Montana Department of LABOR & INDUSTRY

# Licensing Reform Task Force
## Barriers Subcommittee
### TRAINING, EDUCATION, SCOPE OF PRACTICE, WORKFORCE SHORTAGE, AND SERVICE ACCESS BARRIERS

## Executive Summary

This memorandum combines the comparative licensing analysis of Montana and neighboring states with the Task Force record concerning Montana workforce shortages and service access barriers. The general theme is that Montana should preserve licensing requirements that are necessary to protect public health, safety, and welfare, while identifying requirements that are duplicative, procedurally delayed, or more restrictive than needed for public protection.

The Task Force record reflects two distinct but related concerns. First, stakeholders identify actual or perceived shortages in behavioral health, rural emergency medical services, medical laboratory science, appraisers, genetic counselors, nursing pathways, dental/denturist services, certain construction or technical trades, and rural clinical oversight roles. Second, stakeholders repeatedly distinguish between **true workforce shortages** and **administrative or regulatory bottlenecks**—for example, delays in application processing, examination results, supervision approval, insurance credentialing, state licensing requirements that duplicate national certification, degree-title requirements that may exclude competent rural clinicians, or facility-specific scope rules that do not account for correctional or other nontraditional care settings.

This memorandum focuses on training, education, supervision, scope of practice, workforce shortage, and service access barriers. The policy options below are limited to issues that directly affect workforce access and service delivery, including supervision structure, education and training access, administrative bottlenecks, scope and delegation in underserved settings, rural clinical oversight eligibility, and medication-administration authority in correctional or congregate-care settings.

## Key Themes From the Task Force Record

### 1. Workforce access concerns are most acute where licensing intersects with rural practice.

Public comments repeatedly identify rural access as a practical constraint. Examples include behavioral-health supervision in rural areas, rural EMR/EMT/AEMT/paramedic and volunteer EMS burdens, telehealth access to genetic counseling, and the availability of specialized or nationally certified practitioners to serve Montana communities. One commenter addressing rural EMS stated that mismatched state renewal cycles and national certifications place burdens on “Rural EMRs, EMTS, AEMTS, Paramedics, Rural Fire and EMS, Volunteers,” and suggested free state licensing for volunteers to support rural recruitment.

## 2. Some barriers are administrative rather than substantive licensing standards.

The record includes examples of application or examination delays that may prevent otherwise qualified individuals from working. Comments describe delays in real estate licensing, delayed limited X-ray permit exam results, and concerns that behavioral health candidates are delayed by processing or supervision issues. A limited X-ray permit applicant reported waiting seven weeks for computerized exam results and being told that contract issues affected release of results.

## 3. Supervision is a recurring bottleneck in behavioral health and other candidate-license models.

Stakeholders identify supervision rules, ambiguity, and payer policies as barriers to candidate-license practice. One behavioral-health commenter asked for clear language on whether supervisors must hire candidate-licensed therapists as W-2 employees and objected to a payer policy requiring supervisors to remain in "100 percent proximity" to supervisees, stating that rural Montana lacks enough supervisors for such a model.

## 4. Stakeholders are divided on deregulation; many support "right-touch" regulation rather than eliminating licensing.

The record includes comments supporting deregulation or reduced licensing in some fields but also comments cautioning that licensure protects patients and vulnerable consumers. For example, physical therapy and dietitian commenters opposed eliminating licensure, emphasizing accredited education, national examinations, continuing education, and patient safety. Massage therapy comments also recommended "right-touch" regulation, recognizing that some frameworks may be outdated or burdensome while warning that under-regulation can create public-safety and human-trafficking risks.

## 5. Education cost and training access may be larger barriers than licensing fees in some professions.

At least some healthcare commenters reported that Montana licensure itself is relatively easy and low-cost compared to the cost of education or national certification. An occupational therapist stated that Montana's OT licensure and renewal process is comparatively easy and that the "biggest barrier" is the cost of schooling, not the license itself.

## 6. National certification can support workforce mobility, but state oversight may still be needed.

Several comments urge Montana to rely more heavily on national standards. Examples include medical laboratory science comments referencing ASCP/NAACLS credentials, crane operator comments referencing national crane certification, and EMS comments recommending alignment of Montana renewal dates with national certification cycles. One medical laboratory scientist stated that ASCP and NAACLS recognition is "really the important requirement" for hospital and clinic reimbursement.

## 7. Degree-title requirements may unintentionally limit rural clinical oversight when competency is the better measure.

A Task Force member and rural advanced practice clinician identified a concern that some licensure or related rules may tie oversight roles to specific degree titles instead of demonstrated competency, training, or current clinical experience. The example provided was rural EMS or facility oversight roles that may require a physician designation even when the most clinically active and available emergency care providers in a small facility are nurse practitioners or physician assistants.

