

Client name Adam M. Meier
Form Montana Licensing Reform Task Force
Matter Adam M. Meier - Rules
Sent February 24, 2026 at 2:37 PM
Due
Submitted February 24, 2026 at 2:37 PM

Adam M. Meier

Date of birth		Company	The Cicero Institute
Home email	adam@ciceroinstitute.org	Home address	150 N Fort Thomas Ave Fort Thomas, KY 41075
Home phone	18594796070		

Montana Licensing Reform Task Force

This Task Force was created pursuant to Executive Order 1-2026 on January 29, 2026.

Purpose of the Licensing Reform Task Force

The Task Force shall provide the Governor with recommendations and strategies for the State of Montana to reform the professional occupational licensing system for the purposes of:

- identifying and removing burdens and barriers faced by licensees that are not necessary to protect the public; and
- improving access to and availability of professional services for citizens across Montana, including rural communities.

In developing recommendations and strategies, the Task Force shall seek input from Montana citizens, legislators, Montana associations whose members are licensed occupational professionals, professional licensing boards, relevant state agencies, advisory groups and researchers focused on occupational licensing, and other appropriate stakeholders as determined by the Task Force.

Public Record

Please note that all information received through this form is public record.

Which committee would you like to receive your comment?

Full Task Force
Health Care Subcommittee

We want to hear from you!

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Do you have a general comment or a specific person or topic for the Task Force to hear from?

Specific person or topic

What are your comments?

To: Montana Licensing Reform Task Force (LRTF)

From: Adam Meier, The Cicero Institute

Date: February 24, 2026

Subject: Proposal for a Universal Telehealth Registration Pathway to Address Montana's Provider Shortages

Dear Members of the Licensing Reform Task Force,

As you review Montana's occupational licensure framework to identify efficiencies and expand access for our citizens, I strongly urge the Task Force to consider a reform that would modernize how we handle out-of-state healthcare providers: *Telehealth Across State Lines via a Registration Pathway*.

The Problem: Geographic Barriers to Care

Montana's rural character and vast geography create unique challenges for healthcare delivery. Many Montanans, particularly those in frontier counties or those seeking specialized mental health services, face significant travel times or long waitlists for in-state providers. While telehealth has bridged some of these gaps, the current regulatory environment requires out-of-state physicians to obtain full, costly, and time-consuming Montana licensure before they can treat a single patient in our state.

The Solution: The Cicero Institute Telehealth Framework

I recommend the Task Force consider the *Telehealth Across State Lines* policy framework proposed by the Cicero Institute. Rather than requiring a secondary full license, this model creates a streamlined "Registration" pathway that respects state sovereignty while maximizing patient choice.

Key features of this proposal include:

Registration, Not Reciprocity: Out-of-state providers must register with the Montana Board of Medical Examiners, pay a fee, and submit to Montana's jurisdiction and disciplinary authority.

High Standards: To qualify, a provider must hold an active, unencumbered license in their home state and cannot be under investigation for professional misconduct.

Immediate Scalability: During the COVID-19 pandemic, Montana and many other states utilized similar waivers to successfully expand care without compromising safety. Making this permanent via a formal registration process ensures we are prepared for the future.

Protection for Continuity of Care: This reform is vital for Montanans who travel for specialized surgery (e.g., in Seattle or Rochester) and need follow-up care, or for college students and seasonal workers who need to maintain relationships with their established providers.

Alignment with Task Force Goals

This proposal aligns perfectly with the LRTF's mission to "ensure that licensing does not unnecessarily restrict the supply of labor" or "the provision of services." By allowing specialized providers from across the country to serve Montanans digitally, we can drive down costs through increased competition and ensure that no Montanan is denied care simply because of their zip code.

Request for Action

I request that the Task Force include cross-state telehealth registration in its upcoming healthcare licensure review. I would also welcome the opportunity to present the Cicero Institute's model bill and supporting data to the committee to demonstrate how this approach has successfully expanded access in other pro-innovation states.

Thank you for your dedication to modernizing Montana's regulatory environment.

Sincerely,

Adam Meier

Director of Healthcare Policy

The Cicero Institute

Client name Adam M. Meier
Form Montana Licensing Reform Task Force
Matter Adam M. Meier - Rules
Sent February 24, 2026 at 2:33 PM
Due
Submitted February 24, 2026 at 2:33 PM

Adam M. Meier

Date of birth		Company	The Cicero Institute
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Home phone	18594796070		

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Specific person or topic

What are your comments?

