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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
Barriers 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?

I'm submitting this comment along with a one-page brief on three licensing barriers facing Psychiatric Mental Health Nurse Practitioners (PMHNPs) in Montana.

None of these barriers exist because of state law. They exist because administrative practice hasn't caught up to Montana's own laws granting PMHNPs independent practice authority. PMHNPs are filed under a generic provider category instead of being recognized as psychiatric specialists. Institutions still require physician signatures on paperwork the law doesn't actually require. And Montana Medicaid excludes PMHNPs from a treatment other major insurers already let them provide independently in this state.

I'm asking the Task Force to review these three barriers as candidates for its recommendations to the Governor. Fixing outdated administrative practice, so it matches the law Montana already has, is squarely within this Task Force's purpose.

Diane Hurd, PMHNP-BC
Owner & Clinical Director, Beginner's Mind Mental Health Services, Billings, MT

The Workforce That's Already Here

A Policy Brief on Psychiatric Mental Health Nurse Practitioners and Medicaid Reimbursement in Montana

We Are Already Solving Montana's Mental Health Shortage

Despite efforts to replace retiring psychiatrists, the national psychiatrist workforce is on track to shrink 2.5% by 2038 — even as more residents enter training. In that same window, Psychiatric Mental Health Nurse Practitioners (PMHNPs) — psychiatric specialists licensed to diagnose, prescribe, and manage psychiatric care independently — have grown 800% in under a decade. In Montana, nurse practitioners now outnumber physicians statewide. PMHNPs are not a future solution — we are the workforce already answering the shortage, *in the exam room today.*

The 22-Point Reimbursement Gap

Montana Administrative Rule 37.85.105 (effective July 1, 2016) reimburses psychiatrists at 112% of the Medicaid rate and PMHNPs at 90% of the Medicaid rate — a 22-point gap for the same billing codes and identical clinical service. The rule may have made sense in 2016 as an incentive to draw more psychiatrists into the state. A decade later, the workforce data shows the opposite outcome: PMHNPs, not psychiatrists, are the group that is growing. Montana is still paying a premium to attract growth in the group that isn't growing, while discounting the group that is.

Reimbursement Parity Saves Money

Underpaying PMHNPs doesn't just shortchange providers — it shifts costs downstream. Untreated psychiatric illness resurfaces in the emergency room, where psychiatric patients board an average of 18 hours — 3.2 times longer than other patients — at a cost of roughly $2,264 per case. That time buys stabilization, not treatment. Paying PMHNPs fairly keeps care in the outpatient clinic, where it's cheaper and better, instead of the ER, where it's expensive and worse.

Three More Barriers — Administrative, Not Clinical

- **Taxonomy classification.** All medical providers are filed under a national taxonomy code that Montana didn't create and can't change — but Montana chooses how much weight that classification carries in its own fee schedules and credentialing rules. In practice, search Montana Medicaid's provider website under "Psychiatry" and only psychiatrists appear. A psychiatric specialist who has managed a patient's psychiatric care for years is filed instead under a generic "Mid-Level Practitioners" heading, alongside all other nurse practitioners and physician assistants — not among the other psychiatric specialists, where a patient or consumer would expect to find them. The taxonomy or category dictates lower fee schedules and steeper credentialing hurdles for PMHNPs than for psychiatrists doing the same work.
- **Certificate of Need (CON) signatures.** A Certificate of Need is the paperwork required to place a child in residential psychiatric treatment. Montana Code Annotated § 37-8-410 already allows PMHNPs to sign wherever state law requires a physician's signature. Yet institutions routinely still require a physician signature on this paperwork, even when the PMHNP has done the entire clinical workup and managed the child's care for years. This often means scrambling to find a physician willing to sign the CON — usually the child's pediatrician or primary care provider. This gets even harder when the child's primary care provider turns out to be a physician assistant or family nurse practitioner, not a physician at all. This administrative barrier places an undue burden on MDs who may not have specific knowledge of the child's psychiatric needs and leaves the child's own psychiatric provider unable to sign.
- **TMS supervision (Medicaid Policy 475).** Transcranial Magnetic Stimulation (TMS) is a non-drug treatment for depression that hasn't responded to medication. Montana Medicaid's Policy 475 says PMHNPs cannot provide TMS and cannot bill for it — no matter how much training they have. This is true even if a psychiatrist is collaborating and prior authorization is approved. Only a physician may order or supervise TMS treatment. Other payers operating in Montana disagree: as of April 2026, Optum/UnitedHealthcare allows PMHNPs with independent practice authority to order and provide TMS without physician supervision in every full-practice-authority state, Montana included. Same provider, same state, same procedure — different rules depending on which insurance the patient carries.

The Ask

Review reimbursement parity under ARM 37.85.105, alongside the taxonomy and TMS barriers, as candidates for the Task Force's recommendations to the Governor — each is fixable at the state level and removes an obstacle standing between Montana patients and care that's already available. The Task Force should also consider how administrative practice can limit the independent scope of practice already outlined in Montana law, as seen in the CON example above.

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