

SESSION OF 2021

**CONFERENCE COMMITTEE REPORT BRIEF  
SENATE SUBSTITUTE FOR HOUSE BILL NO. 2208**

As Agreed to April 8, 2021

**Brief\***

Senate Sub. for HB 2208 would enact the Rural Emergency Hospital Act (Act) and create a category of licensure to enable certain Kansas hospitals to receive federal health care reimbursement as rural emergency hospitals; establish certification for certified community behavioral health clinics (CCBHCs); authorize licensed out-of-state physicians with telemedicine waivers to practice telemedicine in Kansas; and modify licensure, temporary permit, and regulatory requirements on the Behavioral Sciences Regulatory Board (BSRB) and its licensees.

Rural hospitals. The bill would establish the Rural Hospital Innovation Grant Program (Program) and the Rural Hospital Innovation Grant Fund (Fund). The bill would require a rural hospital to exhaust all opportunities for federal moneys available to such hospital for transitional assistance, including, but not limited to, any federal moneys related to COVID-19 relief that may be used for such purposes, before a Rural Hospital Innovation Grant may be awarded. Additionally, the bill would require the Director of the Budget to certify and determine on June 15, 2021, unencumbered federal funds received by the State that may be used to award such grants. An aggregate amount equal to \$10.0 million in available special revenue bonds would be transferred to the Fund on July 1, 2021. If such aggregate certified special revenue funds are less than \$10.0 million, the

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bill would require the difference between \$10.0 million and the amount certified to be transferred from the State General Fund (SGF) to the Fund on July 1, 2021. The bill would require benefits coverage for services provided by rural emergency hospitals if covered when performed by a general hospital or critical access hospital. The bill would define applicable terms, including “rural emergency hospital” in the Act, and reference the definition in the Kansas Medical Facilities Survey and Construction Act.

CCBHCs. The bill would establish certification for CCBHCs and prescribe the powers, duties, and functions of the Kansas Department for Aging and Disability Services (KDADS) with regard to CCBHCs.

Boards and licensure. The bill would also authorize a licensed out-of-state physician with a telemedicine waiver issued by the State Board of Healing Arts (BOHA) to practice telemedicine in Kansas. The bill would also amend the disciplinary authority of the BSRB and modify licensure and temporary permit requirements of professional counselors, social workers, marriage and family therapists, addiction counselors, psychologists, and master’s level psychologists.

The bill would also make technical amendments.

The bill would be effective upon publication in the *Kansas Register*.

***Rural Emergency Hospital Act (New Sections 1-8)***

The bill would establish eligibility and application requirements for licensure as a rural emergency hospital and require the Secretary of Health and Environment (Secretary) to adopt rules and regulations establishing minimum standards for the establishment and operations of rural emergency hospitals in accordance with the Act. Further, the bill would require the Secretary, in formulating rules and regulations under the Kansas Medical Facilities Survey and

Construction Act, to give due consideration to the requirements for receipt of federal reimbursement for the particular type of medical care facility.

*Definitions (New Sections 3 and 9 [Amending the Kansas Medical Facilities Survey and Construction Act])*

The bill would define multiple terms, including the following:

- “Rural emergency hospital” would mean an establishment that:
  - Meets the eligibility requirements described in Section 4;
  - Provides rural emergency hospital services;
  - Provides rural emergency hospital services in the facility 24 hours per day by maintaining an emergency medical department that is staffed 24 hours per day, 7 days per week, with a physician, nurse practitioner, clinical nurse specialist, or physician assistant;
  - Has a transfer agreement with a level I or level II trauma center; and
  - Meets such other requirements as the Kansas Department of Health and Environment (KDHE) finds necessary in the interest of the health and safety of individuals who are provided rural emergency hospital services and to implement state licensure that satisfies requirements for reimbursement by federal health care programs as a rural emergency hospital.
- “Rural emergency hospital services” would mean the following services, provided by a rural emergency hospital, that do not require in excess

of an annual per-patient average of 24 hours in such rural emergency hospital:

- Emergency department services and observation care; and
- At the election of the rural emergency hospital, for services provided on an outpatient basis, other medical and health services as specified in regulations adopted by the U.S. Secretary of Health and Human Services and authorized by KDHE.

*State Policy (New Section 2)*

The bill would outline how the Kansas Legislature seeks to address the provision and regulation of a structured and integrated system of health care services. The bill would declare the State's policy is to create a category of licensure to enable certain hospitals to receive federal health care reimbursement as rural emergency hospitals, and the implementation of the Act facilitates such policy.

*Eligibility for Licensure (New Section 4)*

The bill would provide that a facility would be eligible to apply for a rural emergency hospital license, if such a facility, as of December 27, 2020, was a:

- Licensed critical access hospital;
- General hospital with not more than 50 licensed beds located in a county in a rural area as defined in Section 1886(d)(2)(D) of the federal Social Security Act; or
- General hospital with not more than 50 licensed beds that is deemed as being located in a rural

area pursuant to Section 1886(d)(8)(E) of the Social Security Act.

