GRAVITY

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MEDICAID PDPM TRANSITION

A STATE-BY-STATE ANALYSIS OF MEDICAID MODEL SHIFTS

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GRAVITY CONSULTING

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Navigating Medicaid PDPM – A Guide for SNFs

The landscape of long-term care reimbursement is undergoing a major shift as many states adopt Patient-Driven Payment Model (PDPM)-based systems for their Medicaid programs. While PDPM has been the standard for Medicare reimbursement since 2019, many states are now at varying stages of transitioning toward PDPM for Medicaid payment. Some states have already implemented PDPM-like structures for Medicaid, others are in active development and more will follow.

Because Medicare has discontinued support for the legacy payment models (i.e. RUGs III and RUGs IV) which many states relied on for Medicaid payment, this is pushing the states towards adopting PDPM or another payment structure. The support for the legacy payment models is ending on September 30, 2025, effectively forcing the states to transition, or at least plan for transition by October 1, 2025. However, there are some states that are not using RUGs-based payment methodology and thus are less likely to transition to a PDPM-based Medicaid model. You can see the full list of those non-PDPM Medicaid states here.

This shift brings a critical change in how reimbursement is calculated: it places greater emphasis on **diagnosis accuracy**, **clinical complexity**, and the **ongoing medical needs** of long-term residents—and SNF can play a vital role in improving their per diem rates through excellent clinical care, documentation and coordination. However, because of the PDPM shift, SNFs can no longer rely on therapy to achieve the higher RUG score and boost their CMI. Nursing, dietary, social work, activities and other key departments will need to increase their assessments, analysis, communication and coordination of care for long term care residents to ensure that all accurate PDPM components are captured on the MDS assessment for Medicaid.

This resource includes:

- Strategies for Success Under PDPM Medicaid
- Medicaid PDPM Nursing and NTA Strategies
- Medicaid PDPM PT, OT and ST Strategies
- State by State listing of the current or planned transition to PDPM for reimbursement
- List of states that are not utilizing PDPM for Medicaid Reimbursement

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Strategies for Success Under PDPM Medicaid

Whether your state adopts the **nursing component alone**, **nursing plus Non-Therapy Ancillaries (NTA)**, or the **full five-component PDPM model**, there are evidence-based strategies that can enhance both **clinical accuracy and reimbursement integrity**. Implementing these approaches not only supports high-quality resident care but can also lead to improved accuracy of reimbursement. In some nursing facilities, these strategies have contributed to **daily rate increases of $10 to $50 per resident** under PDPM.

Under PDPM Medicaid, therapy is no longer the primary driver of Case Mix Index (CMI)—a major shift from prior RUG-III and RUG-IV models.

In legacy systems, the mere presence of therapy services during the look-back period often outweighed most nursing clinical indicators, making therapy the dominant factor influencing CMI. However, **with PDPM Medicaid therapy plays a minimal role in reimbursement.**

This represents a fundamental change: **communities that historically achieved high CMIs through therapy-driven RUGs are now the most vulnerable under PDPM** and must adopt new clinical, documentation, and oversight processes to ensure reimbursement accuracy.

While nursing clinical indicators remain central, the diminished role of therapy demands a strategic shift to sustain or improve financial performance under the new model. While it may not be feasible to adopt all strategies simultaneously, facilities are encouraged to assess which approach best aligns with their current workflows, documentation practices, and clinical culture. Begin by selecting one high-impact strategy, implement it with consistency, and build from there as your team becomes more familiar with the PDPM Medicaid framework.

Disclaimer

All the information in this resource is provided as a general guideline and is based on the publicly available data as of the time of production. Gravity Consulting has made a good faith effort to ensure that the information in this resource is accurate. However, because the PDPM Medicaid transition is fluid and continuing to evolve in many states, Gravity will continue to review and update this resource as new

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information becomes available. If you are aware of any updated information that is not contained in this resource, please kindly share it with us so that we can update this resource for all. You can send any questions, comments or suggestions to Melissa Brown at MBrown@GravityConsulting.com.

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Medicaid PDPM Nursing and NTA Strategies

Specialty Physicians

Consider adding specialty physicians to your care team to promote increased awareness, documentation and care for increasing complex long term care residents. Some communities have added physiatry, wound physicians, cardiologists, nephrologists and pulmonologists to their care teams, and have increased the utilization of these specialists for the care of the long-term care population. These physicians and extenders can provide specialized evaluations and documentation to help shape a facility's reimbursement potential under PDPM Medicaid models. Many Medicaid PDPM states rely exclusively on nursing or nursing and NTA, with only a handful of states including PT, OT and ST. Because most states rely on the **Nursing component** or **Nursing + Non-Therapy Ancillary (NTA) components**, these can be directly impacted by the inclusion of quality specialty physicians in your SNF. Some of the key benefits these physicians can provide under PDPM Medicaid include:

- Confirming that diagnoses are **active** through up-to-date **tests**, **clinical evaluations**, or **ongoing treatment plans**
- Clearly documenting **how a diagnosis affects the resident's daily functioning or medical needs**
- Ensuring that ICD-10 codes are **specific and clinically accurate**, which improves MDS coding precision and payment
- Coordination with MDS and collaborating on the most accurate ICD-10 code, with the clinically appropriate specificity is key.

Part of the key to success with specialty physicians is planning for regular onsite visits to ensure that the appropriate documentation is provided, along with the clinically appropriate treatment for long term care residents. Many of these physicians are able to see the LTC residents at least once per month or quarter based on the clinical needs of the individual resident. Consider coordinating these visits with the MDS assessment schedule to ensure that necessary documentation is obtained during the appropriate look back period. Generally speaking, visits and documentation during the 7-day look back period would be beneficial.

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Respiratory Therapy

In all states that include the Nursing component, but especially for states that use only the nursing component, adding Respiratory Therapy can be a benefit to the resident while also improving Medicaid PDPM reimbursement. RTs can also impact NTA through diagnosis coding, but this impact tends to be less than it is with the nursing component. While the RAI Manual contains full details on how to capture Respiratory Therapy (RT) services on the MDS, here are some key highlights to keep in mind:

1. RT services can be provided by a Respiratory Therapist or by a nurse with additional respiratory training.
2. The RAI manual does not outline what specific training should be provided to an RN or LPN in order for that nurse to provide RT services in the SNF. However, most RT companies can provide this training for a nominal hourly fee. Many providers schedule this training either monthly or quarterly so that all new RN or LPN team members can receive additional RT training. The training often takes about an hour.
3. In order to receive the Special Care High nursing category from RT, the RT services must be provided on all 7 days of the 7 day look back period. Each day must have a minimum of 15 minutes of treatment per day. All treatment must be face-to-face time, which could include assessing vitals prior to treatment, setup of treatment, assistance with treatment, and taking vitals after treatment. The actual treatment time (e.g. length of time a resident is using a nebulizer) is not what is captured, but rather the one-on-one time spent by the nurse in direct care for the patient. Most residents achieve the 15-minute minimum through multiple treatments provided per day by multiple RTs and/or nurses.
4. Take caution about trying to implement RT services for most or all your LTC patients. Consider establishing a care protocol for how you determine whether a resident needs or would benefit from RT services. This may include a pulmonary function test, an initial evaluation by an RT, and ongoing RT assessment to determine if the resident continues to need and can benefit from the RT services. Remember that state surveyors often analyze the ability of an RN or LPN to complete all their regular tasks plus provide RT services with face-to-face time. Consider how many residents an RN or LPN can realistically provide RT services for during any shift along with completing their other required tasks. Adding an RT to your team will often help you achieve supportive documentation, appropriate staff productivity, and the clinical excellence.

