State of California—Health and Human Services Agency
Department of Health Care Services

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DATE: November 28, 2022

ALL PLAN LETTER 22-025

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: RESPONSIBILITIES FOR ANNUAL COGNITIVE HEALTH ASSESSMENT FOR ELIGIBLE MEMBERS 65 YEARS OF AGE OR OLDER

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) about the provision of the new annual Medi-Cal cognitive health assessment to eligible Members 65 years of age or older.

BACKGROUND:
California Senate Bill (SB) 48 (Chapter 484, Statutes of 2021) expands the Medi-Cal schedule of benefits to include an annual cognitive assessment for Medi-Cal Members who are 65 years of age and older if they are otherwise ineligible for a similar assessment as part of an annual wellness visit through the Medicare Program, subject to an appropriation by the state legislature for this purpose as of July 01, 2022.[1] The annual cognitive health assessment is intended to identify whether the patient has signs of Alzheimer's disease or related dementias, consistent with the standards for detecting cognitive impairment under the Medicare Annual Wellness Visit and the recommendations by the American Academy of Neurology (AAN).[2,3]

Additionally, SB 48 outlines requirements that Medi-Cal Providers must complete prior to being eligible to receive payment for conducting annual cognitive health assessments. Medi-Cal Providers must complete training as specified and approved by the Department of Health Care Services (DHCS), and use validated tools recommended by DHCS.

[1] Legislation and state law are searchable at: https://leginfo.legislature.ca.gov/faces/home.xhtml
[2] See the Centers for Medicare and Medicaid Services (CMS) Medicare Wellness Visits webpage at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html
[3] AAN Guidelines on dementia and mild cognitive impairment: https://n.neurology.org/content/56/9/1143 and https://n.neurology.org/content/90/3/126

POLICY:
MCPs must cover an annual cognitive health assessment for their Members who are 65 years of age or older and who do not have Medicare coverage. Details regarding coverage of Current Procedural Terminology (CPT) code 1494F and quantity limits can be found in the Medi-Cal Provider Manual.[4] Any licensed health care professional who is enrolled as a Medi-Cal Provider, is acting within their scope of practice, and is eligible to bill Evaluation and Management (E&M) codes is eligible to conduct and bill for cognitive health assessments for Members of an MCP with whom they are contracted after completing the required training.

Provider Billing Requirements
In order to appropriately bill and receive reimbursement for conducting an annual cognitive health assessment, Providers must do all of the following:

- Complete the DHCS Dementia Care Aware cognitive health assessment training prior to conducting the brief cognitive health assessment;[5]
    - DHCS will maintain a list of Providers who have completed the training; MCPs will have access to the list.
- Administer the annual cognitive health assessment as a component of an E&M` visit including, but not limited to an office visit, consultation, or preventive medicine service (elements of the cognitive health assessment can be conducted by non-billing team members acting within their scope of practice and under the supervision of the billing Provider);
- Document all of the following in the Member's medical records and have such records available upon request:
    - The screening tool or tools that were used (at least one cognitive assessment tool listed below is required);
    - Verification that screening results were reviewed by the Provider;
    - The results of the screening;
    - The interpretation of results; and
    - Details discussed with the Member and/or authorized representative and any appropriate actions taken in regards to screening results.
- Use allowable CPT codes as outlined in the Medi-Cal Provider Manual.

Providers must have completed the required training in order to bill and receive reimbursement. Plans are not obliged to reimburse Providers for assessments that were conducted prior to the completion of the training. Medi-Cal Rates can be found here.

[4] The Medi-Cal Provider Manual, E&M, Cognitive Health Assessment, is available here, p. 38
[5] Cognitive health assessment training is available at: https://www.dementiacareaware.org

Cognitive Assessment Tools

At least one cognitive assessment tool listed below is required. Cognitive assessment tools used to determine if a full dementia evaluation is needed include, but are not limited to:

- Patient assessment tools
  - General Practitioner assessment of Cognition (GPCOG)
  - Mini-Cog
- Informant tools (family members and close friends)
  - Eight-item Informant Interview to Differentiate Aging and Dementia
  - GPCOG
  - Short Informant Questionnaire on Cognitive Decline in the Elderly

MCPs should ensure their Providers are providing the appropriate necessary follow up services based on assessment scores and may include but are not limited to additional assessment or specialist referrals.

CPT 1494F is only applicable for Members 65 years of age and older with or without signs or symptoms of cognitive decline who do not have Medicare coverage. **For Members under 65 years of age who are reporting symptoms or showing signs of cognitive decline**, the MCP will continue to be required to provide medically necessary and appropriate coverage of assessments, which may include but is not limited to cognitive health assessments, appropriate treatment services, and necessary referrals, billed through established practices.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[6] These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

[6] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, "Medi-Cal Managed Care Health Plan Guidance on Network Provider Status," and any subsequent APLs on this topic.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division