The bill would require a facility applying for licensure as a rural emergency hospital to include the following with the licensure application:

- An action plan for initiating rural emergency hospital services, including a detailed transition plan listing the specific services the facility will retain, modify, add, and discontinue;
- A description of services the facility intends to provide on an outpatient basis; and
- Such other information as required by rules and regulations adopted by KDHE.

The bill would outline additional prohibitions and requirements for rural emergency hospital licensure as follows:

- Inpatient beds would be prohibited, except a distinct unit that is part of the hospital and licensed as a skilled nursing facility could provide post-hospital extended care services;
- A rural emergency hospital would be allowed to own and operate an entity that provides ambulance services; and
- A licensed general hospital or critical access hospital that applies for and receives licensure as a rural emergency hospital and elects to operate as a rural emergency hospital would retain its original license as a general hospital or critical access hospital. The original license would remain inactive while the rural emergency hospital license is in effect.

*Authority to Enter into Contracts for Federal Reimbursement  
(New Section 5)*

The bill would authorize all rural emergency hospitals, including city, county, hospital district, or other governmental or quasi-governmental hospitals to enter into any contracts required to be eligible for federal reimbursement as a rural emergency hospital.

*Protections Provided (New Section 6)*

In addition to the limited liability protections provided in KSA 65-4909 when acting in good faith and without malice, the bill would provide that entities engaging in activities and entering into contracts required to meet the requirements for licensure as a rural emergency hospital, and officers, agents, representatives, employees, and directors of such entities, would be considered to be acting pursuant to clearly expressed state policy as established in the Act under the supervision of the State. Such entities would not be subject to state or federal antitrust laws while acting in this manner.

*Rules and Regulations Authority (New Section 7)*

The bill would require the Secretary to adopt rules and regulations establishing minimum standards for the establishment, operation, and licensure of rural emergency hospitals in accordance with the Act.

*Required Service Coverage (New Section 8)*

The bill would require benefits for services performed by a rural emergency hospital to be covered if such services would be covered under the following policies, contracts, or coverage, if performed by a general hospital:

- Each individual and group policy of accident and sickness insurance;
- Each contract issued by a health maintenance organization; and
- All coverage maintained by an entity authorized under KSA 40-2222 (those entities providing coverage in Kansas for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, that are presumed to be subject to the jurisdiction of the Commissioner of Insurance, unless the entities fall under the listed exemptions) or by a municipal group-funded pool authorized under KSA 12-2618.

***Rural Hospital Innovation Grant Program and Fund (New Section 11)***

***Definitions***

The bill would define the following terms:

- “Eligible county” would mean a county in Kansas other than Douglas, Johnson, Sedgwick, Shawnee, or Wyandotte county;
- “Hospital” would mean the same as in KSA 65-425, in the Kansas Medical Facilities Survey and Construction Act; and
- “Transitional assistance” would mean any assistance related to changing a hospital’s current health care delivery model to a model more

appropriate for the community the hospital serves, including, but not limited to:

- Conducting a market study of health care services needed and provided in the community;
- Acquiring and implementing new technological tools and infrastructure, including, but not limited to, telemedicine delivery methods; and
- Acquiring the services of appropriate personnel, including, but not limited to, additional medical residents or individuals trained to be needed health care professionals.

#### *Rural Hospital Innovation Grant Program*

The bill would establish the Program, which would be administered by the Secretary, for the purpose of strengthening and improving the health care system and increasing access to health care services in eligible counties, helping communities in those counties achieve and maintain optimal health by providing transitional assistance to hospitals. The Secretary could award a Rural Hospital Innovation Grant (grant) to a county that applies in accordance with the provisions of the bill.

The board of county commissioners of an eligible county, or the board's designee, could apply to the Secretary for a grant in the form and manner determined by the Secretary. The bill would require the application to include:

- A description of the hospital for which the money would be expended, including the name and location of the hospital;
- The amount of money requested;

- A description of the needs of the hospital, the type of transitional assistance the grant would fund, and how the grant would support the hospital in meeting its needs;
- A certification that the hospital has exhausted all opportunities for federal moneys available to such hospital for transitional assistance purposes, including, but not limited to, any federal moneys related to COVID-19 relief that may be used for such purposes; and
- Any other information the Secretary deems necessary.

The bill would require that, before grant moneys are awarded, the Secretary would enter into a written agreement with the county, requiring the county to:

- Expend the grant moneys to provide transitional assistance to a hospital, as approved by the Secretary;
- Report to the Secretary within one year after the grant moneys are awarded, detailing the effect of the grant on the health and other outcomes in the county and affected community;
- Repay all awarded grant moneys to the Secretary if the county fails to satisfy any term or condition of the grant agreement; and
- Any other terms and conditions the Secretary deems necessary.

The bill would prohibit the awarding of a rural hospital innovation grant unless the hospital has exhausted all opportunities for federal moneys available to such hospital for transitional purposes, including, but not limited to, any federal

moneys related to COVID-19 relief that may be used for such purposes.

The bill would allow any eligible county to enter into memorandums of understanding and other necessary agreements with private stakeholders and other eligible counties.

#### *Private Stakeholders*

The bill would allow the Secretary to award a grant only if the state moneys to be awarded in the grant have been matched by private stakeholders, including hospital foundations or other organizations, on a basis of \$2 of private stakeholder moneys for every \$1 of state moneys.

