VA Community Nursing Home Fee Schedule and Veterans Care Agreement Reference Sheet

VA CNH Fee Schedule Methodology Specifications

The VA Community Nursing Home (CNH) Fee Schedule follows the Prospective Payment System (PPS) billing requirements found in Medicare Claims Processing Manual, Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing with some exceptions. The following is a list of those exceptions and some clarifying payment policy statements. This information is supplemental to the text of the VCA.

1. VA will use the Patient Driven Payment Model-based (PDPM) pricing software using the following specifications:
    a. CNH day 1-100: multiply physical therapy (PT), occupational therapy (OT), speech language pathology (SLP), nursing, and non-case-mix component case-mix index (CMI) values by 0.6 in addition to any other adjustment factors.
    b. CNH day 101+: remove PT, OT, and SLP components (or set CMI adjustment factor multiplier to 0). Multiply nursing and non-case-mix component CMIs by 0.6.
    c. The non-therapy ancillary component will follow PDPM (multiply CMI by 3.0 for the first three days and 1.0 for all remaining days).
2. There are no special prices outside of the VA PDPM-based PPS that may otherwise exist in local VA nursing home contracts. Here are some examples of those services or levels of care: memory care, behavioral, HIV/AIDS, respite, ventilator, tracheostomy, and isolation/private room.
3. Providers with agreements that use existing provider-specific pricing will not use the VA Fee Schedule for Community Nursing Home. Services delivered under these agreements will continue to be priced using the provider-specific negotiated pricing. Request for rates outside of the VA Fee Schedule, will need to be completed through the contracting process, VCAs may not be utilized for provider-specific negotiated pricing.
4. For the purposes of calculating length of stay:
    a. Providers are required to include the admission date in Field 12 of the Form CMS-1450 (also called the UB-04) or its electronic equivalent.
    b. The date of admission to the nursing home is used to calculate the starting point of the length of stay (i.e., change in payor or VA purchasing authority does not change the date of admission). See example below. VA will follow Medicare's interrupted stay policy, section 120.2 of the Medicare Claims Processing Manual Chapter 6. Or, more explicitly, an admission to a nursing home would be considered a continuation of the same nursing home stay if it occurs no later than 12:00am of the third consecutive calendar day following a discharge from the same nursing home. VA will not pay for bed holds under VCA.

    c. The date of discharge from the nursing home is used to calculate the ending point of the length of stay. The last covered day follows the policy in section 40.7 of Medicare Claims Processing Manual Chapter 6.
5. PDPM HIPPS codes will be calculated according to the following Minimum Data Set Assessment Schedule:
    a. For days 1-100 after the admission date, initial Medicare ("5-day") PPS assessment will follow the same schedule as under the previous RUG-IV model and the current PDPM model (assessment reference date anytime between day 1-8 of the stay), as referenced in section 120.1 of Medicare Claims Processing Manual Chapter 6.
    b. For days 101+ after the admission date, Interim Payment Assessment (IPA), as referenced in section 120.1 of Medicare Claims Processing Manual Chapter 6, will be completed at day 180 after the admission date and every 180 days thereafter.
    c. For all days, optional Interim Payment Assessment (IPA) may be completed at any point during a VA CNH stay, as referenced in section 120.1 of Medicare Claims Processing Manual Chapter 6.
    d. Veterans who are current residents of a nursing home during a nursing home's transition to a VCA will have an IPA with an assessment reference date within 7 days of the new authorization start date under the VCA purchasing authority. This is aligned with Medicare's PDPM FAQ answer 14.2.
6. Benefit exhaustion (under section 40 of Medicare Claims Processing Manual Chapter 6) is not one of the circumstances upon which nursing homes would bill. VA authorizations state the dates from and through which care is authorized.
7. VA does not require Veterans to "have been an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days."

