Transition to PDPM: How's it Going?

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About the Speaker

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Robin L. Hillier is a healthcare executive dedicated to post-acute and long-term care. Throughout her career she has been involved in all aspects of facility operations, including ownership roles. She is currently the President of RLH Consulting, which provides operational and reimbursement consulting to providers of skilled nursing, assisted living and intellectual or developmental disabilities. She is a nationally recognized expert on payment system design, quality measurement and the Resident Assessment Instrument, and was actively involved in the design of the Patient Driven Payment Model implemented October 1, 2019.

Ms. Hillier is Past Chair of both the Ohio Health Care Association (OHCA) and its' Educational Foundation (EFOHCA), and has served on the OHCA Board of Directors since 1998. She served on the Board of Governors and Executive Committee of the American Health Care Association (AHCA) from 2010 through 2017, and continues to serve on the Reimbursement Cabinet as Co-Chair. She serves on the American Association of Post-Acute Care Nursing (AAPACN) Board of Directors and chairs its' Expert Advisory Panel. Ms. Hillier was a recipient of the 2018 AANAC Contributor of the Year award, the 2015 AHCA Joe Warner Patient Advocacy award, and the 2004 OHCA President's award. She is a graduate of both the AHCA Future Leader and Political Ambassador programs, and represented AHCA at the 2014 White House Summit on Working Families.

Agenda

Transition Schedule

Immediate Next Steps

Action Plan

Transition Schedule

PDPM Conversion Factor

ORC 5165.19: (4) The department shall multiply each cost per case-mix unit determined under division (C) (1) of this section by the peer group average case-mix score in effect on December 31, 2025, divided by the peer group average case-mix score determined under section 5165.192 of the Revised Code for the semiannual period beginning January 1, 2026.

The product determined under this division for each nursing facility's peer group shall be the cost per case-mix unit used to determine the nursing facility's per Medicaid day payment rate for direct care costs under division (A)(1) of this section for the period beginning January 1, 2026, and ending on the day before the department's next rebasing conducted after that date takes effect.

PDPM Transition Schedule

January 1, 2026 rate

- 1/3 PDPM, 2/3 RUGs
  - PDPM uses Q2 and Q3 2025 scores
  - RUGs uses score from January 1, 2025 rate (Q2 and Q3 2024)

PDPM Data for 1/1/2026 Rate

Ohio Department of Medicaid
Long Term Care Case Mix System
Semi-Annual Final Medicaid Facility PDPM Nursing Component Case Mix Scores

Semi-Annual Run Date: 12/23/2025
Effective Date of Rate: 01/01/2026

Semi-Annual Scores Excluding PA1/PA2 PDPM Nursing Component Groups

Transaction Code	1 Actual	June 2025	Medicaid Score	1.4793
Transaction Code	1 Actual	September 2025	Medicaid Score	1.4968
			Total Score	2.9761
Transaction Code	1 Actual		Semi Annual Score	1.4881

The quarterly Medicaid facility PDPM Nursing Component CMI's shown on the report have been used for the semi-annual score.

*Per HB 96, ORC 5165.19 D4, a multiplier will be used to equalize the PDPM and RUGs score for rates beginning January 1, 2026 and ending the day before the department's next rebasing.

RUGs Data for 1/1/2026 Rate

Direct Care Rate Calculation

Schedule 3.0

Effective Date 01/01/2025
Run Date 1/13/2025

Direct Care Rate				
Line	Category	Schedule	Line	Amount
1	Direct Care Price	2.0	6	$ 48.41
2	Semi-Annual Case-Mix Score - Actual*	[redacted]		2.9917
3	Direct Care Rate (Line 1 x line 2)	[redacted]		$ 144.83

January 1, 2026 Rate Example

PDPM Component:		
◦ Semi-annual average case mix score	1.4968	
◦ X Direct care price	$48.41	
◦ = PDPM Component	$72.75	
◦ X "Conversion Factor" ESTIMATE	2.000	
◦ = "Converted" PDPM Component	$145.50	
◦ X .333 (1/3 Phase-in factor applied)		$48.45
RUGs Component:		
◦ January 1, 2025 direct care rate	$144.83	
◦ X .667 (2/3 Phase-in factor applied)		$96.60
ESTIMATED January 1, 2026 rate		$145.05

PDPM Transition Schedule: FY 2027

July 1, 2026 rate

- 2/3 PDPM, 1/3 RUGs
  - PDPM uses Q4 2025 and Q1 2026 scores
  - RUGs uses score from January 1, 2025

