Montana Department of LABOR & INDUSTRY

Licensing Reform Task Force

Healthcare Subcommittee

TELEHEALTH POLICY RECOMMENDATION

Recommended Action

The **Healthcare Subcommittee** may advance telehealth as a final recommendation by approving a non-legislative recommendation that preserves Montana's current telehealth authority, supports DLI and health licensing board review of telehealth rules and guidance, and promotes interagency coordination on barriers outside DLI's direct licensing authority.

Legislative action should be reserved for any specific statutory gap identified through that review.

The Subcommittee may act on three points:

1. **Confirm the policy direction:** preserve Montana's current telehealth authority and avoid rolling back permanent post-COVID telehealth access.
2. **Assign licensing follow-up:** support DLI and health licensing board review of board rules, policies, FAQs, and provider-facing guidance for consistency with current law.
3. **Identify non-DLI coordination needs**: support coordination with DPHHS, CSI, the Department of Corrections, Medicaid, private payers, and provider organizations on reimbursement, correctional, facility-based, and other setting-specific barriers.

Proposed Motion

The **Healthcare Subcommittee** recommends that the **Licensing Reform Task Force** preserve Montana's current statutory framework for telehealth; request DLI and the health licensing boards to review telehealth rules, policies, and guidance for consistency with current law; and recommend interagency coordination on reimbursement and setting-specific barriers that fall outside DLI's direct licensing authority.

Recommendation Statement

Telehealth should remain available in Montana as a delivery method for otherwise authorized health care services when the provider determines that telehealth is clinically appropriate, the service is within the provider's scope of practice, and the applicable standard of care can be met. This recommendation preserves access for rural, frontier, behavioral health, school-based, facility-based, correctional, and specialty-care settings while maintaining existing patient-safety protections.

The recommendation does not create a new telehealth license, expand scope of practice, require telehealth when in-person care is necessary, or place reimbursement issues within DLI's licensing authority. Instead, it clarifies that Montana's permanent telehealth statutes should be implemented consistently and that any remaining barriers should be addressed by the agency, board, payer, or institution with authority over the specific issue.

Background

At the June 12, 2026, Healthcare Subcommittee meeting, members identified telehealth as an outstanding issue for final review before the July 17 meeting. A subcommittee member noted that COVID-era telehealth allowances have continued to allow providers to work effectively by telehealth, but that stakeholders lacked certainty about how those flexibilities would operate going forward. The discussion identified the need to solidify the Subcommittee's recommendation, including whether COVID-era allowances were temporary or had been made permanent.

Telehealth also arose in connection with speech-language pathology, Medicaid reimbursement, and broader access-to-care discussions. The discussion recognized that Medicaid reimbursement issues are being addressed more holistically for telehealth and should not necessarily be isolated to one profession. The Subcommittee's discussion reflected a consistent distinction between issues within DLI's licensing authority and issues controlled by other agencies, payers, or institutional settings.

Existing Montana Legal Framework

Montana already has a permanent statutory framework supporting telehealth.

- **Professional licensing authority:** Under 37-2-305, MCA, a person licensed under Title 37 to provide health care may provide services by telehealth when telehealth is appropriate for the services being provided, meets the standard of care, and complies with any telehealth rules adopted by the applicable licensing board. The statute also authorizes boards to adopt rules establishing requirements for telehealth by their licensees.
- **Private insurance coverage:** Under 33-22-138, MCA, health insurance policies that cover health care services must cover services provided by telehealth if the services are otherwise covered. The statute prohibits restrictions based on the patient's location or provider's location, prohibits distinguishing between rural and urban telehealth services, and requires coverage equivalent to in-person services, subject to the policy's terms and limitations.
- **Medicaid telehealth:** Under 53-6-122, MCA, Medicaid-enrolled providers may provide medically necessary services by telehealth if the service is clinically appropriate, complies with applicable Medicaid provider manual guidance, and is not specifically required to be provided face-to-face. The statute requires telehealth services to be reimbursed at the same rate as services delivered in person and states that it does not alter an enrolled provider's scope of practice.
- **Speech-language pathology and audiology:** Montana has profession-specific telehealth provisions for speech-language pathologists, audiologists, and assistants. Under 37-15-314, MCA, licensees may engage in telehealth in Montana without obtaining a separate or additional board license, while nonresident unlicensed individuals generally may not provide services to Montana patients through telehealth without Montana licensure or compact authority. Under 37-15-315, MCA, telehealth services must be equivalent in quality to in-person services and must comply with professional standards, technology requirements, patient candidacy assessment, confidentiality, and notice requirements.

