CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: July 1, 2026

ALL PLAN LETTER 26-014

SUPERSEDES ALL PLAN LETTER 22-025

TO: ALL MEDI-CAL MANAGED CARE 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 plans (MCPs) about the provision of the annual Medi-Cal cognitive health assessment to eligible Members who are 65 years of age or older and who do not have Medicare coverage. This APL supersedes APL 22-025 and reflects statutory changes chaptered on June 30, 2025 (Assembly Bill 116, Committee on Budget, Chapter 21, Statutes of 2025), which amended section 14132.171 of the Welfare and Institutions Code (W&I) to remove the cognitive health assessment training requirement.

BACKGROUND:

Senate Bill 48 (Chapter 484, Statutes of 2021) created W&I section 14132.171, which expanded 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

[1] Legislation and state law are searchable at: https://leginfo.legislature.ca.gov/faces/home.xhtml.

standards for detecting cognitive impairment under the Medicare Annual Wellness Visit and the recommendations by the American Academy of Neurology (AAN).[2,3]

W&I section 14132.171 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 use validated tools recommended by the Department of Health Care Services (DHCS). Effective June 30, 2025, Providers are no longer required to complete a cognitive health assessment training in order to receive payment for conducting a cognitive health assessment.

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.

Members with Medicare are excluded from this policy, since cognitive assessments are already covered as part of the Medicare Annual Wellness Visit.[5]

Provider Billing Requirements

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

- 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

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[2] See the Centers for Medicare and Medicaid Services 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 are available at: https://www.aan.com/PressRoom/Home/PressRelease/4908 and https://www.neurology.org/doi/10.1212/wnl.0000000000004826.
[4] The Medi-Cal Provider Manual, E&M, Cognitive Health Assessment, is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/file/manual?fn=eval.pdf, p. 34.
[5] For more information about the Medicare Annual Wellness Visit, see: https://www.cms.gov/medicare/coverage/preventive-services/medicare-wellness-visits/annual-wellness-visit.

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 the 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.

For cognitive health assessments completed prior to June 30, 2025, Providers must have completed the required DHCS Dementia Care Aware cognitive health assessment training in order to bill and receive reimbursement.[6] For cognitive health assessments completed on or after June 30, 2025, Providers are no longer required to complete the training in order to bill and receive reimbursement. Medi-Cal Rates can be found at: https://www.dhcs.ca.gov/services/medi-cal/Pages/Rates.aspx.

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[7]
- Informant tools (family members and close friends)
    - Eight-Item Informant Interview to Differentiate Aging and Dementia[8]
    - GPCOG

[6] The DHCS Dementia Care Aware cognitive health assessment training is available on the DHCS website at: https://www.dementiacareaware.org/.
[7] The Mini-Cog tool is available at: https://mini-cog.com/download-the-mini-cog-instrument/.
[8] The Eight-Item Informant Interview is available at: https://hign.org/sites/default/files/2020-06/Try_This_Dementia_14.pdf.

- Short Informant Questionnaire on Cognitive Decline in the Elderly

MCPs must 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.

MCP Responsibilities for Policies and Procedures, Subcontractors, and Enforcement Actions

MCPs must review their contractually required policies and procedures (P&Ps) to determine if amendments are needed to comply with this APL. If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required P&Ps, the MCP must submit its updated P&Ps to the Managed Care Operations Division (MCOD)-MCP Submission Portal within 90 calendar days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must attach an attestation to the Portal within 90 calendar days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The attestation 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. These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose enforcement actions, including corrective action plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. MCPs should review their Network Provider and/or Subcontractor Agreements to ensure compliance with this APL.

For additional information regarding enforcement actions, see APL 25-007. Any failure to meet the requirements of this APL may result in enforcement actions.

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

Sincerely,

Original Signed by Shaun Garcia

Shaun Garcia

Division Chief, Quality and Health Equity Division