State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
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MEDICAID COMMUNICATION NO. 18-10 **DATE: December 17, 2018**

TO: NJ FamilyCare Eligibility Determining Agencies

SUBJECT: Pre-eligibility Medical Expenses (PEME) for Nursing Homes and Assisted Living Facilities

Replaces Medicaid Communication 17-10

BACKGROUND: The Division of Medical Assistance and Health Services (DMAHS) is issuing this Medicaid Communication to clarify that PEME is available to individuals in a nursing facility (NF) and to individuals residing in an assisted living (AL) facility. This Communication also clarifies the procedure for requesting and processing PEME.

OPERATIONS: A facility (NF and AL) may request PEME for bills incurred up to three months prior to the date of eligibility. The request is made through submitting a PEME form (attached) to the appropriate County Welfare Agency (CWA). PEME is similar to Retroactive Eligibility; the difference is that with PEME you do not have to be otherwise eligible in those three months prior to the eligibility date. Retroactive Eligibility requires that the individual is "otherwise eligible" during the three month period prior to the date of eligibility. Therefore, PEME bills are paid through the monthly cost share of the Medicaid recipient, while Retroactive Eligibility allows claims to be submitted by providers for DMAHS payment.

A Medicaid recipient's monthly cost share is calculated on their Personal Responsibility (PR) form. All individuals receiving long-term services and supports receive a PR form and are required to pay a cost share in every month that they are eligible. There are three different versions of the PR form: PR-1 for NF; PR-2 for AL; and PR-3 for individuals living at home. Each living arrangement includes specific calculations that are outlined in federal regulations at 42 CFR 435.725 and 435.726.

PEME must be billed at the Medicaid rate at the time of service. All services must be submitted to all third parties (as appropriate) for payment and then the remaining balances can be submitted for PEME approval. Documentation/proof of third party payments and denials may be required (i.e. Medicare does not provide Assisted Living Facility benefits). Individuals may have a combination of PEME and Retroactive Eligibility for the three months prior to their Medicaid effective date.

PEME is not available to individuals in a penalty period for a transfer of assets for less than fair market value. When the CWA receives a PEME form, the CWA will look at the individual's PR form to see if they have income available to pay the cost share. The monthly cost share payments are used to pay the PEME, if the individual does not have enough income to pay a cost share, then PEME will not be possible.

It is in the best interest of the facility to request PEME as soon as possible after their resident is

determined Medicaid eligible. PEME payments are only added to the PR form prospectively. If the individual changes their living arrangement or passes away, PEME payments will stop immediately.

When a PEME request is approved by the CWA, the worker will total the facility's bills for the PEME period and divide it by the monthly cost share amount. This equation will determine how many months the cost share will be diverted to pay the facility to satisfy the PEME bill. The CWA will enter this information on the PEME row of the appropriate PR form.

Example:

Three months prior to date of eligibility:

Assisted Living bills = $15,000 Cost Share = $1,500 per month

$15,000 / $1,500 = 10 months of PEME payments to be reflected on the PR form

The facility will receive the full payment for their services during the PEME months, **in addition to** the cost share, until the PEME bill is satisfied. The PR form web application is designed to systemically adjust cost share and the capitation/fee-for-service payments based on the information entered on the PEME row. The CWA will enter the PEME amount on the PEME row for the number of months indicated in the equation. For the example above, the PR-2 form will reflect the $1,500 PEME for 10 months, in the 11th month, the PR-2 form will be revised to reflect no PEME amount and the cost share will then begin to be used to offset the medical assistance costs provided by DMAHS.

For AL Facilities ONLY – Medicaid does not cover room and board for individuals living in AL facilities. The room and board amounts must be paid for through the Medicaid recipient's income. The "Amount due to the AL facility row" on the PR-2 form reflects the cost share amount plus the room and board rate. Individuals may only reside in AL facilities if they have enough income to cover the room and board rate plus their personal needs allowance. Please ensure that the room and board rate is not included in the calculation above.

If you have any questions regarding this Medicaid Communication, please refer them to the Division's Office of Eligibility field staff for your agency at 609-588-2556.

MD:mt
c: Carole Johnson, Commissioner
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PRE-ELIGIBILITY MEDICAL EXPENSES (PEME)

PEME approval is limited to 3 months prior to the month Medicaid eligibility is effective. Please complete your request for each month.

Nursing Facility_____

Resident Name _____

Medicaid Case # _____

Medicaid Eligibility Approval Effective Date:_____

Month 1
Dates of Service_____

Medicaid daily rate for room and board for above dates of service: $_____

Total amount of other insurance /long term care policy reimbursements received for these dates of service: $_____

Total monthly income and/or payments received from Family/Resident during PEME period: $_____

Total room and board amount requested for PEME dates of service: $_____
(Dates of service **times** Medicaid daily room and board rate **minus** other insurance payments received **minus** income from resident = PEME amount)

If additional charges are requested for PEME dates of service: $_____
(Provide all documentation/statements as verification)
(See attached itemized statement which shall include Medicaid rate after other insurance payments)

Total PEME Amount Requested: $_____

Month 2
Dates of Service_____

Medicaid daily rate for room and board for above dates of service: $_____

Total amount of other insurance /long term care policy reimbursements received for these dates of service: $_____

Total monthly income and/or payments received from Family/Resident during PEME period: $_____

Total room and board amount requested for PEME dates of service: $_____
(Dates of service **times** Medicaid daily room and board rate **minus** other insurance payments received **minus** income from resident = PEME amount)

If additional charges are requested for PEME dates of service: $_____
(Provide all documentation/statements as verification)
(See attached itemized statement which shall include Medicaid rate after other insurance payments)

Total PEME Amount Requested: $_____

Month 3
Dates of Service_____

Medicaid daily rate for room and board for above dates of service: $_____

Total amount of other insurance /long term care policy reimbursements received for these dates of service: $_____

Total monthly income and/or payments received from Family/Resident during PEME period: $_____

Total room and board amount requested for PEME dates of service: $_____
(Dates of service **times** Medicaid daily room and board rate **minus** other insurance payments received **minus** income from resident = PEME amount)
If additional charges are requested for PEME dates of service: $_____
(Provide all documentation/statements as verification)
(See attached itemized statement which shall include Medicaid rate after other insurance payments)

Total PEME Amount Requested: $_____

Other Insurance Reimbursement Information:
Reason dates of service were not covered by other insurance
(i.e.: Medicare, Managed Care, Commercial Insurance, Long Term Care Policy)

[ ] Not eligible, did not meet criteria to be billed (see attached documentation)
[ ] Benefits exhausted (see attached documentation)
[ ] Denied Claim by third party insurance (see attached documentation/denial).
_____

Documents submitted by: _____ Date: _____
(Nursing Facility Representative)

Nursing Facility Contact phone number: _____

PEME Request authorized by: _____Date: _____
(Signature of Resident, Applicant or Representative)

Revised: 6/2017