To: Montana Licensing Reform Task Force (LRTF)

From: Adam Meier, The Cicero Institute

Date: February 24, 2026

Subject: Proposal for Integrating Clinical AI into Montana's Occupational Licensure Framework

Dear Members of the Licensing Reform Task Force,

Thank you for your work in streamlining Montana's occupational licensure system to better serve our workforce and citizens. As the Task Force seeks to "identify and remove barriers... while maintaining high standards of safety and quality," I urge you to consider a critical emerging frontier: the integration of Clinical Artificial Intelligence (AI) into our state's licensing framework.

The Opportunity for Montana

Montana has already established itself as a national leader in digital liberty through the Right to Compute Act (SB 212). By affirming that the right to use computational tools is an extension of our constitutional property rights, Montana sent a clear signal that we are "open for business" for the next generation of technology.

However, our professional licensing statutes—particularly in healthcare—were written for a world of human-only service delivery. As clinical AI becomes more capable of routine diagnostics, screenings, and chronic disease management, Montana faces a choice: we can allow these tools to remain in an "unregulated Wild West" of consumer apps, or we can lead the nation by bringing them into a formal, licensed framework.

The Proposal: A Licensed "Provider" Model

I suggest the Task Force review the AI Medical Services Act framework developed by the Cicero Institute. Rather than banning AI or treating it as a static "product," this model treats AI as a clinical service to be licensed and regulated similarly to human providers. Key benefits include:

Increased Access: In rural Montana, where specialist wait times can be months, licensed AI can handle routine screenings and diagnostic support, freeing up human doctors for complex cases.

Safety & Accountability: The framework creates an "AI Augmented & Autonomous Service Provider" (AAASP) license. This requires AI providers to carry malpractice insurance and bonding, providing patients with the same recourse they have with human doctors.

Risk-Based Oversight: It uses a tiered approach—matching the level of autonomy (from advisory to autonomous) with the clinical severity of the condition—ensuring that high-risk applications receive the strictest oversight.

Economic Innovation: By creating "market certainty" with clear rules for liability and billing, Montana can attract the world's leading healthcare technology companies, building on our pro-innovation history.

Request for Action

I ask that the Task Force include "Clinical AI Licensure" as a topic for study in its healthcare subcommittee. Furthermore, I would like to request the opportunity to present the Cicero AI Medical Services Act framework at a future meeting to discuss how this reform can lower costs and improve health outcomes for all Montanans.

Montana has the unique opportunity to prove that safety and innovation are not at odds, but are best achieved through a modern, flexible licensing system.

Link: <https://ciceroinstitute.org/research/ai-medical-services-act/>

Sincerely,

Adam Meier

Director of Healthcare Policy

The Cicero Institute

Client name Adam Meier
Form Montana Licensing Reform Task Force
Matter Adam Meier - Rules
Sent February 24, 2026 at 2:41 PM
Due
Submitted February 24, 2026 at 2:41 PM

Adam Meier

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Home phone 18594796070	

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Specific person or topic

What are your comments?

To: Montana Licensing Reform Task Force (LRTF)

From: Adam Meier, the Cicero Institute

Date: February 24, 2026

Subject: Proposal for International Physician Licensing Reform to Address Rural Provider Shortages

Dear Members of the Licensing Reform Task Force,

As the Task Force works to fulfill its mission of removing unnecessary labor market barriers, I would like to submit a proposal regarding a highly skilled but underutilized population: Internationally Trained Physicians.

The Problem: The "Residency Bottleneck"

Montana is facing a worsening physician shortage, particularly in primary care and rural health. At the same time, there are thousands of highly qualified, experienced physicians living in the U.S. who were trained at top-tier international institutions. Under current Montana law, these doctors—many of whom have practiced for decades—are often required to repeat years of residency training alongside medical school graduates just to obtain a license. This is an arbitrary and burdensome barrier that discourages world-class talent from moving to the Big Sky State.

The Solution: International Physician Licensure Pathway

I suggest the Task Force consider a reform based on the Cicero Institute's International Physician Licensing framework. This model allows the Board of Medical Examiners to grant licenses to experienced international doctors without requiring them to repeat a U.S. residency, provided they meet rigorous safety and competency standards.

Key components of this reform include:

Substantial Equivalency: The doctor must have completed a residency or equivalent training in their home country that is substantially similar to U.S. standards.

Proven Experience: Applicants must have practiced as a fully licensed physician in their home country for a minimum period (e.g., three to five years) in good standing.

Testing & Verification: Doctors must still pass the United States Medical Licensing Examination (USMLE) and have their credentials verified by the Educational Commission for Foreign Medical Graduates (ECFMG).

Provisional "Bridge" Periods: States like Tennessee and Florida have pioneered this by allowing these doctors to practice under a provisional license for a period while their performance is monitored by an in-state hospital or healthcare system.

