February 18, 2026

Post Hospital Extended Care and Hospital Discharge Guidance for CCOs

This document provides guidance to Coordinated Care Organizations that supplements the Post-Hospital Extended Care Benefit Oregon Administrative Rule (OAR 411-070-0033) and Care Coordination: Service Coordination Administrative Rule (OAR 410-141-3870).

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Purpose & Background

In 2023, Oregon legislators established the Joint Task Force on Hospital Discharge Challenges to address the needs of Oregonians who are waiting in hospitals to be discharged to the next appropriate level of care. Senate Bill 296 was passed in 2025 to address several of the identified challenges Oregonians face.

With the Joint Task Force and SB 296 passage in 2025, Oregon lawmakers confronted the problem that people were becoming stuck in hospitals when they were unable to be discharged to an appropriate post-acute care setting. This issue, while not new, was greatly exacerbated during the COVID-19 pandemic when the post-acute care sector faced severe disruptions. These challenges persist now as hospitals serve an aging population with growing needs for mental health, addiction, and housing supports that the traditional post-acute care model was not designed to address. As a result, Oregon's limited hospital beds are often in use to care for people who are ready to be discharged to less intensive care settings. While additional studies are being conducted through SB 296 to research additional options for system improvements for OHP members with complex care needs, immediate changes to the Post Hospital Extended Care Benefit (PHEC) were required by the state legislation.

Changes to the PHEC benefit (detailed in the 1/1/2026 OHA memo) and targeted process improvements are meant to assist OHP members facing these discharge challenges at vulnerable moments in their lives, often following an acute illness or injury necessitating a hospital stay. Many of these individuals face additional challenges such as chronic health conditions, limited social support, housing insecurity, or homelessness.

What Is Post Hospital Extended Care (PHEC)

PHEC is an OHP medical benefit that covers medically necessary daily skilled nursing or rehabilitation care after a hospital stay for up to 100 days. This means care that only a skilled professional (e.g., Nurse, Physical Therapist, Occupational Therapist or Speech-Language Pathologist) can provide. Daily skilled care can be necessary for many different reasons upon discharge, such as:

- The patient is at risk of further injury from falls, dehydration or nutrition because of insufficient supervision or assistance at home.
- The patient's condition requires daily transportation to a hospital or rehabilitation facility by ambulance.
- The patient's home is too far away for a home health nurse to travel and provide daily nursing or rehabilitation services.

Who qualifies for the PHEC benefit?

Current OHP members who are not Medicare-eligible and:

- Are at least three days into a medically necessary, qualifying hospital stay in an OHP-paid acute care bed (not a hold bed, observation bed, or emergency room bed);
- Need skilled nursing or rehabilitation services on a daily basis for a hospitalized condition meeting Medicare skilled criteria that may be provided only in a nursing facility (See OAR 411-070-0033 for additional details); and
- Will transfer to a nursing facility within 30 days of discharge from the hospital.

When is PHEC the Right Benefit

To facilitate a timely discharge and the additional medical care an OHP member requires per discharging medical provider assessment, the CCO should consider the discharging hospital/provider request and determine whether a member needs the higher level of support and care a SNF can provide over home health care services benefits (OARs 410-127-0020, 410-127-0040, 410-127-0045, 410-127-0046, 410-127-0060, 410-127-0065, 410-127-0080, 410-127-0200).This assessment should include determinations on whether the member has adequate home support and setting to facilitate a safe recovery and additional nursing and therapies as necessary.

The CCO and provider should consider the following things when determining if the PHEC benefit is appropriate:

- **Provider's Order & Medical Need**

When a medical provider believes the member needs the care at a SNF, a provider must request/order the care, which must be for a condition treated during the hospital stay. Hospital discharge teams should contact the CCO when they believe a member is ready to discharge to PHEC.

- **Daily Skilled Care Needs**

If the patient needs daily skilled nursing (e.g., injections, wound care) or therapy (Physical Therapy, Occupational Therapy, Speech Therapy) and meets the criteria as noted previously.

