DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: April 1, 2025

TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 25-07
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS
ALL COUNTY MEDS LIAISONS

SUBJECT: STREAMLINING MEDICARE SAVINGS PROGRAMS (MSPs) ELIGIBILITY DETERMINATIONS USING LOW-INCOME SUBSIDY (LIS) LEADS DATA AND ALIGNING THE DEFINITION OF FAMILY SIZE FOR MSPs

SUPERSEDES: ACWDL 10-04 and ACWDL 10-04E

The purpose of this All-County Welfare Directors Letter (ACWDL) is to inform counties that, effective April 1, 2026, the Department of Health Care Services (DHCS) will be:

- Streamlining Medicare Savings Programs (MSPs) eligibility determinations, including verifications using Low Income Subsidy (LIS) application information ("leads data") and
- Aligning the definition of family size for MSPs with that of LIS through a proposed State Plan Amendment (SPA).

Additionally, this letter provides counties with updated information about the data exchange between the Social Security Administration (SSA) and the Department of Health Care Services (DHCS) and revised instructions for processing this information.

This letter supersedes the policy guidance provided in ACWDL 10-04, dated January 13, 2010, and ACWDL 10-04E, dated November 17, 2010.

Background
The Low-Income Subsidy, also called Extra Help, is a Medicare program that helps people with limited income and resources pay Medicare drug coverage (Part D) premiums, annual deductibles and co-payments. In California, individuals can apply for LIS at any time before or after they enroll in Medicare Part D.

On July 15, 2008, Congress enacted the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). One of the outreach provisions under MIPPA required SSA to refer Medicare LIS, Part D, applicants to the state Medicaid agency for MSP

determinations with the applicant's consent. As a result, beginning in January 2010, SSA and DHCS implemented processes for counties to use LIS leads data for MSP determinations. In addition to MSP eligibility, California determines eligibility for full Medi-Cal benefits.

On September 21, 2023, CMS issued a Final Rule that streamlines the enrollment and eligibility determination processes for the Medicare Savings Programs (MSPs). This Final Rule codifies MIPPA provisions and further enhances its requirements to streamline MSP enrollment for LIS enrollees. All states are required to implement these procedures by April 1, 2026:

- Treat LIS application (leads) data as an application for MSPs and determine MSP eligibility without requiring the submission of another application.
- Accept LIS leads data without requiring further verification in most cases.
- Only request missing information that is not provided through LIS leads data or is not reasonably compatible with it but is necessary for making MSP eligibility determinations.
- Separately, provide LIS members not enrolled in Medi-Cal with information about Medi-Cal benefits and allow them to be evaluated for those benefits.
- Finally, define family size for MSPs to be no less than the LIS definition through a proposed SPA.

SSA/LIS Application Information
SSA excludes LIS leads data for initial and non-duplicate applications where the applicant has marked that they do not want their information sent to the state for MSP eligibility determination. SSA excludes LIS leads data for individuals already deemed LIS (SSA knows they have Medi-Cal and/or MSP eligibility).

All states, including California, receive LIS leads data from SSA daily on federal business days. Thus, counties receive this information the next business day after DHCS processes the LIS lead data from SSA through the Medi-Cal Eligibility Data System (MEDS) alerts. This process is outlined in the "Take Action Based on MEDS Alerts" section below.

LIS Leads Data Processing
Counties receive two types of leads data from the Social Security Administration.

- The first type of leads data is for the Medicare Part D LIS program, often referred to as "LIS Extra Help". These leads data include information the SSA uses to determine an individual's LIS Extra Help program eligibility. The SSA verifies this information electronically, matching it with data from other federal sources, such

as the Internal Revenue Service, or through verification provided by the applicant. If SSA denies an application for LIS Extra Help, they will provide the reason for the denial. In these cases, the "LIS Application Completed" field on the LIS1 screen will have an "N" or may be left blank.

- The second type of leads data is from individuals who self-assess that they exceed the LIS income limit and wish to have their information sent to the state to determine their eligibility for MSPs. Note: SSA has not completed a LIS Extra Help determination for this group. Leads data for this group contain less information than those that the SSA has processed, and the SSA has not verified the details provided in these applications. In these cases, the "LIS Application Completed" field on the LIS1 screen will show a "Y".

Take Action Based on MEDS Alerts
When DHCS receives electronic LIS leads data, it compares this information with the MEDS database, which includes existing records for both the MSP and Medi-Cal. This comparison allows MEDS to identify the following MSP and/or Medi-Cal groups.

- Individuals with no existing Medi-Cal, Qualified Medi-Cal Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI) eligibility in MEDS.
- Individuals known to MEDS with past eligibility but no current eligibility.
- Individuals with current QMB, SLMB, or QI eligibility in MEDS.
- Individuals with current Medi-Cal eligibility in MEDS.
- Individuals with current Medi-Cal and QMB, SLMB, or QI eligibility in MEDS.