Why This Fits Montana

This is a "market-driven" solution that requires zero taxpayer dollars. By recognizing the global nature of medical education, Montana can become a premier destination for specialists and primary care doctors who are currently "locked out" of the workforce in more restrictive states. This is a common-sense extension of Montana's commitment to individual liberty and regulatory efficiency.

Request for Action

I request that the Task Force evaluate the legislative models currently being adopted in states like Tennessee, Virginia, and Florida as a blueprint for Montana. I would like to request that this topic be added to the Healthcare Subcommittee agenda, and I am available to provide further research and model bill language from the Cicero Institute.

By modernizing these antiquated rules, we can ensure that every Montanan has access to a qualified doctor, regardless of where that doctor was born or trained.

Sincerely,

Adam Meier

Director of Healthcare Policy

The Cicero Institute

Client name David J. Alvarado
Form Montana Licensing Reform Task Force
Matter David J. Alvarado - Rules
Sent February 20, 2026 at 5:55 PM
Due
Submitted February 20, 2026 at 5:55 PM

David J. Alvarado

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Montana Licensing Reform Task Force

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Which committee would you like to receive your comment?

Health Care Subcommittee
Barriers Subcommittee

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Specific person or topic

What are your comments?

To: Montana Licensing Reform Task Force (Attn: Commissioner Sarah Swanson, Chair)

From: David Alvarado

Organization: Clover Therapy

Date: 2/20/2025

Subject: Eliminating Regulatory Barriers to Faith-Based Counseling Services

My name is David Alvarado, and I am a resident of Billings, MT. I am writing to provide comment to the Task Force regarding the current occupational licensing barriers that prevent biblical counselors (MDIV and Certified) from serving the public through recognized insurance frameworks. As this Task Force seeks to fulfill the Governor's "Red Tape Relief" mandate, I urge you to address the "licensure-only" bottleneck that restricts patient choice and limits the Montana healthcare workforce.

The Barrier: Narrow Licensure Definitions Current Montana regulations create a "one-size-fits-all" model for emotional and mental health care. By requiring a clinical state license (LPC/LCSW/LCPC) for insurance reimbursement, the state effectively discriminates against religious providers who are highly trained and/or certified through rigorous national bodies (such as ACBC or IABC) but choose to operate under a theological rather than a medical framework.

This regulatory wall creates three primary issues:

- 1. Workforce Suppression:* Montana faces a critical shortage of mental health providers. We have a ready workforce of certified biblical counselors who are currently sidelined from the insurance market, leaving Montanans in rural areas without accessible care.
- 2. Economic Exclusion:* Families who pay insurance premiums are denied the "Freedom of Choice and Religious Access" to use those benefits for the provider who shares their deeply held religious values. This is a "faith tax" on Montanans who prefer biblical counseling over secular clinical models.
- 3. Regulatory Overreach:* While licensure is intended to protect public safety, there is no evidence that the unregulated practice of biblical counseling poses a hazard that justifies the total exclusion of these providers from reimbursement networks.

I propose a solution consistent with the 406 JOBS initiative, I recommend the Task Force propose a pathway for "Provisional and Certified Religious Providers." This would allow insurance carriers to recognize non-clinical certifications for reimbursement purposes, provided the counselor meets established national religious certification standards. This is not a request to lower safety standards, but to modernize and broaden them to reflect the diversity of care Montanans actually want.

In Closing, consider what Governor Gianforte has stated that "unnecessary requirements are standing in the way of filling available jobs." The exclusion of biblical counselors is a prime example of such a requirement. I ask this Task Force to recommend reforms that allow for "Patient Choice and Religious Access" in our healthcare system, ensuring that state-mandated licensure is not used as a tool for religious discrimination or market protectionism.

Sincerely,
David Alvarado
Biblical Counselor (Bilingual-Spanish)

Client name Deborah Horton
Form Montana Licensing Reform Task Force
Matter Deborah Horton - Rules
Sent February 23, 2026 at 10:29 AM
Due
Submitted February 23, 2026 at 10:29 AM

Deborah Horton

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Work phone	4064139904		

Montana Licensing Reform Task Force

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Full Task Force
Health Care Subcommittee
Barriers Subcommittee

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Specific person or topic

What are your comments?

Topic - Supervision

I am writing regarding two issues related to supervision. One is for the committee to help create clear language on how supervision can be provided to candidate-licensed therapists (PCLC and SWLC). This language needs to specifically address whether the supervisor must hire supervisees as W-2 employees. There is currently nothing in the language of either the Board of Behavioral Health or the DOLI to address this issue, leaving it open to interpretation.

