Comprehensive Primary Care (CPC) and CPC for Kids Activities

2025

Ohio Department of Medicaid

CPC and CPC for Kids Activities

Background

Foundation of population health management and purpose of per-member-per-month (PMPM) payments

Helps primary care entities support members in managing their health

Primary care providers can offer more health care services to meet the needs of their members to help strengthen the provider-member relationship

Enables members to receive more care from their primary care providers which helps improve the quality of care and reduce unnecessary hospitalizations

CPC Activity Requirements

	Definition
24/7 and Same-Day Access to Care	Complete the “24/7 and same-day access to care” activities in which the CPC entity will: • Offer at least one alternative to traditional office visits to increase access to the care team and clinicians in ways that best meet the needs of the population including but not limited to, e-visits, phone visits, group visits, home visits, alternate location visits, or expanded hours in the early mornings, evenings, and weekends • Provide 24/7 and same-day access to a primary care provider (PCP) with access to the member's medical record • Make clinical information of the member available through paper or electronic records, or telephone consultation to on-call staff, external facilities, and other external clinicians when the office is closed*

Ohio Department of Medicaid

***Source:** https://codes.ohio.gov/ohio-administrative-code/rule-5160-19-01

CPC Activity Requirements

	This activity can be met by
24/7 and Same-Day Access to Care	• Offering same-day reserved appointment slots • Providing access to a primary care provider (PCP) 24/7 (e.g., member portal, on-call providers) • Offering extended weekday or weekend hours • Having manual or automated processes to follow up with members who missed appointments (e.g., outreach, letters, etc.) • Providing members with access to clinical advice through alternatives to traditional office visits (e.g., telehealth, home visits, group visits) • Monitoring and adjusting hours/days based on member feedback and need • Collecting data on reasons for the use of after-hours care such as urgent care or the emergency department (ED) • Identifying members who are high utilizers of the ED

CPC Activity Requirements

	Additional considerations
24/7 and Same-Day Access to Care	• Proactively educate members on the appropriate levels of care • Offer office weekend hours to members • Coordinate with the MCOs to develop interventions/care approaches/care strategies for members that are high utilizers of the ED • Offer online self-scheduling • Utilize notification systems for member appointment reminders (e.g., text, telephone) • Have a technology-based process for filling canceled appointments, such as an automated text message sent to members who need to be scheduled from a waitlist • Proactively screen for SDOH when scheduling appointments • Track ED utilization for dental needs to assess the need for preventive dental services in primary care settings • Provide access to preventive in-house dental services for adults and children (e.g., fluoride varnishes, dental clinic)

CPC Activity Requirements

	Definition
Risk Stratification	Complete the “risk stratification” activities in which the CPC entity will: • Have a developed method for documenting member risk level that is integrated within the attributed Medicaid individual's record • Have a clear approach to implement this across the entire member panel*

*Source: https://codes.ohio.gov/ohio-administrative-code/rule-5160-19-01

CPC Activity Requirements

	This activity can be met by
Risk Stratification	• Having a stated definition and documented methodology for identifying at least two risk levels for members • Utilizing billable and/or non-billable codes to identify health risk factors when defining risk levels (e.g., Z codes, CPT II codes) • Integrating behavioral health (BH) indicators into the risk stratification methodology (e.g., conditions, medications) • Integrating social determinants of health (SDOH) based on their member population into risk stratification methodology (e.g., health literacy, child in custody, unhoused) • Displaying risk levels in member's electronic health record (HER) for ease of team access

CPC Activity Requirements

	Additional considerations

Risk Stratification	• Utilize SDOH screening results when defining risk levels (e.g., >3 SDOH)
	• Utilize BH screening results when defining risk levels
	• Design care models for risk tiers that target interventions and support based on individual members' needs. Some examples:
	  ○ High-risk: assign a nurse, create an individualized care plan, allow longer appointment times, or have weekly/monthly touchpoints
	  ○ Moderate-risk: provide condition-specific self-management tools, annual condition screenings, or quarterly touchpoints
	  ○ Low-risk: provide self-management tools to maintain healthy behaviors and well visit and annual screening reminders
	• Adjust risk scores based on provider discretion (e.g., presence of self-management skills, level of acuity, and/or family health history)
	• Have a policy detailing how and when individual risk stratification is updated with member risk factors (e.g., new information, predetermined schedule)
	• Have a process to review the risk stratification methodology on a regular schedule and update as needed