January 1, 2027 rate

- 2/3 PDPM, 1/3 RUGs
  - PDPM uses Q2 and Q3 2026 scores
  - RUGs uses score from January 1, 2025 rate

July 1, 2026 Rate Example

PDPM Component:

◦ Semi-annual average case mix score	????	Will be based on 12/31/25 and 3/31/26 average
◦ X Direct care price	$48.41	
◦ = PDPM Component	$72.75	
◦ X "Conversion Factor" ESTIMATE	2.000	Once this number is announced, it will stay the same
◦ = "Converted" PDPM Component	$_____	
◦ X .667 (1/3 Phase-in factor applied)		$_____

RUGs Component:

◦ January 1, 2025 direct care rate	$144.83	
◦ X .333 (2/3 Phase-in factor applied)		$48.22

ESTIMATED July 1, 2026 rate $_____

January 1, 2027 Rate Example

PDPM Component:

◦ Semi-annual average case mix score	????	Will be based on 6/30/26 and 9/30/26/26 average
◦ X Direct care price	$48.41	
◦ = PDPM Component	$72.75	
◦ X "Conversion Factor" ESTIMATE	2.000	Once this number is announced, it will stay the same
◦ = "Converted" PDPM Component	$_____	
◦ X .667 (1/3 Phase-in factor applied)		$_____

RUGs Component:

◦ January 1, 2025 direct care rate	$144.83	
◦ X .333 (2/3 Phase-in factor applied)		$48.22

ESTIMATED January 1, 2027 rate $_____

PDPM Transition Schedule: FY 2028

July 1, 2027

- 100% PDPM
  - Uses Q4 2026 and Q1 2027

January 1, 2028

- 100% PDPM
  - Uses Q2 and Q3 2027

The conversion factor goes away once we rebase again

Immediate Next Steps

Immediate Next Steps

Rate settings for January 1 are expected “any day now”

The state will calculate the actual conversion factor for each of the direct care peer groups

These conversion factors will remain the same once calculated until the next time we rebase the prices, they will not be recalculated with each rate period during the transition

- When rebasing occurs, the newly calculated prices will be higher to adjust for the lower average case mix scores

Immediate Next Steps

Have you found case mix reports?

Watch for email notifications from: MSLCWebPortal_OH_FI@mslc.com

Sample:

OMES Cost Report and Rate Setting Web Portal - Upload File Notification

The **Ohio Department of Medicaid** is pleased to inform you that an updated MDS Weekly Provider Report(s) is now available for download. Please log into the **Ohio Medicaid Enterprise Cost Report and Rate Setting Web Portal, click on Files to Download then Choose Provider** to download the PDF file created for provider ID **XXXXXXX**

Thank You,
Myers and Stauffer

Action Plan

Action Plan

1. Estimate your rates and compare with historical rates/budget expectations.
2. Track case mix scores in real time.
3. Evaluate case mix performance against perceived acuity.
4. Reinforce that quality measures should continue to be the primary focus.
5. Reinforce that case mix is a team effort.
6. Look for “low hanging fruit.”
7. Assess your NAC and ask for input about their challenges.

Estimate and Evaluate Rate Adequacy

If you do not already have a rate estimate for January 1, use the slides from this presentation to calculate your rate under PDPM and compare to historic rates and budget expectations.

You need to determine for yourself how the PDPM transition is affecting your facility

- Some facilities will benefit significantly from this transition and they don't know it
- Some facilities will be harmed significantly from this transition and they don't know it
- Many facilities will have either a slight increase or a slight decrease, similar to regular case mix fluctuation, and yet they are terrified
  - My sample facility would have a "full" PDPM rate of $145.50, compared to a RUG rate of $144.83

You can't develop an action plan until you can quantify the potential problem.

Evaluate Case Mix Against Perceived Acuity

This one is difficult. Historic case mix scores are not really a reflection of your center's acuity

- Therapy increased case mix scores for otherwise "lower' acuity residents
- Since 2020, quarterly scores often reflected people who were captured during isolation, which did not reflect those residents' "usual" acuity
- If you froze you case mix score, your current population could look very different from the population you had when that score was calculated

Acuity under PDPM is driven by diagnoses, treatments and function score

- Refer to Nursing Component Clinical Qualifiers handout and case mix weights handout

While behaviors can take a significant amount of staff time, it is generally CNA time which generates lower case mix weights

Track Case Mix Scores In Real Time

You should track your case mix scores throughout the quarter

When a new quarter starts, you should carry over their prior score until another assessment is done

Look for the weekly report posted each week to see the new scores from the prior week submissions and update your spreadsheet.