Under the bill, the Secretary could receive moneys by bequest, donation, or gift to fulfill the public-private match of moneys required by the bill. Any received moneys would be remitted to the State Treasurer and deposited in the State Treasury to the credit of the Fund.

The bill would allow a private stakeholder to certify to the Secretary that an amount of money is dedicated to the Program, but allow the certified dedicated moneys to remain with the private stakeholder until the grant is awarded. The bill would require the Secretary to count such moneys to fulfill the public-private match required by the bill.

In addition, the bill would allow a private stakeholder to specify a certain county to receive a grant using the private stakeholder's moneys. If the Secretary does not award a grant to the specified county in the same fiscal year as the request, the bill would require the Secretary to return the amount of contributed moneys to the private stakeholder, and the certification would lapse.

*Rural Hospital Innovation Grant Fund; Appropriation*

The bill would establish the Fund, which would be administered by the Secretary. The bill would require moneys credited to the Fund to be used only for purposes related to the Program, and all expenditures from the Fund would be made in accordance with appropriation acts upon warrants of the Director of Accounts and Reports pursuant to vouchers approved by the Secretary, or the Secretary's designee.

The bill would provide, notwithstanding the provisions of Chapter 1 of the *Special Session Laws of Kansas* or any other provision of law to the contrary, on June 15, 2021, the Director of the Budget shall determine the amount of moneys received by the State that are identified as moneys from the federal government for aid to the State of Kansas for coronavirus relief as appropriated in the acts listed below; that are eligible to be used for the purpose of awarding grants under this section; that may be expended at the discretion of the State in compliance with the U.S. Office of Management and Budget's uniform administrative requirements, cost principles, and audit requirements for federal awards; and that are unencumbered. The acts specified are:

- The federal CARES Act (Public Law 116-136) the federal Coronavirus Preparedness and Response Supplemental Appropriation Act (Public Law 116-123), the federal Families First Coronavirus Response Act (Public Law 116-127), and the federal Paycheck Protection Program and Health Care Enhancement Act (Public Law 116-139);
- The federal Consolidated Appropriations Act, 2021 (Public Law 116-260);
- The American Rescue Plan Act of 2021 (Public Law 117-2); and
- Any other federal law that appropriated moneys to the State for aid for coronavirus relief.

Of the moneys identified above, the bill would require the Director of the Budget to determine an aggregate amount equal to \$10.0 million available in special revenue funds. If such identified moneys are less than \$10.0 million, the Director of the Budget would be required to determine the maximum amount available. The bill would require the Director of the Budget to certify the amount determined from each fund to the Director of Accounts and Reports. At the same time the certification is transmitted, the Director of the Budget would be required to transmit a copy of such certification to the Director of Legislative Research.

The bill would require, on July 1, 2021, or as soon thereafter as the moneys are available, the Director of Accounts and Reports to transfer an aggregate amount equal to the certified amount determined by the Director of the Budget from such funds to the Rural Hospital Innovation Grant Fund. If the aggregate amount of moneys certified is less than \$10.0 million, the Director of Accounts and Reports would be required to transfer from the SGF to the Rural Hospital Innovation Grant Fund the difference between the \$10.0 million and the amount certified.

#### *Rules and Regulations*

The Secretary would be required to adopt rules and regulations as necessary to implement the Program.

#### *Reporting Requirements*

The bill would require, on or before October 1 of each year, a county to prepare and submit a report to the Secretary on each grant awarded, describing the amount and purposes of any grant moneys, the fulfillment of the terms and conditions of the grant agreement, and the transitional assistance upon which the moneys have been spent.

The bill would also require, on or before February 1 of each year, the Secretary to compile the information received and submit a report to the Governor and Legislature, including the received information and a description of and reasoning for any grant applications that were denied.

#### *Sunset*

The Rural Hospital Innovation Grant Program would sunset July 1, 2025, at which time:

- All moneys in the Fund would be transferred to the SGF;
- All liabilities of the Fund would be transferred to and imposed on the SGF; and
- The Fund would be abolished.

#### ***Kansas Medical Facilities Survey and Construction Act (Sections 12 and 13)***

The bill would define “rural emergency hospital” in Section 12 by referencing the definition in Section 2 of the bill.

#### ***Rules and Regulations (Section 13)***

The bill would amend the Kansas Medical Facilities Survey and Construction Act by adding that, in formulating rules and regulations with respect to different types of medical care facilities to be licensed under such act, KDHE would be required to give due consideration to the requirements for the receipt of medical reimbursement for the type of medical facility. The bill would also provide that a rural emergency hospital would be deemed to satisfy the rules and regulations requirements for a hospital consisting of more than one establishment if such rural emergency hospital

meets its licensing requirements established by the licensing agency.

***KDADS Responsibilities for CCBHC Certification (New Section 9)***

The bill would require KDADS to establish a process to certify CCBHCs.

The bill would require KDADS to certify as a CCBHC any community mental health center (CMHC) licensed by KDADS that provides the following services: crisis services; screening, assessment, and diagnosis, including risk assessment; person-centered treatment planning; outpatient mental health and substance use services; primary care screening and monitoring of key indicators of health risks; targeted case management; psychiatric rehabilitation services; peer support and family supports; medication-assisted treatment; assertive community treatment; and community-based mental health care for military service members and veterans.