- **Level of Care at a SNF is Reasonable & Necessary**

PHEC may be the best choice when the medical condition and services needed for a member's recovery as noted by the medical provider or discharge team requires the daily and weekly level of care that can be provided in a SNF's 24 hour round the clock setting. The quantity and duration of services must be appropriate for the illness or injury. The situation of the member, such as noted previously about member's risks at home, may also influence preference for SNF care.

When considering hospital discharge to a PHEC:

- When a PHEC stay is medically indicated, do not delay hospital discharge in order to complete an LTSS assessment. The LTSS assessment may be completed during the PHEC stay.
- PHEC is not for stays longer than 100 days. Discharge notices must be sent 30 days prior to end of a PHEC 100 days. Individuals may be eligible for longer stays under the long-term nursing facility care benefit if they meet criteria.
- PHEC is not for members who only need assistance with activities of daily living (ADL) or Instrumental Activities of Daily Living (IADLs). Individuals may be eligible for this care through Medicaid's home and community-based services benefit. The following are examples of services and care that would not require a PHEC stay if a skilled care need does not exist:
    - **Custodial Care:** Help with basic activities (bathing, dressing, eating) if skilled care isn't needed.
    - **Non-Skilled Needs:** If care can be safely managed at home by family or non-professionals.
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Additional Considerations

- An individual may still enter a PHEC stay within 30 days after hospitalization. If a member has been discharged to home but the member's medical provider, such as a primary care provider, submits a request for a PHEC admission, the CCO shall review this request promptly.

- An individual shall be deemed not to have been discharged from a skilled nursing facility if, within thirty (30) days after discharge, the member is admitted to such facility or any other skilled nursing facility as noted in 42 USC 1395x(i).
- The individual may qualify for another one hundred (100) day post-hospital extended care benefit only if the individual has been out of a hospital and has not received skilled nursing care for 60 consecutive days in a row and meets all the criteria in this rule (i.e. has a separate qualifying hospital stay).

CCO Authorization and Care Coordination Requirements

The CCO has the direct role of authorizing the PHEC stay at a Skilled Nursing Facility (SNF). The CCO team should review requests of the hospital discharge team and discharging medical provider for PHEC approval and transport. CCO members do not need authorization from ODHS Aging and People with Disabilities (APD) or Area Agency on Aging (AAA) for PHEC, but it is a good idea to notify them as expected in the CCO-LTSS (Long-term Services and Supports) MOU of any care setting transition from hospital to SNF. 14-day Interdisciplinary Team (IDT) follow-up meetings for members should allow for additional partnership to support members after transition to SNF settings.

CCOs shall notify the Member's local ODHS APD office prior to the Member being admitted to PHEC. Upon receipt of such notice, CCO and the Member's APD office must promptly begin appropriate discharge planning.

- CCOs should update the member's care profile, risk stratification level and care plan based on the member's health status changes from hospitalization and discharge to the SNF as outlined in OAR 410-141-3865 and OAR 410-141-3870.
- CCOs shall ensure scheduling of the required IDT meetings to include all parties to discuss member care needs as outlined in OAR 410-141-3870. The IDT meeting must occur within 14 days of a transition between levels, settings or episodes of care.

PHEC Discharge Processes

Decisions about discharge are subject to medical review of member's status and approval of the medical provider. CCOs should ensure that there is adequate time prior to discharge to ensure other support services that may still be needed by the member are authorized and in-place prior to PHEC discharge.

Skilled Nursing Facility discharges fall under 42 CFR 483.15 Federal Nursing Home regulations which require members receive notice 30 days in advance of discharge or transfer. These notices must include content as outlined in 42 CFR 483.15(c)(5) including the effective date of discharge or transfer; reason for discharge; the location to which the resident is transferred or discharged; appeal rights including contact information for entity receiving the appeal request and how to obtain an appeal form and assistance in completing the form; and name, address, email and telephone number of the state long-term care ombudsman; and meet additional requirements for those with disabilities.

