Improving Healthcare Access for Patients With Limited English Proficiency

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Patients whose primary language is not English and who have a limited ability to read, speak, write, or understand English experience worse healthcare access than their English-speaking counterparts, highlighted by fewer healthcare visits and filled prescription medications.[1] These patients with limited English proficiency (LEP) face additional barriers to quality healthcare during the COVID-19 pandemic, including lower rates of telehealth use,[2] lower rates of COVID-19 testing,[3] and challenges with implementing high-quality interpretation.[4] As a result of such long-standing disparities, healthcare policy has focused on improving access to language-concordant care.

The Civil Rights Act of 1964 and Department of Health and Human Services (HHS) regulations require recipients of federal financial assistance to provide reasonable access to programs, services, and activities to persons with LEP. Section 1557 of the Affordable Care Act extends Title VI nondiscrimination standards to the entire healthcare system, including insurers and health plans. In 2016, the Obama administration implemented Section 1557 through regulations that clarified and expanded language accessibility standards, although several years later the Trump administration sought to weaken the rule's protections.

Although the requirement to make healthcare accessible to patients with LEP is unequivocal, "reasonable access" provides clinicians who accept federal funds with flexibility in how they deliver language access services. Differing interpretations of what is considered "reasonable" drives variation in how and when medical facilities provide interpreter services. This results in inconsistency of services provided across care settings and decreased availability of language-concordant care. For example, less than one-third of outpatient providers regularly use qualified interpreters when seeing patients with LEP.[5] Furthermore, only about 69% of hospitals offer language access services.[6] Clinician underutilization of interpreters for patients with LEP results in poor patient satisfaction and worse health outcomes.[7] In light of the Biden administration's commitment to civil rights and healthcare access, we outline a roadmap of actions that this administration must take to ensure access to basic communication needs and improve health equity.

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IDENTIFY CURRENT OPPORTUNITIES FOR IMPROVING REGULATIONS

The Trump-era rules loosened the requirement that care providers notify patients with LEP of their rights to language services and provide instructions on how to access these services. These rules also allowed providers to replace video-based interpreter services with audio-based services, which disproportionately impacts patients in rural areas, who rely on high-quality video interpretation to facilitate telehealth visits, especially during the ongoing COVID-19 pandemic, which has increased patient reliance on telehealth infrastructure for primary healthcare access. The Trump administration weakened both the standards for ensuring adequate access to language assistance services and the compliance tests used to assess whether healthcare organizations have met those standards. The revised regulations deem certain healthcare services effectively exempt from interpreter standards if the projected number of encountered patients with LEP falls below preset minimums and a healthcare entity considers the cost of compliance onerous.[8] The Trump administration justified these changes as a cost-savings matter, but the suboptimal care resulting from these changes will likely offset any savings.

RESTORE AND IMPROVE LANGUAGE ACCESS PROVISIONS

To restore a strong commitment to language access, the HHS Office for Civil Rights, which the Biden administration has targeted for new investments in fiscal year 2022, should reestablish the HHS Language Access Steering Committee. This committee maintains criteria that guide covered health entities in developing language access compliance plans. Maintaining such plans should become a basic element of the revised Section 1557 compliance rules and should also become a core feature of the standards applicable to Joint Commission–accredited healthcare organizations. In addition, the Center for Medicare and Medicaid Innovation (CMMI), whose mission is to identify, test, and implement major improvements in healthcare quality and efficiency, could undertake a special project to identify and incentivize adoption of the most effective language access innovations for incorporation into language access plans.

RESTRUCTURE AND STRENGTHEN COMPLIANCE FOR LANGUAGE ACCESS

Section 1557, as well as federal standards governing the conditions of participation in federal healthcare programs, should ensure that covered entities report on interpreter use and

associated patient health outcomes for patients with LEP. Overall compliance measurement and reporting in connection with language access is a matter of basic health equity. Currently, any individual who believes they have experienced discrimination based on language can report a potential violation for federal investigation. But an individual remedy is insufficient because it cannot ensure the types of systemic changes essential to overcome decades of structural exclusion and achieve broader health equity. Further, barriers from digital literacy gaps and fear of legal repercussions, such as deportation, hamper individual reporting efforts. Any policy focused on improving language access use should apply to all patients, regardless of immigration status.

INCENTIVIZE LANGUAGE-CONCORDANT CARE

Ultimately, there is little benefit to imposing standards without a concomitant assurance of the resources needed to achieve full adoption and ongoing compliance. For this reason, a commitment to language access must be accompanied by payment reforms that enable Medicare and Medicaid providers to embrace this vital feature of accessible healthcare by recognizing interpreter costs as part of the clinical encounter and care management. Covered entities could use these resources either to strengthen their own staffing or contract with third-party interpreter services organizations. Currently, the Centers for Medicare & Medicaid Services (CMS) allow states to claim federal matching funds for language assistance services provided to Medicaid enrollees, though rates are dependent on how service claims are categorized. State Medicaid programs can facilitate the provision of such services by optimizing reimbursements for provider organizations under CMS policy.

The Merit-based Incentive Payment System (MIPS) provides an opportunity to incorporate the provision of interpreter services into quality measure reporting. Such efforts could improve health equity and address long-standing needs for research into how language barriers affect healthcare outcomes. Given that analyses of inaugural MIPS data revealed that safety-net practices were more likely to receive lower composite scores, additional scoring flexibility under pay-for-performance schemes (rather than strict penalties) may be necessary to ensure the solvency of safety net practices that disproportionately care for patients with LEP.[9] Here, CMMI can play a critical role in expanding the use of patient-facing resources by designing new alternative payment models that reward participants for providing high-quality language concordant care.

The COVID-19 pandemic has exacerbated disparities in care for patients with LEP and even starker disparities among immigrant communities and patients of color. These disparities will only worsen if regulations aimed at improving access to language access services are not reinstated and improved. Failing to focus on healthcare access for patients with LEP hurts individual patient health and public health, as we have seen through lower rates of testing and vaccination in communities of color during this pandemic. The Biden administration can put healthcare on a more equitable pathway by expanding and strengthening language access as a core feature of healthcare, as a matter of both civil rights and health care quality.

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