These statutes indicate that many COVID-era telehealth flexibilities have been codified or superseded by permanent statutory authorization. The remaining policy question is not whether Montana allows telehealth generally, but whether remaining licensing, board rule, payer, facility, correctional, or program-specific barriers should be clarified or removed.

Correctional Setting Considerations

The Montana statutes reviewed for this recommendation do not appear to impose a correctional-setting-specific prohibition on telehealth. Montana's general telehealth statutes focus on licensure, scope of practice, clinical appropriateness, standard of care, privacy, documentation, and reimbursement. Accordingly, telehealth in a correctional setting appears to be allowed if the provider is appropriately licensed or otherwise authorized, the service is clinically appropriate, privacy and security requirements can be met,

and the service is not otherwise required by law, policy, provider manual, facility rule, contract, or clinical judgment to occur in person.

Because correctional health care may involve additional operational, security, confidentiality, consent, transport, contracting, and facility-specific requirements outside DLI's direct licensing authority, correctional telehealth should not be resolved through a DLI-only recommendation. Coordination with the Department of Corrections and correctional health providers would allow the appropriate entities to identify any non-licensing barriers and determine whether statutory, rule, contract, or policy clarification is needed.

Policy Rationale

Telehealth supports the Task Force's broader goals of reducing barriers, improving workforce capacity, and increasing access to licensed services. Maintaining telehealth flexibility can help Montana address provider shortages and geographic access barriers without reducing licensure standards or expanding scope of practice beyond existing law.

A formal recommendation is appropriate because stakeholders have expressed uncertainty about whether COVID-era flexibilities remain available. Current Montana statutes provide substantial permanent authority for telehealth, but practical barriers may remain where board rules, facility policies, provider guidance, payer requirements, or institutional practices have not been updated to align with current law.

The recommendation is also consistent with the subcommittee's approach in other areas: where DLI has direct licensing authority, recommendations should be specific and actionable; where the issue involves Medicaid, insurance, corrections, facility operations, or reimbursement, the Task Force should recommend coordination with the appropriate agency or stakeholder rather than overstate DLI's authority.

Implementation Options

Option A – Adopt a final-report recommendation only

The Task Force could include a final-report recommendation stating that Montana should preserve current telehealth authority and direct agencies and boards to continue monitoring implementation barriers. This option avoids unnecessary legislation if the existing statutory framework is sufficient.

Option B – Direct DLI and health licensing boards to conduct a rule and policy review

The Task Force could recommend that DLI and relevant health licensing boards review existing rules, policies, FAQs, and application materials to identify telehealth provisions that are inconsistent, outdated, duplicative, or unclear. This review should focus on whether any board-level requirement limits telehealth without a patient-safety basis or conflicts with the general authority in 37-2-305, MCA..

Option C – Recommend interagency coordination on reimbursement and institutional barriers

The Task Force could recommend that DLI coordinate, as appropriate, with DPHHS, the Commissioner of Securities and Insurance, the Department of Corrections, Medicaid, private payers, and provider organizations to identify whether reimbursement or setting-specific barriers are limiting access to otherwise lawful telehealth services.

Option D – Prepare a statutory clarification bill only if specific gaps are identified

The Task Force could recommend legislation only if the July 17 review identifies a concrete statutory gap. Any bill should be limited to clarifying access and consistency, not creating a new telehealth license, expanding scope of practice, or mandating telehealth where it is not clinically appropriate.