



# Licensing Reform Task Force Healthcare Subcommittee

---

## Telehealth: State-by-State Analysis & Policy Options

Below is a high-level summary of the 50-state table, followed by a comparison to Montana and policy options for the consideration by the Healthcare Subcommittee.

### National patterns across states

#### Most states now expressly authorize telehealth as a lawful modality of care

A dominant pattern is that states have enacted statutes or board rules saying telehealth is permissible if:

- the provider is properly licensed;
- the service is within scope of practice;
- the provider meets the same standard of care as in-person care;
- patient identity/location is verified; and
- consent, privacy, and recordkeeping rules are followed.

That pattern appears in many states across the chart, including Alaska, Alabama, Arkansas, California, Colorado, Connecticut, Delaware, D.C, Florida, Georgia, Hawaii, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, *Montana*, Nevada, New Hampshire, New Jersey, Ohio, Oklahoma, Oregon, Virginia, Washington, and West Virginia.

#### Coverage parity is now the norm

A second common practice is coverage parity, meaning that if a service is covered in person, the payer cannot deny it solely because it was delivered by telehealth.

This is one of the most common legislative patterns in the table and appears in states such as Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, D.C., Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, *Montana*, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and West Virginia.

### Payment parity is common, but not universal

Many states go beyond coverage parity and require reimbursement parity, often:

- same basis;
- same rate; or
- at least no lower than in-person reimbursement.

But this is less universal than coverage parity. States in the table with broad or substantial payment parity include Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Kentucky, Maryland, Minnesota, Missouri, Nevada, New Hampshire, New Mexico, Oregon, Rhode Island, Vermont, Virginia, Washington, and parts of West Virginia and Mississippi.

Other states are more limited:

- **Florida** largely leaves reimbursement to contract negotiation.
- **Indiana** is primarily coverage parity only.
- **Kansas** and **South Dakota** are coverage parity only.
- **Montana** has coverage parity commercially, but explicit payment parity in Medicaid.

### Prior authorization usually remains allowed, but telehealth-specific burdens are often restricted

A common policy is that telehealth is not exempt from prior authorization, but payers may not impose stricter telehealth-specific authorization rules than for the same in-person service.

This policy appears clearly in states such as Arkansas, Arizona, Colorado Medicaid, Connecticut, D.C., Georgia, Illinois, Indiana, Kentucky, Maryland, Minnesota, Nevada, New Hampshire Medicaid, Oklahoma, Oregon, and Washington.

A smaller number go further and expressly prohibit telehealth-only prior authorization burdens in stronger terms, such as: Georgia, Kentucky, Nevada, Rhode Island, some Louisiana discipline-specific statutes, and Delaware's regulation.

### Audio-only treatment is increasingly recognized, but often limited

Many states now recognize audio-only telehealth in some form, especially for:

- behavioral health;
- Medicaid;
- rural access;
- established patients; or
- where clinically appropriate

But audio-only is often limited. Common restrictions include:

- only for behavioral health/SUD;
- only if the patient has an established relationship;
- only if video is unavailable or clinically unnecessary; or
- excluded from general telehealth definitions unless specifically authorized.

That pattern appears in Alaska, Arizona, Arkansas, California, Colorado, Connecticut Medicaid, Delaware, D.C., Florida practice rules, Georgia, Hawaii, Illinois programmatically, Indiana, Iowa (generally excluded), Louisiana, Maine, Maryland Medicaid limits, Massachusetts, Michigan Medicaid, Minnesota, Mississippi, Missouri, *Montana* Medicaid, Nebraska limited, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oklahoma, Oregon, South Dakota limited, Tennessee, Texas Medicaid/program-specific, Utah Medicaid limited, Vermont, Virginia in some contexts, and Washington.

### Medicaid telehealth rules are usually more operationally detailed than commercial insurance rules

Across the table, Medicaid rules more often specify:

- billing modifiers;
- place-of-service codes;
- originating-site fees;
- documentation content;
- provider enrollment requirements;
- service-specific limitations; and
- modality restrictions.