CPC Activity Requirements

	Definition
Population Health Management	Complete the "population health management" activities in which the CPC entity will: • Identify members in need of preventive or chronic services • Begin outreach to schedule applicable appointments • Identify additional services needed to meet the needs of the member*

***Source:** https://codes.ohio.gov/ohio-administrative-code/rule-5160-19-01

Department of Medicaid

CPC Activity Requirements

	This activity can be met by
Population Health Management	• Systematically identifying members in need of preventive or chronic care services (e.g., breast cancer screening, immunizations, eye exam, etc.) • Having a process to ensure that preventive or chronic care services are obtained by members • Utilizing best practices, designing tailored interventions to assist members with preventive care that promote wellness services (e.g., flu vaccine clinic, lead screenings, health fairs, cancer screenings, BP screenings, nicotine education, mailings, transportation assistance, scheduling appointments). • Utilizing best practices, designing tailored interventions to assist members in the management of chronic conditions such as asthma, diabetes, depression, or hypertension (e.g., asthma action plans, remote monitoring, CGM, psychotherapy with antidepressant)

CPC Activity Requirements

	Additional considerations
Population Health Management	• Stratify members (e.g., organizing member lists/registries by race, ZIP, gender, ethnicity, SDOH) that have not completed preventive services to identify healthcare disparities • Stratify members (e.g., organizing member lists/registries by race, ZIP, gender, ethnicity, SDOH) that have not completed chronic care services to identify healthcare disparities • Have a process to address healthcare disparities by closing the gaps in preventive services (e.g., oral health for adults with intellectual and developmental disabilities) • Have a process to address healthcare disparities in closing the gaps in chronic services (e.g., retinal eye exams, depression follow-up care). • Identify a list of members with SDOH needs (e.g., transportation, food, housing). • Have a process to assist/care for/ support members with SDOH needs (e.g., working with food banks for food insecurity) • Identify trends in population-level health data such as preventive, chronic or SDOH • Implement population health initiatives or programs based on identified trends • Offer chronic condition management programs to a member panel and/or community

CPC Activity Requirements

	Definition
Team-Based Care Delivery	Complete the "team-based care delivery" activities in which the CPC entity will: • Define care team members, roles, and qualifications • Provide various care management strategies in partnership with payers, ODM, and other providers as applicable for members in specific segments identified by the CPC entity*

***Source:** https://codes.ohio.gov/ohio-administrative-code/rule-5160-19-01

CPC Activity Requirements

	This activity can be met by
Team-Based Care Delivery	• Having standardized workflows/policies with defined roles for staff • Having a care coordinator or blocks out time for other staff to perform care coordination activities that address health and social needs • Training staff to perform key services matching their abilities and licensure (e.g., MA - self-management coaching, chart documentation, immunizations, portal message management, follow-up phone calls; RN – managing chronic illnesses and members with high-risk needs, titrate medications under standing orders, completes well-care visit documentation) • Involving the care team in quality improvement activities • Designing care teams for continuity of care (e.g., consistent clinical teams working with members) • Having members and/or families be active participants in the care team (e.g., referrals, shared decision-making, communication preferences).

CPC Activity Requirements

	Additional considerations
Team-Based Care Delivery	• Have access to non-traditional workers that can be integrated into the care team when needed (e.g., CHWs, peer supporters, lactation consultants, family members) • Have standing orders in the EHR that can be acted on by non-independent providers under protocols (e.g., immunizations, labs, prescription refills • Design a physical environment for information sharing (e.g., co-locating staff, common workrooms) • Identify external care manager in the EHR as part of the team (e.g., MCO, hospital discharge, OhioRISE) • Have implemented synchronized prescription renewal (renewing long-term meds on the same date)

CPC Activity Requirements

	Definition
Care Coordination	Complete the "care coordination" activities in which the CPC entity will: • Identify and close gaps in care • Refer members for further intervention as needed, including referrals to MCOs or community resources as appropriate*

***Source:** https://codes.ohio.gov/ohio-administrative-code/rule-5160-19-01

Department of Medicaid

CPC Activity Requirements

	This activity can be met by
Care Coordination	• Utilizing EHR/gaps in care data for pre-visit planning or daily huddles prior to member appointments • Leveraging best practice or clinical practice guidelines when coordinating care (e.g., ADA or CDC standards of care for members with diabetes, and/or APA clinical practice guideline for depression) • Facilitating exchanges of information between members, providers, services, and community services • Integrating BH, physical health, and SDOH factors and plans, from both internal and external providers and community organizations, into one personalized care plan for high-risk members