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Capture Clinical Conditions That Elevate Nursing Case-Mix

Proactively assess and document qualifying conditions such as:

- **Behavioral symptoms** (e.g., aggression, wandering, rejection of care) – Remember that every single instance of behaviors should be documented. Even if a behavior is a "regular" occurrence for a resident, it should still be documented each time it occurs. The increased payment from increased behaviors is included with PDPM to help cover the increased costs that occur from proactively managing behaviors.
- **Cognitive impairment** While the BIMs assessment only captures the most significant cognitive impairments, it is still an important component of reimbursement. Audit your team member that conducts the BIMs assessment to ensure that they are following all the instructions exactly as they are outlined in the RAI Manual. Refer to the appendix in the RAI that includes useful tips for conducting an interview/assessment with the resident.
- **Depression** (PHQ 2-9): With the recent transition to the PHQ 2-9, many providers have seen the rate of depression captured with this assessment decline to around 10-12% of all residents. It's important to remember that this score is not based on whether the resident has a diagnosis of depression, but rather if they have a poorly controlled mood disorder or signs and symptoms of depression. This may mean that a resident with a diagnosis of depression that is well controlled will not flag on the PHQ 2-9 assessment, but another resident without a depression diagnosis may score a depression end split on the PHQ 2-9. Use this assessment to help your team identify which residents may require increased psychiatric care to effectively manage their depression or mood disorder. Many communites utilizie psychiatrists, whether virtual or in person, to conduct this assessment as part of their physciatric services, and this often results in higher ratesof depression captured on the MDS.
- **Infections requiring isolation:** Isolation achieves the highest nursing category – Extensive Services – under PDPM. With only ventilators and tracheostomies resulting in higher reimbursement, capturing isolation is a key item under PDPM Medicaid. If a resident achieves all the requirements for capturing isolation on the MDS, set your MDS assessment as soon as possible to ensure that isolation can be captured for that quarterly Medicaid assessment.

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- **COPD:** Residents with a diagnosis of COPD who demonstrate or report shortness of breath (SOB) while lying flat can receive Special Care High nursing reimbursement. Ensure that you have a process in place to continue to document the SOB for all residents with a diagnosis of COPD.
- **Restorative Nursing:** While Restorative Nursing Programs only affect reimbursement for the two lowest nursing categories (Behavioral Cognitive Symptoms and Reduced Physical Function), the impact can be significant, both financially and clinically. Consider adding RNPs as clinically indicated for any LTC resident (regardless of nursing category).

Section GG

While Section GG has been a part of the MDS since before the implementation of PDPM, the focus on Section GG for LTC residents has been limited. With the transitions to PDPM for Medicaid reimbursement, communities should increase their focus on accuracy of Section GG, and provide adequate supportive documentation that justifies the scores coded on the MDS.

Many communities continue to rely solely on therapy documentation to support the coding of Section GG on the MDS. However, the RAI manual clearly states that SNFs should, "*Assess the resident's self-care performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. **CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period**.*" In most communities, this includes, at a minimum, documentation from both nursing and therapy.

Often, the most effective strategy to achieve the necessary Section GG documentation from nursing is to transition the electronic medical record so that all the Certified Nurse Aide (CNA) documentation is completed utilizing Section GG terminology (similarly to how it was/is currently completed using Section G terminology). This provides a clear, detailed documentation record of the resident's usual performance. This is even more critical for LTC residents because often those residents will not be on therapy caseload during the look back period, and thus therapy cannot document the resident's current Section GG status. Adding this daily nursing Section GG documentation also allows the care team to identify and address avoidable declines in self care or

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mobility, so that they can be proactively addressed by therapy, thus helping to reducing the negative impact on Quality Measures.

ICD 10 Coding

All communities should consider adding a skilled coder to the care team that can help to ensure that the highest specificity can be accurately included in the medical record. This coder, which could also be an MDS Coordinator or DON, should be well versed in PDPM and understand how the coding can impact all 5 PDPM categories. While many communities have increased their ICD 10 coding scrutiny for skilled residents, many lack a focus on LTC resident diagnoses and fail to ensure that the most accurate diagnoses are included in the medical record.

Morning Meeting Process

Many of the key strategies above can be supplemented by improving your daily meeting process. While the majority of the meeting has historically focused on skilled residents, with the shift to Medicaid PDPM, SNFs should enhance their daily meeting to include a wide array of key clinical indicators for all LTC residents. This will help the MDS Coordinator to identify when a quarterly, annual, or IPA should be completed, ensuring accuracy of reimbursement. Some key items to review during the meeting include:

Nursing:

- New/worsening wounds (pressure, venous, arterial)
- New IVs (fluids or medication)
- Tube feeding order changes
- New diagnosis
- Transfusions
- New diabetic foot ulcers
- Wound infection/New wound infection
- MDROs
- Suctioning/New orders for suctioning
- Surgical wound/surgical wound care

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- New diabetic wound
- Dialysis
- Resident placed in isolation without roommate
- New placement of Oxygen
- Development of a fever/fever with vomiting
- New respiratory therapy orders
- Radiation
- Tracheostomy care
- Intermittent Catheterization

Social Services:

- Changes in cognition
- New symptoms of depression
- Changes in BIMS or PHQ 2-9 score
- Changes in discharge planning
- New or worsening behaviors

Dietary:

- Changes in diet/diet downgrade
- New swallowing difficulties / changes in swallowing
- New chewing difficulties
- Weight changes (loss or gain)
- Tube feeding order changes
- New order for IV fluids
- New malnutrition/at risk for malnutrition diagnosis
- Morbid Obesity

Therapy:

- Changes in resident self-care/mobility status (potential change in GG score)
- New therapy orders/changes in therapy orders
- Noted swallowing difficulty/difficulty chewing/coughing with meals

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- Complaints of pain during therapy
- Shortness of breath during therapy
- Changes in cognition, mood or behavior

Implementing these strategies ensures that nursing homes are capturing the full scope of resident care complexity, ultimately leading to **accurate and appropriate PDPM Medicaid reimbursement** for the nursing and NTA components—especially in **long-term care** settings.

