

March 16, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Impact of Practice Expense RVU Reductions on Access to Care in Skilled Nursing Facilities

Dear Administrator Oz:

On behalf of the undersigned organizations, we write to express serious concern regarding the recently implemented reductions to indirect Practice Expense (PE) RVUs for services furnished in Skilled Nursing Facilities (POS 31). While nursing facility (POS 32) services were not subject to the same reduction, the decreased Practice Expense valuation for POS 31 services creates a disparity that does not reflect how care is delivered in nursing home settings. We urge CMS to act expeditiously to correct this issue as it can have serious implications for frail, complex patients in the Skilled Nursing Facility setting.

In nursing home settings, the current Practice Expense differential between POS 31 (Skilled Nursing Facility) and POS 32 (Nursing Facility) does not reflect operational reality. In both settings, physicians and advanced practice practitioners (APPs) bill Medicare Part B directly for professional services. Importantly, physician and APP services are not included in SNF consolidated billing and are not paid to the facility under Part A. Skilled Nursing Facilities do not receive separate Medicare payment for these professional services and do not furnish or subsidize physician practice expenses.

Just as practitioners supply their own overhead and infrastructure in nursing facilities (POS 32), they do so in skilled nursing facilities (POS 31). The facility itself provides no discriminatory or additional practice expense support to physicians in one setting versus the other.

The practitioners providing care in SNFs and NFs are the same clinicians, using the same equipment, and bearing the same costs. These expenses extend well beyond bedside tools such as oto/ophthalmoscopes, reflex hammers, cerumen removal cures, sharp debridement equipment, laptops or tablets, and a stethoscope. Nursing home practitioners are independently responsible for substantial ongoing costs including:

- Electronic Health Record systems separate from the facility's electronic health record, along with associated licensing and maintenance fees;
- Coding and billing services necessary for Medicare compliance;
- Staffing and infrastructure to support 24/7 on-call coverage;

- Malpractice coverage;
- State medical licensure fees, DEA registrations, and state controlled substance certificates;
- Maintenance of board certification and continuing medical education;
- Two-factor authentication devices and services required for electronic prescribing of controlled substances (EPCS);
- Secure messaging platforms for managing multiple facilities; and
- Hotspot or Wi-Fi access necessary to document and transmit care.

In practice, clinicians often must maintain and utilize two separate electronic platforms, and pragmatically, two separate computers, to meet documentation and billing requirements across settings. None of these costs change based on whether the patient is in a SNF bed or a NF bed. They are fixed expenses borne by the practitioner regardless of the facility's certification status or POS designation.

As one independent physician explained:

“I work for an independent doctor group, and I have seen many patients in both a SNF (POS 31) and NF (POS 32) and have had to bring the same equipment including my own stethoscope, laptop, and other supplies needed to deliver care. In many cases, the POS designation is not known to the practitioner providing the care as this is handled by the facility”.

This real-world example underscores the core issue: practice expense remains the same whether the clinician sees a patient in POS 31 or POS 32, and the POS designation is handled administratively by the facility and may not even be known to the practitioner at the time of service. The patient may remain in the same bed, under the care of the same physician, with identical equipment, staff support, and documentation requirements. Yet payment changes solely based on certification status. The physician's overhead and indirect costs do not change. To even determine this can actually significantly increase administrative burden as well and many electronic medical records are not well equipped to manage this in real time to ensure billing accuracy.

It is also important to recognize that the vast majority of physicians and APPs who care for nursing home residents are not employed by the facility. They are independent practitioners or members of independent medical groups who personally bear the full cost of running their practices. This stands in sharp contrast to hospital-based physicians, who are typically employed by the hospital and do not pay for these expenses because they are covered by the employing institution. Nursing home practitioners receive no such institutional support. Reducing PE RVUs for POS 31 services therefore places a disproportionate and inequitable financial burden on

independent clinicians, while hospital-based practitioners providing facility-based services under similar codes are insulated from these same costs by their employers.

The reduction in PE RVUs for POS 31 is particularly concerning because post-acute SNF patients are among the most medically complex patients a clinician will encounter outside of the hospital. These individuals are often transitioning directly from acute care hospitalizations and require more frequent clinical attention, adjustment of complicated medication regimens, interpretation of laboratory and imaging results, and close monitoring to identify early signs of deterioration and prevent re-hospitalization. The clinical demands and cognitive intensity involved in managing these patients are substantial. Reducing payment in the very setting where patients require attentive and resource-intensive physician involvement is counterproductive and undermines the quality of care these vulnerable beneficiaries need most.

There is already a well-documented and persistent shortage of physicians and advanced practice practitioners willing to practice in nursing homes, a challenge that was further exacerbated by the COVID-19 pandemic. Decreasing payments to practitioners who provide care in SNFs will discourage clinicians from continuing to work in or entering this setting, creating serious access concerns for nursing home residents. Fewer clinicians in nursing homes means delayed assessments, missed changes in condition, increased emergency department visits, and more avoidable re-hospitalizations. These outcomes not only harm patients but also increase overall Medicare spending. This is not a theoretical concern; it is an immediate threat to access for some of Medicare's most frail and vulnerable beneficiaries.

We respectfully urge CMS to address this issue immediately either through guidance or an interim final rule by:

- Exempting nursing home evaluation and management codes from the current Practice Expense redistribution framework, and
- Restoring Practice Expense RVU parity for nursing home evaluation and management services, regardless of whether they are billed under POS 31 or POS 32.

Medicare beneficiaries in skilled nursing facilities deserve equitable access to clinician care. Payment policy should reflect the realities of care delivery and the true costs borne by practitioners.

We appreciate your consideration and stand ready to work with CMS to help ensure continued access to high-quality clinician care in nursing homes.

Sincerely,

Post-Acute and Long-Term Care Medical Association

American Healthcare Association

American Geriatrics Society

LeadingAge