Secondly, to address the new policy from BCBS that includes BCBS MT, which states that supervisors must be within 100 percent proximity of their supervisees at all times, including during sessions, as stated in the current policy. In a rural state like Montana, there are not enough licensed supervisors to ensure 100 percent proximity to candidate-licensed therapists. Also, being in every session with someone you supervise not only impacts the supervisor's ability to have clients but also interferes with the counseling process, as a supervisor sitting in on every session. This policy creates a host of issues for the counseling framework, including the inability to provide this service in rural areas, which will lead to fewer licensed counselors in Montana, not more. Please refer to this policy at <https://www.bcbsmt.com/docs/provider/mt/education/provider-policies/provider-in-training-policy-mt.pdf>

Thank you

Deborah Horton, M.Ed., LCPC, LPSC, NCC, CCTP II

Client name Isabella Mc Shea
Form Montana Licensing Reform Task Force
Matter Isabella McShea - Rules
Sent February 23, 2026 at 4:53 PM
Due
Submitted February 23, 2026 at 4:53 PM

Isabella McShea

Date of birth	Company
Home email	Home address
Phone	

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Specific person or topic

What are your comments?

My name is Isabella McShea, and I am a partially licensed clinical professional counselor serving Montana communities. Thank you for the opportunity to provide input as healthcare workforce and licensing priorities are considered. I respectfully offer several considerations to strengthen Montana's behavioral health workforce, protect families and children, support rural communities, and ensure responsible stewardship of taxpayer resources.

Counseling Interstate Compact

First, the Counseling Interstate Compact should be prioritized.

The Compact improves workforce mobility and allows qualified professionals to begin serving Montanans more quickly—particularly in rural and underserved areas—while fully maintaining professional standards. It also enhances interstate coordination of disciplinary oversight, strengthening accountability and patient protection without expanding government bureaucracy.

Inclusion of Licensed Counselors in Licensing Review

Second, any review of Title 37 healthcare licensing should include direct input from actively practicing licensed counselors. Behavioral health licensing requirements—including graduate education, supervised clinical experience, and a defined scope of practice—exist to safeguard the safety of parents and children, promote family stability, and ensure high-quality care for vulnerable individuals. Thoughtful streamlining of administrative processes may be appropriate; however, reducing core clinical safeguards would risk poorer outcomes for children and families, increase reliance on crisis and emergency services, and ultimately generate higher long-term costs for state systems such as healthcare, child welfare, and public assistance.

Strong access to effective behavioral health care is, therefore, not only a clinical concern but also a family stability and economic resilience issue. When parents receive timely, competent care, children are safer, families remain intact, workforce participation improves, and communities are strengthened. These outcomes reduce dependence on costly government interventions and support long-term fiscal responsibility.

Barriers to Workforce Entry and Rural Access

As this committee identifies barriers to strengthening Montana's behavioral health workforce, several issues warrant attention:

The recent federal misclassification of Master's-level counseling degrees as non-professional for financial aid eligibility, which limits students' ability to access the education required for entry into the profession

Limited access to supervised clinical placements—particularly in rural and frontier communities—delaying full licensure and workforce participation

Administrative or processing delays in licensure that postpone the entry of qualified clinicians and may drive workforce migration to other states

Barriers to interstate practice prior to full implementation of the Counseling Interstate Compact

Student debt burdens that discourage service in rural, school-based, or community behavioral health settings

Insurance reimbursement and sustainability challenges that reduce provider retention and local service availability

Addressing these barriers would expand Montana's locally trained rural behavioral health workforce, improve timely access to care, and reduce long-term reliance on higher-cost crisis, institutional, and emergency services.

Requests to the Committee

For these reasons, I respectfully request:

Inclusion of licensed clinical professional counselor representation in this subcommittee's work

Identification of the Counseling Interstate Compact as a top workforce priority

Recognition of counseling education access and licensure pathway barriers as key factors in long-term rural workforce development

These steps would strengthen Montana's behavioral health workforce, protect children and families, preserve high professional standards, and support long-term cost savings for taxpayers.

Thank you for your service to the people of Montana and for your careful consideration of these issues.

*Respectfully,
Isabella McShea*

Client name Kathleen Poteete
Form Montana Licensing Reform Task Force
Matter Kathleen Poteete - Rules
Sent February 19, 2026 at 1:16 PM
Due
Submitted February 19, 2026 at 1:16 PM

Kathleen Poteete

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Montana Licensing Reform Task Force

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Specific person or topic

What are your comments?

My name is Kathleen Poteete, and I am a licensed social worker candidate in Montana. As you identify healthcare priorities, I want to emphasize two things.

First, the Social Work Interstate Compact should be prioritized. It improves workforce mobility without lowering standards and strengthens disciplinary coordination across states.