***KDHE Responsibilities***

The bill would require KDHE to establish a prospective payment system (PPS) under the Kansas Medical Assistance Program to fund CCBHCs on or before May 1, 2022. Daily or monthly rate payments would be allowed in the PPS.

The bill would require KDHE to submit to the U.S. Centers for Medicare and Medicaid Services any approval request necessary to implement the PPS.

### *KDADS Rules and Regulation Authority*

The bill would authorize KDADS to adopt rules and regulations as necessary to implement and administer provisions related to CCBHCs.

### *Implementation Schedule*

The bill would establish a staggered implementation schedule for CCBHC certification and require KDADS, subject to certification applications, to certify:

- Six facilities currently receiving grants to operate as CCBHCs by no later than May 1, 2022;
- Three additional facilities by no later than July 1, 2022;
- Nine additional facilities by no later than July 1, 2023; and
- Eight additional facilities by no later than July 1, 2024.

The bill would authorize KDADS to certify CCBHCs, including portions of the specified facility numbers, in advance of the above-cited deadlines.

### ***Out-of-state Telemedicine Practice (New Section 10)***

The bill would authorize a physician holding a license issued by the applicable licensing agency of another state or who otherwise meets the requirements of the bill to practice telemedicine to treat patients located in Kansas if the physician receives a telemedicine waiver issued by the BOHA. The bill would require the BOHA to issue the waiver within 15 days from receipt of a complete application, if the physician:

- Submits a complete application, which may include an affidavit from an authorized third party that the applicant meets the requirements, in a manner determined by the BOHA, and pays a fee not to exceed \$100; and
- Holds an unrestricted license to practice medicine and surgery in another state or meets the qualifications required under Kansas law for a license to practice medicine and surgery and is not the subject of any investigation or disciplinary action by the applicable licensing agency.

The bill would require a physician to practice telemedicine in accordance with the bill to conduct an appropriate assessment and evaluation of a patient's current condition and document an appropriate medical indication for any prescription issued.

The bill would not supersede or affect the provisions of KSA 65-4a10 (Performance of abortions restricted to a physician licensed to practice medicine in Kansas) or KSA 2020 Supp. 40-2,210 *et seq.* (Kansas Telemedicine Act).

#### *Rules and Regulations for Telemedicine Waivers*

The bill would require any person who receives a telemedicine waiver to be subject to all rules and regulations pertaining to the practice of the licensed profession in Kansas and be considered a licensee for the purposes of the professional practice acts administered by the BOHA. The bill would also require any waiver issued to expire on the date established, unless renewed by the BOHA upon receipt of payment of an annual renewal fee not to exceed \$100 and evidence that the applicant continues to meet the qualifications of the bill. The bill would not prohibit a licensing agency from denying a waiver application if the licensing body determines granting the application may endanger the health and safety of the public.

### *Out-of-state Authorizations*

The bill would authorize:

- A physician holding a license issued by the applicable licensing agency of another state to provide, without limitation, consultation through remote technology to a physician licensed in Kansas; and
- An applicable health care licensing agency of this state to adopt procedures consistent with this section to allow other health care professionals licensed and regulated by the licensing agency to practice telemedicine within the profession's scope of practice by Kansas law as deemed by the licensing agency to be consistent with ensuring patient safety.

### *Definition of Telemedicine*

The bill would define "telemedicine" to mean the delivery of health care services by a health care provider while the patient is at a different physical location.

### ***Clinical Professional Counselor Licensure (Section 14)***

The bill would amend the licensure requirements to become a clinical professional counselor to:

- Reduce from 350 to 280 the minimum number of hours of direct client contact or additional postgraduate supervised experience as determined by the BSRB;
- Reduce from 4,000 to 3,000 the minimum number of hours of supervised professional experience;

- Reduce from 150 to 100 the minimum number of hours of face-to-face clinical supervision as defined by the BSRB in rules and regulations;
- Require no less than 50 of the face-to-face clinical supervision hours to include individual supervision, although the BSRB could waive:
  - The requirement such supervision be face-to-face upon finding extenuating circumstances; and
  - Half of the required hours for an individual who has a doctoral degree in professional counseling or a BSRB-approved related field and who completes half of the required hours in one or more years of supervised professional experience;
- Specify a temporary license may be issued after the applicant pays the temporary license fee; and
- Increase from 6 to 12 the number of months after issuance a temporary license would expire, absent extenuating circumstances approved by the BSRB.

***Clinical Social Work Licensure (Section 18)***

The bill would amend requirements to become a licensed specialist clinical social worker to:

- Remove the requirement an individual complete 350 hours of direct clinical contact or additional postgraduate supervised experience as determined by the BSRB;
- Specify the 100 hours of clinical supervision would be face to face, as defined by the BSRB in rules and regulations; and

- Require the 100 hours of face-to-face clinical supervision to include no less than 50 hours of individual supervision, although the BSRB could waive the requirement such supervision be face to face upon finding extenuating circumstances.

