Comprehensive Primary Care (CPC) and CPC for Kids Activities

2026

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.

CPC Activity Requirements

	Required Criteria
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). • 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 feedback and need. • Collecting data on reasons for the use of after-hours care such as urgent care or the emergency department (ED).

CPC Activity Requirements

	Optional Criteria
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 patients for health-related needs that are barriers to achieving full health potential when scheduling appointments. • Track ED utilization for dental needs to assess the need for preventive dental services in primary care settings.

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

CPC Activity Requirements

	Required Criteria
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 health related needs that are barriers to achieving full health 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

	Optional Criteria

Risk Stratification	• Utilize health related patient needs screening results when defining risk.
	• Utilize BH screening results when defining risk.
	• Design care models for risk tiers that offer support based on individual members' needs.
	  ○ High-risk: create an individualized care plan, allow longer appointment times, have weekly/monthly touchpoints.
	  ○ Moderate-risk: provide condition-specific self-management tools, annual condition screenings, quarterly touchpoints.
	  ○ Low-risk: provide tools to maintain healthy behaviors and screening reminders.
	• Have a policy on how and when risk stratification is updated (e.g., new information, predetermined schedule).

CPC Activity Requirements

	Definition
Population Health Management	Complete the "population health management" activities in which the CPC entity will: • Identify members in groups or segments by using practice-defined common characteristics in need of preventive or chronic services. • Begin outreach to schedule applicable appointments. • Identify additional services needed to improve the health of the identified group or segment of attributed Medicaid individuals.

CPC Activity Requirements

	Required Criteria
Population Health Management	• Systematically identifying members in groups or segments by using practice-defined common characteristics in need of preventive or chronic care services (e.g., breast cancer screening, immunizations). • Having a process to ensure that preventive or chronic care services are obtained by members in an identified group or segment by using practice-defined common characteristics. • Utilizing best practices, designing tailored interventions to assist members in groups or segments by using practice-defined common characteristics with preventive care that promote wellness services (e.g., flu vaccine clinic). • Utilizing best practices, designing tailored interventions to assist members in groups or segments by using practice-defined common characteristics in the management of chronic conditions such as asthma or hypertension.

CPC Activity Requirements

	Optional Criteria
Population Health Management	• Stratify members by race/ethnicity, ZIP, gender, or patient health related needs that have barriers to achieving optimal health (e.g., transportation) that have not completed needed preventive services to assist them with this. • Stratify members by race/ethnicity, ZIP, gender, or patient health related needs that have barriers to achieving optimal health (e.g., transportation) that have not completed chronic care services to assist them with this. • Identify a list of members in a group that have other needs that are barriers to achieving optimal health (e.g., housing insecurity) to assist them with this. • Identify trends in data for preventative care and chronic conditions outcomes including health related patient needs that are barriers to achieving full health potential. • Implement population health initiatives or programs based on identified trends • Offer chronic condition management programs for an identified group using practice-defined common characteristics to a member panel and/or community.

CPC Activity Requirements

	Definition
Continuous Quality Improvement	Complete the “continuous quality improvement (QI)" activities in which the CPC entity will: • Demonstrate regular and ongoing QI using QI projects, quality goals for outcome metrics, QI education for staff, QI committees, or other QI activities that includes the voice of the patient and the provider to continuously improve the quality of care for individuals.

CPC Activity Requirements

	Required Criteria
Continuous Quality Improvement	• Implementing regular and ongoing quality improvement through one quality improvement process (i.e., quality improvement projects, quality goals for outcome metrics, quality improvement education for staff, quality improvement committees, or other quality improvement activities). • Actively participating in state Medicaid sponsored quality improvement opportunities (SDPs, OAK, Regional QI hubs). • Leveraging the voice of the patient to continuously improve the quality of care for attributed Medicaid individuals. • Leveraging the voice of the provider to continuously improve the quality of care for attributed Medicaid individuals.

CPC Activity Requirements

	Optional Criteria
Continuous Quality Improvement	• Implements regular and ongoing quality improvement through more than one quality improvement process (i.e., quality improvement projects, quality goals for outcome metrics, quality improvement education for staff, quality improvement committees, or other quality improvement activities.)

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.

CPC Activity Requirements

	Required Criteria
Care Coordination	• Has a care coordinator or other staff that performs care coordination activities that address patient needs that are barriers to achieving full health potential. • Utilizing gaps in care data for pre-visit planning. • Leveraging best practice or clinical practice guidelines when coordinating care (e.g., CDC standards of care for those with diabetes). • Facilitating exchanges of information between members, providers, services, and community services. • Coordinates the integration of care and addresses needs from both internal and external providers and community organizations.

CPC Activity Requirements

	Optional Criteria
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.