Second, any review of Title 37 healthcare licensing must include direct input from social workers. Behavioral health licensing involves education, supervised clinical experience, and scope protections that are essential for public safety.

Streamlining administrative processes makes sense. Reducing clinical safeguards does not.

I respectfully ask that social work representation be included in this subcommittee's work and that the Compact be identified as a top priority.

Thank you,

Kathleen Poteete, MSW, SWLC

Client name Theresa Clearman
Form Montana Licensing Reform Task Force
Matter Theresa Clearman - Rules
Sent February 19, 2026 at 2:17 PM
Due
Submitted February 19, 2026 at 2:17 PM

Theresa Clearman

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Full Task Force
Health Care Subcommittee
Barriers Subcommittee
Sunset Review Subcommittee

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General comment

What are your comments?

Note to Tribal Health Directors: I am submitting this testimony to highlight that while the Federal Government recognizes the true cost of clinical care through the All-Inclusive Rate, the State of Montana is attempting to bypass formal Tribal consultation to capture these funds for state-run infrastructure, while simultaneously deregulating professional clinical standards to accommodate out-of-state corporate providers.

To the Members of the Sunset Subcommittee: Please enter this letter into the official public record as formal testimony regarding the proposed restructuring of the Board of Behavioral Health. As a licensed professional, I am submitting this data to address significant fiscal disparities, the lack of Tribal consultation, and the administrative backlogs currently impacting the behavioral health workforce in Montana.

To: Commissioner Swanson and the members of the Sunset Subcommittee,

My name is Dr. Theresa Clearman. I hold a PhD in Community Psychology, a Master's degree in Counseling Psychology, and I am a licensed LCPC in Montana. My husband is also a licensed LCPC practicing in our state. I am writing today as a concerned professional to express my grave objections regarding the proposed "reforms" to the Board of Behavioral Health.

In the field of Community Psychology, we study the systems and infrastructures that support—or fail—the public. From a systemic perspective, the narrative being pushed to the public regarding a "workforce shortage" is fundamentally flawed. We do not have a shortage of qualified professionals; we have a manufactured administrative bottleneck within the State of Montana.

I. Data vs. Narrative: The Reality of Montana's Workforce

The public we serve deserves a functioning system, not lower standards. The data reveals that the "shortage" is an administrative myth being used to mask a collapse in state processing infrastructure:

Workforce Growth Outpacing Population: Montana's population growth has settled significantly since the peak of the COVID-19 pandemic. While the state saw a surge of 1.7% in 2021, that trend has stabilized. By 2025, Montana's annual growth settled to an estimated 0.3%–0.4% (roughly 7,137 people). In stark contrast, the number of counselors/clinical social workers graduating from the four state colleges and two private schools in Montana, are entering the workforce at an increased rate of 1.5% annually. Between 2020 and 2025, our employee growth rate hit 10.4%. We are expanding our provider pool at 3x the rate of the current population growth.

The 1,200 Candidate Backlog: We have over 1,200 graduates already in the pipeline. These individuals have completed their education and are providing services while acquiring their 3,000 hours, yet they are trapped by pervasive administrative processing failures.

Documented Systemic Failure: These failures are not isolated. A 2025 Legislative Audit (Report 25P-01) flagged "profound instability" and "systemic communication breakdowns" across monitoring programs for several fields of healthcare professionals. Furthermore, the Governor's 2026 Licensing Reform Task Force Briefing admitted that while the number of licenses in Montana has doubled in the last decade, the state's administrative processing capacity has failed to scale accordingly.

Digital Infrastructure: It is critical to note that healthcare professions including doctors, nurses, psychiatrists, pharmacists, as well as social workers and counselors, heavily utilize Telehealth to expand their reach; the failure to process these licenses is a failure to activate Montana's digital healthcare infrastructure. The state must not hold this infrastructure hostage until regulatory changes are made that specifically welcome out-of-state corporate Telehealth providers at the expense of our local workforce.

II. Reimbursement Inequity: Trade Interests vs. Clinical Reality

The Licensing Reform Task Force's push for deregulation is a "supply-side" economic tactic that ignores the actual financial and clinical landscape of Montana.

The Funding Gap: Tribal health facilities and Indian Health Service clinics utilize a federally mandated All-Inclusive Rate, which is currently \$826 per encounter for 2026. In contrast, private LCPCs and MSWs are reimbursed at the standard Montana Medicaid rate—typically near \$136 per session. The state is being hypocritical by acknowledging it costs \$826 to treat a person in a facility, but then claims it only costs \$136 to treat them in a private office.

