Payment instruments for contracting outpatient specialists (ambulatory care)

Voluntary Exchange with Cyprus
Nikosia, 26 Sept 2018

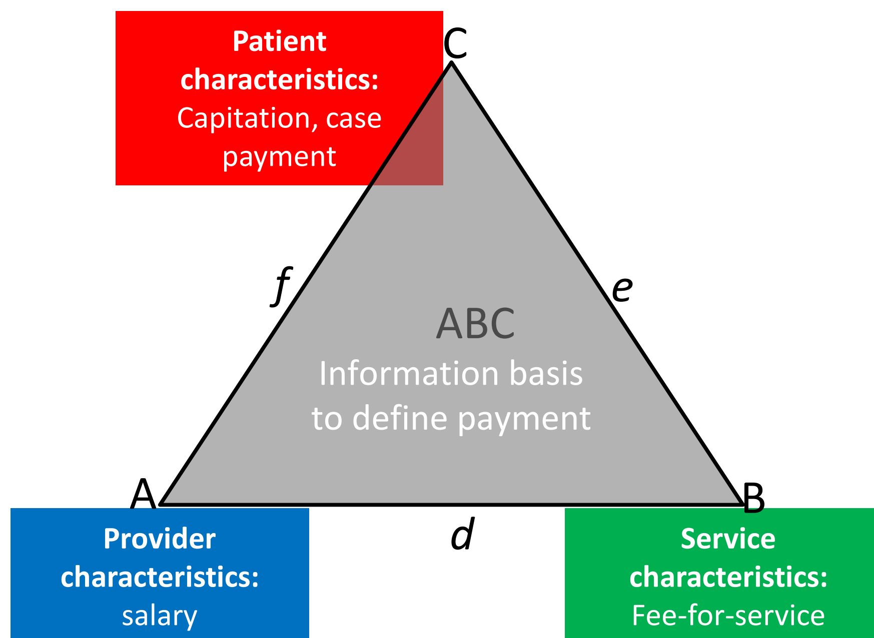
PD Dr. med. Wilm Quentin, MSc HPPF
Senior Research Fellow
Technische Universität Berlin

European
Observatory
on Health Systems and Policies
a partnership hosted by WHO

Context is important for physician payment in ambulatory care

	Primary care	Ambulatory secondary care	Inpatient care
France	Office-based GPs	(Primarily) Office-based specialists	Hospitals
Germany	Office-based GPs	(Primarily) Office-based specialists	Hospitals
England	Office-based GPs	Outpatient departments: hospital-based specialists	Hospitals
Netherlands	Office-based GPs	Outpatient departments: hospital-based specialists	Hospitals

A framework for analysis of payment systems



Source: based on Ellis and Miller, 2009

Physician payment (ambulatory care)

	England	France	Germany	Netherlands
Specialists				
FFS	For work in private practice (i.e., not within NHS)	Self-employed specialists (including specialists in private for profit clinics)	Contact capitation + FFS up to cap (RLV)	52% of specialists (i.e., those working independently in hospitals)
Capitation	--	--		--
P4Q	Clinical Excellence Awards	P4P programme (ROSP)	--	--
Salary	Physicians working under the NHS contract	Specialists working in public hospitals	Specialists working in hospitals	48% of specialists working in hospitals

Dominant payment mechanism

Part of DRG payment

A framework for analysis of payment systems

too generous

Adequacy of payment

too small (not cost-covering)

Patient characteristics: Capitation, case payment

C

f

e

ABC

Information basis to define payment

A

B

d

Provider characteristics: salary

Service characteristics: Fee-for-service

Source: based on Ellis and Miller, 2009

Adequacy of payment requires cost and expenditure data

Radiology	1132 910
Interdisciplinary practices	535 612
General internal medicine	486 392
Internal medicine - other	796 756
Ophthalmology	485 279
Gastro-entero	518 777
Dermatology	455 874
Cardiology	415 800
Pneumonolgy	520 138
Orthopedics	432 926
Urology	378 809
Neurology and Psychiatry	319 147
Surgery	419 828
ORL	333 904
Pediatrics	326 680
Neurology	296 749
Gynaecology	321 250
Nuclear Medicine	446 176
Primary care	304 155
Anaesthesia	317 593
Average	312 290
Pediatric psychiatrists	341 998
Rehab	239 683
Psychiatry	194 642
Psychosomatics	102 797
Psycotherapy	102 943