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PDPM Medicaid Therapy Strategies

Some states include PT, OT or ST Case Mix Groups in the Medicaid PDPM methodology, increasing the responsibility on the care team to ensure accuracy of reimbursement for these categories. While the greatest opportunity to impact the therapy PDPM Medicaid reimbursement is with ST, ensuring that Section GG and the primary diagnosis are accurate will also be critical as that impacts PT and OT as well.

ICD 10 Coding- LTC Primary Diagnosis

All communities should consider adding a skilled coder to the care team that can help to ensure that the highest specificity can be accurately included in the medical record. This coder, which could also be an MDS Coordinator or DON, should be well versed in PDPM and understand how to accurately select the primary diagnosis. While many communities have increased their ICD 10 coding scrutiny for skilled residents, many lack a focus on LTC resident diagnoses, and ensuring that the most accurate **primary diagnosis** is included in the medical record. Follow the guidelines of the RAI Manual, which instruct that the primary diagnosis is the the main diagnosis that necessitates SNF level services as of the MDS ARD. Ensure there is a process for reviewing the clinical record every quarter and reassesing the primary diagnosis for every LTC MDS assessment to establish the most appropriate primary diagnosis as of the ARD.

Speech Therapy Specific ICD 10 Coding

The speech therapist is the primary clinician responsible for ensuring that all appropriate ST related diagnoses are included in the medical record. Ensure that any diagnoses added to the therapy evaluation or documentation is shared with the physician and signed off as clinically indicated. This ensures that the most accurate ST related diagnoses are included in the medical record. Utilize an ICD 10 coding expert to review all ST related coding to ensure that the most accurate codes are selected.

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Section GG

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Many communities continue to rely solely on therapy documentation to support the coding of Section GG on the MDS. However, the RAI manual clearly states that SNFs should, "*Assess the resident's self-care performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. **CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period***." In most communities, this includes at a minimum documentation from both nursing and therapy.

When nursing and therapy Section GG scores are combined, this will generally lower the overall Section GG score, which will increase the total per diem rate.

Often, the most effective strategy to achieve the necessary Section GG documentation from nursing is to transition the electronic medical record so that all the Certified Nurss Aide (CNA) documentation is completed utilizing Section GG terminology. This provides a clear, detailed documentation record of the resident's usual performance. This is even more critical for LTC residents because often those residents will not be on therapy caseload during the look back period, and thus therapy cannot document the resident's current Section GG status. Adding this daily nursing Section GG documentation also allows the care team to identify and address avoidable declines in self care or mobility, so that they can be proactively addressed by therapy, thus reducing any negative impact on Quality Measures.

Swallowing

Consider providing education for your entire care team at least annually on the importance of recognizing, reporting and documenting any observed or reported incidence of a resident's difficulty or pain with swallowing medications, foods and liquids, as this can contribute toward ST reimbursement. Even if the

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difficulty with swallowing is “normal” for a resident, the medical record needs to continue to include evidence of the swallowing difficulty so that it can be captured on the MDS assessment. And every instance of observed or reported swalling issues should be documented every time.

Cognitive impairment

While the BIMs assessment only captures the most significant cognitive impairments, audit your team member that conducts the BIMs assessment to ensure that they are following all the instructions exactly as they are outlined in the RAI Manual. Refer to the appendix in the RAI Manual that includes useful tips for conducting an interview/assessment with the resident.

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State by State PDPM Medicaid Analysis:

This guide offers **state-by-state insights** into Medicaid PDPM implementation and provides practical tips on how clinicians can support PDPM documentation and appropriate reimbursement—while continuing to deliver exceptional care to long-term care residents.

States that Use/Plan to Use PDPM:

(Click on the blue link below to go straight to the state pages for additional education.)

Colorado
Georgia
Hawaii
Idaho
Illinois
Indiana
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Minnesota
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New York
North Carolina
North Dakota
Ohio
Pennsylvania
Rhode Island
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

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States that DO NOT Use PDPM:

(Click on the blue link below to go straight to the state pages for additional education.)

Alabama
Alaska
Arizona
Arkansas
California
Connecticut
Delaware
Florida
Iowa
Michigan
Mississippi
Montana
New Jersey
New Mexico
Oklahoma
Oregon
South Carolina

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State-by-State PDPM Medicaid Transition Summary

Alabama

Alabama is using a cost-based reimbursement system and there is no indication of transition to PDPM at this time.

You can find out more at the Alabama Department of Health website: Alabama Medicaid and https://medicaid.alabama.gov/documents/9.0_Resources/9.2_Administrative_Code/9.2_Adm_Code_Chap_22_Nursing_Facility_Reimbursement_3-20-24.pdf

Alaska

Alaska uses a cost-based reimbursement system and does not utilize RUGs III/IV or PDPM methodologies, and there is no indication of a planned transition to PDPM at this time.

You can find out more at: https://dhss.alaska.gov and Alaska Statutes § 47.07.070 (2024) - Payment rates for health facilities :: 2024 Alaska Statutes :: U.S. Codes and Statutes :: U.S. Law :: Justia

Arizona

Arizona uses a cost-based reimbursement system and does not utilize RUGs III/IV or PDPM methodologies, and there is no indication of a planned transition to PDPM at this time.

You can find out more at https://www.azahcccs.gov/Resources/Downloads/StatePlans/Section4/SP_4.19-D.pdf?

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Arkansas

Arkansas uses a cost-based reimbursement system and does not utilize RUGs III/IV or PDPM methodologies, and there is no indication of a planned transition to PDPM at this time.

You can find out more at https://humanservices.arkansas.gov/wp-content/uploads/Medical-Assistance-Program-Manual-of-Cost-Reimbursement-Rules-for-Long-Term-Care-Facilities-8.1.2022.pdf?

California

California uses a cost-based reimbursement system and does not utilize RUGs III/IV or PDPM methodologies, and there is no indication of a planned transition to PDPM at this time.

You can find out more at https://www.dhcs.ca.gov/services/medi-cal and https://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.aspx.

Colorado

Colorado Medicaid uses a partial cost based and partial acuity adjusted payment model. The acuity adjustments use the PDPM nursing only component.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

More information can be found at: https://www.medicaid.gov/medicaid/spa/downloads/CO-24-0007.pdf and https://www.sos.state.co.us/CCR/GenerateRulePdf.do?fileName=10+CCR+2505-10+8.400&ruleVersionId=11620&

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Connecticut

Connecticut Medicaid continues to use a RUG-IV based case-mix model for nursing facility reimbursement. The state began collecting PDPM-related MDS data (Sections GG, I, and J) on October 1, 2020, and is reportedly planning a transition to PDPM as of September 2026, but as of late September 2025 there are no firm publicly available transition plans.

