and Health Care Disparities," *JAMA* 305, no. 16 (2011): 1706-1707.
63. See A. Chien, M. H. Chin, A. M. Davis, and L. P. Casalino, "Pay for Performance, Public Reporting, and Racial Disparities in Health Care: How Are Programs Being Designed?" *Medical Care Research and Review* 64, Supplement 5 (2007): 283S-304S; Pollack, *supra* note 62.
64. ACO assignment usually occurs based on where a patient sought care in the past.
65. Alabama Medicaid Agency, Section 1115 Demonstration Proposal: Alabama Medicaid Transformation 43 (May 2014); Illinois 2014 Solicitation at Attachment G; Illinois 2014 Solicitation at Addendum #1 p. 27; Oregon 2012 RFA at Appendix F.
66. Minnesota 20l5 RFP at 8. Minnesota's Medicaid ACO initiative aligns its quality metrics with a statewide system. Minnesota 2015 RFP at 12, 68. A new statute requires the statewide system to stratify for race, ethnicity, language, and country of origin. By 2017, the system is required to risk adjust for these factors to the extent that they "are correlated with health disparities and have an impact on performance on cost and quality measures." Minn. Stat. § 62U.02, as amended by Chapter 71 of the Minnesota Laws of 2015.
67. Alabama Medicaid Agency, Section 1115 Demonstration Proposal: Alabama Medicaid Transformation 43 (May 2014); Illinois 2014 Solicitation at Attachment G; Illinois 2014 Solicitation at Addendum #1 p. 27; Oregon 2012 RFA at Appendix F.
68. Illinois 2014 Solicitation at Attachment G; Maine 2014 SPA attachment 4.19-B Page 7a; Maine 2013 RFA at 15; Minnesota 20l5 RFP at 8, 12, 68; see note 69.
69. *Id.*
70. Alabama Medicaid Agency, Section 1115 Demonstration Proposal: Alabama Medicaid Transformation 43 (May 2014); Illinois 2014 Solicitation at Attachment G; Illinois 2014 Solicitation at Addendum #1 p. 27; Oregon 2012 RFA at Appendix F.
71. As of 2009, Maine and Minnesota Medicaid programs paid for language services fee-for-service. It is unclear whether that practice continues for Medicaid ACO members in those two states. Youdelman, *supra* note 36.
72. For an example of language services paid fee-for-service and "carved out" of Medicaid managed care, see National Health Law Program, *How Can States Get Federal Funds to Help Pay for Language Services for Medicaid and CHIP Enrollees?* (2010): 6 (States have the ability to carve out language services from bundled or capitation rates).
73. See National Association of Public Hospitals and Health Systems, Medicaid and SCHIP Funding for Language Services (2007).
74. See Families USA, *supra* note 54.
75. Alabama, Colorado, and Oregon offered quality incentive payments if certain quality benchmarks were met. Alabama Medicaid Agency, Section 1115 Demonstration Proposal: Alabama Medicaid Transformation 14, 44 (May 2014); Colorado 2010 RFP at 49, 56, 58; Oregon 2012 RFA at Appendix F, Section 7; Oregon 1115 Demonstration Special Term and Condition 35 (September 4, 2015). Illinois, Maine, and Minnesota made a portion of shared savings payments contingent on meeting quality benchmarks. Illinois 2014 Solicitation at 3.1.6.4.3, Addendum 1 p. 28; Maine 2014 SPA Attachment 4.19-B at 7d and 7e; Maine 2013 RFA at 23; Minnesota 2015 RFP at 9.
76. See Teitelbaum, *supra* note 25, at 353.
77. See Minnesota 2015 RFP at Attachment F; Oregon Health Authority, *Technical Specifications and Guidance Documents for CCO Incentive Measures*, *available at* <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx> (last visited July 25, 2016).
78. Centers for Medicare and Medicaid, *HCAHPS: Patients' Perspectives of Care Survey* at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospi-

talQualityInits/HospitalHCAHPS.html> (last visited July 25, 2016).