200 000 400 000 600 000 800 000 1 000 000 1 200 000

Income: € 372 000

Income: € 74 000

Germany

ZiPP

- Expenses per owner
- Income per owner

Income disparaties raise concerns about FFS catalogue adequacy

FIGURE 4–6

Disparities in physician compensation are widest when primary care physicians are compared with nonsurgical proceduralists and radiologists, 2016

REPORT TO THE CONGRESS

Medicare Payment Policy

Median annual compensation (in thousands of dollars)

All	Primary care	Nonsurgical, nonprocedural	Surgical	Nonsurgical, procedural	Radiology
297	236	290	409	435	466

Y-axis: 0, 100, 200, 300, 400, 500

Source: MedPAC analysis of data from SullivanCotter's Physician Compensation and Productivity Survey, 2016.

A framework for analysis of payment systems

Source: based on Ellis and Miller, 2009

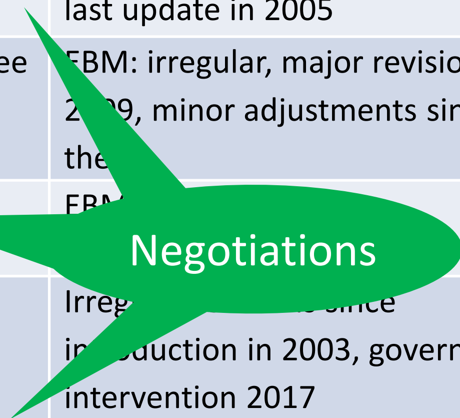
FFS system development: political economy

		Responsible institutions	Regularity of updates
France	FFS catalogue + relative values	French National Health Insurance Fund (NHIF) together with specialist societies – each responsible for fees applicable to its specialty.	irregular, 10 amendments between 2011 and the beginning of 2014
Germany	FFS catalogue + relative values	Valuation Committee of the Federal Joint Committee (representatives of SHI funds and SHI physicians)	EBM: irregular, several minor adjustments since 2009, major revision planned for 2019
Switzerland	FFS catalogue + relative values	TARMED Suisse (company representing payers and providers), Federal Government intervention	Irregular revisions since introduction in 2003, government intervention 2017
USA (Me[illegible]	[illegible]	Centers for [illegible]edicare & Medicaid Services (CMS) on [illegible] of advice from the specialty societies	annually (since 2012)

Satekholders failed to agree

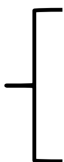
FFS system development: political economy

		Responsible institutions	Regularity of updates
France	FFS catalogue + relative values	French National Health Insurance Fund (NHIF) together with specialist societies – each responsible for fees applicable to its specialty.	irregular, 10 amendments between 2011 and the beginning of 2014
	Conversion factor	Negotiated between NHIF and physicians	last update in 2005
Germany	FFS catalogue + relative values	Valuation Committee of the Federal Joint Committee (representatives of SHI funds and SHI physicians)	[illegible]BM: irregular, major revision in 2[illegible]9, minor adjustments since the[illegible]
	Conversion factor	Negotiated between regional Associations of SHI Funds and regional Associations of SHI Physicians	EB[illegible]
Switzerland	FFS catalogue + relative values	TARMED Suisse (company representing payers and providers), Federal Government intervention	Irreg[illegible]since in[illegible]duction in 2003, government intervention 2017
	Conversion factor	Negotiated between SHI companies and providers (cantonal associations of physicians and hospitals)	annually
USA (Medicare)	FFS catalogue + relative values	Centers for Medicare & Medicaid Services (CMS) on the basis of advice from the specialty societies	annually (since 2012)
	Conversion factor	Congress	annually



FFS system development: Basis for updates of RVUs

- Germany, Switzerland, France:
  - Always two parts: (1) physician work RVUs and (2) practice expense RVUs (→ no distinction by setting, e.g. in-facility).
  - Time estimates per service always based on expert opinion (physicians‘ input).
  - Practice expenses include capital costs, personnel costs, rents etc. → estimated based on fiscal data (F), costing studies (CH, D), etc.
  - Normative physician income per minute based on normative annual income (US$217,000 in CH, US$125,000 in D), and estimates of annual working time (→ taking into account physician productivity).



