The patient-centered medical home (PCMH) is a model of value-based purchasing (VBP) and pay-for-performance (P4P) systems. As stated in the textbook, PCMH initiatives are often organized by health plans, states, payers, providers, or multi-stakeholder groups. PCMHs are being widely implemented with a four-fold increase in the number of PCMH initiatives between 2009 and 2013 (Edwards et al. 2014, 1829). This trend is expected to continue because the PCMH model of care is endorsed by federal and state health agencies.

This assignment focuses on the organization of PCMHs by states. Many states have adopted policies and programs to advance PCMHs. Go to the web site of the National Academy for State Health Policy (NASHP) to learn about PCMHs in the states: [http://www.nashp.org/med-home-map](http://www.nashp.org/med-home-map)

After you have gone to the site, answer the following questions in a Word document and when you are finished, submit them in the location provided.

**Questions and Application Activity**

1. Click on the tab Activities since 2006. Click on your state. What is the activity in your state?

2. Click on the tab for Multi-Payer Medical Home Initiatives. Known as multi-payer medical homes, PCMH initiatives may involve patients that have multiple, different insurance companies, and public payers; such as federal Blue Cross Blue Shield, TRICARE, Medicaid, and other payers; and multiple providers. These multi-stakeholder groups may develop payment methods through collaborative processes. What is your state’s activity in multi-payer medical home initiatives?

3. Click on the tab for 2703 Health Homes. Section 2703 of the Affordable Care Act gives state Medicaid programs the option of establishing health homes. Health homes provide a comprehensive system of care coordination for Medicaid beneficiaries with chronic conditions. In health homes, providers treat the “whole-person” across the lifespan by integrating and coordinating all primary care, acute inpatient care, behavioral health, and long term services and supports. Is your state pursuing ACA Section 2703 Health Homes?

4. Click on the tab for Qualification Standards. As an example of national standards, the National Commission for Quality Assurance (NCQA) has standards for PCMHs (2014). The standards are in the areas of patient-centered access, team-based care, population health management, care management and support, care coordination and care transitions, and performance measurement and quality improvement. Does your state align payments to medical homes with national or state-developed qualification standards?

5. Click on the tab for Shared Support Teams. Is your state making payments to community-based teams or networks to support primary care practices?