Reform of provider payment in ambulatory care

Country: Germany
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Health Policy Issues: Remuneration / Payment

Current Process Stages

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1. Abstract

In 2009, the methods for paying SHI-affiliated physicians in ambulatory care were changed. The era of capitation fees and strict budgeting is over. GPs and specialists are now paid on a capped fee-for-service basis, with a payment ceiling that is set for each doctor and adjusted for specialization, the number of cases and patient age. Instead of a floating-point fee schedule, a fee schedule with fixed euro prices is used.

2. Purpose of health policy or idea

In 2009, the German system for paying providers of ambulatory care changed. Although fee-for-service (FFS) is still the main method of resource allocation to office-based GPs and medical specialists, there are substantial differences in controlling service volumes. The reform abolished the floating point values used previously in the fee schedule known as the Uniform Value Scale and combined these with fixed euro prices. Furthermore, the global payments made to the regional physicians’ associations are now based, in part, on morbidity-related criteria. The following provides a more detailed description of the new system of physician reimbursement.

In Germany, provider payment in ambulatory care consists of two major steps:

First, instead of paying physicians directly, sickness funds make a global payment to each regional physicians’ association in whose region their insured persons reside. This payment is based on patients' average utilization of services and is meant to cover the remuneration of all SHI-affiliated physicians in a given region. Second, each regional physicians’ association distributes this payment among its GPs and specialists on a fee-for-service basis according to the Uniform Value Scale, which lists all reimbursable services and their relative weights expressed in points. A payment ceiling is set quarterly for each physician and adjusted for (a) a physician’s specialization, (b) the total number of cases he or she treated during the same quarter of the previous year and (c) the age of his or her patients. Points for services provided within this case-volume- and age-based payment ceiling (CVAPC) are reimbursed with a uniform nation-wide conversion rate per point, i.e. guaranteeing a fixed payment. Services provided beyond the CVAPC are reimbursed at a much lower rate.

Exemptions from the CVAPC (and thus additional revenue for physicians) are possible:

(i) Special CVAPCs exist for groups of services requiring special training and/or equipment (e.g. sonography, psychosomatic medicine) and for services that may be underprovided as a part of the regular CVAPC but overprovided if paid only through uncapped FFS (e.g. home visits).
Uncapped fees exist for services that should be provided more often. This concerns services that are otherwise under-demanded by patients (e.g. early detection and immunizations). It should be noted that this is not funded from the global payment to the Association of Statutory Health Insurance Physicians but as extra payments from the sickness funds.

**Main objectives**
The reform of provider payment in ambulatory care has four main goals:

1. Inclusion of utilization-based criteria in global payments (at the expense of the sickness funds)
2. Harmonizing the level of remuneration for SHI-affiliated physicians across regions
3. Determination of fixed prices for services instead of the "floating point values" used previously in the Uniform Value Scale
4. Introduction of CVAPC as a new mechanism for reducing incentives to provide an excessive number of services

**Type of incentives**
All provider payment mechanisms, such as capitation and fee-for-service, create financial incentives and have a varying impact on the provision of health care services. For example, a capitation payment may encourage providers to work efficiently and to limit their activities to necessary services only. On the other hand, it can also tempt physicians to avoid treating individuals with higher health care needs, because the physician would not receive extra compensation for the higher treatment intensity. Compared to capitation, FFS payment, which may reward physicians financially for every single procedure they perform, creates strong incentives for physicians to provide more health services. The CVAPC attempts to overcome the limitations of pure capitation or FFS providing physicians with an incentive to accept patients with higher risks without providing unnecessary services.

**Groups affected**
SHI-affiliated GPs and medical specialists, sickness funds

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3. **Characteristics of this policy**

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<tr>
<th>Characteristic</th>
<th>Score</th>
<th>Description</th>
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<tr>
<td>Degree of Innovation</td>
<td></td>
<td>traditional [3]   innovative [1]</td>
</tr>
<tr>
<td>Public Visibility</td>
<td></td>
<td>very low [5]      very high [1]</td>
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The assignment of CVAPCs as the main payment mechanism in ambulatory care can be described as an enhancement of the traditional fee-for-service payment. However, it does not indicate a high level of innovation. The reform neglected quality as an important factor, even though this is of increasing relevance to payment mechanisms and the way they incentivise providers.