CPC Activity Requirements

	Additional considerations
Care Coordination	• Communicate with MCOs to coordinate services and eliminate duplicative services including but not limited to accessing the MCOs' care coordination portals • Convene multidisciplinary care conferences to address concerns for members with medically complex needs • Have members and/or families as active participants in the care planning process • Integrate oral health into care planning (e.g., oral health in members with diabetes) • Train care coordinator(s)in motivational interviewing

CPC Activity Requirements

	Definition
Follow Up After Hospital Discharge	Complete the "follow-up after hospital discharge" activities in which the CPC entity will: • Have established relationships with all emergency departments and hospitals from which it frequently receives referrals • Have an established process to ensure a reliable flow of information*

***Source:** https://codes.ohio.gov/ohio-administrative-code/rule-5160-19-01

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CPC Activity Requirements

	This activity can be met by
Follow Up After Hospital Discharge	• Having established processes with the EDs and hospitals from which regular referrals are received to ensure a reliable flow of information • Having a process for member outreach after a hospital inpatient stay or ED visit within 7 days based on acuity • Having a policy/workflow that defines how to determine members' acuity after a hospital inpatient stay or ED visit • Having a distinct process to connect members to a mental health provider within 7 days following a hospital stay for a mental health condition • Connecting members with newly identified risk factors after hospital discharge to internal, MCO, or other assigned care managers

CPC Activity Requirements

	Additional considerations
Follow Up After Hospital Discharge	• Have a process for reviewing clinical information after a hospital inpatient stay during the outreach call • Have a generalized EHR template/question script for use during follow-up outreach after an inpatient stay • Have a targeted EHR template/question script for use during follow-up outreach after an inpatient stay specifically for complex chronic conditions • Collaborate with MCOs to avoid duplication. • Include hospital readmission risk score when determining a member's acuity for appropriate level of follow up

CPC Activity Requirements

	Definition:

Tests and Specialist Referrals	Complete the "tests and specialist referrals" activities in which the CPC entity will:
	• Have established bi-directional communication with the following for tracking referrals:
	  • Specialists
	  • Pharmacies
	  • Laboratories
	  • Imaging facilities*

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***Source:** https://codes.ohio.gov/ohio-administrative-code/rule-5160-19-01

CPC Activity Requirements

	This activity can be met by
Tests and Specialist Referrals	• Having established relationships and connections with various specialists based on member population • Having a bidirectional process for referrals with specialists, pharmacies, laboratories, and imaging facilities • Having an EHR template for referring members to a specialist • Having a process to ensure the referral loop is closed • Utilizing electronic prescription transmission systems

CPC Activity Requirements

	Additional considerations
Tests and Specialist Referrals	• Have an onsite lab or complete point-of-care testing • Update referral lists based on member feedback, experiences, and outcomes • Have the ability to complete “curbside” consultations or real-time specialist input (e.g., direct phone line to the children’s hospital psychiatrist for real-time consultation or guidance)

CPC Activity Requirements

	Definition
Patient Experience	Complete the "patient experience" activities in which the CPC entity will: • Orient all members to the practice and incorporate member preferences in the selection of a primary care provider to build continuity of relationships throughout the entire care process • Ensure all staff who provides direct care or otherwise interacts with members complete cultural competency training within 6 months of enrollment and annually thereafter • Ensure that new staff who will provide direct care or otherwise interact with members complete cultural competency training within 30 days of their start date • Routinely assess demographics and adapt training needs based on demographics • Assess its approach to member experience and cultural competency at least once annually using a member and family advisory council (PFAC) or other quantitative and qualitative means, such as focus groups or a member survey that covers access to care, communication, coordination, whole person care, and self-management support • Use information collected to identify and act on opportunities to improve member experience and reduce cultural disparities including disparities in the identification, treatment, and outcomes related to chronic conditions such as asthma, diabetes, and cardiovascular health and report findings and opportunities to members, the PFAC, payers, and ODM*

