

# Spoken Language Healthcare Interpreter Work Group

**DATE: APRIL 30, 2026**

**MINUTES PREPARED BY: LEA BITTNER**

**LOCATION: VIA WEBEX**

## Attendance

- Jose Tori Maguina – member
- Katie Freeman – member
- Lailee Tung – member
- Maikhou Vang – member
- Marisa Rueda – member
- Michele Reither – member
- Munna Yasiri – member
- Rachel Herring – member
- Rick Michals – member
- Rosemond Owens
- Jia Vang – MDH
- Jill Freudenwald – MDH
- Todd Hoover – MDH
- Tammy Winters - MDH
- Lea Bittner – Alliant Consulting
- Jessie Schuppe – Alliant Consulting
- Soo Lauby – public member
- Christien Rositas – public member
- Chelsey Olson – public member

## Agenda

- 2:00 - 2:05 Welcome and Housekeeping
- 2:05- 2:15 Meeting Recap and Project Plan
- 2:15 - 3:00 Member Discussion
- 3:00 – 3:20 Voting on Reimbursement Recommendations
- 3:20 - 3:30 Future Meeting Topic Prep, Next Steps and Closing

## Meeting Recap

- Members reviewed, discussed and revised recommendations on barriers to joining the health care spoken language interpreter roster/registry.
- Final recommendations were not voted on as members wanted more time to fine tune specific language.
- A meeting invite has been sent for June 25th; this meeting may need to be used to review unresolved recommendations such as those for roster barriers and reimbursements or to review the total recommendations for final revision.

## Work Group Discussion

**Topic: Identify gaps in interpreter services in rural areas and recommend ways to address interpreter training and funding needs.**

- A difficult part of interpreting – a roster of having more people sign up rurally would help; not many available in rural areas; consideration of traveling far when people aren't available locally. Territories are large.
- Promoting the roster – make sure health care providers or counties know there's a roster system and ensure they know how to access; show them where they can find interpreters; promote the roster.
- Challenge: less training opportunities and less requirements rurally, e.g. Some metro hospitals require 40-hour training and prefer certification. Not the case rurally. Many interpreters in rural areas aren't aware of training and qualifications, are often offered less pay and there's less demand; they don't have a lot to keep them busy.
- The roster is set up to reimburse for 'where the interpreter will travel to' vs where they are located. Need to list where they are located which will help source interpreters more quickly in rural areas.
- Potential for waivers for rural interpreters – help offset or waive costs for certification and professional development. Piggyback off designations that exist. In MN there are "critical access hospitals"; people are reimbursed more for those locations, to keep those locations viable. Could do same for rural interpreters designating rural locations as critical access locations.
- There are more independent health systems that might not be as comfortable working with interpreters. Need to have better training for health care providers and how to access interpreters in rural areas; can access and use better than they do now.
- Consider how the roster could be a clearinghouse for background and certifications; rural could rely on statewide system to leverage interpreters more.
- Many rural facilities use telephone interpreters for speed and ease.
- Waive certification costs: set up scholarships for training/certification.
- Member in chat: National designation. Why not ignore the issue of starting/ending point and simply put travel reimbursement based on # miles traveled? e.g. one reimbursement rate if under 60 miles, a higher reimbursement rate if over 60 miles of travel.... etc.
- Member supports the idea of knowing there are interpreters that are located in rural areas; to utilize them before sending someone from the metro; sometimes phone is not great for people who are hard of hearing; believes in-person interpreting is most effective
- Member's company provides continuing education, 40 hours of training, and conferences. DEED has funding for career training, education and certification; could DHS work with DEED on that?