***Clinical Marriage and Family Therapist Licensure  
(Section 21)***

The bill would amend the licensure requirements to become a clinical marriage and family therapist to:

- Reduce from 4,000 to 3,000 the minimum number of hours of supervised professional experience;
- Reduce from 150 to 100 the minimum number of hours of clinical supervision and specify such hours be face to face, as defined by the BSRB in rules and regulations; and
- Require the face-to-face clinical supervision hours include no less than 50 hours of individual supervision, although the BSRB could waive:
  - The requirement such supervision be face to face upon finding extenuating circumstances; and
  - Half of the required hours for an individual who has a doctoral degree in marriage and family therapy or a BSRB-approved related field and who completes half of the required hours in one or more years of supervised professional experience.

***Clinical Addiction Counselor Licensure (Section 25)***

The bill would amend the licensure requirements to become a clinical addiction counselor to:

- Reduce from 4,000 to 3,000 the minimum number of hours of supervised professional experience;
- Reduce from 150 to 100 the minimum number of hours of clinical supervision and specify such hours be face to face, as defined by the BSRB in rules and regulations;
- Require the face-to-face clinical supervision hours to include no less than 50 hours of individual supervision, although the BSRB could waive:
  - The requirement such supervision be face to face upon finding extenuating circumstances; and
  - Half of the required hours for an individual who has a doctoral degree in addiction counseling or a BSRB-approved related field and who completes half of the required hours in one or more years of supervised professional experience.

***Clinical Psychotherapist Licensure (Section 30)***

The bill would amend the licensure requirements to become a clinical psychotherapist to:

- Reduce from 4,000 to 3,000 the minimum number of hours of supervised professional experience;
- Reduce from 150 to 100 the minimum number of hours of clinical supervision and specify such hours be face to face, as defined by the BSRB in rules and regulations; and
- Require the face-to-face clinical supervision hours include no less than 50 hours of individual supervision, although the BSRB could waive the

requirement such supervision be face to face upon finding extenuating circumstances.

***Temporary Permits (Sections 15, 19, 22, 26, 28, and 31)***

The bill would amend the requirements for professional counselors, clinical social workers, clinical marriage and family therapists, clinical addiction counselors, psychologists, and clinical master's level psychologists licensed in another jurisdiction to practice in Kansas under a temporary permit to:

- Require individuals to have practiced in their jurisdiction for at least two years immediately preceding the application, except clinical social workers must only have practiced in their jurisdiction, without the two-year requirement;
- Increase from 15 to 30 the maximum number of days per year the individual could practice in Kansas; and
- Require the individual to provide quarterly reports to the BSRB detailing the total days of practice in Kansas.

The bill would also specify the temporary practice permit would expire one year after issuance, and the BSRB could extend the permit for no more than one additional year upon the individual's written application no later than 30 days before the permit's expiration and under emergency circumstances, as defined by the BSRB. The bill would provide that any extended permit would authorize the individual to practice in Kansas for an additional 30 days during the additional year and require the individual to provide quarterly reports to the BSRB detailing the total days of practice in Kansas.

***Board License Refusal and Revocation Authorities  
(Sections 17, 20, 23, 27, 29, and 32)***

The bill would amend the reasons the BSRB may refuse to issue, renew, reinstate, condition, limit, revoke, or suspend a professional counseling, social work, marriage and family therapy, addiction counseling, psychology, or master's level psychology license or censure or impose a fee on such licensee to:

- Remove reference to specific professions and specify the condition whether the individual has had any professional registration, license, or certificate revoked, suspended, or limited, or has had other disciplinary action taken, or an application for registration, license, or certification denied, by the proper regulatory authority of another state, a territory, the District of Columbia, or another country;
- Add the District of Columbia as another location where a substantiated finding of abuse and neglect would result in an individual being listed on a child abuse registry or an adult protective services registry, except the District of Columbia is not included with regard to psychologists; and
- Add the condition whether the individual has violated any lawful order or directive of the BSRB.

***Clinical Supervisor Application Fee (Sections 16 and 24)***

The bill would authorize the BSRB to establish, by rules and regulations approved by the BSRB, a maximum \$50 fee for an application for approval as a BSRB-approved clinical supervisor of professional counselors or marriage and family therapists.

## ***Effective Date***

### **Conference Committee Action**

The Conference Committee agreed to the provisions of Senate Sub. for HB 2208, as recommended by the Senate Committee on Public Health and Welfare, with the following amendments:

- Requiring KDHE to submit to the U.S. Centers for Medicare and Medicaid Services any approval request needed to implement a prospective payment system (PPS) and to implement the PPS on or before May 1, 2022; and
- Insert the language of HB 2174 pertaining to the Program and Fund that passed the House in SB 175, as amended by the House Health and Human Services Committee, with the following amendments:
  - Requiring rural hospitals to certify, on the grant application, they have exhausted all opportunities for federal money available for transitional assistance purposes, including COVID-19 relief that may be used for such purposes, before a Rural Hospital Innovation Grant could be awarded, and prohibiting such a grant to be awarded to any hospital that has not exhausted all opportunities for federal moneys; and
  - Requiring that all federal funds for aid to the State for coronavirus relief eligible to be used for the purposes of the Program and unencumbered to be applied to meet the \$10.0 million State funding requirement. If such unencumbered special revenue funds

are less than \$10.0 million, the bill would require the difference between \$10.0 million and those unencumbered funds to be transferred from the SGF to the Fund;

- Changing the effective date of the bill to upon publication in the *Kansas Register*.