Exceptions to 30-day discharge notices are allowable for the following and should be provided in these cases as soon as practicable before transfer or discharge and no less than two full days prior to discharge (410-141-3870(6)(e)(C) and Exh. B, Pt. 2, Sec. 6, Para. D, Sub Para. (3), when:

- The safety or health of other individuals in the facility would be endangered;
- The resident's health improves sufficiently to allow a more immediate transfer or discharge,
- An immediate transfer or discharge is required by the resident's urgent medical needs, or
- A resident has not resided in the facility for 30 days.

CCOs shall ensure that all of a Member's post-discharge services and care needs are in place prior to discharge from the PHEC, including but not limited to Durable Medical Equipment (DME), medications, Home and Community Based Services (HCBS), discharge

education or home care instructions, scheduling follow-up care appointments, and provide follow-up care instructions that include reminders to:

- Attend already-scheduled appointments with Providers for any necessary follow-up care appointments the Member may need; and/or
- Schedule follow-up care appointments with Providers that the Member may need to see.

CCOs may consider other additional home supports such as community health care workers, who may support discharge to home if needs still exist. CCOs should work with LTSS Home and Community Based Services providers to request assessment when a member may benefit from these additional Medicaid support programs to promote safe and effective transitions. Timelines for approvals should be considered so that members have all needed services when discharging to home. A PHEC stay is still appropriate for those who need skilled medical therapies and a custodial care need exists to support their recovery. LTSS programs and services are likely a better match when the member only requires assistance with ADLs or IADLs to safely be at home but does not have a need for skilled medical therapies or other risks to member health and recovery don't exist.

CCOs must ensure that post-discharge services and supports are provided consistent with the care coordination process as specified in OAR 410-141-3860, OAR 410-141-3865, and OAR 410-141-3870 and reflected in the member's care plan. Services provided to support discharge from a PHEC stay, including Medicaid home and community-based services (HCBS), non-skilled supports and other transitional services should be identified through the assessment, incorporated into the care plan and implemented in a manner that ensures continuity of care and safe transition to the community.

Medicare Skilled Nursing Benefit

OHP members with Medicare [dual eligibles] already have a Medicare benefit that provides coverage similar to PHEC. OHP continues to cover deductibles and cost sharing for Qualified Medicare beneficiaries (OHP benefit packages BMM and MED).

CCOs should be working directly with the member's Medicare providers and affiliated Medicare Advantage (MA) or Dual Eligible Special Needs (DSNP) plans to facilitate timely discharge to SNF facilities for members with qualifying hospital stays. For members with Medicare Advantage plans, check with the Medicare Advantage plan provider for facilities covered by the MA plan.

As noted previously, CCOs should update the dual eligible member's care profile, risk stratification level and care plan based on the member's health status changes from hospitalization and discharge to the SNF as outlined in OAR 410-141-3865 and OAR 410-141-3870. Close coordination with the Medicare Advantage (MA) or DSNP plan or Medicare providers to align and complete care coordination tasks, as well as to assure communication with APD/AAA is critical. CCOs shall ensure scheduling of the required IDT meetings to include all parties to discuss member care needs as outlined in OAR 410-141-3870. The IDT meeting must occur within 14 days of a transition between levels, settings or episodes of care.

Coordinating Post-PHEC Long-Term Services and Supports

Members often require careful coordination and planning between PHEC and other long-term services and supports. OHA recommends the implementation of the following best practices.
Before the PHEC stay ends:

- Engage medical providers to review member's condition and needs as part of any transition planning.
- Ensure adequate time to coordinate transition between the nursing facility and the member's CCO discharge requirements.

Reach out to the appropriate APD/AAA, Office of Developmental Disabilities Services or Comagine or Acentra team for 1915(i) services approximately 45 days before the PHEC stay ends. It is encouraged to start the communication process as soon as you can after a member enters PHEC about the discharge planning where you anticipate a member may qualify for 1915 home and community-based services programs. Request LTSS assessments through APD/AAA as appropriate and as soon as possible.

- Notify members as soon as practicable as outlined in 42 CFR 483.15 before any transition of eligibility or discharge due to health status improvements where possible or as required at least 30 days prior to the end of the 100 day benefit period.
- On-going communication and partnership with APD/AAA is important to ensuring critical care setting transitions occur timely and support members.

