Kansas Hospital ASSOCIATION

TO: Senate Public Health and Welfare

FROM: Tara Mays, Vice President of State Legislative Affairs

DATE: February 4, 2025

RE: SB 3

Thank you for the opportunity to address the committee on behalf of our 121 community hospital members regarding Seante Bill 3.

The KHA believes that Senate Bill 3 is unnecessary government duplication. Currently, Kansas Hospitals must meet federal CMS Conditions of Participation which include several components of discharge planning that overlap with the requirements set fort in K.S.A. 65-431(a).

CFR 482.43(a)-482.43(c) requires that a hospital must take steps to assure that its discharge planning policies and procedures are implemented consistently. The discharge planning specifically addresses the role of the patient's representative, by requiring the hospital to develop a discharge planning evaluation and to discuss the evaluation and plan with the patient. Further, the discharge planning evaluation requirements require an assessment of the patient's capability for post-discharge self-care and requires our hospitals, to actively solicit information not only from the patient or the patient's representative, but also from family, friends, and support persons. Below you will find the Conditions of Participations language that exclusively lays out discharge planning that includes caregivers:

§ 482.43 Condition of participation: Discharge planning.

The hospital must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions.

*(a) **Standard: Discharge planning process.** The hospital's discharge planning process must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and must provide a discharge planning evaluation for those patients so identified as well as for other patients upon the request of the patient, patient's representative, or patient's physician.*

(1) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

(2) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including, but not limited to, hospice care services, post-hospital extended care services, home health services, and non-health care services and community based care providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.

(3) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

(4) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

(5) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel.

(6) The hospital's discharge planning process must require regular re-evaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(7) The hospital must assess its discharge planning process on a regular basis. The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs.
(8) The hospital must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The hospital must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.
(b) ***Standard: Discharge of the patient and provision and transmission of the patient's necessary medical information.*** *The hospital must discharge the patient, and also transfer or refer the patient where applicable, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.*
(c) ***Standard: Transfer protocols.*** *Effective July 1, 2025, the hospital must have written policies and procedures for transferring patients under its care (inclusive of inpatient services) to the appropriate level of care (including to another hospital) as needed to meet the needs of the patient. The hospital must also provide annual training to relevant staff regarding the hospital policies and procedures for transferring patients under its care.*
(d) ***Standard: Requirements related to post-acute care services.*** *For those patients discharged home and referred for HHA services, or for those patients transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services, the following requirements apply, in addition to those set out at paragraphs (a) and (b) of this section:*
(1) The hospital must include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.
(i) This list must only be presented to patients for whom home health care post-hospital extended care services, SNF, IRF, or LTCH services are indicated and appropriate as determined by the discharge planning evaluation.
(ii) For patients enrolled in managed care organizations, the hospital must make the patient aware of the need to verify with their managed care organization which practitioners, providers or certified suppliers are in the managed care organization's network. If the hospital has information on which practitioners, providers or certified supplies are in the network of the patient's managed care organization, it must share this with the patient or the patient's representative.
(iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the patient's representative.
(2) The hospital, as part of the discharge planning process, must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services and must, when possible, respect the patient's or the patient's representative's goals of care and treatment preferences, as well as other preferences they express. The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patient.
(3) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of part 420, subpart C, of this chapter

Further, if patients or caregivers have concerns about these standards not being met there are appropriate channels available for the patient to find remedy. Currently all complaints can be filed by calling 800-842-0078 and including the hospital name, the patient name, what happened including dates, and your name and contact information (unless you prefer to file anonymously). The complaint processs then will kick of an investigation process by the Kansas Department of Health and Environment. At the federal level you can also file a complaint by calling the Joint Commission by visiting:

Joint Commission Connect –

Between requirements already upon or hospitals with respect to meeting these guidelines and processes already in place to find remedy if those processes are not met, we don't see this government duplication as a need at this time.

We thank you for the opportunity to provide comments on Senate Bill 3.