



State of New Jersey  
Department of Human Services  
Division of Medical Assistance & Health Services

# NEWSLETTER

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**TO:** Medicaid Assisted Living Facility Providers

**SUBJECT:** Pre-eligibility Medical Expenses (PEME) for Assisted Living Providers

**EFFECTIVE:** Immediately

**PURPOSE:** Operational Procedures to Process PEME Requests

**BACKGROUND:** The Division of Medical Assistance and Health Services (DMAHS) is issuing this Provider Newsletter 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 is also written to clarify 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 for payment and then the remaining balances can be submitted for PEME approval. Documentation/proof of third party payments and denials may be required. 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 of PEME Calculation:**

Amount of unpaid bills incurred by an individual living in an AL facility during the three months prior to the date of Medicaid eligibility: \$15,000

Individual's Monthly Cost Share = \$1,500

$\$15,000 / \$1,500 = 10$  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 in the PEME row on the PR form. 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 11<sup>th</sup> 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 PEME calculation above.

**Questions regarding this Newsletter should be directed to the Medicaid Member/Provider Hotline at 1-800-356-1561.**

**RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE**

**PRE -ELIGIBILITY MEDICAL EXPENSES (PEME) REQUEST FORM**

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 R & B rate minus TPL 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 TPL payment)

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 R & B rate minus TPL 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 TPL payment)

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 R & B rate minus TPL 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 TPL payment)

Total PEME Amount Requested: \$ \_\_\_\_\_

**Other 3<sup>rd</sup> Party Insurance Reimbursement Information:**

Reason dates of service were not covered by other Third Party Insurance

(i.e.: Medicare, Managed Care, Commercial Ins. 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)