The public visibility of the reform was high and caused a high degree of controversy. As is the case with most reforms, there are winners and losers. Shortly after the introduction of CVAPCs, the German media reported about upset physicians in ambulatory care closing their practices or asking patients for advance payment of services. This was
mostly the case in regions where the physicians’ remuneration did not increase significantly or for certain medical specialties only. The physicians justified this practice by stating that the increase in remuneration was lower than expected and, thus, insufficient to cover the costs for delivering services.

4. Political and economic background

Before 2009, the payment of all SHI-affiliated physicians was subject to strict budgeting and was linked to SHI revenue. Sickness funds paid fixed capitations for all patients regardless of actual health care utilization. As a result, physicians - and not the sickness funds - bore all risk related to higher service utilization.

Until 2009, every service in the Uniform Value Scale was allocated a point value without a fixed price. At the end of each quarter, each SHI-affiliated physician in the ambulatory care sector invoiced the physicians’ association for the total number of service points he or she had delivered. The actual reimbursement depended on a number of factors. The monetary value of a point was calculated by dividing the amount of the global payment received by a given regional physicians’ association by the total number of service points delivered in that region. As a result, the monetary value of each point decreased as the number of services delivered increased, resulting in a decrease in an individual physicians’ total remuneration. In short, by abolishing the system of floating point values, the reform aims to make financial planning easier and more reliable for ambulatory care physicians. In 2009, each service point was allocated a fixed value of 3.5001 eurocent; this monetary value is negotiated on an annual basis between the Federal Association of Sickness Funds and the Federal Association of SHI Physicians.

Complies with

Other - The reform complies with the Act to Strengthen Competition in Statutory Health Insurance (GKV-WSG) (also see “Health Fund now operational (13/2009)).

Change based on an overall national health policy statement

Equal access to services is a national health policy goal. But density of SHI-affiliated physicians differs between metropolitan vs. rural areas. Furthermore, sectoral boundaries of care including different payment mechanisms should be reduced.

5. Purpose and process analysis

Origins of health policy idea

One of the main purposes of German health policy is to reduce regional differences in service provision and, thus, to avoid over- and under-provision. Before the reform, physicians prioritized regions with higher monetary value for each point. As a consequence, areas with lower monetary value for each point were less attractive for physicians. This, in turn, led to scarcity of physicians in certain areas. To abolish this situation, equal services are now being reimbursed with equal payments across regions.

Additionally, the reform harmonizes ambulatory payments methods with those used in the hospital sector, which is meant to help overcome the sectoral boundaries between these types of care.

Furthermore, apart from the fact that remuneration becomes more equitable, SHI-affiliated physicians will receive a higher remuneration on average.
**Initiators of idea/main actors**

- **Government**: The Valuation Committee is responsible for payment mechanisms in ambulatory care. The Ministry of Health considers the lawfulness of the agreements and is authorized to intervene in case of illegality.

- **Providers**: Positions of physicians vary between regions and specialties. Medical specialists with former above-average payments voice their concern, whereas the others are satisfied.

- **Payers**: The Federal Association of Sickness Funds had to spend additional €2 billion in 2009 for the global payment. They claim that the problem lies within the distribution policies of the physicians' associations.

- **Others**: Some of the regional physicians' associations assumed a reduced global payment. They argued that they are not able to guarantee provision of SHI services and filed lawsuits against the Valuation Committee.

**Approach of idea**

The approach of the idea is described as: new: After 20 years of varying budgeting between regions and different floating point values, the introduction of CVAPCs and nationwide prices for services is a new approach in the way of paying providers in ambulatory care.