Some centers find it helpful to monitor by unit, or if you have multiple NACs, to monitor each NAC individually.

When a new assessment is completed, compare scores to the prior assessment and make sure differences make sense

My experience has been that there is less variability under PDPM

Reinforce that Quality Measures Continue to be Primary Focus

If your case mix score has been frozen, make sure that your NAC understands that quality measures continue to be the most important focus.

You can lose a lot more money if your quality measures slip than you will gain through case mix increases.

If the NAC is considering completing an "extra" assessment for case mix purposes, be sure to identify if that assessment will capture any of our QIP quality measures that could be avoided if the assessment is not completed.

- I have provided a tool that can be used to review the MDS items that would trigger a QIP measure before you complete and transmit an assessment that is not otherwise required

Reinforce that Case Mix is a Team Effort

The entire clinical team impacts case mix:

- Communication regarding changes in resident condition is critical
- Accurate and timely documentation is critical
- Other members of the IDT have to complete their interviews and assessments timely

Look for "Low Hanging Fruit"

Ensure your team understands how "Medicaid" status is determined

Evaluate Medicaid residents who return from a hospital stay if you aren't going to skill them

- IV fluids related to nutrition or hydration
- Diagnoses that map to high nursing categories, such as septicemia (special care high), respiratory failure (special care low if also receiving oxygen), pneumonia (clinically complex)

Identify residents who have a diagnosis of COPD, asthma or other lung disease and ensure shortness of breath is being properly assessed and documented

Identify resident with diabetes and daily insulin injections and ensure insulin order changes are being tracked

Consider implementing respiratory therapy programs such as incentive spirometers and ensure they are being captured if the criteria are being met

Look for "Low Hanging Fruit"

Identify residents with a diagnosis of cerebral palsy, Parkinson's disease or multiple sclerosis and determine their nursing function score; must be 11 or lower to qualify for special care low)

Ensure that the assessment team understand services that can be provided as an outpatient outside the facility while the resident remains your resident: dialysis or radiation (special care low); chemotherapy, transfusions, oxygen, or IV meds (clinically complex)

For residents who are grouping in the reduced physical function who have a function score of 11 or higher (PA1, PA2, some PBC1 and PBC2), discuss if there are behavior issues that are not being documented

Evaluate how mood interviews are being conducted

Evaluate restorative nursing program potential for residents in the behavior and cognition or reduced physical function category

Look for "Low Hanging Fruit"

Evaluate your process for determining "usual performance" in self care and mobility tasks (Section GG)

- How many of your Medicaid residents have high function scores? "A" or "BC"
- Does this make sense to you?
- **KEY POINT:** If you determine that this is not being done correctly, you need a thoughtful plan to be able to capture the higher acuity without triggering ADL decline for the quarter
  - **Identify potentially impacted residents and schedule an assessment in January to capture the accurate functional status; schedule another assessment for the same resident in March, ensuring there are at least 46 days between the ARDs.**
  - **The second assessment is the one that will count for the case mix score for the quarter and will eliminate the ADL decline which will trigger after the first assessment is complete.**

Assess Your NAC and Ask for Input

How frequently do you evaluate your NAC's skills?

Do you provide ongoing training and education?

Do you reinforce using the RAI manual regularly?

Schedule a time for a discussion with your NAC(s)

- What resources would be beneficial for them?
- What are their biggest frustrations and time wasters?

Upcoming Training Opportunities

Managing Reimbursement and Quality Metrics (Presented by Robin Hillier)

- Two-day program covers Medicaid and Medicare reimbursement topics, quality measures, 5 star
- Perfect for the entire IDT, offered four times per year, usually in Columbus
- Next session: February 3-4, Columbus
- Watch for June program in Northeast Ohio

Mastering the New Reality: MDS, Five-Star, Case Mix and QIP Update (Presented by Tammy Cassidy)

- Warren: February 18
- Cleveland: February 19
- Cincinnati: February 26

Final Thoughts

Some facilities will be so negatively impacted by the transition to PDPM that this brief session will not come anywhere close to solving your problem. For example:

- Some facilities might have to evaluate their “desired admission” and think about moving toward providing higher acuity services
- Some facilities might have to evaluate whether their therapy contract terms still make sense now that therapy doesn’t drive case mix any longer
- Some facilities might identify that their NACs need significant improvement in their assessment skills

But the first step is to make sure you know where you really are situated relative to the transition