Once the information has been matched, an alert is automatically generated for each identified action, as outlined below. Note that this is an existing process, and additional information on these MEDS alerts can be found in the MEDS Network User Manual, Chapter 2—Shared Eligibility Features (MEDS/CDB) / Inquiries / Inquiry Screens. The alerts require appropriate action by the counties and are classified as "urgent". Starting April 1, 2026, MSP-linked MEDS alerts will require a change in action.

- 9055: MIPPA LIS APP – NO MATCHING RECORD FOUND ON MEDS: This alert is for individuals who have no information in MEDS. Therefore, counties must take both actions.
    - **Medi-Cal Action:** Evaluate the applicant for Medi-Cal unless the applicant indicates they do not want to be evaluated for Medi-Cal.
    - **New MSP Action:** Accept the applicant's LIS leads data as consent for the MSP application and promptly evaluate their eligibility for the MSP unless additional information is needed.

- 9056: MIPPA LIS APP – NOT CURRENT MEDI-CAL OR MSP ELIGIBLE: This alert is for individuals who have no current Medi-Cal or MSP eligibility in MEDS. Therefore, counties must take both actions.
    - **Medi-Cal Action:** Evaluate the applicant for Medi-Cal unless the applicant indicates they do not want to be evaluated for Medi-Cal.
    - **New MSP Action:** Accept the applicant's LIS leads data as consent for the MSP application and promptly evaluate their eligibility for the MSP unless additional information is needed.

- 9057: MIPPA LIS APP - CURR MSP ELIG BUT NOT CURR MEDI-CAL ELIG: This alert is for individuals with current MSP eligibility. Therefore, counties must take Medi-Cal action.
    - **Medi-Cal Action:** Evaluate for Medi-Cal eligibility unless the applicant indicates that they do not want to be evaluated for Medi-Cal.

- 9058: MIPPA LIS APP – CURR MEDI-CAL ELIG BUT NOT CURR MSP ELIG: This alert is for individuals with current Medi-Cal eligibility. Therefore, counties must take MSP action.
    - **New MSP Action:** Accept the applicant's LIS leads data as consent for the MSP application and promptly evaluate their eligibility for the MSP unless additional information is needed.

- 9059: MIPPA LIS APP – CURRENT MEDI-CAL AND MSP ELIGIBLE: This alert is for individuals who currently have Medi-Cal and MSP eligibility. Therefore, counties must take Medi-Cal and/or MSP action.
    - **Medi-Cal and/or MSP Action:** Evaluate the Medi-Cal and/or MSP application date. Deny the application as duplicate application if the MIPPA LIS application date is later than the Medi-Cal and/or MSP application date. Evaluate the member for Medi-Cal and MSP eligibility in the month(s) before their current eligibility if the LIS application date is before the Medi-Cal and/or MSP application date.

Determining the Medi-Cal/MSP Application Date
The application date for MSP/Medi-Cal is the date when an individual filed their LIS application with the SSA. This date is located in the “LIS Application Date” field on the LIS1 screen. Counties are to use the LIS application date to evaluate the beginning date of Medi-Cal or MSP eligibility.

- If the individual has existing Medi-Cal and/or MSP eligibility, counties must compare the LIS and Medi-Cal application date and evaluate which application date would be most beneficial to the individual.

- If the counties use the LIS application date as the Medi-Cal and/or MSP application date, the counties are required to report the date to MEDS by documenting it in the journal or case file.

- For additional information about the county case processing timeline, refer to the "MSP County Case Processing Timeline" section below or ACWDL 24-06.

NOTE: Qualified Medicare Beneficiary (QMB) application date processing has not changed. QMB eligibility is effective the month following the month in which the county approves QMB eligibility. (See Medi-Cal Eligibility Procedures Manual (MEPM) Section 5L-B(2)).

Multiple LIS Applications
SSA has stated that only non-duplicate initial applications for LIS Extra Help will be forwarded to the states. However, the Inquiry LIS (ILIS) screens have been designed to accommodate multiple sets of application information. Although the DHCS does not anticipate this occurring, if it does happen, the counties must evaluate each application to determine which application date is most beneficial for the applicant. The LISM screen can display up to eight different application dates if multiple submissions for the same individual are received from the SSA.

Each application date is linked to the information received from SSA. If the income information on the applications differs, this information must be considered to assess eligibility for Medi-Cal and/or the MSP. If no information differs, any application dates not relevant for determining eligibility for Medi-Cal and/or MSP must be denied, either as duplicate applications or due to not meeting other Medi-Cal and/or eligibility requirements. Counties may deny multiple application dates on the same Notice of Action (NOA) if there is more than one. (See Notice of Action section).