The Profit Margin on Inexperience: Many large agencies are primarily staffed by unlicensed counselors-in-training who are often paid under \$50 per hour. This creates a massive profit margin for administrative trade interests, as they bill the high All-Inclusive Rate while exploiting pre-licensed candidates for profit. By lowering standards for licensing, more bodies can be added to this exploitative workforce, allowing agencies to maximize revenue while utilizing cheaper, pre-licensed, and untrained labor. The task force is also proposing a new tier of Behavioral Health Support Specialists who only have a high school diploma and a few months of training.

The Value of Experience: Private practice professionals represent the highest level of clinical experience and expertise in our state. Yet, the state's strategy seeks to maintain a system that prioritizes the use of a cheaper, unskilled labor pools rather than supporting the stability of the seasoned professionals who provide the highest quality of care.

III. Constitutional and Legal Obligations of the State

Right to Earn a Living: Article II, Section 3 of the Montana Constitution guarantees the right to "pursue life's basic

necessities." In *Wadsworth v. State* (1996), the Court ruled that this right must be protected under strict scrutiny, meaning the state must show a compelling justification for any law that interferes with livelihoods.

Anti-Competitive Barriers: In 2026, the Montana Supreme Court recognized in the *Noland* case that anti-competitive barriers are potential violations of constitutional economic liberty. Deregulation without safeguards devalues established professions and suppresses wages for current providers.

Fundamental Health Rights: The Montana Supreme Court reaffirmed in *Held v. Montana* that the right to "seeking safety, health and happiness" is a fundamental right. Lowering standards constitutes a state interference with this right.

The Myth of "Redundant Training": While the Governor's Task Force claims to look for "redundant" training, I must be clear: the 3,000 required clinical hours are not redundant—they are the bedrock of patient safety. Removing these is a reckless dismantling of clinical rigor.

Protection Against Unqualified Practice: Under MCA 37-3-101, the state has a mandate to ensure the public is "properly protected against unprofessional, improper, unauthorized, and unqualified practice."

The Mandatory Duty to Process: Per MCA 37-1-101, the state has a mandatory duty to provide clerical services and issue routine licenses within a 45-day window. This suggests they are currently in violation of this rule.

IV. Lack of Accountability and Exploitation of Tribal Nations

Montana has \$300 million earmarked for behavioral health. It is an affront to use this "generational investment" to build new facilities while dismantling the professional standards of the clinicians who serve our communities.

The goal of funneling these specialized funds primarily into physical buildings and "blended" general fund accounts is highly suspect. This infrastructure-heavy focus appears to be a tactical maneuver designed to access federal matching funds—which, as shown by the \$826 All-Inclusive Rate, are significantly higher for facility-based encounters.

While these rates are extraordinarily lopsided, this strategy directly exploits Tribal nations by using their identities to pull in 100% federal match funds while simultaneously stripping the professional standards from the clinicians who serve those very communities.

V. The Governor's Oath to Protect

Violating the Public Trust: Governor Gianforte took an oath to protect the citizens of Montana. That oath includes ensuring state resources benefit the people of this state, not corporate interests or unethical therapy farms. Two of multiple examples of consumer betrayal include BetterHelp that paid \$7.8 Million Dollars in an FTC Settlement (2023) for unethical practices and Cerebral, another therapy farm that was ordered to pay \$7 million (2024) for deceptive billing and aggressive prescribing of controlled substances.

The Lack of Accountability: We must oppose the practice of centralizing these specialized funds into a general fund. This administrative maneuver erodes transparency and removes the necessary oversight. Without dedicated fund accounting, there is zero accountability.

Direct Care for the Uninsured: HB 872 funds should provide grants directly to uninsured Montanans, allowing them to seek care from qualified clinicians without degrading the quality of service.

VI. Missing Clinical and Tribal Representation

It is unacceptable that the "behavioral health" voice on this task force is held by an unlicensed administrative executive representing trade interests from the Behavioral Health Alliance of Montana. It is a systemic failure to have an individual representing dozens of distinct clinical fields while holding zero experience or licensure in any of them.

Furthermore, there is a glaring absence of Tribal consultation. The Governor has excluded representatives from Montana's eight federally recognized Tribal Nations from this task force, despite the fact that these nations are primary stakeholders in the state's healthcare delivery and federal funding models.

VII. Montana's Approach in National Context

While several states have recently implemented licensing reforms to address workforce needs, none have pursued Montana's specific strategy of reducing core clinical standards. The national trend is focused on investment in clinicians, not deregulation:

Utah created new support roles with reduced exam requirements but preserved an additional 500 clinical hours to ensure patient safety.

Oklahoma removed certain onsite supervisor mandates to help rural areas but strictly maintained the 3,000-hour clinical requirement for licensure.