## 8. Facility-specific scope rules may leave gaps in correctional, group home, or other nontraditional care settings.

A separate concern involves medication administration in jails or similar settings. The correspondence notes that Medication Aide I authority is tied to assisted living facilities, Medication Aide II authority is tied to long-term care facilities, and the cited scope language does not reference correctional facilities.

# Comparative Licensing Context

Montana is not alone in using continuing education, supervision, national examinations, provisional licensing, portability tools, and setting-specific practice rules. This section uses other states to identify comparative design lessons for the issues addressed in this memo: supervision clarity, education and training access, administrative bottlenecks, scope and delegation in underserved settings, rural clinical oversight eligibility, and medication-administration authority in non-traditional settings.

## Montana

Montana's recent HB 414 reforms are relevant background because they standardize provisional licensure and authorize limited temporary practice For this memo, Montana's key question is whether requirements governing supervision, education and training, scope, delegation, and practice setting are calibrated to public-safety risk and rural service needs.[1]

## Idaho

Idaho provides the clearest regional benchmark for reviewing whether occupational licensing is justified and proportionate. Its occupational-licensing reform framework requires proponents of new regulation to explain why regulation is necessary to protect against present, recognizable, and sufficient harm; why the proposed regulation is the least restrictive necessary; why other means cannot protect the public; and whether benefits outweigh costs. For Montana, this supports asking whether supervision rules, setting restrictions, or title-based oversight requirements are actually the least restrictive way to protect the public.[2]

## Wyoming

Wyoming's recent licensing activity appears more compact- and profession-specific than a single broad least-restrictive licensing framework. For example, Wyoming enacted the occupational therapy licensure compact and EMS licensure interstate compact legislation[3], both of which facilitate multistate practice while preserving state authority over practice standards and discipline. Wyoming is useful because EMS and OT are examples of regulated fields where rural access, supervision, delegation, and setting-specific practice can be addressed through profession-specific mechanisms rather than broad deregulation.

## Colorado

Colorado has adopted a broader occupational credential portability approach. Its 2020 legislation created an occupational credential portability program for recognition of qualifying out-of-state credentials.[4] Colorado's approach reflects a policy preference for reducing barriers while still requiring regulators to decide whether an applicant's credential, experience, and discipline history are sufficient. For Montana's supervision and rural-oversight questions, the analogous issue is whether actual competency and current clinical experience should matter more than formal title alone.

## Utah

Utah's licensing materials reflect frequent profession-specific rulemaking through its professional licensing system, including rule notices and amendments addressing individual occupations. Utah is relevant as a state that often uses board- or occupation-specific rules to adjust practice standards.[5] For Montana, this supports a targeted review model: rather than creating broad new credentials, the Subcommittee can ask each affected board or program to identify the particular supervision, training, scope, or setting rule that is causing the access barrier.

## Oregon

Oregon's licensing materials similarly show extensive occupation-specific administrative rulemaking and show that Oregon addresses occupational requirements through board and program rules across regulated

[1] Montana Chapter 279, HB 414 (2025) – Revise laws related to licensing applications.
[2] Idaho Chapter 175, SB 1351 (2020) – Occupational licensing.
[3] Wyoming Chapter 54, HB117 (2022) - Occupational therapy licensure compact; Wyoming Chapter 38, HB112 (2017) - EMS licensure-interstate compact.
[4] Colorado Chapter 126, HB1326 (2020) - Create Occupational Credential Portability Program.
[5] Utah State Bulletin Number 2024-06, March 15, 2024.

professions.[6] For Montana's purposes, Oregon is most useful as a comparator for rule-level maintenance: supervision methods, continuing education access, and setting-specific permissions can often be modernized through targeted rule review if statutory authority is adequate.

## Washington

Washington's licensing materials also reflect substantial agency and board rulemaking across regulated professions.[7] For Montana, Washington's comparative value is process-oriented: ongoing rule review can be used to update supervision, documentation, training, and setting-specific requirements without necessarily creating new license types.

## North Dakota and South Dakota

North Dakota and South Dakota have enacted occupational therapy compact legislation that facilitates multistate practice while preserving state regulatory authority. The compact model requires participating states to use recognized national examinations, maintain continuing education requirements, exchange disciplinary information, and allow compact privileges for licensees in good standing.[8] The compact approach is relevant because it reduces geographic barriers without abandoning state oversight.

## Comparative Takeaways

1. **Use Idaho as the policy-test model.** For supervision, education and training, scope, delegation, and setting restrictions, ask whether the rule addresses a present and recognizable public safety risk and whether a less restrictive alternative would work.