This is especially true in Alaska, California, Colorado, D.C., Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, [Montana](#), Nebraska, New Mexico, New York, Ohio, Oklahoma, Oregon, Texas, Vermont, Virginia, and Washington.

### Remote patient monitoring is commonly treated separately

Many states now have separate RPM rules, often with:

- condition-specific eligibility;
- special billing codes;
- special rates; or
- narrower authorization rules.

That appears in Alaska, Colorado, Hawaii, Louisiana, Maryland, Mississippi, [Montana](#), Nebraska, New Mexico, Texas, Virginia, Washington, and others.

# How Montana compares to these common practices

Montana fits several national norms, but not all.

## Where Montana aligns with common state practice

### Montana allows telehealth as a lawful practice modality

Montana follows the national norm of allowing licensed providers to use telehealth if:

- it is appropriate;
- it meets the standard of care; and
- it complies with board rules.<sup>1</sup>

### Montana has commercial coverage parity

Montana's commercial insurance rule in 33-22-138, MCA is consistent with the common state approach in that if a service is otherwise covered, medically necessary, and not otherwise excluded, it must be covered when delivered by telehealth.

### Montana has strong Medicaid payment parity

Montana is actually stronger than some states on Medicaid reimbursement because 53-6-122, MCA expressly says telehealth services "must be reimbursed at the same rate of payment as services delivered in person." That is fully consistent with the modern Medicaid parity trend.

### Montana recognizes multiple telehealth modalities in Medicaid

Montana Medicaid is relatively flexible on modality because 53-6-122, MCA allows:

- secure portal messaging;
- secure instant messaging;
- telephone communication;
- audiovisual communication.

This policy is broader than some states' Medicaid statutes.

## Where Montana is less developed than many other states

### Montana does not appear to have an express statewide commercial prior-authorization parity rule

Many other states expressly say something like:

- telehealth prior authorization cannot be more restrictive than in-person; or
- prior authorization may be required only if the same service would require it in person.

Montana does not appear to have that express protection. Instead, Montana relies on medical necessity, covered-benefit limits, and department rules or provider manuals for Medicaid.

That makes Montana less explicit than Arkansas, Connecticut, Georgia, Illinois, Kentucky, Minnesota, Nevada, Rhode Island, Oregon, and Washington.

---

<sup>1</sup> 37-2-305, MCA; ARM 24.156.813

### **Montana's Medicaid billing framework depends heavily on rules and provider manuals**

Many states specify more operational telehealth billing details directly in regulations:

- required modifiers;
- place-of-service codes;
- originating-site fee rules;
- documentation elements;
- audio-only rules;
- RPM codes.

By contrast, Montana's statute delegates many billing details to agency rules and manuals under 53-6-122, MCA and 53-6-113, MCA. That gives flexibility, but less certainty and transparency.

### **Montana's commercial payment parity is less explicit than in many states**

Montana's statute provides coverage parity, cost-sharing parity, and site neutrality, but does not clearly establish a general commercial same-rate reimbursement rule comparable to states like: Arkansas, California, Colorado, Connecticut, Delaware, Maryland, Nevada, Oregon, Vermont, and Washington.

### **Montana's treatment of home-originating-site reimbursement is narrower than some states**

Section 53-6-122, MCA states that an enrollee's residence is not reimbursable "as an enrolled originating site provider." That does not bar home-based telehealth, but it is narrower than states that more clearly allow home-site reimbursement or remove site-based payment barriers more fully.

## Policy options for consideration

The following options are presented for Healthcare Subcommittee discussion.

### Option 1. Clarify commercial telehealth payment policy

Montana could clarify whether commercial insurers must reimburse telehealth at the same rate as in-person services, or whether payment rates remain subject to provider-insurer contracts.

