Post-Hospital Extended Care Benefit (20-Day Skilled Nursing)

This summary is intended to support Oregon Health Authority (OHA) conducting a cost-impact analysis of extending the post-hospital extended care (PHEC) — also known as the 20-day skilled nursing facility benefit — from 20 days to 30, 60 or 100 days. The Joint Task Force on Hospital Discharge Challenges (2023-2024) has requested OHA analyze scenarios and cost impacts of extending the benefit.

Overview

Oregon provides a PHEC medical benefit for eligible people to stay up to 20 days in a nursing facility as part of the Oregon Health Plan (OHP) Plus benefits for individuals 21 years old and older. OHP members may qualify for additional rounds of the benefit if they have not received skilled nursing care during the past 60 days and they continue to be eligible. If a member interrupts their 20-day stay, they may return within 14 days to continue the remaining time.

People who are dually eligible for Medicaid and Medicare will access skilled nursing facility benefits through their Medicare benefits. Medicare Part A covers skilled nursing facility care for its members fully up to 20 days. Medicare members can also access skilled nursing facility care for days 21-100 — Medicare partially covers care up to 100 days, but members are subject to a $200 per day copay for 21-100 days. If members are dually eligible and part of the Qualified Medicare Beneficiary (QMB) Program or QMB Plus, then Medicaid pays for deductibles and copays for skilled nursing facility services and other Part A and Part B services. People who are dual members are also eligible for full OHP Plus benefits receive the same skilled nursing facility services, plus coverage of non-Medicare benefits.

People receiving services through the Oregon Department of Human Services (ODHS) Aging and People with Disabilities (APD) Long Term Services and Supports program can also access nursing facility care without a qualifying hospitalization and stay more than 20 days.

Authority

The authority and detail for providing PHEC benefits lies in administrative rules including:

- OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System
- OAR 411-070-0033, Post Hospital Extended Care Benefit
- OAR 411-070-0043, Pre-Admission Screening and Resident Review (PASRR)

- OAR 410-410-3870, Care Coordination: Service Coordination (CCOs)

Any changes to the benefit will need to be reflected in rules.

Oregon's Medicaid State Plan has limited information about nursing facility services in reference to the PHEC. Unless eligibility changes, any changes to the length of the benefit for OHP members will not need to be updated in the State Plan.

Coordinated care organization responsibilities

Coordinated care organizations (CCOs) must ensure non-Medicare members receive PHEC coordination. If someone is not already enrolled in the CCO at the time of hospital admission prior to needing PHEC, the CCO is not responsible. CCOs pay for the PHEC benefit out of their global budget.

As part of PHEC coordination, CCOs will notify the APD office upon admission to the nursing facility. The CCO and APD will coordinate PHEC discharge planning and communicate the discharge date to the member and the facility within two days of being discharged.

CCOs have additional responsibilities pre-discharge from the nursing facility to ensure members' needs are met post-discharge such as durable medical equipment, medications and other needs.

For CCO members that are also Medicare members, the CCO is not responsible for paying any Medicare deductibles, coinsurance or co-payments for skilled nursing facility benefits for days 21-100.

Authorization

All members must have prior authorization to access this benefit. For Open Card members, pre-admission screening must be conducted by one of the following:

- Aging and People with Disabilities (APD).
- Area Agency on Aging (AAA).
- Private admission assessment (PAA) programs.
- Professional medical staff working directly under the supervision of the attending physician.
- Other organizations designated by ODHS.

CCOs may waive the 20-day limit if they choose to but it is still paid within their global budget.

Eligibility

People must be able to receive OHP Plus benefits and must not be a Medicare member to be eligible for the PHEC benefit. They must also meet the Medicare Skilled Care criteria for a post-hospital skilled nursing placement.

Members must also have a medically necessary, qualifying hospital stay. The hospital stay must be a Medicaid-paid admission to an acute-care hospital bed (not including a hold bed, observation bed, or emergency room bed). The stay must consist of three or more consecutive days, not counting the day of discharge or observation time.

Members must be transferred to the nursing facility within 30 days of being discharged from the hospital.

Members must have a daily need for services for a condition meeting Medicare skilled criterion that may only be provided in a nursing facility. To meet this need, a member must be at risk for falling, dehydration, or malnutrition, need daily transportation by ambulance to a hospital or rehab facility, or be too far away to receive services at home.

For Open Card members, screeners conduct a first screening — Pre-Admission Screening and Resident Review (PASRR) Level I — to ensure members are eligible and they don't have a mental illness or intellectual or developmental disability.

Members are screened as part of PASRR Level I. Eligibility includes:

- Admitted from a hospital after receiving acute inpatient care.
- Admitted from a hospital after receiving care as an observation-status for a condition they were treated for in a hospital as referred by their attending physician and they will need nursing facility care for 30 days or less.
- Need for end-of-life care.
- Experiencing certain emergency situations.

Members with mental illness or intellectual or developmental disabilities with no Level I conditions are screened using PASRR Level II to determine if they need special services.

Limitations

- People eligible for Medicare cannot access the Medicaid benefit — they would access their similar Medicare benefit solely for skilled nursing care needs.
- The PHEC benefit must be accessed within 30 days of being discharged from the hospital.

Claims

According to ODHS Policy Transmittal Document SPD-PT-04-032, clients should use SSH and not NH for all PHEC claims, beginning August 1, 2004. Billing claims should use the code 0101 for PHEC. Nursing facilities are claiming a rate of $617.15 for the PHEC benefit. This matches the daily rate for complex care for nursing facilities published by ODHS Aging and People with Disabilities.