***Source:** https://codes.ohio.gov/ohio-administrative-code/rule-5160-19-01

CPC Activity Requirements

	This activity can be met by
Patient Experience	• Ensuring staff providing direct care or otherwise interacting with members complete cultural competency training within 30 days of their start date and then annually • Collecting and assessing member demographics such as race, ethnicity, and language • Adapting staff training based on the demographics of the member population • Based on demographics, creating culturally appropriate service delivery and communications (e.g., translators, translated materials, community-based staff) • Having a process to orient members to the CPC entity • Collecting experience data from members, including access to care, communication, coordination, whole-person care, self-management support, and cultural competency, at least annually • Utilizing experience data to inform strategies to improve the member's experience. • Reporting these findings and improvement plans back to members, the PFAC and staff

CPC Activity Requirements

	Additional considerations
Patient Experience	• Address member barriers to participating in member experience assessments (e.g., health literacy, language, lack of email/phone/internet) • Stratify member experience data (e.g., race, ethnicity) to identify potential trends or potential disparities in member experience (e.g., respect, trust, listening) • Have a strategy to address population-level disparities in member experience. (e.g., focus groups, community leaders) • Identify population-level disparities in member experience to inform strategies that target outcome disparities (e.g., utilizing an identified disparity in member trust to inform member outreach strategies to improve cancer screening rates)

CPC Activity Requirements

	Definition
Community Services and Supports Integration	Complete the "community services and supports integration" activities in which the CPC entity will: • Identify members in need of community services and supports • Maintain a process to connect members to necessary services*

***Source:** https://codes.ohio.gov/ohio-administrative-code/rule-5160-19-01

CPC Activity Requirements

	This activity can be met by
Community Services and Supports Integration	• Using an SDOH screening tool to identify individual health-related social needs within at least 5 domains (e.g., PRAPARE®, custom EHR template) • Having a process to refer/link individual members with identified SDOH to appropriate community services and supports • Having a process to ensure recommended services and supports were received by the member and the gap is closed

CPC Activity Requirements

	Additional considerations
Community Services and Supports Integration	• Demonstrate established relationships with local community partners that provide resources and support for all SDOH needs that are screened for • Have implemented an improvement strategy for community services and support needs (e.g., EHR functionality, new web-based technology, lunch and learns for community resources)

CPC Activity Requirements

	Definition
Behavioral Health (BH) Integration	Complete the "behavioral health integration" activities in which the CPC entity will: • Use screening tools to identify members in need of behavioral health services • Track and follow up on BH service referrals • Have a planned improvement strategy for BH outcomes*

***Source:** https://codes.ohio.gov/ohio-administrative-code/rule-5160-19-01

CPC Activity Requirements

	This activity can be met by
Behavioral Health (BH) Integration	• Using validated screening tools to identify members in need of BH services including SUD (also in pediatric population, if applicable). • Using standardized guidelines/workflows for the initiation of BH screenings • Partnering with external BH providers for referrals to services not provided within the entity • Having a process to ensure that recommended services are received by the member and the gap in care is closed • Monitoring and assessing BH quality metrics (e.g., BH-related inpatient admissions, follow-up after hospitalization for mental health, engagement of alcohol and other drug dependence treatment, antidepressant medication management)

CPC Activity Requirements

	Additional considerations
Behavioral Health (BH) Integration	• Have implemented strategies to improve BH quality outcomes • Have BH services on-site or telehealth on-demand at entity

CPC For Kids Bonus Activities

	This activity can be met by
Additional Supports for Children in the Custody of a Title IV-E Agency	• Having appointments available within 24 hours to complete the initial screening for children in custody • Having bidirectional communication with the local public children services agency • Providing targeted care coordination to all children in custody. • Having access to specific resources for children in custody (e.g., support groups, OhioKAN, Youth Navigator Network, iFoster) • Having resources available for guardians of children in custody (e.g., legal, foster education, Triple P parenting program, iFoster). • Having a process for incorporating feedback from children in custody and/or families on a group- or population-level to improve understandings of system and/or process barriers related to unique member experiences

CPC For Kids Bonus Activities

Additional Supports for Children in the Custody of a Title IV-E Agency	Additional considerations
	• Utilize the OH|ID site to access Managed Care Entity Care Coordination Portal to obtain information on children in custody • Implement strategies to improve the care of children in custody (e.g., workflows, trauma-informed education) • Provide trauma-informed care training for care coordinators and providers

CPC For Kids Bonus Activities

	This activity can be met by
Integration of Behavioral Health (BH) Services	• Using validated pediatric screening tools to identify those in need of BH services • Using standardized guidelines/workflows for the initiation of pediatric BH screenings • Using a specific risk screening tool for those with suicide ideation (e.g., ASQ, C-SSRS) and implementing an intervention protocol within the entity when appropriate (e.g., gun locks, safety plans) • Having a process to refer members to pediatric BH services • Partnering with external pediatric BH providers for BH services not provided within the entity • Understanding how to refer members to OhioRISE for the administration of CANS assessments as appropriate