2. **Use Wyoming, North Dakota, and South Dakota as profession-specific models.** Rural workforce issues may be better addressed through targeted professional rules, supervision standards, or compact-related safeguards than through broad deregulation.

3. **Use Colorado as a competency-and-experience comparator.** Even when recognizing outside credentials, regulators still evaluate whether the applicant's qualification and history are sufficient; Montana can apply the same concept to rural oversight and title-based eligibility.

4. **Use Utah, Oregon, and Washington as rule-maintenance comparators.** These states illustrate that many access barriers can be addressed through board- or program-level rule review rather than creating new statutory credentials.

[6] Oregon Administrative Rules; ex: 2026 rules for Occupational Therapy Licensing Board, Board of Accountancy.
[7] Washington State Register, 2025 list for Dept. of Labor, Dept. of Licensing.
[8] North Dakota Chapter 402, SB 2146 (2025); South Dakota Chapter 139, HB 1183 (2023).

# Policy Framework for Subcommittee Review

The Subcommittee may wish to evaluate each requirement using four questions:

1. **Necessity:** What specific public health, safety, welfare, consumer protection, or fiduciary risk does the requirement address?
2. **Fit:** Is the requirement tailored to that risk, or is it broader, longer, more local, or more expensive than necessary?
3. **Workforce effect:** Does the requirement delay entry, reduce mobility, limit rural service, restrict telehealth, or reduce availability of supervised placements?
4. **Less restrictive alternatives:** Could the same public protection be achieved through registration, national certification, provisional licensure, supervision modification, competency-based eligibility, delegation protocols, discipline authority, disclosure, bonding/insurance, inspections, or targeted continuing education?

This framework aligns with Montana's Task Force purpose of removing burdens not necessary to protect the public and improving access to professional services, including rural communities.

# Policy Options for Consideration

### Option 1: Clarify Supervision Rules that Affect Candidate Practice and Rural Service Delivery

**Description:** Review supervision requirements for candidate-licensed, trainee, assistant, apprentice, and supervised-practice roles. The review should clarify permissible supervision methods, whether remote or hybrid supervision is allowed, whether group supervision is permitted, whether the supervisor must employ the supervisee, and how supervision must be documented.

| Pros | Cons | Other Considerations |
|---|---|---|
| Directly addresses behavioral-health and rural workforce constraints. | Some professions require hands-on or on-site supervision for safety. | This option focuses on the substance and structure of supervision after a person is authorized to practice in a supervised role. |
| Reduces ambiguity for boards, employers, supervisors, supervisees, and payers. | Requires careful drafting to avoid weakening clinical safeguards. | The subcommittee may wish to separate state licensing requirements from payer credentialing or reimbursement rules. |
| May increase the number of available rural placements and supervisors. | Payers may impose more restrictive supervision rules than state licensing law. | Consider model definitions for direct, general, indirect, remote, and group supervision. |

## Option 2: Create a Workforce-Access Review for Education and Training Requirements

**Description:** Review education and training requirements that may limit entry into high-need occupations. This review would focus on whether Montana-specific education hours, experience hours, clinical-placement requirements, or degree-pathway rules are proportionate to the public-safety risk and whether workforce-development tools can reduce access barriers.

| Pros | Cons | Other Considerations |
|---|---|---|
| Addresses root causes where schooling cost, clinical placement access, or required training time is the primary barrier. | Requires coordination beyond DLI licensing staff, including education providers and employers. | Public comments suggest that education cost may be a larger barrier than Montana licensure itself. |
| Helps build a Montana-trained workforce rather than relying only on portability. | Takes longer to produce workforce results than application-process reforms. | Consider rural clinical placements, paid training models, credit for prior learning, and employer-supported training. |
| Can be targeted to shortage occupations and rural communities. | Program design must avoid lowering entry-level competence. | The focus should remain on improving access to existing education and training pathways rather than creating unnecessary new credentials. |

## Option 3: Establish Administrative Performance Metrics for Licensing Bottlenecks

**Description:** Establish internal performance metrics and subcommittee-facing reporting for licensing steps that affect time to work. Examples include exam-result processing, third-party testing-vendor delays, inspection scheduling, application communication response times, and handoffs between board staff, vendors, and applicants.

| Pros | Cons | Other Considerations |
|---|---|---|
| Addresses concrete bottlenecks without changing substantive licensing standards. | Requires staff capacity and reliable data collection. | Public comments identify exam-result delay as a potential bottleneck. |
| Improves applicant confidence and employer planning. | Some delays are outside DLI control, especially testing vendors or third-party verifications. | Metrics should distinguish applicant-caused delay, vendor delay, inspection delay, board review, and internal processing time. |
| Improves applicant and employer predictability. | Public metrics may draw attention to temporary backlogs. | Metrics should focus on practical time-to-work barriers and identify which steps are within DLI control and which depend on third parties. |

