Spoken Language Health Care Interpreter Work Group Recommendations

The 2025 Minnesota Legislature passed a law establishing a Spoken Language Health Care Interpreter Work Group. This work group met from October 2025 through June 2026, to discuss topics outlined in statute. The Work Group website contains meeting summaries organized by date and discussion topic and can be found here:

https://www.health.state.mn.us/facilities/providers/interpreter/workgroup/index.html

This document contains the work group's draft recommendations related to these topics. Interested parties are encouraged to review these draft recommendations and provide comments during the live comment events on Sept. 24, 10:30–11:30 a.m. and Sept. 29, 2–3 p.m. or via the Comment Form found here: https://forms.cloud.microsoft/g/zk1fKHTpwx.

Recommendation: Establish spoken language health care interpreter registry

Purpose and intent

Establish a verified registry of certified spoken language health care interpreters in Minnesota that supports patient safety, improves communication in health care settings, and maintains statewide access to interpreter services. The verified registry would reflect varying levels of interpreter preparation, while creating pathways for advancement, and minimizing disruption to current service availability.

The verified registry shall be maintained by the commissioner of health. Interpreters on the registry will be verified in one of four categories based on documented qualifications. Health care interpreters (whether in-person or virtual) must renew every two years. This registry recommendation would strengthen interpreter standards in Minnesota by building on the current Spoken Language Health Care Interpreter Roster and previous spoken health care interpreter registry bills while addressing access concerns raised about prior bills. This spoken language health care interpreter registry recommendation balances verification with flexibility, supports spoken language health care interpreters across all languages, and promotes safe, equitable communication in healthcare settings.

The Spoken Language Health Care Interpreter Work Group recommends that the legislature prioritizes review of the registry structure for in person interpreting prior to review of requirements for remote interpreting as well as other topic areas, as the creation of a registry will inform processes and requirements in these areas.

Verification requirements

The Commissioner shall review documentation submitted for the Qualified and Certified categories to verify training, proficiency, and certification. For entry-level health care interpreters, verification requirements shall prioritize ethical compliance and language proficiency, as determined by the Minnesota Department of Health (MDH), to avoid creating unnecessary barriers for underserved language communities. All categories must attest to compliance with nationally recognized codes of ethics and standards of practice.

Interpreter categories

Tier I: Basic Interpreter

Requirements:

- Be at least 18 years old.
- Pass a background check.
- Provide evidence of language proficiency including either (as determined by the legislature):
    - Self-attestation of language proficiency.
    - Proof of language proficiency (Certification Commission for Healthcare Interpreters (CCHI) Tier 1, 2, 3).
- Meet ethics requirements including either (as determined by the legislature):
    - Sign an acknowledge of healthcare interpreter ethics
    - Take a one-to-three-hour asynchronous course on the U.S. medical system and healthcare interpreting ethics, established/approved by MDH with a quiz or attestation to verify completion.

Tier I individuals are required to complete two (2) continuing education units annually after initial certification.

Individuals in Tier I may provide language support only within the scope defined by MDH and may not represent themselves as certified, qualified, or Advanced spoken language health care interpreters.

Advancement out of Tier I: The work group did not decide if after a period of time Tier I individuals would move to the next qualified tier, or if individuals were able to stay at Tier I indefinitely.

Tier II: Qualified Interpreter

Requirements:

- Meets all Tier I requirements.
- Provide proof of 40-hours or more of medical interpreter training.
- Provide proof of language proficiency in English and their working languages.
- Complete four (4) continuing education units annually after initial certification.
    Complete four (4) medical interpreter continuing education units per year, to be verified by MDH upon renewal.

Tier III: Certified Interpreter

- Meets all Tier I and II requirements.
- Provide proof of active full national certification (passing the written and oral exam) through the Certification Commission for Healthcare Interpreters (CCHI) and/or the National Board of Certification for Medical Interpreters (NBCMI) and/or any other accrediting body recognized by MDH.
- Complete eight (8) continuing education units annually after initial certification maintained through the national certifying body.

    Complete eight (8) medical interpreter continuing education units per year, to be verified by MDH upon renewal.

Tier IV - Advanced Interpreter

- Meets all Tier I, II, and III requirements.
- Provides proof of successful completion of an undergraduate or graduate certificate, diploma, or degree in interpreting or interpreting and translation.

Miscellaneous

Background check required to be on registry (Tier I requirement) will be done through a verified organization (Minnesota Department of Human Services NETStudy). The goal is to limit the need for repeat background checks of spoken language health care interpreters when working with multiple agencies and healthcare systems. This will also allow for disqualification of interpreters who should not be on the registry.