CPC Activity Requirements

	Required Criteria
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

	Optional Criteria
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

CPC Activity Requirements

	Required Criteria
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

	Optional Criteria
Tests and Specialist Referrals	• Have an onsite lab or complete point-of-care testing. • Update referral lists based on member feedback, experiences, and outcomes. • Can 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, Staff and Provider Experience	Complete the "patient, staff and provider experience" activities in which the CPC entity will: • Orient all members to the practice and incorporate member preferences in the selection of a PCP to build continuity of relationships throughout the process. • Ensure all staff who provides care/interacts with members complete cultural competency training within 6 months of enrollment and annually thereafter. • Ensure that new staff who will provide care/interact with members complete cultural competency training within 30 days of their start date. • Routinely assess demographics and use it to adapt to training needs. • 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 variations in health outcomes including reducing performance gaps in the identification, treatment, and outcomes related to chronic conditions and report findings and opportunities to members, the PFAC, payers, and ODM • Demonstrate a means of assessing staff and provider satisfaction at least once annually by using resources such as meeting minutes, surveys, or a comment box.

CPC Activity Requirements

	Required Criteria
Patient, Staff and Provider 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 findings and improvement plans back to members, the PFAC and staff • Assessing staff and provider satisfaction annually by using meeting minutes, surveys, or a comment box.

CPC Activity Requirements

	Optional Criteria
Patient, Staff and Provider Experience	• Address member barriers to participating in member experience assessments (e.g., health literacy, language, lack of email/phone/internet). • Stratify member experience data by race/ethnicity to identify potential trends or variations in member experience (e.g., respect, trust, listening). • Have a strategy to address any identified variations in member experience (e.g., focus groups, community leaders). • Identify variations in member experience to inform strategies that target the reduction of patient experience gaps (e.g., utilizing an identified variation to inform strategies to increase trust 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.

CPC Activity Requirements

	Required Criteria
Community Services and Supports Integration	• Using a screening tool to identify individual health-related needs that are barriers to achieving full health potential (e.g., transportation, food insecurity) within at least 5 domains (e.g., PRAPARE®, custom EHR template). • Having a process to refer/link individual members with identified needs 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

	Optional Criteria
Community Services and Supports Integration	• Demonstrate established relationships with local community partners that provide resources and support for all health-related needs that members 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 providers).

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.

CPC Activity Requirements

	Required Criteria
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. • Has a planned improvement strategy for at least one BH quality metric (e.g., BH-related inpatient admissions, follow-up after hospitalization for mental health, engagement of alcohol and other drug dependence treatment).

CPC Activity Requirements

	Optional Criteria
Behavioral Health (BH) Integration	• Have implemented strategies to improve BH quality outcomes. • Have BH services on-site or telehealth on-demand.

CPC For Kids Bonus Activities

Additional Supports for Children in the Custody of a Title IV-E Agency	Required Criteria
	• 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-level to improve understandings of system and/or process barriers related to unique member experiences.

CPC For Kids Bonus Activities

	Optional Criteria
Additional Supports for Children in the Custody of a Title IV-E Agency	• Utilize the OH|ID site to access Managed Care Organization Care Coordination Portal to obtain information on children in custody. • Has a direct contact at the local children services agency for referrals and addressing needs. • 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. • Any innovative method the entity is using for this activity.

CPC For Kids Bonus Activities

	Required Criteria
Integration of Behavioral Health (BH) Services	• Using validated pediatric screening tools to identify BH service needs. • 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 OhioRISE and how to refer members to OhioRISE for the administration of CANS assessments as appropriate

CPC For Kids Bonus Activities

	Optional Criteria
Integration of Behavioral Health (BH) Services	• Participates in Outcomes Acceleration for Kids (OAK) as appropriate. • Implement strategies to improve BH pediatric quality metrics (e.g., education, new screenings, developed quality dashboard) • Use standardized pediatric screening tools for SUD • Has a process to request records from the correctional system as applicable • Provides care coordination for justice-involved youth (e.g., mentorships, re-enrollment in school, tutoring, employment, housing, peer support services, dental and medical needs) • Offers mental health and SUD peer support services to members after release from incarceration as needed • Completes mental health screenings for justice-involved youth • Any innovative method the entity is using for this activity.

CPC For Kids Bonus Activities

	Required Criteria
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

	Optional Criteria
School-Based Health Care Linkages	• Participates in Outcomes Acceleration for Kids (OAK) as appropriate. • 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. • Provide alternatives to provide care in schools that do not have a specific healthcare service (e.g., mobile unit for oral health services). • Measure the effect of SBHC on health and/or academic outcomes (e.g., absenteeism, missed class time). • 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 a student at the school. • Any innovative method the entity is using for this activity.

CPC For Kids Bonus Activities

	Required Criteria
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). • 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 PCPC, sending records). • Utilizing a transition readiness assessment tool to prepare members for transitioning to adult care (e.g., how to use health care services, self-care needs, managing medications, employment).

CPC For Kids Bonus Activities

	Optional Criteria
Transitions of Care	• Participates in Outcomes Acceleration for Kids (OAK) as appropriate. • 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. • Any innovative method the entity is using for this activity.

CPC Activity Requirements

	Required Criteria
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 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). • Stratifies data by race/ethnicity, income, or disability status to identify and address variations in completion of oral health evaluations.

CPC Activity Requirements

	Optional Criteria
Oral Evaluation, Dental Services	• Offer fluoride varnish application at time of well-care visits with in-house trained practitioners • Collaborate with MCOs on dental service reports • Provide outreach to close the identified gaps for comprehensive exams • Any innovative method the entity is using for this activity.

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