Learn more at https://portal.ct.gov/dss/health-and-home-care/medicaid-nursing-home-reimbursement/nursing-home-reimbursement-acuity-based-methodology?language=en_US and Connecticut Case Mix and Related Services | Myers & Stauffer and Nursing Home Reimbursement Acuity Based Methodology

Delaware

Delaware does not use RUGs III, RUGs IV or PDPM Methodologies for Medicaid payments.

You can find more information at https://regulations.delaware.gov/register/december2007/final/11%20DE%20Reg%20792%2012-01-07.htm.

Florida

Florida uses a cost-based reimbursement system and does not utilize RUGs III/IV or PDPM methodologies, and there is no indication of a planned transition to PDPM at this time.

You can find more information at https://ahca.myflorida.com/medicaid/statewide

Georgia

Georgia Medicaid transitioned to the PDPM methodology effective July 1, 2024. However, Georgia is only utilizing the Nursing component of PDPM for Medicaid payment. They are using all 25 nursing Case Mix Groups (CMGs) that align with Medicare PDPM CMGs.

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Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at https://dch.georgia.gov/providers/provider-types/nursing-home-providers/pdpm

Hawaii

Effective January 1, 2024, Hawaii Medicaid transitioned to a price-based reimbursement system for nursing facilities, where the Direct Care component is adjusted by case mix using the PDPM Nursing component only. The Administrative & General and Capital components remain flat-priced, without case mix adjustment.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at https://www.medicaid.gov/medicaid/spa/downloads/HI-23-0014.pdf

Idaho

Idaho was using RUGs-III but switched to PDPM effective 7/1/25. Idaho is currently using only the Nursing and NTA components of PDPM, but the State RAI MDS Coordinator reported that, "they are working towards full PDPM implementation (which includes all six components: Physical Therapy, Occupational Therapy, Speech-Language Pathology, Nursing, Non-Therapy Ancillaries, and a non-case-mix component.)"

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at https://healthandwelfare.idaho.gov and ID H0345 | 2025 | Regular Session | LegiScan and IDAPA 16.03.026.485 and ID-21-0012.

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Illinois

Beginning October 1, 2024, Illinois implemented a Medicaid Value-Based Payment (VBP) system that incentivizes nursing homes to meet or exceed staffing levels based on the Patient-Driven Payment Model (PDPM) and STRIVE study benchmarks. The PDPM reimbursement will be based on the Nursing component only.

The PDPM nursing component per diem for each nursing facility shall be the product of the facility's:

1. Statewide PDPM nursing base per diem rate adjusted for the facility average PDPM case mix index calculated quarterly, and
2. The regional wage adjuster, and
3. Add the Medicaid access adjustment.

To facilitate the transition to the PDPM STRIVE model, Illinois employs a blended approach for calculating staffing percentages:

- October 1, 2024 – December 31, 2024: 20% PDPM STRIVE Target + 80% Case-Mix Total Nurse Staffing Hours.
- January 1, 2025 – February 28, 2025: 40% PDPM STRIVE Target + 60% Case-Mix Total Nurse Staffing Hours.
- March 1, 2025 – June 30, 2025: 60% PDPM STRIVE Target + 40% Case-Mix Total Nurse Staffing Hours.
- July 1, 2025 – September 30, 2025: 80% PDPM STRIVE Target + 20% Case-Mix Total Nurse Staffing Hours.

Beginning January 1, 2025, the staffing percentage used in the calculation of the per diem staffing add-on shall be its PDPM STRIVE Staffing Ratio which equals: its Reported Total Nurse Staffing Hours Per Resident Per Day as published in the most recent federal staffing report (the Provider Information File), divided by the facility's PDPM STRIVE Staffing Target. Each facility's PDPM STRIVE Staffing Target is equal to .7122 times the facility's Illinois Adjusted Facility Case-Mix Hours Per Resident Per Day. A facility's Illinois Adjusted Facility Case Mix Hours Per Resident Per Day is equal to its Case-Mix Total Nurse Staffing Hours Per Resident Per Day (as published in the most recent federal staffing report Provider Information file) times 3.79 (which is the

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Reported Total Nurse Staffing Hours Per Resident Per Day for the Nation as reported the January 2024 State US Averages file), divided by the Reported Total Nurse Staffing Hours Per Resident Per Day for the Nation as reported in the most recent State US Averages file. Facilities receive additional per diem payments based on their staffing ratio relative to the STRIVE benchmark.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at https://ilga.gov/legislation/publicacts/102/PDF/102-1035.pdf

Indiana

Indiana is transitioning to the PDPM Methodology effective 6/1/26 and will be using the nursing category only.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at RESIDENT DATA REPORTING MANUAL or by contacting your state RAI Coordinator.

Iowa

Iowa Medicaid transitioned to the PDPM methodology effective July 1, 2023. Iowa is utilizing the Nursing component of PDPM for Medicaid payment. They are using all 25 nursing Case Mix Groups (CMGs) that align with Medicare PDPM CMGs. Iowa Medicaid will assign a CMI to each of the 25 nursing groups and that will be listed on the case mix roster.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You may find more information at PDPM Weighted Methodology for Case Mix Classification and INFORMATIONAL LETTER NO. 2442-MC-FFS

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Kansas

Kansas Medicaid transitioned to the PDPM methodology effective July 1, 2024. Kansas is only utilizing the Nursing component of PDPM for Medicaid payment. They are using all 25 nursing Case Mix Groups (CMGs) that align with Medicare PDPM CMGs.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at https://sos.ks.gov/publications/Register/Volume-43/Issues/Issue-25/06-20-24-52235.html

Kentucky

Kentucky Medicaid fully transitioned to the PDPM methodology effective April 1, 2025. However, Kentucky is only utilizing the Nursing component of PDPM for Medicaid payment. They are using all 25 nursing Case Mix Groups (CMGs) that align with Medicare PDPM CMGs.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at: Kentucky State Plan Amendment & Title 907 Chapter 1 Regulation 065 • Kentucky Administrative Regulations • Legislative Research Commission

Louisiana

Louisiana transitioned from RUG-III to the Patient Driven Payment Model (PDPM) in FY 2026 for its Medicaid Case Mix (CMI) reimbursement. Louisiana is using all 5 PDPM categories including Nursing, NTA, PT, OT and ST and is weighted as follows:

- 50% Nursing Component

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- 15% PT/OT Component – same Case Mix group, varied case mix index values
- 12% Non-Therapy Ancillary Component
- 8% Speech Language Pathology Component

There is a corridor methodology being used for the transition period, starting on July 1, 2025. Each quarter during the 18-month phase-in (July 1, 2025 – December 31, 2026), the calculated PDPM-based facility specific direct care and care related rate will be compared to the actual June 30, 2025 rate July 1, 2025 facility-specific direct care and care related rate component (calculated under RUG-based methodology) and will be subject to the ±$5 corridor methodology.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies and Medicaid PDPM Therapy Strategies.