Any spoken language health care interpreter providing remote, on-demand, and/or Telehealth services to a client(s) located in Minnesota must hold a current spoken language health care interpreter registration.

All spoken language health care interpreters who work with or for healthcare providers serving Minnesota clients will be required to be listed on the registry. Healthcare systems serving Minnesotans have to follow the same minimum requirements as interpreter agencies.

Fee structure

Fees paid by applicants will be used to support the creation and maintenance of the spoken language health care interpreter registry. Fee structures should remain reasonable and not create barriers to entry, especially for entry-level (Tier I) individuals.

Fees paid by applicants utilizing a language outside of the top 15 most common languages without regard to dialect spoken in Minnesota will be set at 50% of the standard cost. (Language frequency to be determined via state demographic center data.)

The fee for all spoken language health care interpreters in their first two years on the registry (initial registration) will be waived. The fee for health care interpreters in years three and four (first renewal) will pay 50% of the standard fee.

Complaint and oversight process

The spoken language health care interpreter registry shall include a process for receiving and evaluating complaints involving ethical violations or conduct that compromises patient safety. The commissioner of health may take corrective action ranging from education to suspension or removal from the registry in accordance with established procedures.

MDH will maintain a list of spoken language health care interpreters not in good standing with the register and will ensure those deemed a danger to public safety are removed from the register in a timely manner. In support of this end, MDH will support a system to report instances of abuse, fraud, and unprofessional behavior to allow for appropriate investigation, remediation or disciplinary action. Progressive correction and reinstatement are desired outcomes, if possible.

Phased Implementation

Implementation shall occur in phases to maintain interpreter availability.

- Phase 1: Tier titles added to the existing Spoken Language Health Care Interpreter Roster and allow voluntary submission of documentation by interpreters.
- Phase 2: MDH verifies Tier II, III, and IV for new applicants to align with tiered requirements.
- Phase 3: Continuing education units required for spoken language health care interpreters at renewal.
- Phase 4: MDH and interpreters evaluate statewide access with a focus on rare languages, and adjust requirements as needed.

Recommendation: Create a permanent Spoken Language Health Care Interpreter Advisory Council

Purpose and intent

A Spoken Language Health Care Interpreter Advisory Council should be convened to advise the Commissioner of Health on spoken language health care interpreter qualification requirements; access barriers; approved training and assessment programs; continuing education; partnering with local and national organizations to sponsor financial assistance for training, testing, and certification to promote upward mobility; and needed adjustments to the registry over time.

Membership

The Spoken Language Health Care Interpreter Advisory Council shall consist of the following members:

- One representative from the Minnesota Department of Health;
- One representative from the Minnesota Department of Human Services;
- One provider representative utilizing spoken language health care interpreter services;
- One (registered) interpreter representing a commonly used language; and

- One interpreter representing an uncommon language.

Non-state staff shall serve for two-year terms.

Advisory Council operation and charge

Non-state staff shall receive standard per diem compensation for their participation in meetings under Minnesota Statutes section 15.059, subdivision 3. The Council will meet at least quarterly. The Council will make recommendations regarding:

- Advise on updates or upgrades to the Spoken Language Health Care Interpreter Registry (such as updating languages, approved trainings, registry removal if appropriate, fraud, and complaints),
- Advise on enforcement actions including exclusion from the Spoken Language Health Care Interpreter Registry for interpreters who violate the code of ethics,
- Recruitment of rare language health care interpreters and/or health care interpreters serving rural areas, and
- Funding and scholarship opportunities for health care interpreters to cover registry cost, training and continuing education units.

Recommendation: Spoken Language Health Care Interpreter Advisory Council will explore improvements to telehealth and remote interpreting

Purpose and intent

The Spoken Language Health Care Interpreter Advisory Council will collect information on the employment requirements, training standards and other aspects of health care interpreters' qualifications and readiness. This information will be used to develop standards and best practices for use by all remote health care interpreters who work in Minnesota as well as the companies that contract to provide remote interpreting services within Minnesota. The Spoken Language Health Care Interpreter Advisory Council may form a subgroup of experts to complete this charge. Alternatively, the legislature may define the membership of this work group.

Directive to the work group

- Create and disseminate standards and best practices related to occupational health for remote spoken language health care interpreters, including considerations related to audio quality, work breaks, and ergonomics.
- Create and disseminate educational information regarding auditory health and safety as well as occupational health for remote spoken language health care interpreters. Educational information should be different for different groups (e.g., healthcare service providers vs. spoken language health care interpreters). At a minimum, education information should target spoken language health care

interpreters, language service providers, and people who employ spoken language health care interpreters whether as staff or contractors.