Potential approaches include:

- Require full payment parity for all covered telehealth services.
- Require payment parity only for specified services, such as behavioral health, primary care, or rural access services.
- Require payment parity for audio-video services but allow different rules for audio-only services.
- Preserve negotiated rates but require plans to disclose reimbursement policies clearly.
- Request to the Commissioner of Securities and Insurance to collect data and report on the access, cost, and utilization effects of payment parity.

This option would make Montana's commercial insurance policy more explicit. It would also align Montana more closely with states that have adopted commercial payment parity, while preserving flexibility if the Legislature chooses a targeted approach.

### Option 2: Prohibit Telehealth-Specific Prior Authorization Barriers

Montana could add language stating that an insurer may not impose prior authorization, medical necessity, documentation, or utilization review requirements on telehealth services that are more restrictive than those applied to the same service when delivered in person.

This would be consistent with Montana's existing coverage parity framework and with common state practices that allow ordinary utilization review but disfavor modality-based barriers. Such a provision could preserve insurers' ability to require prior authorization for services that already require authorization, while preventing additional authorization requirements solely because telehealth is used.

### Option 3: Require Clear Provider and Consumer Notice of Telehealth Billing Rules

Montana could require health plans to publish clear telehealth billing and authorization policies, including:

- Covered telehealth modalities.
- Audio-only coverage rules.
- Billing modifiers and place-of-service requirements.
- Prior authorization requirements.
- Cost-sharing rules.
- Any excluded services.
- Appeal rights for denied telehealth claims.

This option would not require a substantive coverage expansion, but it could reduce administrative uncertainty for providers and patients.

#### **Option 4: Establish a Uniform Minimum Consent and Notice Standard**

Montana could consider a baseline consent or notice provision for telehealth encounters. A uniform standard might require providers to disclose:

- The provider's identity and credentials.
- The nature of telehealth and any technology limitations.
- Privacy and security considerations.
- The patient's right to ask questions or request in-person care when available.
- Emergency or follow-up instructions.

Any such requirement could be satisfied verbally and documented in the medical record, unless a licensing board or payer requires a higher standard for a specific service.

#### **Option 5: Expand Cross-State Access Through Compacts or Registration**

Montana could continue to evaluate interstate licensure compacts and limited registration models for out-of-state telehealth providers.

Potential models include:

- Joining additional professional licensure compacts.
- Creating a telehealth registration for out-of-state providers in good standing.
- Allowing limited episodic follow-up care for established patients who are temporarily located in Montana.
- Authorizing consultation exceptions when the Montana-licensed provider remains responsible for patient care.

This option may be particularly relevant for specialty care, behavioral health, speech-language pathology, chronic disease management, and rural access.

#### **Option 6: Preserve and Monitor Audio-Only Flexibility**

Montana's inclusion of audio-only communication is consistent with access-oriented telehealth policy, especially for rural areas, older adults, low-income patients, and patients with limited broadband access. Montana could preserve audio-only authority while collecting data on quality, utilization, fraud prevention, and patient outcomes.

Potential safeguards include:

- Requiring documentation that audio-only care was clinically appropriate.
- Limiting audio-only coverage for services that require visual examination unless clinically justified.
- Requiring patient consent to audio-only services.
- Monitoring claims data for overutilization or inappropriate billing.

#### **Option 7: Align Medicaid and Commercial Policies Where Appropriate**

Montana Medicaid has more explicit telehealth payment and billing requirements than Montana commercial insurance law. The Task Force could consider whether selected Medicaid concepts should be adapted for commercial coverage, such as:

- Same-rate reimbursement for selected services.
- Clear billing guidance.
- No more restrictive telehealth-specific authorization requirements.
- Recognition of audio-only services when clinically appropriate.
- Standard recordkeeping requirements.

Alignment could reduce administrative complexity for providers who serve both Medicaid and commercially insured patients.