You can find more information by contacting your State RAI Coordinator.

Maine

Effective January 1, 2025, Maine Medicaid transitioned to the PDPM methodology. Maine is only utilizing the Nursing component of PDPM for Medicaid payment. However, MaineCare employs its own standardized case mix weights, tailored to reflect the state's specific care delivery patterns and cost structures.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

These Maine-specific case mix weights are detailed in the Nursing Home Guide for Billing PDPM Nursing Component, which provides comprehensive billing codes and standardized weights used for reimbursement calculations.

You can find more information at: https://mainecare.maine.gov/Billing%20Instructions/Supplemental%20Billing%20Info/Nursing%20Home%20Guide%20for%20Billing%20PDPM%20Nursing%20Component.docx

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Maryland

Maryland Medicaid began transitioning from RUG CMIs to the PDPM CMIs for nursing facility rate calculation on January 1, 2025. The PDPM nursing component CMIs were phased in at intervals but as of July 1, 2025, the rate is fully PDPM and is based on the Nursing component only.

Please note that COMAR 10.09.10 Nursing Facility Services is still in the process of being updated to reflect these changes.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at: https://health.maryland.gov/mmcp/longtermcare/Pages/patientdrivenpaymentmodel.aspx and Pages - Web Pages

Massachusetts

Massachusetts Medicaid transitioned to the PDPM methodology effective October 1, 2023. Massachusetts is utilizing the Nursing component of PDPM for Medicaid payment and increased reimbursement accuracy through updated cost factors that include increased monetary value of capital costs and expanded specialized add-ons for behavioral care. They are using all 25 nursing Case Mix Groups (CMGs) that align with Medicare PDPM CMGs.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at Massachusetts Medicaid PDPM Resource and https://www.mass.gov/doc/standard-payments-to-nursing-facilities-effective-october-1-2024-0/download?

Michigan

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Michigan uses a cost-based reimbursement system and does not utilize RUGs III/IV or PDPM methodologies, and there is no indication of a planned transition to PDPM at this time.

You can find more information at https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Inside-MDHHS/Budget-and-Finance/State-Plan-Amendments/11-16-23/SPA_230017_APPROVED.pdf?hash=F68681D12483953DBF0298F1A3863905&rev=b85b60df974b4956a04abcd3e8ade093&utm and https://www.medicaid.gov/medicaid/spa/downloads/MI-24-0012.pdf

Minnesota

Minnesota is set to transition its nursing facility case mix classification system from the current Resource Utilization Groups (RUG-IV) model to the Patient Driven Payment Model (PDPM) beginning October 1, 2025. This change will apply to assessments with an Assessment Reference Date (ARD) on or after that date. There is no official public designation of which PDPM categories Minnesota will be using, however the State RAI Coordinator reported that Minnesota will only be using the Nursing component of PDPM in this official transcript here: https://www.health.state.mn.us/facilities/regulation/casemix/docs/20250716transcript.pdf.

To facilitate a smooth transition, Minnesota will implement a phased approach over three years:

- October 1, 2025 – December 31, 2026: Payments will be based on a blend of 75% RUG-IV rates and 25% PDPM rates.
- January 1, 2027 – December 31, 2027: The blend will shift to 50% RUG-IV and 50% PDPM.
- January 1, 2028 – December 31, 2028: The blend will be 25% RUG-IV and 75% PDPM.
- Starting January 1, 2029, the PDPM system will be fully implemented, and RUG-IV will be discontinued.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies

You can find more information at: https://www.house.mn.gov/comm/docs/QydMNojXfEiknALm8Z82_w.pdf

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Mississippi

Mississippi is utilizing all 5 components of PDPM for Medicaid, "effective for rate periods on or after January 1, 2026." The SPA has been submitted to CMS but not officially approved yet as of late September, 2025. However, the SPA outlines Mississippi's plan to use all 5 components.

"The PDPM methodology will be implemented beginning with the assessments that correspond to the base cost reporting period ending 2024 and onward. A blended approach to determining the Case-Mix Index (CMI) will be used. This approach involves applying the CMI weights as listed in the final Skilled Nursing Facility (SNF) Prospective Payment System (PPS) payment rule for FY 2025 (CMS-1802-F):

a. Physical Therapy: 15 percent;
b. Occupational Therapy: 15 percent;
c. Speech Language Pathology 8 percent;
d. Non-Therapy Ancillary: 12 percent; and
e. Nursing: 50 percent.

You can find more information at https://medicaid.ms.gov/programs/nursing-facility-case-mix/ and Mississippi Division of Medicaid Provider Portal | Myers & Stauffer and Public Notice for 25-0015 Patient-Driven Payment Model (PDPM) and state-owned Pediatric Skilled Nursing Facility (PSNF) - Mississippi Division of Medicaid.

Missouri

Missouri Medicaid transitioned to the PDPM methodology effective July 1, 2024. However, Missouri is only utilizing the Nursing component of PDPM for Medicaid payment. They are using all 25 nursing Case Mix Groups (CMGs) that align with Medicare PDPM CMGs.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

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You can find more information at https://ltc.health.mo.gov/wp-content/uploads/sites/18/2024/06/3.-Missouri-Medicaid-Case-Mix.pdf and https://myersandstauffer.com/client-portal/missouri/ and https://www.sos.mo.gov/CMSImages/AdRules/csr/current/13csr/13c70-10a.pdf

Montana

Montana uses a flat per-diem rate combined with a quality component based on CMS five-star staffing and quality ratings. Montana does not utilize RUGs III/IV or PDPM methodologies, and there is no indication of a planned transition to PDPM at this time.

You can find more information at https://medicaidprovider.mt.gov/26 and https://dphhs.mt.gov/assets/ProviderRateStudy/Reports/FinalMTNursingFacilityRateStudyReport.pdf?utm

Nebraska

Nebraska Medicaid transitioned to the PDPM methodology effective July 1, 2023. However, Nebraska is only utilizing the Nursing component of PDPM for Medicaid payment. They are using all 25 nursing Case Mix Groups (CMGs) that align with Medicare PDPM CMGs.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at https://dhhs.ne.gov/Pages/Medicaid-Provider-Nursing-Facility-Casemix.aspx

Nevada

Nevada transitioned its Medicaid nursing facility reimbursement system from the Resource Utilization Group (RUG) model to the Patient-Driven Payment Model (PDPM) through a phased approach starting October 1, 2024, and culminating in full implementation by July 1, 2026.

