PALTmed
POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION

PE RVU Reductions: Impact on Skilled Nursing Facility Care Access

BACKGROUND

CMS recently reduced indirect Practice Expense (PE) RVUs for services in Skilled Nursing Facilities (POS 31), while Nursing Facility (POS 32) services were not subject to the same cut, creating a payment disparity that does not reflect the operational realities of care delivery in nursing home settings.

Same clinicians. Same costs. Different pay.
Clinicians bill Medicare Part B directly in both SNFs and NFs. They are not employed by facilities, receive no institutional support, and bear all practice costs themselves — regardless of whether a patient is in a SNF or NF bed.

Payment varies by administrative status alone
The same clinicians using the same equipment now get paid differently based solely on a facility's certification status — a designation handled administratively and not always known to the practitioner at the time of care.

WHAT PRACTITIONERS PAY FOR — OUT OF POCKET

- Separate EHR systems, licensing, and maintenance
- Coding and billing services for Medicare compliance
- 24/7 on-call staffing and infrastructure
- Malpractice coverage
- State licensure, DEA registrations, controlled substance certificates
- Board certification and continuing medical education
- Two-factor authentication for electronic prescribing
- Secure messaging platforms across multiple facilities
- Computers/laptops
- Personal hotspot/Wi-Fi for documentation
- Opthalmoscopes and otoscopes (medical equipment)

None of these costs change based on POS designation.

WHY THIS MATTERS

Highly complex patients
SNF patients typically require intensive monitoring, medication management, and close follow-up to prevent hospitalization, reimbursement should not be lower.

Existing workforce shortage
A documented clinician shortage in nursing homes — already worsened by COVID-19 — will accelerate with lower reimbursement.

Higher Medicare spending
Fewer clinicians means delayed assessments, missed changes in condition, more ER visits, and avoidable hospitalizations — increasing costs.

WHAT CMS SHOULD DO

1. **Exempt** nursing home E&M codes from the current Practice Expense redistribution framework
2. **Restore** PE RVU parity for nursing home E&M services billed under POS 31 and POS 32