**Stakeholder positions**

Both GPs and medical specialists are represented by regional physicians' associations, which are responsible for guaranteeing the provision of SHI services in ambulatory care, representing the practitioners' rights vis-à-vis the sickness funds and monitoring their members' duties. As a result of the reform, provider payment in ambulatory care was expected to increase on average. However, expectations concerning the distribution of remuneration differed between physicians in the eastern part and the western part of Germany. Physicians who benefited from a high monetary point value in their region and who received above-average payments before 2009 feared that the lower nationwide uniform point values would lead to declining payments and a lower income. Physicians who received below-average payments before 2009 are pleased about the reform. Physicians' opinions also varied between medical specialties. Especially specialists who received their payments with extra budgetary services voiced their concern.

Changes concerning the payment mechanisms in ambulatory care are administered by the Valuation Committee, with equal representation on the Federal Association of Sickness Funds and the Federal SHI Physicians' Association. If these parties do not come to an agreement, three additional referees join the committee to form the Extended Valuation Committee. Because of the widely diverging positions in the Valuation Committee, pushing through individual interests is difficult.

One contentious issue (though not directly relating to the reform) are selective contracts (i.e. contracts between individual physicians and individual sickness funds) alongside the collective contracts (i.e. contracts negotiated between the regional physicians' associations and the sickness funds). When services that are normally delivered and reimbursed as part of collective contracts are delivered and reimbursed, instead, as part of selective contracts, the corresponding CVAPCs are lowered, thus reducing the overall payments received by all physicians in a particular region. This aspect of the system places physicians who do not take part in selective contracts at a disadvantage.

In general, patients are not affected by the reform of provider payment in ambulatory care. As a temporary effect, some physicians demand payments in advance or refuse treating patients. However, this is an illegitimate practice and leads to uncertainty among patients.

**Actors and positions**

Description of actors and their positions

**Government**
Considering the process of introducing the new provider payment system in ambulatory care, the general idea of the reform was already enacted in 2004, as a part of the SHI Modernization Act. The system of capitation fees and fixed budgets was to be abolished in 2007 and replaced with a system based on FFS payments. Ultimately, however, this did not take place. In 2007, the Act to Strengthen Competition in Statutory Health Insurance specified a new timeline for enacting provider payment reform. Developing and elaborating the system in detail was delegated to the self-governing bodies. The main actors in the process of developing and introducing the payment system in ambulatory care are, therefore, the Federal Associations of Sickness Funds and the Federal Association of SHI Physicians. Furthermore, the Valuation Committee was assigned to set up an institute (Institute of Valuation Committee) to support the development of payment mechanisms for SHI-affiliated physicians in ambulatory care.

### Legislative outcome

**Influences in policy making and legislation**

Considering the process of introducing the new provider payment system in ambulatory care, the general idea of the reform was already enacted in 2004, as a part of the SHI Modernization Act. The system of capitation fees and fixed budgets was to be abolished in 2007 and replaced with a system based on FFS payments. Ultimately, however, this did not take place. In 2007, the Act to Strengthen Competition in Statutory Health Insurance specified a new timeline for enacting provider payment reform. Developing and elaborating the system in detail was delegated to the self-governing bodies. The main actors in the process of developing and introducing the payment system in ambulatory care are, therefore, the Federal Associations of Sickness Funds and the Federal Association of SHI Physicians. Furthermore, the Valuation Committee was assigned to set up an institute (Institute of Valuation Committee) to support the development of payment mechanisms for SHI-affiliated physicians in ambulatory care.

#### Actors and influence

**Description of actors and their influence**

**Government**
- Federal Ministry of Health: very strong
- Valuation Committee: very strong

**Providers**
- GPs in general: very strong
- Medical Specialists in general: very strong
- Medical Specialists who were formerly paid above-average: very strong

**Payers**
- Federal Association of Sickness Funds: very strong

**Government**
- Federal Ministry of Health: very strong
- Valuation Committee: very strong

**Providers**
- GPs in general: very strong
- Medical Specialists in general: very strong
- Medical Specialists who were formerly paid above-average: very strong

**Payers**
- Federal Association of Sickness Funds: very strong
Adoption and implementation

The main actors being involved in the adoption process are GPs and medical specialists, their representatives and the sickness funds.

Since 2009, the calculation of the global payment has been partly based on utilization-related criteria. CVAPCs have been used instead of predetermined fixed budgets, and fixed euro prices have been set in addition to point values in the fee schedule.