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Under the new PDPM-based methodology, Nevada Medicaid will incorporate the following three case-mix adjusted components to calculate each facility's CMI:

1. Nursing Component: Reflects the clinical complexity and nursing needs of residents.
2. Non-Therapy Ancillary (NTA) Component: Accounts for the use of medications, treatments, and services that are not part of therapy but contribute to resident care.
3. Speech-Language Pathology (SLP) Component: Considers factors such as cognitive status, swallowing disorders, and communication needs.

These components will be weighted to determine a blended CMI for each resident:

- Nursing CMI: 65%
- NTA CMI: 25%
- SLP CMI: 10%

The facility's overall Medicaid CMI will be calculated as the simple average of the individual residents' blended CMIs. This average will be used to determine the facility's reimbursement rate.

The transition involves a gradual blending of RUG and PDPM rates for the Direct Health Care (DHC) component as follows:

- October 1, 2024: 87.5% RUG / 12.5% PDPM
- January 1, 2025: 75.0% RUG / 25.0% PDPM
- April 1, 2025: 62.5% RUG / 37.5% PDPM
- July 1, 2025: 50.0% RUG / 50.0% PDPM
- October 1, 2025: 37.5% RUG / 62.5% PDPM
- January 1, 2026: 25.0% RUG / 75.0% PDPM
- April 1, 2026: 12.5% RUG / 87.5% PDPM
- July 1, 2026: 0% RUG / 100% PDPM

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies and Medicaid PDPM Therapy Strategies.

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You can find more information at https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Public/AdminSupport/MeetingArchive/Workshops/2024/PW_09-27-24_Nursing_Facility_MDS_PDPM_Conversion_Presentation.pdf

New Hampshire

New Hampshire Medicaid transitioned to the PDPM methodology effective July 1, 2024. New Hampshire is only utilizing the Nursing component of PDPM for Medicaid payment.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at https://www.dhhs.nh.gov/news-and-media/budget-adjustment-factor-and-patient-driven-payment-model-pdpm

New Jersey

New Jersey continues to use a RUGs-IV based case-mix classification system for Medicaid nursing facility reimbursement. There is no evidence that the state has implemented PDPM for Medicaid payment at this time.

More information is available through New Jersey's Medicaid and long-term care policy documentation at https://www.nj.gov/humanservices/providers/rulefees/regs/rulesfiles/NJAC%208_85%20LONG-TERM%20CARE%20SERVICES.pdf

New Mexico

New Mexico is not a CMI state and does not use RUGs III, RUGs IV or PDPM.

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More information available from New Mexico's approved State Plan Amendment (SPA 24-0007): https://www.medicaid.gov/medicaid/spa/downloads/NM-24-0007.pdf and https://www.hca.nm.gov/wp-content/uploads/23-0013-Attachment-4.19D-Part-1-Page-1-Clean-8-18-2023-w.pdf?

New York

New York is transitioning its Medicaid nursing facility reimbursement system from the RUG-IV model to the Patient-Driven Payment Model (PDPM). A statewide Case Mix Index (CMI) freeze was implemented in July 2023 to allow for redevelopment of the reimbursement methodology, which is planned to pay through late 2026 when the implementation of PDPM is expected. New York is working with Myers and Stauffer to develop and implement a PDPM-based case mix methodology for Medicaid rates. The target date for final implementation is late 2026 with the potential of an interim methodology prior to that. The state has reconstructed the Nursing and Non-Therapy Ancillary (NTA) components of PDPM using Minimum Data Set (MDS) information, which are expected to form the basis of an interim case mix adjustment.

As part of the proposed transition:

- Summer 2025: Facilities must begin collecting additional MDS items (including I0020, J2100, and O0400D) for all assessments, including OBRA assessments.
- Fall 2025: The state will review the collected data to evaluate PDPM classification accuracy and modeling.
- Fall 2026: New York anticipates fully implementing PDPM-based Medicaid reimbursement, including finalized methodology and case mix adjustment structure.

There is no confirmation yet whether other PDPM components (PT, OT, or SLP) will be included in the final model, but there is no indication of their inclusion at this time.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

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More information is available in the NYSDOH PDPM Case Mix Project Update: https://health.ny.gov/facilities/long_term_care/reimbursement/nhr/2025/docs/2025-05-13_pdpm_slides.pdf

North Carolina

Effective October 1, 2025, North Carolina North Carolina will transition its Medicaid nursing facility reimbursement system from the current RUG-IV model to the Patient-Driven Payment Model (PDPM). Everything North Carolina Medicaid has released so far points to using only the PDPM Nursing component to set the Medicaid case-mix index (CMI) however this has not been formally approved.

The most recent PDPM Medicaid related post on the NCDHHS website from May 2, 2023 states: "On Oct. 1, 2025, CMS will replace the current case-mix model, RUG-IV with the patient driven payment model (PDPM).

- States will no longer be able to use RUGs and the OSA effective Oct. 1, 2025.
- NC Medicaid has not decided on a transition date from RUGs to PDPM and will inform providers when a decision is made.
- The transition date will be no later than Oct. 1, 2025."

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at https://medicaid.ncdhhs.gov/blog/2023/05/02/patient-driven-payment-model-and-implementation-optional-state-assessment

North Dakota

North Dakota will implement the PDPM methodology effective January 1, 2026. They are currently using RUGS IV for Medicaid case mix reimbursement. Once implemented, they propose using a blended case mix consisting of 60% nursing, 20% NTA and 20% Speech, although this is not officially outlined in any regulation.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies and Medicaid PDPM Therapy Strategies.

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You can find out more at https://www.hhs.nd.gov/sites/www/files/documents/medicaid-policies/mds-submission-guidelines.pdf and https://www.hhs.nd.gov/sites/www/files/documents/nd-pdpm-resident-faq.pdf.

Ohio

Starting in July 2025, Ohio will begin phasing in the Patient Driven Payment Model (PDPM) using the Nursing Category only to calculate the Medicaid direct care rates for nursing homes. This change affects how the state determines what it pays per day for each resident's care, based on the facility's case mix (acuity level).

Phase-In Timeline

July 1 – December 31, 2025:

Ohio will continue to use its existing case-mix scoring system to calculate direct care rates. Rates will be adjusted based on either:

1. The score used for fiscal year 2025, or
2. A new case-mix score calculated for the July–December 2025 period, depending on the facility's status.

Starting January 1, 2026:

Ohio will begin applying PDPM-based case mix scores, but only partially. Rate changes will be phased in gradually:

2026: Facilities will receive one-third of the difference between their current direct care rate (as of Jan 1, 2025) and what their rate would be under PDPM.

2027: That increases to two-thirds of the difference.