Texas addressed its workforce needs by expanding loan repayment programs up to \$180,000 for psychiatrists and mental health professionals.

Montana's current focus on infrastructure over licensure support—while simultaneously cutting standards—stands in direct contrast to evidence-based efforts in other states which focus on professional sustainability, equity, and public protection.

VIII. A Better Investment: Supporting Clinicians, Not Just Infrastructure

A. Strengthening the Workforce Pipeline

The state should prioritize the 1,200 candidates already in-state by removing administrative and financial barriers to licensure. The clinicians have done their work. The state should follow suit.

Clear the Backlog: Utilize funds to hire additional licensing clerks to accelerate the credentialing process. This does not mean lowering requirements or standards.

Facilitate Mentorship: Provide supervision grants to licensed counselors. Supervision is a vital professional duty; the state should subsidize this mentorship to ensure a steady flow of new clinicians rather than bypassing existing professional structures.

B. Expanding Access through Direct Care & Sustainability

Investment must reach the patient-provider level to be effective.

Direct-to-Uninsured Grants: Use HB 872 funds to provide care grants directly to uninsured Montanans, allowing them to access qualified clinicians without compromising the quality of service.

Private Practice Sustainability: To offset rising operational costs and high rent, the state should:

Expand operational support grants for practices serving low-income or uninsured populations.

Enact tax incentives for property owners who lease space to mental health providers at reduced rates.

Fund Behavioral Health Hubs, providing low-cost, state-affiliated shared spaces where Montana clinicians and not corporations can practice and hire associates.

C. Modernizing Financial Incentives (SLRP Expansion)

With student debt for mental health professionals often exceeding \$78,000 to \$200,000 or more, Montana must offer incentives that reflect the true cost of education. I propose expanding the Montana State Loan Repayment Program (SLRP) to:

Increase Awards: Offer up to \$60,000 per year for clinicians serving recipients of Medicaid, Medicare, or sliding-scale cash agreements.

Set ethical standards for loan repayment eligibility based on reasonable client loads.

Inclusive Eligibility: Open SLRP participation to private group and solo practices that offer services to low-income clients.

Prioritize Mentorship: Focus award distribution on clinicians who supervise pre-licensed candidates, doubling the impact on the state's workforce.

Support funding for more robust associations and in-state annual CEU trainings for Counselors and Social Workers.

Assist with affordable group health insurance programs for professionals.

Conclusion

I urge this subcommittee to fulfill its mandate to the citizens of Montana by protecting the integrity of the Board of Behavioral Health. We are at a critical crossroads: we can either choose a path of administrative convenience that exploits pre-licensed labor and tribal funding for the sake of facility-based profit, or we can choose a path of clinical excellence by restoring the administrative systems that support our existing workforce.

Lowering standards is not a "reform"—it is a dangerous dismantling of the clinical rigor that ensures patient safety. I ask you to reject these deregulatory measures and instead prioritize the transparency, accountability, and high professional standards that Montana's families deserve. Let us support the human infrastructure of our state by investing in the clinicians who have dedicated their lives to Montana's health, rather than clearing a path for corporate interests to profit from a race to the bottom.

Respectfully,

*Dr. Theresa Clearman, PhD, LCPC
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Held v. Montana, 2023 MT 158 (Affirming fundamental rights to health and safety).

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Wadsworth v. State, 275 Mont. 287, 911 P.2d 1165 (1996) (Establishing strict scrutiny for the right to earn a living).

Montana Statutory Law

MCA 37-1-101: Duties of Department — 45-day mandate for license processing.

MCA 37-3-101: Purpose of regulation — Mandatory protection against unqualified practice.

MCA 90-11-101: State policy for consultation with Tribal Nations.

House Bill 872 (2023): Behavioral Health System for Future Generations Fund (\$300M investment).

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Federal Register (2026): Reimbursement Rates for Indian Health Service and Tribal Facilities; Outpatient Per-Visit Rate (Lower 48): \$826.

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Client name William Krupa
Form Montana Licensing Reform Task Force
Matter William Krupa - Rules
Sent February 21, 2026 at 7:16 AM
Due
Submitted February 21, 2026 at 7:16 AM

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Montana Licensing Reform Task Force

This Task Force was created pursuant to Executive Order 1-2026 on January 29, 2026.

Purpose of the Licensing Reform Task Force

The Task Force shall provide the Governor with recommendations and strategies for the State of Montana to reform the professional occupational licensing system for the purposes of:

- identifying and removing burdens and barriers faced by licensees that are not necessary to protect the public; and
- improving access to and availability of professional services for citizens across Montana, including rural communities.