Recent reforms I

- Switzerland (2018) – government intervention
  - Discontinuation of differential valuation of physicians‘ time
  - Assuming higher productivity for surgical services (→ reduces estimated time requirements)
  - 10% reduction of RVUs for technical services (e.g. CT, MRI)
  - Reduction of time estimates for certain services (cataract surgery, colonoscopy, radiotherapy etc.)
- Germany stepwise reform (originally planned for 2013)
  - 2013: Introducing age-weighting of contact capitations
  - Planned for 2019: recalculation of RVUs using practice cost data of federal statistical office, redefining normative income, re-estimating time needs

Proposed payment for specialist care in Cyprus

- Service provision: 1750 specialists; (public health centres?)
- Information basis:
  - Service based (FFS)
  - KPI = Quality?
- Scope:
  - FFS: determined by chosen FFS catalogue
  - Including all costs of running the practice (assistants, equipment, rent…)?
- Adequacy:
  - Absolute level: Calculated based on available budget and service volume
  - Relative level: depends on imported FFS catalogue
- Fineness
  - Depends on FFS catalogue

Should all specialists be contracted? → Needs-based purchasing?

Will lead to price deflation

May be problematic

Combining FFS payment with physician budgets

German payment systems for ambulatory specialists (since 2008)

Morbidity-adjusted total reimbursement (MGV)

Deductions for psychotherapy, lab tests, Out-of-hours care

Distribution of MGV

Budget for primary care	Budget for specialist care
Budgets of participating specialties	**Budgets of participating specialties**

Definition of budgets for essential services (RLV) and qualification dependent additional services (QZV)	Definition of budgets for essential services (RLV) and qualification dependent additional services (QZV)

RLV	**RLV**	**RLV**	**RLV**	**RLV**	**RLV**
QZV	QZV	QZV	QZV	QZV	QZV
QZV	QZV	QZV	QZV	QZV	QZV
QZV	QZV	QZV	QZV	QZV	QZV

Definition of RLV and QZV at individual practice level	Definition of RLV and QZV at individual practice level

Adequacy in (hospital) specialist payment

Netherlands:

- 2005 to 2011:
  - No practice expense costs → included in DRGs
  - RVUs based on time per service + negotiated hourly rate
- 2012 to 2015:
  - National budget divided between 26 specialties based on FTE.
  - Specialty specific RVUs calculated based on specialty service volume → RVU updates affect only distribution within specialty
- Since 2015:
  - Market-based approach: hospitals negotiate with collective of specialists at hospital level → distribute income to members.

Thank you!

If you have further questions:

wilm.quentin@tu-berlin.de

OK to make slides available?

www.mig.tu-berlin.de

MiG Health Care Management

Technische Universität Berlin

Source of revenue by specialty, Germany 2015

Specialty	Total revenue
Radiology	1 132 910
Internal medicine, other	796 756
Multiple specialties	535 612
Pneumonology	520 138
Gastroenterology	518 777
Internal medicine, multiple	486 392
Ophthalmology	485 279
Dermatology	455 874
Nuclearmedicine	446 176
Orthopedics	432 926
Surgery	419 828
Cardiology	415 800
Urology	378 809
Pediatric psychiatry	341 998
ORL	333 904
Pediatrics	326 680
OBGYN	321 250
Neurology and psychiatry	319 147
Anaesthesia	317 593
Total	312 290
Family medicine	304 155
Neurology	296 749
Rehab	239 683
Psychiatry	194 642
Psychotherapy	102 943
Psychotherahpy and psychosomatics	102 797

Axis: - 200 000 400 000 600 000 800 000 1000 000 1200 000

Legend: SHI, PHI, Accident, Other

ZiPP

Broad scope of payment means that providers bill few fees

Histogramme of individual (EBM) codes billed by ambulatory physicians in Germany, 2016

110%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

1 56 111 166 221 276 331 386 441 496 551 606 661 716 771 826 881 936 991 1046 1101 1156 1211 1266 1321 1376 1431 1486 1541 1596 1651 1706 1761 1816 1871 1926 1981 2036 2091 2146 2201 2256 2311 2366 2421 2476