After evaluating the application date for cases involving both Medi-Cal and MSP eligibility (Alert 9059), if the county determines that the LIS application date does not benefit the applicant in terms of when Medi-Cal/MSP eligibility begins, or if the applicant does not meet other Medi-Cal and/or MSP requirements during that month, the county may deny that application. In such cases, a NOA will be issued. No further processing is required for these applications.

Evaluating and Requesting Information Needed to Complete the Medi-Cal Eligibility Determination

- Counties must follow all normal Medi-Cal application processes for evaluating or requesting information needed to complete the Medi-Cal determination.

- Counties are reminded to follow DHCS Medi-Cal applicant contact reminder requirements as outlined in ACWDL 08-07 and ACWDL 22-12 when requesting Medi-Cal information from the LIS enrollee. DHCS plans to issue a future ACWDL to update the policy for application contacts in accordance with the Federal Rule.

Evaluating and Requesting Information Needed to Complete the MSP Eligibility Determination On or After April 1, 2026

- Counties must accept applicants' LIS leads data as consent for the MSP application and determine MSP eligibility without requiring the submission of another application.

- Counties should only request additional information if the LIS leads data is not reasonably compatible, cannot be obtained from third-party sources, or if the existing LIS leads data is insufficient to determine eligibility. This includes situations where an individual's income information is unclear. When requesting information, DHCS recommends that counties inform the individual on how to contact the local Health Insurance Counseling & Advocacy Program (HICAP) for further assistance if needed. The MIPPA cover letter (MC 4605), and supplemental questions (MC 4604) will be updated to remove outdated language and will be published in a future letter.

- Consistent with current policy, if an applicant or member claims lawful presence status, the counties must verify their status when evaluating or determining eligibility for Medi-Cal and/or MSP. This verification is required if the individual claims to be a U.S. citizen/national or has satisfactory immigration status, as outlined in 42 CFR 435.406 and 42 CFR 435.956.

  For MSP applicants or members, verifying lawful presence status during renewal or subsequent applications is not required if the immigration status verification is already documented in the case record. Re-verification is only required if the applicant or member reports a change in their immigration status or if the county receives information indicating a possible change in immigration status.

As a reminder, the return of form MC 13 is also not required when verifying lawful presence status. Counties must grant, without delay, full scope Medi-Cal benefits to otherwise eligible applicants attesting to citizenship or satisfactory immigration status, pending verification of their status. For more information on Medi-Cal's immigration status verification policies, refer to MEDIL 14-21, ACWDL 17-01, or ACWDL 18-09.

- Per 42 CFR 435.911(8), counties must notify individuals that they may be eligible for assistance with their Medicare premium and/or cost-sharing charges, and additional information is needed within 30 days of that notice to assess their MSP eligibility. For additional guidance, refer to ACWDL 24-06.

  The 15-day minimum request period for submitting additional information at the application stage, as outlined in the second final rule released on April 2, 2024, is separate from this 30-day timeframe for determining MSP eligibility for Medicare premium and/or cost-sharing charges. If the individual fails to submit the information within this 30-day timeframe, a denial notice must be issued in accordance with 42 CFR 431.210 and 42 CFR 435.917(b).

- Counties must inform applicants who are only eligible for the MSP about the availability of Medi-Cal benefits. This should be done by mailing the revised MIPPA cover letter (MC 4605) and the supplemental questions (MC 4604) to the address listed on the LIS2 or LIS3 screens. (Please note that the updated MC 4605 and MC 4604 forms will be available at a later date). Additionally, include a postage-paid return envelope for the applicants to use when providing general information about Medi-Cal and Estate Recovery.

Forms MC 4604 and MC 4605
Completion of Supplemental Questions for Medi-Cal/Medicare Savings Program Application (MC 4604) and Important Information on Medi-Cal and Medicare Savings Program (MC 4605) forms is not required, and counties may use other means, such as telephone contact, to determine if the applicant wishes to apply for Medi-Cal, retroactive coverage and to obtain information needed to determine Medi-Cal and/or MSP eligibility. Counties can also refer to MEDIL I 20-13 for information on the use of the CW 2200.

County eligibility workers (CEWs) should document the type of contact attempted and the results in the case file. If the applicant wishes to withdraw the Medi-Cal and/or MSP application, the withdrawal can be in writing or verbal. Applicants may respond to information requests by mail, telephone, in person, and online.

If the applicant returns the MC 4605, indicates that they want to be evaluated for the Medi-Cal program, and answers the extra questions on the MC 4604, counties will first use all available sources of information to complete the determination. This includes:

- Information from SSA available on the ILIS screens on MEDS.
- Denied applications screens, if an application was processed for Supplemental Security Income/State Supplementary Payment.
- Information from MEDS.
- Information from the Income Eligibility Verification System.
- Information from county systems or hard copy cases.