2028 and beyond: Full use of PDPM-based rates.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies

You can find more information at this links: House Bill 96 | 136th General Assembly | Ohio Legislature and House Bill 33 | 135th General Assembly | Ohio Legislature

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Oklahoma

Oklahoma uses a cost-based nursing facility rate methodology. However, they calculate the Upper Payment Limit Demonstration using RUG data, which will change to PDPM data starting in SFY2025 and will use the Nursing component only.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies

You can find more information at Long Term Care Rate Methodology Summary - Oklahoma

Oregon

Oregon uses a cost-based reimbursement system and does not utilize RUGs III/IV or PDPM methodologies, and there is no indication of a planned transition to PDPM at this time.

You can find more information at https://oregon.public.law/rules/oar_411-070-0025

Pennsylvania

Pennsylvania transitioned to PDPM-based case-mix classification as of August 2, 2025, and is using the nursing category only. "The transition will now take place in four phases, with the PDPM accounting for a percentage of rate setting that will increase in each phase until it accounts for 100% of rate setting in the fourth and final phase. During the phases in which the PDPM is used for only a portion of rate setting, the remaining portion will be set according to a frozen rate derived from an average of the RUG-III rates from the October 1, 2025, through December 31, 2025, rate quarter and the January 1, 2026, through March 31, 2026, rate quarter. These phases will occur as follows:

- Phase 1: Picture date 11/01/2025—April 2026 rates = 25% PDPM/75% RUG-III.
- Phase 2: Picture date 02/01/2026—July 2026 rates = 50% PDPM/50% RUG-III.
- Phase 3: Picture date 05/01/2026—October 2026 rates = 75% PDPM/25% RUG-III.
- Phase 4: Picture date 08/01/2026—January 2027 rates = 100% PDPM.

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Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can learn more about the transition and the reasoning behind the methodology at: https://www.pacodeandbulletin.gov/Display/pabull?file=/secure/pabulletin/data/vol55/55-31/1033.html#:~:text=The%20PDPM%20system%20classifies%20residents,on%20the%20volume%20of%20services.

Rhode Island

Rhode Island Medicaid will transition its nursing facility reimbursement from a RUG-IV based case-mix model to the PDPM Nursing component only, with implementation effective October 1, 2025. With the exception of the ventilator/tracheostomy related case mix groups of ES3 and ES2 (which have adjusted CMIs to reflect the costs), Rhode Island plans to adopt the Medicare CMI standards for nursing CMGs.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more details in the Rhode Island "Nursing Facility Rate Development" report: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2025-06/PDPM%20Transition%20Report.pdf and here: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2025-04/PDPM%20Information%20Guide%20%20v0.2%20-%2004292025.pdf.

South Carolina

South Carolina continues to use a RUG-IV based case-mix classification system for Medicaid nursing facility reimbursement. As of October 1, 2023, the South Carolina Department of Health & Human Services requires the use of the Optional State Assessment (OSA) tied to RUG-IV for case-mix reporting and payment calculation. There is no indication that the state has adopted, or plans to adopt, PDPM methodologies at this time nor is it clear how the state will calculate rates when the OSA retires on October 1, 2025.

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You can find more information in the SCDHHS public notice on payment rates for long-term care facilities: https://scdhhs.gov/communications/public-notice-proposed-action-setting-payment-rates-long-term-care-facility-0 and https://scdhhs.gov/sites/dhhs/files/SC%2024-0014%20CMS%20SPA%20Approval%20Packet.pdf?

South Dakota

As of July 1, 2023, South Dakota Medicaid transitioned its nursing facility reimbursement methodology from the RUGs system to the Patient-Driven Payment Model (PDPM) using the Nursing component of PDPM only.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find out more at https://dss.sd.gov/docs/medicaid/medicaidstateplan/4_GeneralProgramAdministration/4.19/Attachment_4.19_D_Payment_Methodologies_for_NFs_and_ICFs.pdf

Tennessee

Tennessee implemented to PDPM as of July 1, 2024 and is using the Nursing component only. They are using all 25 nursing Case Mix Groups (CMGs) that align with Medicare PDPM CMGs.

The Tennessee division of Myers and Stauffer further commented that, “This change was applied to the Nursing Facility Cost Report Period Case Mix Index utilized in rate rebasing procedures, as well as the Nursing Facility-Wide Semi-Annual Average Case Mix Index utilized in the semi-annual rate setting process. The July 1, 2024 rates utilized Medicaid PDPM CMI data for the period of September 1, 2023 through February 29, 2024 for the Nursing Facility-Wide Semi-Annual Average Case Mix Index.”

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at Tennessee Division of Health Care Finance and Administration Provider Portal | Myers & Stauffer and https://myersandstauffer.com/documents/TN/NF/Downloads//Frequenly%20Asked

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%20Questions%20-%20PDPM.pdf and https://myersandstauffer.com/documents/TN/NF/Review%20Resources//Time-Weighted/Time-Weighted%20CMI%20Resident%20Roster%20User%20Guide-PDPM%20Nursing%20Classification%20System%20(Rev.%20January%202024).pdf

Texas

Beginning September 1, 2025, the Texas Health and Human Services Commission (HHSC) will implement a state-specific version of the Patient Driven Payment Model (PDPM) for Medicaid nursing facility reimbursement.

Under Texas's PDPM LTC model, residents are classified into one of 36 groups based on:

- Nursing Case-Mix Classifiers: Six levels reflecting the intensity of nursing care required. These are based on one CMG for each of the main nursing categories (i.e. Special Care High, Extensive Services, etc.) and do not include all 25 skilled PDPM Nursing CMGs. Because of this, the Section GG functional score, Restorative Nursing Programs and Depression do not impact reimbursement.
- Non-Therapy Ancillary (NTA) Case-Mix Classifiers: Texas collapsed the NTA categories into only three levels accounting for comorbidities and extensive services. These new CMGs are based on: 0-2 points, 3-8 points, and 9+ points.
- Brief Interview for Mental Status (BIMS) Classification: Only severe cognitive impairment qualifies for additional reimbursement.

The total per diem rate comprises four components. Each component is calculated using median allowable costs from recent cost reports, adjusted for inflation, and multiplied by 1.07.

1. Nursing Rate Component: Covers compensation for nursing staff, including Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), and nurse aides.
2. NTA Rate Component: Includes costs for ancillary services such as medical supplies, diagnostics, and pharmaceuticals.

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3. BIMS Rate Component: Provides a 5% add-on to the nursing rate for residents with severe cognitive impairment.
4. Non-Case-Mix Rate Component: Accounts for fixed costs like dietary services, administration, maintenance, and capital assets.