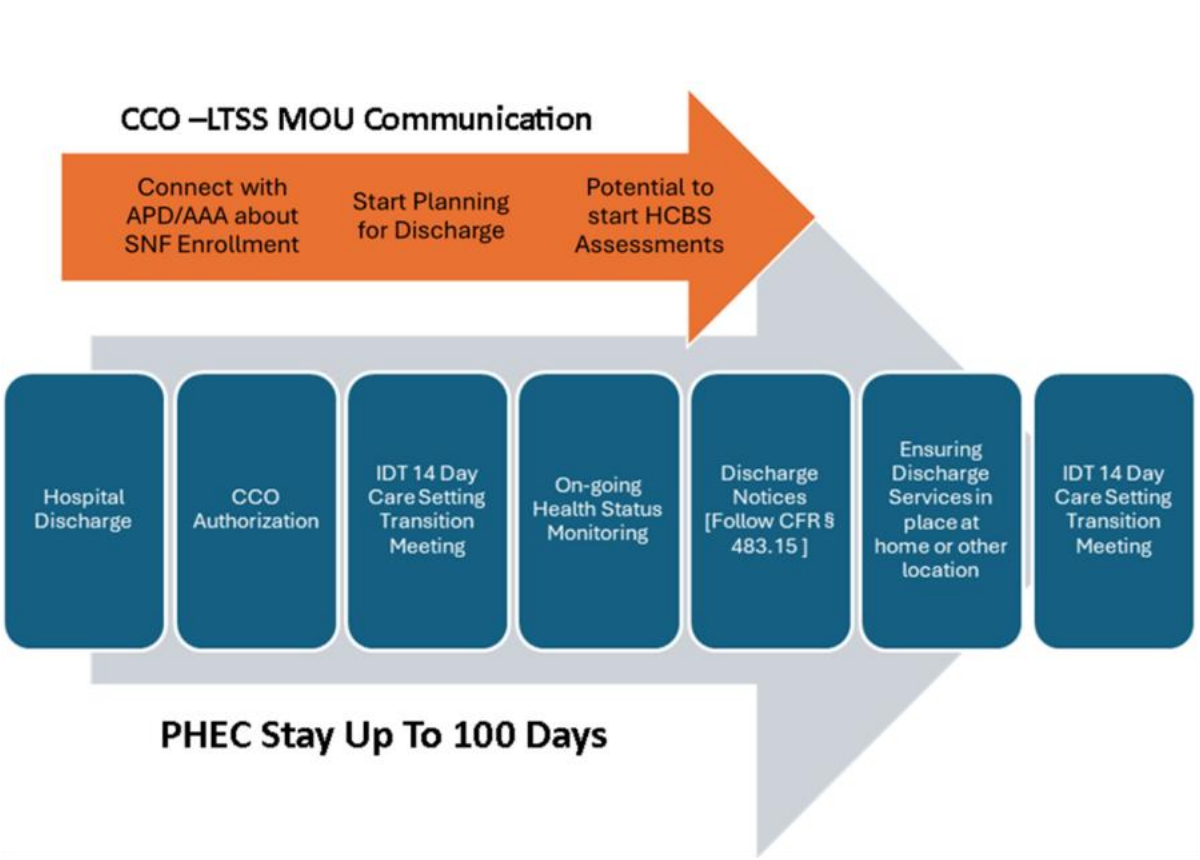

Diagram highlights that processes to coordinate with LTSS service needs should be parallel

PHEC Billing Reminders:

Skilled Nursing Facilities (SNFs) bill with Revenue Code 101, which is a bundled payment code. OHA Provider guidance is posted.

CCOs are not responsible for the PHEC benefit unless the Member was enrolled with the CCO at the time of the hospitalization preceding the PHEC facility placement. Contact your CCO Account Representative if modifications to dates of CCO enrollment are necessary.

Technical Assistance Questions:

For additional questions, contact Jennifer Valentine at Jennifer.B.Valentine@oha.oregon.gov

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You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact CCO Operations at HSD.QualityAssurance@odhsoha.oregon.gov or 800-527-5772 (TTY 711) We accept all relay calls.

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