Value Based Care in Primary Care

South Dakota
Department of
Social Services

What is Fee For Service?

- Providers are paid **per service delivered** (e.g., each visit, test, or procedure).
- **Incentive:** Higher volume = higher payment.
- **Challenges:**
  - Fragmented care
  - Limited coordination
  - No financial reward for improved outcomes
- **Example:** A provider receives separate payments for each lab test and follow-up visit, regardless of patient improvement.

A note about IHS and 638

- Technically still fee-for-service since it is volume based, but the “service” is a bundle of all things done in on the day
- **Challenges:**
  - More cost effective for fewer services on same day to maximize bundled payment
  - Like FFS, no financial reward for improved outcomes
- **Example:** A provider receives a lump sum for seeing a patient and then doing labs and providing immunizations

What is Value Based Care?

- **Definition:**
  A healthcare delivery model that links payment to **quality, outcomes, and efficiency**, not just volume.

Goals:

  - Improve patient outcomes
  - Enhance care coordination
  - Control costs
  - Reward prevention and quality

- **Example:** A provider may receive a set payment for care of a patient with a bonus for meeting good health outcomes.

Value-Based Care Model Types

Model Type	Risk Level	Description
FFS + Quality Reporting	Low	Traditional FFS with pay-for-reporting or small bonuses
Shared Savings (Upside Only)	Moderate	Providers share in savings if costs are below benchmark
Shared Risk (Upside + Downside)	Moderate–High	Providers share savings and losses
Bundled Payments	Moderate	Single payment for all services for an episode of care
Capitation / Population-Based Payments	High	Fixed per-member-per-month payment for total care management

Current State of Value-Based Care in SD Medicaid

Baby Ready

- Pregnancy specific program with enhanced payment to support case management
- FFS with per-member-per-month payments for case management
- Incentive payments for meeting quality goals
- All recipients are eligible, but not all providers are enrolled

Health Home

- Person-centered care management program
- The designated provider is responsible for providing all the recipient's health care needs or taking responsibility for appropriately arranging care (monitoring, arranging, and evaluating appropriate evidence based and/or evidence informed preventive services) with other qualified professionals.
- FFS with per-member-per-month payments for case management
- Incentive payments for meeting quality goals
- Limited to recipients with complex medical needs

Benefits and Challenges in Value-Based Care

Benefits

- Improved patient outcomes
- Reduced avoidable hospitalizations
- Incentives for prevention and chronic care
- Cost containment for Medicaid programs
- Greater alignment between providers and payors

Challenges and Considerations

- Data and reporting infrastructure
- Provider readiness (including infrastructure) and risk tolerance
- Health equity and social drivers of health
- Aligning incentives across multiple stakeholders

What is missing?

- Many models tend to be "all or nothing" and make providers responsible for the total cost of care.
- Do not address unique challenges in smaller, more rural areas that cannot sustain full-time case management or other supportive staff.
- Patients' priorities are not considered and not rewarded.

What does SD Medicaid want to do?

- Create a value-based payment model focused on primary care.
- Create a model that supports primary care to stay in rural locations by providing more flexible payment structure
- Provide incentives to both providers and patients to align goals of care
- Utilize Rural Health Transformation grant money to finance the upfront infrastructure requirements to maximize success

What is different?

- Not responsible for total spend
- Case management is key and part of the payment model
- Shared case management for providers for whom direct hire doesn't make sense
- Flexibility to utilize time/team members differently to meet needs
- Recipient level incentives
- Initially pay for reporting, then pay for performance benchmarking against SD only

Questions

1

What have your experiences with value-based care been?

2

To move towards value-based payments, what resources/infrastructure would you need (or anticipate others would need)?

3

What is the biggest limitation to value-based care in South Dakota?

Feedback/Questions?

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