Due to restrictions on including HIV/AIDS diagnoses in MDS data, HHSC provides an add-on for affected residents:

- Nursing Component: An 18% increase to the assigned nursing rate.
- NTA Component: An adjustment equal to the difference between the resident's NTA rate and the highest NTA rate.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies

You can find out more at https://rad-apps.hhsc.texas.gov/downloads/ovrvw-prop-nf-pat-drvn-pymnt-ltc-rate-method.wmv and 1 Tex. Admin. Code § 355.318 - Reimbursement Setting Methodology for Nursing Facilities on or after September 1, 2025 | State Regulations | US Law | LII / Legal Information Institute and https://www.sos.state.tx.us/texreg/pdf/backview/0711/0711prop.pdf.

Utah

Effective May 2023, Utah began transitioning its Medicaid nursing facility case-mix reimbursement methodology to the Patient-Driven Payment Model (PDPM) implementing all five PDPM components with full alignment to the Medicare model.

Utah's Medicaid program applies the following PDPM components, each with CMS-defined CMI values, to determine reimbursement rates:

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech-Language Pathology (SLP)

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- Nursing
- Non-Therapy Ancillary (NTA)

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies and Medicaid PDPM Therapy Strategies.

Each component's CMI reflects the relative resource intensity associated with a resident's clinical characteristics and service needs. The same CMIs are being used as skilled PDPM residents, and the Salt Lake City wage index is being used for all providers for Medicaid payment.

You can find more information at:

https://medicaid-documents.dhhs.utah.gov/stateplan/spa/A_4-19-D.pdf and https://medicaid.utah.gov/stplan/longtermcarenfra/

Vermont

Vermont Medicare transitioned to the PDPM methodology effective July 1, 2024. However, Vermont is only utilizing the Nursing component of PDPM for Medicaid payment. They are using all 25 nursing Case Mix Groups (CMGs).

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find out more at the Vermont Department of Health website: https://vtmedicaid.com/assets/manuals/NursingFacilityProviderManual.pdf

Virginia

Virginia Medicaid has implemented PDPM Medicaid using all 5 categories (Nursing, NTA, PT, OT and ST) as of October 1, 2025.

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Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies and Medicaid PDPM Therapy Strategies.

You can find out more at https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/nursing-facilities/.

Washington

Effective July 1, 2025, Washington Medicaid program transitioned to the Patient-Driven Payment Model (PDPM) for nursing facility reimbursement. Only the nursing component of PDPM is used for calculating the Case Mix Index. The PDPM Nursing Component includes all 25 case-mix groups (like skilled PDPM), each with an associated CMI value.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find more information at https://www.dshs.wa.gov/altsa/management-services-division/patient-driven-payment-model-pdpm and Nursing Facility Rates and Reports | DSHS

West Virginia

West Virginia's Medicaid program transitioned to the Patient-Driven Payment Model (PDPM) for nursing facility reimbursement effective October 1, 2024. Only the nursing component of PDPM is used for calculating the Case Mix Index. The PDPM Nursing Component includes 25 case-mix groups, each with an associated CMI value.

To facilitate this shift, the state has implemented a phase-in adjustment period spanning from October 1, 2024, to June 30, 2027. This approach is designed to ease providers into the new reimbursement methodology by gradually blending the previous RUG-IV-based rates with the new PDPM-based rates.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find out more at West Virginia Medicaid Provider Portal | Myers & Stauffer

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Wisconsin

Effective January 1, 2022, Wisconsin transitioned its Medicaid nursing facility reimbursement system to the Patient-Driven Payment Model (PDPM) for case mix calculations. Since then, Wisconsin has used PDPM's Nursing and NTA components to determine Medicaid rates. They are utilizing the 3rd and 4th digits of the HIPPS code for calculating the Case-Mix Index (CMI).

Wisconsin Medicaid will apply the same CMIs as PDPM Medicare for the Nursing component and NTA components of PDPM. No durational factor will be applied (i.e. NTA will not have a 300% bonus for the first 3 days of the stay). The Nursing component CMI will be used for weighting the Direct Care and the NTA component CMI will be used for weighting the Direct Care – Other Supplies and Services cost center.

"Under PDPM, the Case-Mix-Neutral Nursing Services Allowance is multiplied by the NPG CMI represented by the 3rd digit of the HIPPS code on the resident-specific claim and summed with the Direct Care – Other Supplies and Services Base multiplied by the Non-Therapy Ancillary (NTA) CMI represented by the 4th digit of the HIPPS code on the resident-specific claim. The summation of the Direct Care –Nursing and Direct Care – Other Supplies and Services components is the total Direct Care allowance paid on the resident-specific claim line."

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

You can find this quote and further information at https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/medicaid/nursingfacility/MethodsOfImplementation.pdf.spage

Wyoming

Wyoming Medicaid implemented the Patient-Driven Payment Model (PDPM) for case mix reimbursement and is using the Nursing component only.

Learn how you can strategize for your state here: Medicaid PDPM Nursing and NTA Strategies.

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You can find out more at https://wyomingmedicaid.com/portal/sites/default/files/inline-files/Manuals_and_Bulletins/Optional_State_Assessment_Discontinued.pdf? And Wyoming Department of Health Provider Portal | Myers & Stauffer

Note: All the information in this resource is provided as a general guideline and is based on the publicly available data as of the time of production. Gravity Consulting has made a good faith effort to ensure that the information in this resource is accurate. However, because the PDPM Medicaid transition is fluid and continuing to evolve in many states, Gravity will continue to review and update this resource as new information becomes available. If you are aware of any updated information that is not contained in this resource, please kindly share it with us so that we can update this resource for all. You can send any questions, comments or suggestions to Melissa Brown at MBrown@GravityConsulting.com.

About Gravity Consulting

At Gravity Consulting, we understand the complex challenges that nursing facilities face as states adopt and refine Medicaid PDPM-based reimbursement systems. Our team brings decades of practical, hands-on experience working with senior living and skilled nursing operators navigating these evolving requirements.

We partner with communities like yours to go beyond compliance — ensuring you optimize reimbursement accuracy while supporting outstanding resident care.

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Do You Need Help with PDPM Medicaid? Did Your CMI Drop? Gravity Can Help.

Whether your state is fully transitioned, phasing in, or just beginning to plan for PDPM Medicaid, we can help you get ahead. Call us directly at **240-803-7999** or email at Mbrown@GravityConsulting.com.

How We Help Skilled Nursing Providers Succeed Under PDPM Medicaid

- **CMI audits** to improve accuracy and capture resident acuity
- **MDS training** for coding accuracy under PDPM Medicaid
- **Morning meeting optimization** for PDPM Medicaid and interdisciplinary coordination
- **PDPM Medicaid consulting** for Nursing, NTA, Section GG, restorative care strategies and beyond

Let's Talk

Gravity Consulting is here to ensure your team is prepared, informed, and equipped to achieve success — no matter where your state is on the Medicaid PDPM journey.

For questions, consultation inquiries, or updated information, contact:

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