- Design and create an online, asynchronous training module to provide spoken language health care interpreters from other states and countries with the necessary context of the healthcare system and healthcare service delivery in Minnesota to effectively provide services in Minnesota.
- Compile and evaluate options to incentivize healthcare providers and organizations to prioritize working with Minnesota-based spoken language health care interpreters when feasible.
- Develop standards and best practices for use by all remote health care interpreters who work in Minnesota as well as the companies that contract to provide remote interpreting services within Minnesota. The Spoken Language Health Care Interpreter Advisory Council may form a work group of experts to complete this charge. Alternatively, the legislature may establish an independent work group to explore this topic.

Recommendation: MDH, DHS, and the Spoken Language Health Care Interpreter Advisory Council will convene a meeting of public and private sector representatives of the spoken language health care interpreters' community to identify ongoing sources of financial assistance to aid individual interpreters in meeting interpreter training and testing registry requirements

- MDH/DHS/Advisory Council shall invite organizations based on stakeholder categories to a virtual meeting of broad locations. The goal is to have a minimum of 6 attendees via the live meeting. Invitees should include representatives from state agencies, health plans, hospital and clinic systems, interpreter agencies, interpreter training/testing organizations, community-based organizations serving limited English proficiency communities, nonprofit scholarship or grantmaking organizations, colleges or training providers, and interpreter professional associations.
- Within the invite, include, "If you cannot attend, what potential sources of financial assistance or funding opportunities would you recommend attendees consider to help individual spoken language health care interpreters meet training, testing, and registry requirements?"
- The meeting should be structured to include introduction, goal of outcome, and brainstorming to identify sources of ongoing support in the categories that include but are not limited to:
    - scholarships opportunities
    - grants
    - employer-supported training funds
    - workforce development funds
    - payer contributions
    - non-profit partnerships
    - shared funding models
    - other

Recommendation: Provide spoken language health care interpreter advancement and support

Purpose and intent

Provide resources to spoken language health care interpreters in Minnesota to advance and improve health care interpreter access and quality particularly for spoken language health care interpreters in rare languages and rural areas.

Actions

- MDH will curate and post evidence-based information concerning occupational health on the Spoken Language Spoken Language Health Care Interpreter Roster webpage. The Spoken language Health Care Advisory Council, and any future work groups related to this topic, will provide input on curating these resources.
- The Commissioner of Health may collaborate with community organizations, interpreter agencies, and training programs to improve access to approved training statewide.
- MDH will establish financial assistance to spoken language health care interpreters to advance and improve spoken language health care interpreter access and quality. Assistance would be used for training, testing, and certification to increase interpreters' skills and promote upward mobility, particularly for spoken language health care interpreters in rare languages and rural areas.

Recommendation: Require companies hiring interpreters to attest to their interpreter's minimum standards

Require all companies who contract to provide interpreting services within Minnesota to attest that their contracted spoken language health care interpreters meet minimum standards equivalent to those included in the proposed Tier 1 – Basic Interpreter level of the registry of spoken language health care interpreters.

Recommendation: MDH creates searchable database

MDH will create a searchable database similar to the Registry of Interpreters for the Deaf (RID) for spoken language health care interpreters. The database will include at least the following information: language(s), registry tier, physical location, contact information (phone and email), distance willing to travel, interpretation modes utilized, and freelance status.

Recommendation: Conduct a survey of people receiving and providing interpreter services

1. Identify key stakeholders including:

Major healthcare systems with experience working with spoken language health care interpreters, state entities, interpreting agencies, healthcare plan companies, interpreter training programs, Minnesota Limited English Proficiency community associations, interpreters association – Upper Midwest Translators and Interpreters Association, hospital interpreters, providers, health care interpreters, insurers, and other administrators who authorize interpreter services.

2. Form a work group to develop survey questions:
    a. The work group should be selected from the key stakeholders and include even and balanced representation. Stakeholders should be selected from those identified in #1.
    b. The Work Group may be legislatively mandated or formed with input from the advisory council.
3. Different versions of the surveys should be available for:
    a. Patients receiving interpreter services;
    b. Providers using interpreter services;
    c. Health care interpreters;
    d. Groups that hire or arrange interpreter services – healthcare systems; and
    e. Interpreter agencies (language services provider).
4. Surveys should be available in the five common languages other than English spoken in Minnesota. At the time of this drafting, those languages are Spanish, Hmong, Somali, Vietnamese, and Mandarin Chinese. This list may be updated with input from the advisory council.