## **Background**

HB 2208, as introduced, would have amended the disciplinary authority of the BSRB and modified licensure and temporary permit requirements of several health professions. The House Committee on Health and Human Services amended HB 2208 to incorporate new and modified language from HB 2066, as introduced, concerning the practice of telemedicine by out-of-state licensed physicians. The Senate Committee on Public Health and Welfare recommended a substitute bill be created that incorporates the provisions of HB 2208, as amended by the House Committee on Health and Human Services; SB 138 (CCBHC certification and funding, including new provisions related to the staggered implementation structure); and SB 175, as amended by the Senate Committee on Public Health and Welfare (Rural Emergency Hospital Act). The Conference Committee added the language of HB 2174, pertaining to establishing the Rural Hospital Innovation Grant Program (Program) and the Rural Hospital Innovation Grant Fund (Fund), with additional amendments, including addressing funding for the Program with federal resources.

## ***HB 2208***

HB 2208 was introduced by the House Committee on Health and Human Services at the request of the BSRB. Portions of the bill were recommendations of the 2020 Special Committee on Kansas Mental Health Modernization and Reform.

[*Note:* A companion bill, SB 238, has been introduced in the Senate.]

*House Committee on Health and Human Services*

In the House Committee hearing on HB 2208 on February 11, 2021, a representative of the BSRB and representatives of the Association of Community Mental Health Centers of Kansas, the Children’s Alliance of Kansas, the Kansas Chapter of the National Association of Social Workers, and the Washburn University Social Work Department provided **proponent** testimony. The BSRB representative stated lowering hourly requirements for the professions enumerated in the bill would make it easier to earn a clinical license in Kansas while still protecting the public. The BSRB representative stated the amendments to temporary out-of-state permits, which have been in higher demand during the COVID-19 pandemic, would allow individuals to receive services for longer periods of time. The other proponents stated the adjustments to the requirements for direct service hours would allow for telehealth services, and the hour requirement reductions would help Kansas retain social work students and address workforce shortages.

Written-only **proponent** testimony was provided by representatives of KVC Kansas, the Behavioral Health Association of Kansas, the Johnson County Mental Health Center, and the Kansas Counseling Association, and by a marriage and family therapist and a retired clinical social worker.

An associate professor of practice at the University of Kansas School of Social Welfare provided neutral testimony. The conferee stated no other state requires social workers to complete a specific number of hours of direct client contact.

No **opponent** testimony was provided.

The House Committee amended HB 2208 to:

- Insert new and modified language from HB 2066 concerning the practice of telemedicine by out-of-state licensed physicians (new section 1 of HB 2208, as amended by the House Committee);
- Remove the licensure requirements for specialist clinical social workers that individuals complete at least 350 hours of direct client contact or additional postgraduate supervised experience as determined by the BSRB;
- Remove language requiring BSRB approval of clinical supervisors of social workers working toward licensure as a clinical social worker (section 1 of HB 2208, as introduced); and
- Remove language concerning an application fee for BSRB-approved clinical supervisors of social workers (section 9 of HB 2208, as introduced).

[*Note:* The Conference Committee retained these amendments.]

*Senate Committee on Public Health and Welfare*

In the Senate Committee hearing on HB 2208, representatives of Americans for Prosperity and the BSRB provided **proponent** testimony. Written-only **proponent** testimony was provided by representatives of the Association of Community Mental Health Centers of Kansas and the Kansas Chapter of the National Association of Social Workers; an associate professor of practice at the University of Kansas School of Social Welfare; and a private citizen.

No other testimony was provided.

The Senate Committee amended HB 2208 as follows and created a substitute bill:

- Add the contents of SB 138 (CCBHCs), including new provisions to:
  - Remove the requirement that KDHE submit to the federal Centers for Medicare and Medicaid Services (CMS) any approval request necessary to implement such payment system [*Note:* The Conference Committee reinserted this language.]; and
  - Replace the January 1, 2022, deadline for implementation of CCBHC certification with a staggered implementation schedule requiring specific numbers of certifications by set dates, subject to receipt of applications, and allowing KDADS to certify CCBHCs in advance of the deadlines and in portions of the specified numbers [*Note:* The Conference Committee retained this amendment.]; and
- Add the contents of SB 175 (Rural Emergency Hospital Act), as amended by the Senate Committee on Public Health and Welfare and passed by the Senate. [*Note:* The Conference Committee retained this amendment but added language from HB 2174 pertaining to the Program and Fund.]

#### *Fiscal Information*

According to the fiscal note prepared by the Division of the Budget on HB 2208, as introduced, the BSRB estimates enactment of the bill would increase annual revenues from a one-time \$50 application fee required of new BSRB-approved clinical supervisors for social workers, professional counselors, and marriage and family therapists by \$2,000, of which \$1,800 would be remitted to the BSRB Fee Fund and

\$200, or 10.0 percent, would be remitted to the State General Fund (SGF). The BSRB indicates the bill would also increase expenditures for additional staff time spent processing licenses, but any costs would be negligible and could be absorbed within existing resources.