Like in Chapter 6 of the Medicare Claims Processing Manual, VA covers some services under nursing home authorizations that are not considered part of the nursing home PPS. If providers delivering these services are separate from the nursing home and wish to be reimbursed directly, the providers must sign a separate VCA with the VA in order to bill under the same authorization. Otherwise, nursing homes with VCAs and active authorizations can bill VA for these services under the conditions listed below.

1. Physician Services
    a. Federally mandated or separately authorized physician services shall be billed fee-for-service. These services will be reimbursed at the lesser of billed charges or the Medicare Physician Fee Schedule.
2. Physical therapy (PT), occupational therapy (OT), speech language pathology (SLP)
    a. When physical therapy (PT), occupational therapy (OT), or speech language pathology (SLP) therapy is indicated during days 101+ of a Veteran's stay, providers must request prior authorization from VA for these services (see VA Form 10-10172). For care delivered on days 101+ of a Veteran's stay, these services shall be billed fee-for-service using the following procedure codes: G0151, G0152, G0153, G0157, G0158, G0159, G0160, G0161. These services will be reimbursed at the lesser of billed charges or the VA Fee Schedule. These services will follow the Medicare SNF Therapy Consolidated Billing Requirements.

3. Escort Services
    a. When a Veteran under a community nursing home authorization requires an escort to a medical appointment, providers must request prior authorization from VA for these services (see VA Form 10-10172). These services shall be billed fee-for-service using the following procedure code: G0156. These services will be reimbursed at the lesser of billed charges or the VA Fee Schedule.

Here is an example of changing purchasing agreement while caring for a Veteran under VA authorization:

Veteran was admitted to a nursing home on 1 May 2022 under a VA contract with the nursing home. In July, the nursing home chooses to sign a Veterans Care Agreement (VCA). The VCA is activated/effective 1 September 2022. A new authorization using the VCA purchasing authority is issued on 13 September 2022. The reimbursement process and all other aspects of the VCA are effective for care delivered under the new authorization starting on 13 September 2022. However, the admission date, to be included on all nursing home claims under VCAs, remains the actual admission date of 1 May 2022.

Other VA CNH VCA Specifications

1. For the purposes of the "PROVIDER REQUIREMENTS AND CONDITIONS FOR PROVISION OF COVERED SERVICES" section in the VCA template, VA requires the following:
    a. Prompt notification (within one business day) of the following events for Veteran receiving care at the facility at VA expense: death; emergency room visit; hospitalization; allegation of abuse; police activity involving the Veteran; elopement; and, intervention of Adult Protective Services.
    b. Prompt notification (within one business day) of any State Survey Agency (SSA) activity at the CNH and any SSA finding rated on the scope and severity scale as levels H-L.
2. For the purposes of the "INSPECTION OF SERVICES" section in the CNH VCA template, VA is describing its annual CNH provider assessment:
    a. The Veterans Health Administration (VHA) conducts the annual Community Nursing Home (CNH) assessment to ensure VHA is making sound clinical and business decisions by purchasing skilled nursing and rehabilitation care at CNHs. This is an in-person discussion, unless otherwise directed by the VA medical center chief of staff, with CNH leadership; this is generally the administrator, director of nursing, and director of admissions. This discussion should cover three topics:
        i. Veterans' experience at a CNH as documented during VHA staff on-site resident assessments, and/or as feedback from Veterans families or caregivers.
        ii. Review of CNH's current Medicare Nursing Home Compare scores.
        iii. Plans to maintain or improve care over the coming year.
    b. VHA does not regulate the care or inspect CNHs. VHA acts as an informed purchaser of care in order to purchase quality services for Veterans and enhance the Veterans' experience in CNHs.

3. For the purposes of the “MEDICAL RECORDS” section in the VCA template, VA requests the following:
    a. Remote access to Veteran electronic medical records, when available, for selected VA staff. This will assist VA staff in preparing for periodic visits to Veterans to assess Veterans’ care and wellbeing. Advance preparation will minimize interruption of nursing home operations during these visits.

Points of Contact

VA Geriatrics and Extended Care

Purchased Long Term Services and Supports

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