CPC For Kids Bonus Activities

	Additional considerations
Integration of Behavioral Health (BH) Services	• Implement strategies to improve BH pediatric quality metrics (e.g., education, new screenings, developed quality dashboard) • Use standardized pediatric screening tools for SUD • Have a process to request records from the correctional system as applicable • Provide care coordination for justice-involved youth (e.g., mentorships, re-enrollment in school, tutoring, employment, housing, peer support services, dental and medical needs) • Offer mental health and SUD peer support services to members after release from incarceration as needed • Complete mental health, suicide ideation, SUD, and trauma/PTSD screenings for justice-involved youth

CPC For Kids Bonus Activities

	This activity can be met by
School-Based Health Care Linkages	• Identifying the needs of the local schools (e.g., utilizing demographic data, a community needs assessment, or inquiring what health-related needs are in the schools) • Promoting wellness by caring for students and/or their families through an informal relationship with a school or school district (e.g., sports physicals, action plans, health fairs) • Coordinating care of children with health care providers (e.g., school-based psychologists, social workers, counselors, nurses) within the local schools • Coordinating care of justice-involved youth re-entering the schools (e.g., immunization gaps, screenings, referrals)

CPC For Kids Bonus Activities

	Additional considerations
School-Based Health Care Linkages	• Initiate the individualized education plan (IEP) process for the child in need in partnership with schools. • Through a coordinated system, provide healthcare to students and their families with a formal partnership (e.g., school-based health clinic, joint protocols, shared EHR, provides staffing) • Provide alternatives to provide care in schools that do not have a specific healthcare service (e.g., mobile unit for oral health services, telehealth for mental health services) • Measure the effect of SBHC on health and/or academic outcomes (e.g., absenteeism, missed class time, immunizations, well-care visits) • Support or facilitate a school health youth advisory council • Have a dedicated liaison between the school and the entity • Utilize consent while a child is student at the school

CPC For Kids Bonus Activities

	This activity can be met by
Transitions of Care	• Proactively identifying transition-aged youth • Tracking and monitoring members who transition from youth to adult care • Having an established process to assist pediatric members transitioning to an adult approach to healthcare without changing providers (e.g., legal changes in decision-making, self-advocacy, self-care, access to portal) • Having an established process to assist pediatric members with transitions to new adult care providers within the same entity (e.g., warm handoff, EHR transition summary/note) • Having an established process to assist pediatric members with transitions to new adult care providers external to the entity (e.g., assist with selection of new provider/specialist, sending summary of care letters and records). • Utilizing a transition readiness assessment tool to identify members' needs to prepare for transitions to adult care (e.g., how to use health care services, self-care needs, managing medications, employment)

CPC For Kids Bonus Activities

	Additional considerations
Transitions of Care	• Provide warm handoffs to new care providers during transition for all members with medically complex needs (e.g., telephone and/or in-person) • Conduct an appointment or equivalent consultation with the member and the new adult care physician, once the member has concluded care with the pediatric physician for members with medically complex needs • Elicit feedback from young adults regarding the transition process for quality improvement

CPC Activity Requirements

	This activity can be met by
Oral Evaluation, Dental Services	• Completing an oral health assessment or having a process to ensure an oral health assessment is completed by a dentist and/or specialist • Referring members to a dental practitioner for comprehensive or periodic exams • Discussing the importance of oral preventive health annually at well-care visits with the member and family (e.g., brushing, flossing, cleanings, fluoride treatments, tobacco cessation) • Completing an oral health risk assessment of dental health including history and clinical presentation to identify conditions and treatments impacting overall health (e.g., risk assessment covers use of bottles/sippy cups with something other than water, presence of fluoride in water, sugar intake, dental habits, benefits of dental sealants). • Utilizing data to assess and addressing potential disparities in completing oral health evaluations (e.g., race and ethnicity, income, disability status)

CPC Activity Requirements

	Additional considerations
Oral Evaluation, Dental Services	• Offer fluoride varnish application at time of well-care visit with in-house trained practitioners • Collaborate with MCOs on dental service reports • Provide outreach to close the identified gaps for comprehensive exams

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