



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
P.O. Box 11729  
Albany, NY 12211

**Notice of Decision**

Decision Date: February 16, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000025349

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

On February 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health’s determination regarding your eligibility for the Medicare Insurance Premium Payment program.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:  
 NY State of Health Appeals  
 P.O. Box 11729  
 Albany, NY 12211
- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the Account ID at the top of this notice.

**Legal Authority**

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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## Decision

Decision Date: February 16, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000025349

[REDACTED]  
[REDACTED]  
[REDACTED]

## Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health (NYSOH) fail to determine you eligible for the Medicare Insurance Premium Payment (MIPP) program, effective January 1, 2018?

## Procedural History

On December 21, 2016, NYSOH issued an eligibility determination notice stating, in relevant part, that you remained eligible for Medicaid, effective February 1, 2017.

Also on December 21, 2016, NYSOH issued a plan enrollment notice confirming that as of December 20, 2016, you were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of August 1, 2015.

On December 1, 2017, your NYSOH account was updated.

On December 2, 2017, NYSOH issued three notices:

- (1) An eligibility determination notice stating, in relevant part, that you remained eligible for Medicaid, effective as of February 1, 2018;
- (2) An enrollment notice confirming, in relevant part, that as of December 1, 2017, the type of Medicaid coverage you were eligible for did not require or allow you to enroll in a health plan;

(3) A disenrollment notice stating that your MMC plan coverage would end on January 31, 2018, because the type of Medicaid coverage you were eligible for did not require/allow you to enroll in a plan.

On December 5, 2017, you contacted NYSOH's Account Review Unit and requested an appeal insofar as you lost your eligibility for the MIPP program.

On January 5, 2018, NYSOH issued a notice stating that Medicaid would reimburse you for your monthly Medicare Part B premiums, effective February 1, 2018 ( [REDACTED] ).

On January 23, 2018, an evidence packet from NYSDOH'S Third Party Liability Unit was uploaded to your NYSOH account ( [REDACTED] ). This packet has been made part of the record as "NYSDOH Exhibit 1."

Also on January 23, 2018, NYSOH issued a notice stating that Medicaid would reimburse you for your monthly Medicare Part B premiums, effective January 1, 2018 ( [REDACTED] ).

On February 8, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing and the record was fully developed. The record was closed at the end of the hearing.

## **Findings of Fact**

A review of the record supports the following findings of fact:

- 1) You testified that you want to be reimbursed for the Medicare Part B premium that you paid out-of-pocket for the month of January 2017.
- 2) According to your NYSOH account, you have been continuously enrolled in an MMC plan from August 1, 2015, through January 31, 2018.
- 3) According to your NYSOH account, on December 1, 2017, your account was updated to reflect that you would be eligible for Medicare, effective January 1, 2018.
- 4) You testified that on December 1, 2017, you requested assistance with your Medicare Part B premiums.
- 5) You testified that your Medicare, Parts A and B, were effectuated as of January 1, 2018.

- 6) According to NYSDOH'S Third Party Liability Unit evidence packet:

On January 22, 2018, [Third Party Liability] staff issued a one-time payment for the Medicare Part B Premium for January 2018. A notice was created [to this effect]. At this time, we consider the issue of MIPP reimbursement to begin on January 1, 2018 to be resolved.

( [REDACTED] ).

- 7) You testified that you paid the January 2018 Medicare Part B premium and have not be reimbursed for that payment.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

## **Applicable Law and Regulations**

### Medicaid Premium Reimbursement

When a Medicaid eligible individual has third party health insurance in force, the Medicaid program may determine to pay part all cost of the premiums when payment of the premium is determined to be cost-effective. By paying the premium, the Medicaid program may cost avoid claims that would otherwise be covered by Medicaid (see NYS Social Services Law § 367-a(1)(b), 18 NYCRR § 360-7.5(g)).

Payment of Medicare part B premiums will be made by Medicaid if a Medicaid recipient is a qualified Medicare beneficiary, pursuant to 18 NYCRR § 360-7.7(g). Payment of the part B premium begins in the month following the month in which the qualified Medicare beneficiary applies for Medicaid payment of the premiums (18 NYCRR § 360-7.8(b)(5)).