The bill includes provisions regarding telemedicine from HB 2066. According to the fiscal note prepared by the Division of the Budget on HB 2066 as introduced, the BOHA would require \$14,120 in FY 2021 and \$48,485 for FY 2022 from the Healing Arts Fee Fund for 1.0 FTE position.

Any fiscal effect associated with the bill is not reflected in *The FY 2022 Governor's Budget Report*.

#### *SB 175 (Rural Emergency Hospitals)*

SB 175 was introduced by the Senate Committee on Public Health and Welfare at the request of the Kansas Hospital Association (KHA).

[*Note:* A companion bill, HB 2261, was introduced in the House but was stricken from the House Calendar by Rule 1507.]

**Senate Committee on Public Health and Welfare.** In the Senate Committee hearing on SB 175, **proponent** testimony was provided by representatives of KHA, Lindsborg Community Hospital, and Wilson Medical Center.

The KHA representatives stated the rural emergency hospital model would allow Kansas hospitals the option to take advantage of action taken in December 2020 at the federal level, which was similar to an alternative rural health model that KHA has been working on since 2012. The KHA representatives noted Kansas needs to update its licensure categories to include the new facility type to allow critical access hospitals and prospective payment system hospitals the option to convert to the new model if it best fits the

hospitals' needs. The KHA representatives stated the rural emergency hospital model would help rural hospitals focus their efforts on the primary care needs of the community, chronic disease management, and emergency services most needed but would allow the flexibility to add other services as determined by the facility and the community the hospital services. The KHA representatives stated, while still being finalized, the Medicare payment methodology for rural emergency hospitals looks to help stabilize the financial situation of rural communities.

The Lindsborg Community Hospital representative stated the rural emergency hospital model would assist hospitals that cannot financially sustain acute inpatient beds by allowing the hospitals to sustain and maintain the needs of the population in rural communities.

Written-only **proponent** testimony was provided by representatives of the Kansas Association of Counties, the Kansas Bankers Association, the Kansas Farm Bureau, the Kansas Medical Society, the Kansas Association of Osteopathic Medicine, the League of Kansas Municipalities, and the United Methodist Health Ministry Fund; U.S. Senator Jerry Moran; and U.S. Senator Roger Marshall.

No other testimony was provided.

The Senate Committee amended SB 175 to:

- Remove managed care contracts for the state program of medical assistance and the Children's Health Insurance Program as required benefit providers for services performed by a rural emergency hospital if such services would be covered under such contracts if performed by a general hospital;
- Require all coverage maintained by entities authorized under KSA 40-2222 to provide benefits for services when performed by a rural emergency

hospital if such services would be covered under such contracts if performed by a general hospital; and

- Remove critical access hospital as an institution whose qualified services would be covered by the entities authorized in KSA 40-2222.

[*Note:* Senate Sub. for HB 2208 incorporates these changes.]

**House Committee on Health and Human Services.**

The House Committee did not hold a hearing on SB 175. SB 175 contains language similar to that in HB 2261; the House Committee held a hearing on HB 2261 on February 16, 2021, and recommended the bill favorably for passage. Additional details on HB 2261 may be found in the supplemental note on the bill. HB 2261 was stricken from the House Calendar on March 5, 2021, by Rule 1507.

The House Committee amended SB 175 to add the language of HB 2174. [*Note:* This amendment was not retained in Senate Sub. for HB 2208, as passed the House; instead, SB 175, as amended by the Senate Committee, was inserted.]

[*Note:* The Conference Committee reinserted the language of HB 2174, with additional amendments.]

**Fiscal Information**

According to the fiscal note prepared by the Division of the Budget on SB 175, as introduced, KDHE estimates enactment of the bill would require additional expenditures of \$183,680 from the SGF and 2.0 FTE positions for FY 2022. The amount includes \$129,000 for salary and wages (\$64,500 for each position); \$40,600 for two vehicles; \$10,000 for travel; \$2,520 for computers and data; and \$1,560 for communications. One position would be needed to

develop state licensure regulations and collaborate with CMS. The other position would conduct the initial licensure surveys of rural emergency hospitals. This would require traveling to facilities; conducting observations, interviews, and record reviews; writing reports; and following up with facilities not found in compliance. KDHE indicates it is possible that a portion of the expenditures could be paid with federal funds, but the amount or percentage is currently unknown. Additionally, no estimate is available at this time for revenues, as licensure fees have not been determined.

The Kansas Association of Counties and the League of Kansas Municipalities note that allowing certain hospitals to receive federal reimbursement as rural emergency hospitals could result in improvements to rural health care that would benefit cities and counties. However, the fiscal effect on local governments is unknown. Any fiscal effect associated with the bill is not reflected in *The FY 2022 Governor's Budget Report*.