## Considerations for Subcommittee discussion

When evaluating telehealth policy changes, the Healthcare Subcommittee may wish to balance the following considerations:

- **Access:** Telehealth can expand access to primary care, behavioral health, specialty care, and follow-up services, particularly in rural and frontier communities.
- **Quality and safety:** Telehealth should be used only when clinically appropriate and should meet the same standard of care as in-person services.
- **Cost and utilization:** Payment parity and broad coverage may increase access but may also affect utilization patterns and premiums, depending on service mix and substitution effects.
- **Administrative simplicity:** Consistent billing and authorization rules can reduce provider burden and claim denials.
- **Fraud and program integrity:** Telehealth expansion may require documentation, coding, and audit safeguards.
- **Broadband and technology limitations:** Audio-only authority may remain important in areas with limited connectivity.
- **Workforce supply:** Cross-state licensing flexibility may improve access, but Montana may wish to preserve board oversight and patient protection.

## Summary

Montana's telehealth laws are broadly consistent with common state practices and, in several respects, are comparatively access oriented. Montana authorizes telehealth under the ordinary standard of care, includes audio-only communication, prohibits commercial plan site restrictions, bars rural/urban distinctions, and requires Medicaid payment parity. The principal areas for potential refinement are not whether telehealth is allowed, but whether commercial payment rules, authorization procedures, consumer notice, consent standards, and cross-state access should be clarified or expanded.

Policy options that appear most consistent with common state approaches while expanding telehealth opportunity in Montana include: prohibiting telehealth-specific prior authorization barriers; requiring clearer payer billing and authorization guidance; preserving audio-only services with appropriate safeguards; adopting targeted commercial payment parity or data-reporting requirements; and expanding interstate licensure pathways for high-need services.

## Comparison of Common State Practices with Montana Law:

Issue	Common State Practice	Montana Law	Analysis
<b>General authorization</b>	Telehealth allowed if within scope, clinically appropriate, and standard of care is met.	Montana expressly authorizes licensed providers to use telehealth when appropriate and consistent with standard of care.	Montana is aligned with common practice.
<b>Licensure</b>	Provider usually must be licensed where the patient is located, with compacts or limited exceptions.	Montana's general law authorizes persons licensed under Title 37; profession-specific rules and compacts may apply.	Montana is generally aligned; access could be expanded through additional compacts or registration options.
<b>Prior in-person visit</b>	Usually not required for all services; limited exceptions for selected services.	Montana generally does not require a previously established patient-provider relationship for commercial telehealth coverage, subject to exceptions.	Montana is more access-oriented than states that retain broad in-person requirements.
<b>Consent</b>	Many states require consent or notice, often documented in the record.	Montana Medicaid requires providers to follow consent and patient information protocols consistent with in-person visits; some professional rules may add detail.	Montana could clarify a uniform minimum consent or notice standard if desired.
<b>Commercial coverage parity</b>	Commonly required for otherwise covered services.	Montana requires coverage for otherwise covered services delivered by telehealth.	Montana is aligned with common practice.
<b>Commercial payment parity</b>	State approaches vary; some require equal payment; others leave rates to contract.	Montana commercial law requires equivalent coverage but does not expressly require same-rate payment.	Montana is within the mainstream but less prescriptive than payment-parity states.
<b>Medicaid payment parity</b>	Many states expanded Medicaid telehealth; payment parity varies.	Montana Medicaid requires same-rate reimbursement for telehealth and in-person services.	Montana is comparatively supportive of Medicaid telehealth payment.
<b>Site restrictions</b>	Many states prohibit strict originating-site requirements in commercial coverage.	Montana prohibits restrictions based on patient site, provider site, or rural/urban location.	Montana is aligned with broad-access states.
<b>Audio-only</b>	States vary; many allow audio-only for selected services.	Montana includes audio-only communication in telehealth definitions, subject to limited exceptions.	Montana is relatively flexible and access oriented.
<b>Prior authorization</b>	Usually same rules as in-person services; telehealth-specific barriers are often disfavored.	Montana prohibits more restrictive telehealth limitations in commercial coverage but does not provide detailed telehealth-specific authorization procedures.	Montana could add clarity without changing the basic parity framework.