- Focus on the population that's already in rural areas; educate younger people for the interpreting opportunity; supports a scholarship; advisory council could work with schools and counties to promote interpreter training; need the younger generations to enter this career
- Advisory council: could provide a list of programs for interpreters to promote younger generations to recruit to the field
- Consider a function in the roster system to be able to search by city to find an interpreter close to the rural town where the service is needed
- Current roster system can search by county; it's what the interpreter provides in their profile as to where they offer services
- Currently the roster asks where the interpreter is willing to (travel to) provide services; their willingness to go to certain areas. Sometimes you contact them and they're not willing to go as far as they may have said in profile.
- Make the roster easier to work with; be able to search by where an interpreter is actually located - by zip code vs county.
- There are mini agencies that are not real interpreting agencies; they send interpreters on jobs, the agency gets paid, and they don't always pay the interpreter. The interpreter goes to the clinic to get paid but it's the agency that owes them, not the clinic. (FRAUD!) It has been recommended that interpreters having experienced this, call the State's Attorney General's office to file a complaint.
- MDH must consider annual CEU requirements on risks and compliance; what their responsibilities are/are not (e.g. drive patients to clinic).
- Especially in rural areas: There's a no-show issue for patients that don't show up. Then the interpreter doesn't get paid. Interpreters are turned off by the career when they hear/experience this. This is part of the reimbursement discussion.
- Providers don't get paid when patients don't show up either. Interpreters should get paid in these no-show situations. It can be financially straining.
- Interpreters are independent contractors; if they don't get paid they won't want to keep doing the work.
- Idea for interpreters to get paid to call patients to remind them of their appointment which will help with keeping more appointments scheduled; it's more likely patients will show up with reminders.
- Some agencies have an interpreter who does this at their place of work.
- Many agencies have interpreters do the reminder calls or use phone interpreters to do it.
- Member's agency gets asked to confirm appointments with patients; a lower rate is charged for this service.
- Consider what happens when patients don't show up; the doctors still get paid; the interpreter doesn't; not equal.

## Recommendations on Reimbursements

- Reviewed recommendations from previous meeting.
- **Review and update Interpreter Reimbursement Rates:**
  - Tiers 1-4; different rates and minimums; all billed in 15 minute increments.
  - Member feedback:
    - The units of 7 and 8 minutes is how it's administered by Medicaid; what's reimbursable and might pass.
    - Add "after the minimum has lapsed" to the units of 7 and 8 round up or down.
  - Group vote on Recommendation 1.
    - 9 members voted and approved.
- **Establish a Minimum Reimbursement Equivalent to 30 minutes:**
  - Member feedback:
    - MA doesn't reimburse if the interpreter doesn't stay for longer than 30 minutes; trying to meet that recommendation.
    - Seems contradictory to the one hour minimum.
    - Member said to wipe this out and go with the one hour minimum above.
- **Reduce Administrivia Barriers to Interpreter Service Billing:**
  - Member feedback:
    - Why does the agency need medical record access if the clinic has it?
    - We don't need access to the portal if we're not billing and checking eligibility.

[review of recommendations paused until next meeting]

Member offers to meet with other interested members before next meeting to begin drafting recommendations for rural gaps.

## Next Steps

Subgroup of members may meet to draft recommendations for the next meeting.

## Reminders

- Next meeting will be Meeting #2 on rural gaps; Tuesday, May 12<sup>th</sup>, 1:00 – 2:30.
- Draft recommendations are due the Thursday before the next meeting – Thursday, May 7<sup>th</sup>, and will be shared with members on Friday, May 8<sup>th</sup> for your review – please come with revisions in mind to make best use of time!

SPOKEN LANGUAGE HEALTHCARE INTERPRETER WORK GROUP

- Please submit resources and SME suggestions for this and other future topics to the shared folder and/or [SLHCIWG.MDH@state.mn.us](mailto:SLHCIWG.MDH@state.mn.us) (copy Rick).
- Submit Expense Forms **for this meeting** to [SLHCIWG.MDH@state.mn.us](mailto:SLHCIWG.MDH@state.mn.us), and **copy** [Rick.Michals@state.mn.us](mailto:Rick.Michals@state.mn.us) and [Julianna.Leintz@state.mn.us](mailto:Julianna.Leintz@state.mn.us).

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