    Interpretation services should be available for those survey takers who may not read or who prefer spoken language interpretation.
5. MDH should set up outreach events:
    a. Offer in-person (preferred) and remote health care interpreters (non-biased) to help Limited English Proficiency individuals understand and fill out surveys (two different roles).
    b. This could be done at Limited English Proficiency community events or Limited English Proficiency community associations location/office.
    c. MDH should contract interpreters of rare and common languages to help Limited English Proficiency groups with completing the survey via events such as town hall meetings and focus groups.
6. The survey(s) should follow generally accepted principles for the creation, piloting, and revision of scientifically sound survey research, including cultural responsiveness.
7. Survey channels: MDH should promote the survey(s) through different media channels, including but not limited to emails, social media, MDH website(s), mail, and partnering with different community groups and organizations.

Recommendation: Convene an expert work group to make additional spoken language health care interpreter reimbursement recommendations

Upon discussion, the Spoken Language Health Care Interpreter Work Group determined that it did not have the necessary procedural subject matter expertise to directly recommend changes to reimbursement structures or amounts. Consequently, the Spoken Language Health Care Interpreter Work Group recommends that MDH

convene an expert work group to make additional recommendations related to spoken language health care interpreter reimbursement. This work group must take into account the points of concern and suggestions brought forward by the Spoken Language Health Care Interpreter Work Group, including:

- Review of documentation of current reimbursement rates and practices;
- Requiring review of and updates to spoken language interpreter reimbursement rates annually;
- Reviewing and updating the Medicaid interpreter reimbursement rate to better reflect inflation and the current cost of providing qualified interpreter services;

  Note: The current reimbursement rate of approximately $50 per hour has remained largely unchanged since approximately 2007 or 2008. Adjusting the rate to approximately $75 per hour, while maintaining the existing billing structure, may better reflect current conditions and help support continued access to qualified interpreters for patients with limited English proficiency.
- Reduce administrative barriers to interpreter service billing;
  - The workgroup recommends reviewing and addressing administrative barriers that discourage healthcare organizations and interpreter agencies from submitting interpreter service reimbursement claims.
  - Issues raised during discussion include the complexity of the billing portal, repeated claim submissions, claim submission fees, and challenges verifying patient eligibility. The workgroup recommends exploring options to simplify the billing process, including allowing interpreter service claims to be submitted in bulk or batch format rather than individually. Allowing batch submissions could reduce administrative burden and help offset claim submission fees for organizations providing interpreter services.
- Simplify interpreter service billing by incorporating payment into the provider rate structure and making all providers responsible for the services. Explore incorporating interpreter payment into every provider's rate structure, thus making interpreter costs the direct responsibility of the provider (and reimbursed as part of the provider's rate);
- Increase spoken language health care interpreters' reimbursement rates within the four proposed levels of a new registry (tier 4 (advanced) = highest and tier 1 (entry level) = lowest). Each tier must have a different reimbursement rate due to differences in training and education;
- Remote reimbursement rates - The Spoken Language Health Care Interpreter Work Group recognizes that remote (MA) interpretation incurs fewer expenses. The workgroup recommends establishing a tiered remote MA reimbursement fee schedule that follows the four proposed tiers in the MDH. Fee schedules would be adjusted to ⅔ of onsite schedule. At the moment there is no incentive for interpreters to take onsite appointments. A modified fee schedule based on mode of delivery of service would provide a market incentive for interpreters to take on-site cases. Payment could increase by the minute beyond minimum. For phone interpreting: if longer than 10 minutes, the Spoken Language Health Care Interpreter Work Group recommends an in-person interpreter;
- Correct onsite reimbursement length: The Spoken Language Health Care Interpreter Work Group recommends interpreters be compensated for their time, that is, paid for time requested by providers, minimums, or total time of service, whichever is greater. If an interpreter is asked to stay longer, even if simply waiting, there needs to be an expectation of payment, like any other industry.
- No-show onsite reimbursement length: Unlike clinics or other medical centers, an interpreter has no ability to control or to influence if a patient is scheduled or canceled. They should therefore not be responsible for the cost. Travel to and from a medical center incurs a cost. The cost of no-shows should

not fall on interpreters. No-shows should be reimbursed (for transportation/time) at the rate of $50/hour to the interpreter/agency.

- Cost of Living Adjustment (COLA): The Spoken Language Health Care Interpreter Work Group recommends that rates be approved with an annual cost of living increase of 3% to offset inflation.
- Spoken language health care interpreters will be reimbursed mileage at the federal rate for miles traveled to an interpreting assignment when the travel is greater than 20 miles each way from their registered zip code work location. In the event the interpreter must travel more than 20 miles one way from point A to point B, then mileage will be reimbursed round trip.