Enhanced Care Management Program Completion Questionnaire

California | Anthem Blue Cross | Medi-Cal Managed Care (Medi-Cal)

Program Completion Questionnaire (*PCQ*): Enhanced Care Management (ECM) lead care managers are encouraged to review the following questions with the member to assess their readiness for completing the ECM program or transitioning to a lower level of care management.

Graduation or step down:

- Exclude the member via the return transmission file (RTF) process and add the appropriate reason for the exclusion.
- Upload the *PCQ* along with the most recent member assessment and care management plan, summarizing the services provided during the period of enrollment, via Care Central through Payer Spaces at https://Availity.com.

Note: Decisions may be subject to clinical review.

ECM authorization extension: If the member has unmet goals and you believe they should continue receiving ECM services, this form can also be used to request a six-month extension for ECM authorization.

Reauthorization timeline: Submit the completed *PCQ* 30 days before the authorization expires via Care Central to ensure timely processing. Alternately, send the questionnaire by encrypted email to calaimreferrals@anthem.com.

Today's date:	
ECM enrollment date:	
Lead care manager name:	
Member name:	
CIN:	
Authorization number (if available):	

Medicaid coverage provided by Anthem Blue Cross, trade name of Blue Cross of California. Anthem Blue Cross and Blue Cross of California Partnership Plan, Inc. are independent licensees of the Blue Cross Association. Blue Cross of California is contracted with L.A. Care Health Plan to provide Medi-Cal Managed Care services in Los Angeles County. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
CABC-CD-081557-25 | April 2025

Care plan	
Have I met the goals on my care plan?	☐ Yes ☐ No
Other (describe):	
Physical health	
I can do the following on my own or with the help of a caregiver or support person (mark all that apply):	
☐ Make appointments	
☐ Track appointments on a calendar	
☐ Know how to call the PCP or Nurse Advice Line	
☐ Use the ER appropriately	
☐ Know how to attend telehealth appointment	
☐ Call Customer Service to ask questions or request services (change provider request case management)	
☐ Call Modivcare to schedule rides to appointments, pharmacy, food pantries	
☐ Understand the *Member Bill of Rights*	
☐ Use the *Member EOC Handbook*	
Do I understand why I take each of my medications and do I take them as instructed by my doctor?	☐ Yes ☐ No
☐ Other (describe):	
Do I know when I need to see my care provider? Do I feel comfortable talking to the care provider about what is bothering me and asking questions?	☐ Yes ☐ No
☐ Other (describe):	
Can I follow my care team's recommendations (for example, eating right or exercising)?	☐ Yes ☐ No
☐ Other (describe):	

Do I feel like I can manage my stress?	☐ Yes ☐ No
☐ Other (describe):	
Do I know how to take care of my health and ask for help when I need it?	☐ Yes ☐ No
☐ Other (describe):	

Mental/emotional health (if the member has a serious mental illness diagnosis)
I can do the following on my own or with the help of a caregiver or support person (mark all that apply):
☐ Understand my mental health diagnosis and treatment
☐ Know where and when to seek care and make informed decisions about care
☐ Recognize warning signs related to emotional health/mental health diagnosis
☐ Recognize things that upset me and respond in a healthy way
☐ Understand why I take my medications and know how to take my medications
☐ Know how to attend telehealth appointment
☐ Call Customer Service to ask questions or request services (change provider request case management)
☐ Identify one or more people I can talk to (for example, support person or group)
☐ Find help when I need it

Housing	
Do I have safe and stable housing? Do I know how to find help if I need it?	☐ Yes ☐ No
☐ Other (describe):	
Do I know my rights in my current housing situation?	☐ Yes ☐ No
☐ Other (describe):	
Do I know how my actions, such as paying rent late, hoarding, and smoking, can affect my housing?	☐ Yes ☐ No

☐ Other (describe):	
Do I understand why I need to maintain my relationship with the landlord?	☐ Yes ☐ No
☐ Other (describe):	
Daily living	
Can I do things like cook, clean, and shop for myself, or with the help of a caregiver or support person? Can I ask for help when I need it?	☐ Yes ☐ No
☐ Other (describe):	
Can I perform activities of daily living such as bathing, dressing, toileting, transferring, continence, and feeding	☐ Yes ☐ No
☐ Other (describe):	
Do I have all the supplies and equipment to live on my own or with the help of a caregiver or support person?	☐ Yes ☐ No
☐ Other (describe):	
Am I able to get food, transportation, and seek help when I need it?	☐ Yes ☐ No
☐ Other (describe):	
Do I have my birth certificate, Social Security card, driver's license, and other records to prove my identity?	☐ Yes ☐ No
☐ Other (describe):	

Do I know how to keep track of my money* and how and where I spend it (for example, rent, bills, and groceries)? *** Note: intended to be inclusive of all income sources, including CalFresh**	☐ Yes ☐ No
☐ Other (describe):	

Provide details for the following:
Required: Identify any programs or services to which the member was linked during ECM. Is the member still receiving services from these programs today?
Required: Describe any ongoing need for care management services related to a specific need or concern.
Required: If member meets criteria to transition to a lower level of care management, identify a program(s) that may be a good fit to continue to serve the member after the end of ECM services (if known).