In developing recommendations and strategies, the Task Force shall seek input from Montana citizens, legislators, Montana associations whose members are licensed occupational professionals, professional licensing boards, relevant state agencies, advisory groups and researchers focused on occupational licensing, and other appropriate stakeholders as determined by the Task Force.

Public Record

Please note that all information received through this form is public record.

Which committee would you like to receive your comment?

Full Task Force
Health Care Subcommittee

We want to hear from you!

We would like to receive any comments you would like the Task Force, or one of its subcommittees, to review. In addition, we are specifically looking for feedback for:

1. Specific topics a committee or the task force should consider, and
2. Specific people or organizations you think the task force should hear from.

Do you have a general comment or a specific person or topic for the Task Force to hear from?

Specific person or topic

What are your comments?

#1 Amy Nerison does not represent ECPs in Montana, nor is there anything to suggest she works for AMR in publically available information. ECPs need representation in the Licensing Task Force, and she is not it.

#2 - Renewing MT license with an NREMT license with the same expiration date. No matter what the expiration date on your NREMT, as long as you submit a Montana ECP renewal before the expiration date, you are automatically granted a renewed ECP license, no questions asked. Hypothetically, I could have been planning to drop my NREMT that year, have done no CEs to that end, yet still get a new Montana license. And the only "enforcement" is a checkbox verification that you are subject to audit by the state if they so choose... I would be interested to see if that is ever enacted with out other cause (ie complaint filed, or anonymous tip, etc.) as there is no publically-available way to check how many CEs someone has accumulated with out reaching out to (x) agency directly (if it is state-based) or CAPCE-like organization and having a reason for your inquiry. Thus, I do not see someone at our state level doing this on a regular basis.

Also:

"Please note: ARM 24.101.408 allows a licensee to practice for 45 days on a lapsed status license. A licensee who practices while a license is lapsed is not considered to be practicing without a license"

This is unacceptable and is not reflective of any other healthcare professional license regulations across the United States that I am aware of (not that we should be comparing our standards to others in the first place). This IS allowing someone to practice without current licensure, regardless of what ARM24.101.408 says. Do we allow people to drive with lapsed drivers license, registration and insurance? Then why are we doing it here?

Proposed Solution: If your ECP license expires the same year / same date as your NREMT that you would typically use (in off-years) to renew, then you should be required to upload all relevant CEs manually to meet the minimum required renewal number needed (NCCP model).

#3- Endorsement Refresher There is no information easily accessible on the licensure process and requirements for ECPs. Honestly, I don't even remember what they were initially because as long as you upload your NREMT, it doesn't matter. The state uses the NCCP Model minimum CE requirements and these should be seen as such. Yet, the NCCP model is a general protocol and does not incorporate any state-specific categories for ECP refresher training, such as Endorsements.

Endorsements, in many aspects, can go above and beyond what (x) ECP license would normally allow at the NREMT level. Basically, if I were an EMT with all of the endorsements possible in Montana, as long as I submitted my minimum hours to the state during renewal time, I would be granted a renewed license good for the next few years – all without having to prove that I received refresher training in all of those areas.

The recertification process is not difficult and the CE requirements are not above NREMT requirements – if ECPs are already having issues with that, I think it signifies a bigger problem with those who are in / trying to remain in the profession.

Endorsements were introduced to expand the level of care in rural areas (primarily) while maintaining a lower level (mostly EMT endorsements), but there is no enforcement when it comes to licensure renewal. Essentially, Montana slapped more responsibilities onto those with licensure but did not bring up the standard of training and re-training for those ECPs.

Proposed solution: In addition to the NCCP minimums, Endorsed ECPs must also upload relevant refresher CEs for those applicable. If they cannot produce a specific endorsement CE training certificate, or have taken a nationally-approved review course that covers those topics annotated in the endorsement document = then you will be stripped of your endorsements. This will cut down on the amount of dangerous practice that I assure you is going on around the state.

#4- Joining the EMS COMPACT states would be a good start. This would raise the bar for ECP as I do not think, I know that we are not up to par with the majority of the United States when it comes to standards of care and protocols. This is a ground-truth realization that you may not hear from anyone in a "supervisor" or "management" position with any government or private entity within Montana.

EMS COMPACT would allow for easier transitions from and to other states for licensure, as well as raise the bar when it comes to recertification, as the barrier for entry and re-entry is relatively low. Additionally, I have case reports of people being reinstated as EMRs and EMTs with lapsed licenses but no additional training or CE requirement to do. Just a wave of the magic wand and they are current ECPs again. This has to stop – it is detrimental to the state of Montana as a whole and is a slap in the face of all the hard work done just to become an ECP.