*SB 138 (CCBHC Certification and Funding)*

**Senate Committee on Public Health and Welfare.** In the Senate Committee hearing on SB 138 on February 23, 2021, representatives of the Association of Community Mental Health Centers of Kansas, COMCARE, Four County Mental Health Center, Johnson County Mental Health Center, the Kansas Mental Health Coalition, and the Kansas Sheriffs Association provided **proponent** testimony.

The proponents generally stated the CCBHC model would provide a comprehensive range of mental health and substance use disorder 24-hour crisis care services and receive an enhanced Medicaid reimbursement rate based on the anticipated costs of expanding services to meet the needs of these complex populations. The proponents noted the state's shortage of mental health professionals, which is further challenged by being surrounded on all four borders by states that have either expanded Medicaid, implemented the CCBHC model, or both, which provides those states with

additional resources and the ability to recruit away already scarce Kansas behavioral health professionals. The proponents also noted an increased demand for services and stagnant reimbursement rates and stated the CCBHC model would provide an integrated and sustainably financed model for care delivery. The Four County Mental Health Center representative noted the success of its CCBHC “look alike” program funded through a CCBHC-expansion grant from the federal Substance Abuse and Mental Health Services Administration and its goal to become a CCBHC by the end of the two-year grant cycle.

Neutral testimony was provided by a representative of KDHE. The KDHE representative stated concerns with implementing the CCBHC model by July 1, 2021, and indicated, ideally, 18 months would be needed for implementation. The representative stated the CCBHC model was discussed at a high level during the 2020 Special Committee on Mental Health Modernization and Reform, but establishing the program would be more complex. The representative stated CMS had requested 18 months to review and approve any Section 1115 waiver amendments or substantial state plan amendments. The PPS planning and rate-setting process would involve the completion of multiple steps, including assessing the impact of the CCBHC model on Section 1115 waiver budget neutrality and addressing any budget neutrality concerns, and a unique PPS rate would need to be developed for each CCBHC based on each facility’s cost. Written-only neutral testimony was provided by KDADS.

No other testimony was provided.

#### *Fiscal Information*

According to the fiscal note prepared by the Division of the Budget on SB 138, as introduced, although the bill would require a start date of no later than July 1, 2021, CMS recommends at least 18 months to allow for the drafting of a

Medicaid state plan amendment or Section 1115 waiver amendment and an impact assessment of the CCBHC program on the state's Section 1115 waiver budget neutrality. This recommendation would make an FY 2022 implementation date highly challenging. However, the fiscal effect is calculated assuming the July 2021 start date. KDHE and KDADS estimate the combined cost for the agencies would range from \$43.0 million to \$74.2 million from all funding sources, including \$17.4 million to \$29.9 million from the SGF for FY 2022. The expenditures are detailed below.

KDADS estimates administrative costs associated with creation of the CCBHC program would require \$1.1 million from the SGF for FY 2022. Included in these costs, the agency estimates it would require an additional 14.0 FTE positions, at a cost of \$616,858 for salaries and benefits. These positions would include those needed to adequately support all certification, rate setting, and monitoring functions. Also, Medicaid support contracts would increase due to system changes that would need to be implemented to account for the new program. KDADS estimates consultant work to develop and design the program structure would cost \$37,500, technology system changes and rate setting would cost \$277,000, and actuarial services would cost \$150,000.

Medicaid services costs would be projected to range from \$40.8 million to \$71.9 million from all funding sources, including a range of \$16.3 million to \$28.8 million from the SGF. It is assumed that, over time, 26 CMHCs would eventually transition to CCBHCs. At that point, the agency estimates the cost would be the projected high end of the range.

Any fiscal effect associated with the bill is not reflected in *The FY 2022 Governor's Budget Report*.

***HB 2174 (Rural Hospital Innovation Grant Program)***

The bill was introduced by the House Committee on Appropriations at the request of Representative Waymaster.

[*Note:* The provisions as introduced are the same as those of 2020 HB 2522 as amended by the House Committee on Health and Human Services, with technical updates.]

#### House Committee on Health and Human Services

In the House Committee hearing, representatives of the KHA and the League of Kansas Municipalities provided **proponent** testimony. Written-only testimony was provided by representatives of Kansas Farm Bureau and the Kansas Medical Society. Proponents stated the grant program would benefit rural hospitals and rural communities and allow rural hospitals to adjust to community changes. (The bill remains in the House Committee.)

#### Fiscal Information

According to the fiscal note prepared by the Division of the Budget on the bill as introduced, a maximum of \$30.0 million would be available for the Program, including \$10.0 million transferred from the SGF and \$20.0 million from private stakeholder funds raised through the state match requirement. The Kansas Department of Health and Environment estimates \$100,000 in yearly costs, including funding for a program manager position and other operating expenditures. Any fiscal effect associated with enactment of the bill is not reflected in *The FY 2022 Governor's Budget Report*.

Behavioral Sciences Regulatory Board; State Board of Healing Arts; telemedicine; licensure; disciplinary action; temporary permits; professional counselors; social workers; marriage and family therapists; addiction counselors; psychologists; physicians; certified community behavioral health clinics; community mental health centers; certification; mental health services; substance use services; rules and regulations; Kansas Medical Facilities Survey and Construction Act; Rural Hospital Innovation Grant Program; Rural Hospital Innovation Grant Fund

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