When counties receive MEDS alerts 9057 or 9058, counties must first review the existing case to see whether the applicant has been evaluated for Medi-Cal or MSP. If the client has already received a determination for Medi-Cal or MSP, and the information from the ILIS screens does not show a change in circumstances, counties may deny the application as a duplicate and send a denial NOA.

If the applicant has not received a Medi-Cal or MSP determination, counties shall follow the procedures as stated above, but do not need to send the information listed below for new application packets. Counties will ask the applicant to provide additional information necessary to complete the Medi-Cal or MSP determination, if the information is unavailable from the above sources, and/or the information in the county file is different from the information on the ILIS screens in MEDS.

Counties will also mail the same information sent with all new application packets and request any information the county needs to complete the Medi-Cal and/or MSP determination. For more information, refer to ACWDL 20-22E and MEDIL I 24-14.

If the applicant returns the MC 4605 and marks that they do not want Medi-Cal, counties can treat this information as a written withdrawal for Medi-Cal and deny the Medi-Cal case. If the applicant marks that they do not want both Medi-Cal and MSP, counties should deny both applications (counties may use one NOA for both programs).

When the Medi-Cal and/or MSP eligibility determination is complete, the county should send the appropriate NOA to notify the applicant of the outcome.

If the LIS applicant contacts the county and states they wish to appeal the denial of their LIS application, the county should direct that individual to SSA's national toll-free number (1-800-772-1213) to file an appeal.

MSP County Case Processing Timeline
Under the 2023 CMS Final Rule, the state must determine MSP eligibility within 45 days from the date the state receives the LIS leads data from the SSA or the date of the LIS application. In California, the state will maintain the current 45-day timeline for processing MSP applications, which begins when the county receives the MEDS alert. This alert is typically generated one business day after DHCS processes the MIPPA LIS data file from the SSA.

The date when DHCS processes the LIS data file from SSA can be found in the "County-Referral-Date" field on the LIS1 screen. Counties are to narrate the date the county received the alert, the "County-Referral-Date," and the reason for any delays beyond one business day between the "County-Referral-Date" and the date the county received the alert. For instance, if the county received the alert on a holiday that is not recognized as a state holiday, this should be noted.

Retroactive Coverage
The LIS Extra Help application does not ask whether the applicant received medical care or wants Medicare Part B premiums covered for the three months prior to the month of application. This question is included in the MC 4604.

To request retroactive coverage for any of the three months immediately preceding the month of application, applicants must have received health care services or have medical expenses for the month(s) requested. Medicare Part B premiums are considered medical expenses for retroactive coverage.

Applicants have up to one year from the month in which they had medical expense(s) to make their request for coverage for that retroactive month. Counties should inquire with the applicant about any need for retroactive Medi-Cal and process for retroactive coverage accordingly.

New Policy: Aligning the Definition of Family Size for MSPs With That of the LIS
The current definition of household size for Medi-Cal/MSP is limited to spouses and children. This differs from the household size defined by the SSA for Medicare Part D LIS. As a result, the 2023 CMS final rule requires states to align their definition of family size for all MSPs with that of LIS through a proposed SPA effective April 1, 2026.

The new definition of MSP household size will include the following:
- The applicant,
- The applicant's spouse (if the spouse resides in the same household) and

- All other individuals who reside in the same household and who are related to the applicant(s) by blood, marriage, or adoption and are financially dependent on the applicant or applicant's spouse for at least one-half of their financial support.

The SSA collects information about family size to determine the number of dependent relatives living in the household, excluding the applicant and their spouse. This information is included in the LIS leads data sent to states and can be found in the "Household-Size" field on the LIS1 screen. When applicable, the spouse and all other relatives must be counted as part of the applicant(s) household composition.

The California Statewide Automated Welfare System (CalSAWS) shall make programming changes during the next available CalSAWS release to incorporate a new federally mandated definition of MSP household size.

Notices of Action (NOA)
No new Medi-Cal NOAs or NOA language has been developed. Existing NOAs can be used to notify all Medi-Cal determinations. However, new MSP NOA snippets have been created and will be released soon.

DHCS is allowing counties to handle the NOAs for the MIPPA LIS applications in a manner consistent with how their systems are currently set up for one or more NOAs. It is currently acceptable to include all actions on one NOA, or to send several separate NOAs, when there are multiple application dates, until receipt of further instructions from DHCS.

For example, a county may send one combined NOA or a county could send three separate NOAs for each action, depending on their current process. All NOA language can be taken from a county's existing system to explain the reason for the application being denied in the instance of an earlier application being filed. The NOA must include language that makes it clear whether eligibility exists for either Medi-Cal and/or MSP.

If you have any questions regarding the information provided in this letter, please contact the Non-MAGI unit at DHCSMSPInbox@dhcs.ca.gov. County questions regarding policy guidance should be sent to MCED-Policy@dhcs.ca.gov.

Sincerely,

Sarah Crow

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