79. For guidance on translating CAHPS, see Agency for Healthcare Research and Quality, United States Department of Health and Human Services, *Translating Surveys and Other Materials*, *available at* <https://cahps.ahrq.gov/surveys-guidance/helpful-resources/translating/index.html> (last visited July 25, 2016).
80. National Quality Forum measures 1824:L1A and 1821:L2, respectively. Quality measures appear to be more developed for foreign language populations than for deaf populations.
81. J. S. Weissman et al., *Health Care Disparities Measurement* (2011): at 36, *available at* < https://www2.massgeneral.org/disparitiessolutions/z_files/Disparities%20Commissioned%20Paper.pdf> (last visited July 25, 2016).
82. Oregon Health Authority, *Oregon's Health System Transformation 2014 Performance Report*, *available at* <http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf> (last visited July 25, 2016). See note 66, *supra*, for Minnesota information.
83. See Weissman et al., *supra* note 81.
84. See Chien, *supra* note 63; D. P. Andrulis and N. J. Siddiqui, "Health Reform Holds Both Risks and Rewards for Safety-Net Providers and Racially and Ethnically Diverse Patients," *Health Affairs* 30, no. 10 (2011): 1830-1836; Pollack, *supra* note 62.
85. S. H. Sheingold, R. Zuckerman, and A. Shartzer, "Understanding Medicare Hospital Readmission Rates and Differing Penalties between Safety-Net and Other Hospitals," *Health Affairs* 35, no. 1 (2016): 124-131 ("Based on the results of this study, we cannot determine to what extent this fact reflects quality differences that can reasonably be addressed by hospitals, and to what extent it reflects other unmeasured patient and hospital characteristics that affect outcomes and are beyond hospitals' control.")
86. American Hospital Association, Letter to HHS Secretary Berwick Regarding Risk Adjustment of Quality Measures in the CMS Readmission Reduction Program (2011). See also L. Gillespie, "Hospitals Push Medicare to Soften Readmission Penalties in Light of Socio-Economic Risks," *Modern Healthcare* (May 21, 2016).
87. National Quality Forum, *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors* (2014). The National Quality Forum recommended that risk adjustment never occur for process measures, because ACOs should follow the same care process regardless of patient characteristics. Before risk adjusting measures, the National Quality Forum recommends that policymakers show a conceptual and measured link between the characteristic and lower quality scores.
88. See National Quality Forum, *supra* note 87.
89. Colorado 2010 RFP at 14; Maine 2014 SPA attachment 3.1 Page 12a; Maine 2013 RFA at 19-20.
90. Section 1115 Demonstration Proposal: Alabama Medicaid Transformation 10 (May 2014); Illinois 2014 Solicitation at Attachment 1 p. 5; Oregon 2012 RFA at Appendix G, Exhibit B, Part 4 (3)(a)(6).
91. See E. Edwards and M. Youdelman, *Medicaid Managed Care Model Provisions: Accessibility & Language Access* (National Health Law Program 2014): 3. See, e.g., Or. Rev. Stat. 414.625(k)(G) (2013); Or. Admin. Rules 410-141-3015(15)(2014). States can make sure that Medicaid managed care regulations related to network adequacy are enforced in their states.
92. See, e.g., Oregon's out-of-network policy. Oregon 2012 RFA at Appendix G, Exhibit B, Part 4 (3)(a)(6).
93. Colorado 2010 RFP at 36; 305 Ill. Comp. Stat. 5/5-30(a) (2013); Or. Rev. Stat. 414.625(2)(e) (2013); Or. Admin. Rules 410-141-3320(1)(p) (2012). In Oregon, CCO members have the right to receive "linguistically appropriate" services and "certified or qualified health care interpreter services." CCO members must have access to people who speak their language and can help guide them through the health care system. Illinois ACE applicants will be judged in part on cultural competency.
94. 42 CFR §438.68.