Further modifications have been implemented in July 2010. Until then, there were services (e.g. home visits, acupuncture, pain therapy) paid through FFS out of the CVAPC, i.e. without a payment ceiling. As a result, the number of delivered services increased significantly and less funding became available for CVAPCs. In order to stabilize CVAPCs, the Valuation Committee enacted a payment ceiling for these services as well. Further modifications concerning the calculation of CVAPCs are planned. The increasing number of cases per practice entails decreasing CVAPCs. For this reason, the Valuation Committee determines a limit for an additional number of cases per practice, i.e. number of patients who are treated per practice.

Despite the introduction of fixed euro prices, physicians and their representatives have voiced their dissatisfaction with the level of these prices. The sickness funds, however, claim that the problem lies with the regional physicians’ associations and their distribution policies. The finalization of the reform was planned for 2012, but recently the government presented a bill that makes it questionable that this deadline will be met. According to the draft bill of the SHI Financing Act the monetary value in the Euro Value Scale will be frozen at the level of 2010 (3.5048 eurocent) until 2012.
Monitoring and evaluation
A regular monitoring or evaluation is not intended.

6. Expected outcome

As a result of the reform, the average remuneration level of physicians in ambulatory care increased. The overall remuneration (pre-tax and including costs of practice) of the 153,895 SHI-affiliated physicians increased by 6.1% from €14,540 billion in the first half of 2008 to €15,425 billion in the first half of 2009. Regarding the allocation among the physicians, there are substantial differences between federal states (Länder) as well as between the different medical specialities.

The federal states in the eastern part of Germany (formerly part of the GDR) benefit from the reform. Physicians in these states received, on average, a 13.2% higher monetary contribution in 2009. For the federal states in the western part of the country this percentage is only 4.9%. This difference results from one aim of the reform: to adjust the level of remuneration in ambulatory care nationwide. In some states, particularly in the West, the point value before the reform was higher than the nationwide reference value of 3.5 eurocent in 2009. Hence, after the reform, the physicians’ average payments in these areas declined. In the first half of 2009, this was the case in Baden-Württemberg (-3.5%) and Bavaria (-1.3%). In Saxony-Anhalt (17.4%), Lower Saxony (17.1%) and Hamburg (15.1%), where the point value used to be below the nationwide reference value, the increase in payment was above average.

Among physicians with different specialities, variations are not that strong. Nearly all groups of physicians attained an increased remuneration in the first half of 2009. The strongest average growth recorded specialists in internal medicine (30%), followed by psychiatrists (17%) and neurologists (16%). However, there are some specialists who sustained a loss in their average income, being orthopaedists and anaesthetists with a decrease of 4.6% and 2.4%, respectively.

It is necessary to mention that the physicians’ remuneration does not consist of payments through CVAPCs exclusively. Some services are always reimbursed at their full price, regardless of the number of delivered services. The payment out of CVAPCs varies between 30% and 70% of the total remuneration. This depends on the physicians’ specialization and the relevant case value. Payments for patients covered by private health insurance are generally higher and are not subject to quantitative restrictions. Additionally, physicians can deliver individual services that are not covered by SHI (Individuelle Gesundheitsleistungen - IGeL). Patients must pay these services out-of-pocket according to the prices in private delivery settings. Depending on the physicians’ specialization and the type of patient (SHI or private sickness funds), the share of these different payment mechanisms varies significantly.

Quality of Health Care Services
- marginal
  - fundamental

Level of Equity
- system less equitable
  - system more equitable

Cost Efficiency
- very low
  - very high

The Federal Association of Sickness Funds increased the global payment in 2009. Compared to 2008, the physicians’ payment was €2 billion higher in 2009. Physicians’ representatives and sickness funds agreed on further payments of €1.7 billion for 2010. As mentioned above, quality is not a driving factor in the negotiation process between physicians and sickness funds. The sickness funds are interested in quality-related outcome measures. However, experiences with payment mechanisms that remunerate physicians according to treatment results (i.e. pay-for-performance) still only are in the pilot phase.
7. References

Sources of Information


Author/s and/or contributors to this survey

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