## **Legal Analysis**

The issue under review is whether NYSOH failed to determine you eligible for the MIPP program, effective January 1, 2018.

You were eligible to receive Medicaid and enrolled in a MMC plan from August 1, 2015, through January 31, 2018.

An individual who is eligible for Medicaid may be eligible to be reimbursed for the payment of their third-party health insurance premiums, if the payment is cost-

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effective and so reduces the cost of providing Medicaid services. Payment of an individual's Medicare part B premiums will be made by Medicaid if a Medicaid recipient is a qualified Medicare beneficiary.

The record reflects that on December 1, 2017, your account was updated to reflect that you would be eligible for Medicare, effective January 1, 2018. Further, you requested assistance with your Medicare Part B premiums.

Payment of the part B premium begins with the month following the month in which the qualified Medicare beneficiary applies for reimbursement of the third - party health insurance premiums. As stated above, on December 1, 2017, you informed NYSOH that you were enrolled in Medicare and applied for the reimbursement of your Medicare part B premiums. Therefore, you were eligible for reimbursement of your Medicare part B premiums, effective January 1, 2018.

The January 5, 2017 notice stating that Medicaid would reimburse you for your monthly Medicare part B premiums, effective February 1, 2018, is RESCINDED.

The January 23, 2018, notice stating that Medicaid would reimburse you for your monthly Medicare part B premiums, effective January 1, 2018, remains in full force and effect.

You testified that, as of date of your telephone hearing, you have not been reimbursed for the January 2018 Medicare part B premium. Therefore, your case is RETURNED to DOH's Office of Health Insurance Programs, Third Party Liability Unit, to ensure compliance with this decision.

## **Decision**

The January 5, 2018, eligibility determination notice is RESCINDED.

The January 23, 2018, eligibility determination notice remains in full force and effect.

Your case is RETURNED to DOH's Office of Health Insurance Programs, Third Party Liability Unit, to ensure compliance with this decision.

**Effective Date of this Decision:** February 16, 2018

## **How this Decision Affects Your Eligibility**

You were eligible to be reimbursed for your Medicare part B premiums as of January 1, 2018.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

## **If You Disagree with this Decision (Appeal Rights)**

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:  
Health Insurance Marketplace  
Attn: Appeals  
465 Industrial Blvd.  
London, KY 40750-0061
- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

## **If You Have Questions about this Decision (Customer Service Resources):**

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- By calling the Customer Service Center at 1-855-355-5777
- By mail at:  
NY State of Health Appeals  
P.O. Box 11729  
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- By fax: 1-855-900-5557

## **Summary**

The January 5, 2018, eligibility determination notice is RESCINDED.

The January 23, 2018, eligibility determination notice remains in full force and effect.

Your case is RETURNED to DOH's Office of Health Insurance Programs, Third Party Liability Unit, to ensure compliance with this decision.

You were eligible to be reimbursed for your Medicare part B premiums as of January 1, 2018.

## **Legal Authority**

We are issuing this determination in accordance with 45 CFR § 155.545.



**A Copy of this Decision Has Been Provided To:**

[REDACTED]  
[REDACTED]  
[REDACTED]

## Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

### Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

### 中文 (Traditional Chinese)

這是重要的文件。如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

### Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

### 中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您提供相应语种的口译服务。

### Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

### 한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

### Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

### العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجاناً.

### বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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## **Français (French)**

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

## **हिंदी (Hindi)**

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

## **日本語 (Japanese)**

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

## **नेपाली (Nepali)**

यो एउटा महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

## **Polski (Polish)**

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

## **Twi (Twi)**

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye srε wo, frε 1-855-355-5777. ye&εtumi ama wo obi a okyerε kasa a woka no ase ama wo kwa a wontua hwee.

## **(Urdu) اردو**

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

## **Tiếng Việt (Vietnamese)**

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

## **אידיש (Yiddish)**

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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