## Option 4: Conduct a Targeted Scope-of-Practice and Delegation Review for Underserved Settings

**Description:** Review whether existing scopes of practice and delegation rules allow trained professionals to perform tasks consistent with their education and supervised experience in underserved settings. This option does not propose creating a new credential. It asks whether existing scopes, delegation rules, or setting-specific limitations prevent safe use of already trained personnel.

| Pros | Cons | Other Considerations |
|---|---|---|
| May increase service capacity without creating new license types. | Scope changes can create interprofessional disputes. | Examples from the record include OT dry needling, denturist scope, and rural clinical roles. |
| Helps identify whether workforce shortages are caused by underuse of existing licensees. | May require statute or rule amendments. | Use evidence from other states, malpractice or discipline data, and training standards. |
| Supports rural and underserved settings where specialists are scarce. | Public confusion may increase if scopes overlap. | Consider patient disclosure, referral requirements, supervision, and setting-specific safeguards. |

## Option 5: Develop a Rural Clinical Oversight Eligibility Review

**Description:** Review statutes and rules that require a specific professional title, degree, or license type for rural clinical oversight, EMS supervision, facility medical direction, or similar oversight roles. The review should determine whether the public-safety function could be performed by another licensed clinician with equivalent competency, training, current clinical experience, and accountability.

| Pros | Cons | Other Considerations |
|---|---|---|
| Helps rural facilities use clinicians who are actually available and clinically active. | May raise concerns from professions currently named in statute or rule. | This should be function-specific and should not operate as a blanket substitution of one profession for another. |
| Aligns oversight with demonstrated competency rather than title alone. | Requires review of federal requirements, reimbursement rules, medical staff bylaws, liability, and facility accreditation. | Commenter specifically asks whether competency-based eligibility could replace strict degree-title eligibility in rural or limited-access settings. |
| May reduce reliance on nominal supervisors who satisfy title requirements but do not provide meaningful clinical oversight. | Could create inconsistent approaches if each board addresses eligibility differently. | Consider a rural or limited-access pilot before statewide expansion. |

### Option 6: Inventory Medication-Administration Authority in Correctional and Congregate-Care Settings

**Description:** Conduct a legal and operational inventory of who currently administers medications in jails, correctional facilities, group homes, and similar settings; under what authority; and with what training, supervision, documentation, and error-reporting requirements. This option is framed as a fact-finding and gap-analysis project rather than a recommendation to create a new medication-administration credential.

| Pros | Cons | Other Considerations |
|---|---|---|
| Addresses a potential patient-safety and service-access gap in rural correctional and congregate-care settings. | The issue may involve agencies and authorities outside DLI. | Clarify whether the relevant authority sits in DLI licensing statutes, Department of Corrections policy, local detention standards, DPHHS rules, facility policy, or professional delegation law. |
| Provides a factual basis before deciding whether statutory, rule, policy, or training changes are needed. | Fact-gathering may reveal inconsistent local practices that require sensitive coordination. | Commenter notes that medication-aide authority is tied to assisted living and long-term care facilities and does not reference correctional facilities. |
| Avoids prematurely creating a new license or credential. | Does not by itself solve any identified gap. | If a gap is confirmed, the subcommittee can decide whether the issue belongs with the Healthcare Subcommittee, Corrections stakeholders, DPHHS, local governments, or DLI boards. |

# Requirement-Specific Analysis

- **Continuing Education:** Continuing education remains relevant to the broader topic. A targeted CE review should focus on whether CE requirements are available online, proportionate to risk, accessible in rural communities, and not unnecessarily limited to in-person or Montana-only providers.
- **Supervision and Oversight Eligibility:** Supervision rules can create bottlenecks after an individual is already in a supervised or candidate role. Particular issues include remote supervision, group supervision, supervisor employment status, documentation, and payer-imposed restrictions.
- **Education and Training:** The education question is whether required education, training hours, clinical placements, or experience pathways are proportionate to the public-safety risk and feasible in rural Montana. The focus is on access to existing education and training pathways.
- **Scope of Practice and Delegation:** Scope of practice review should focus on whether existing licensees are being underutilized in underserved settings. The emphasis should be on existing scopes, existing delegation authority, and setting specific restrictions.
- **Facility and Practice-Location Restrictions:** Facility or setting restrictions remain relevant where a rule permits a service in one setting but not another. The medication-administration issue should begin as a setting-specific inventory and gap analysis rather than a recommendation to create a new credential.

The Subcommittee's next step is to determine which of these issues are supported by sufficient data or stakeholder evidence to warrant board-level review, rulemaking, statutory clarification, or coordination with other agencies and payers.