

Special Care in Germany

Country Background Note: Germany

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1. Contextual information

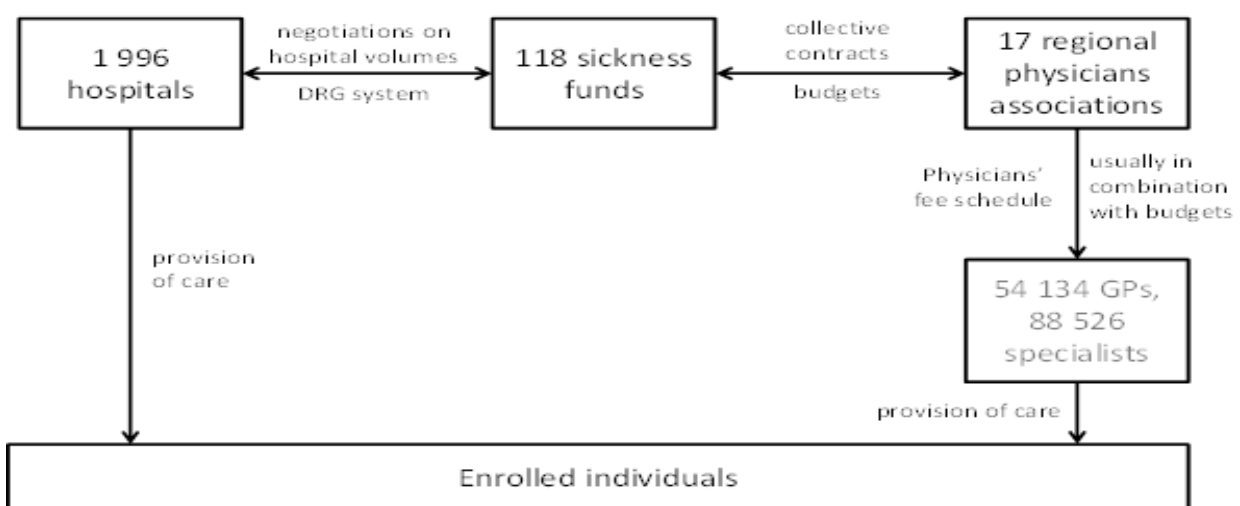
Special care within the § 140a SGB V (German Social Security Code: volume V) is one element of selective contracting in the German social health insurance (SHI) system. The predecessor programme, *integrated care*, was introduced on 1 January 2000 (former §§ 140a-d SGB V) and is now fully integrated in the new framework. However, both programmes show many similarities and main objectives of both programmes have been to foster cross-sectoral cooperation and to increase efficiency and quality of care. As specific regulations on special care are still being further defined during the beginning of 2016, this study mainly focusses on integrated care but outlines specific changes made in special care.

The next sections are structured as follows: First, standard commissioning of in- and outpatient care as well as characteristics and mechanisms of integrated care are introduced. Within this chapter, the historic development, challenges and the differentiation to other innovative concepts are presented. Second, two examples of integrated care programmes within the former §§ 140a-d SGB V framework are given. Until now, most contracts on integrated care are concluded before introduction of the special care framework and are subject to operate under a continuation permit. The study ends with a discussion and conclusion showing future trends.

2. Standard delivery of care

Self-administration plays a major role in the German statutory health insurance system (SHI). Payers and providers guarantee the delivery of care, whereas the Federal Ministry of Health has more a governing than an active decision-making function. Sickness funds are obliged to commission outpatient care services from the regional physicians' associations and inpatient care directly from the hospitals (see Figure 1). Individuals covered by one of the 118 sickness funds are free to choose the provider of their choice within the in- and the outpatient sector.

Figure 1. Standard commissioning of an- and outpatient care services



Source: Authors' compilation

In 2014, sickness funds spent EUR 33.43 billion for outpatient-care services provided by members of the physicians' associations (BMG, 2014). Delivery of outpatient care is organized by the physicians' associations, including planning of the number and the place of business, quality controlling and management, as well as fee-for-service based reimbursement.

For inpatient care services, sickness funds spent about EUR 67.86 billion in 2014 (BMG, 2015). Sickness funds are obliged to contract all hospitals that are listed in the so-called hospital plan or that are licensed otherwise. Hospitals are paid directly by the sickness funds using a diagnosis-related group (DRG) system that is based on cost data from a sample of German hospitals.

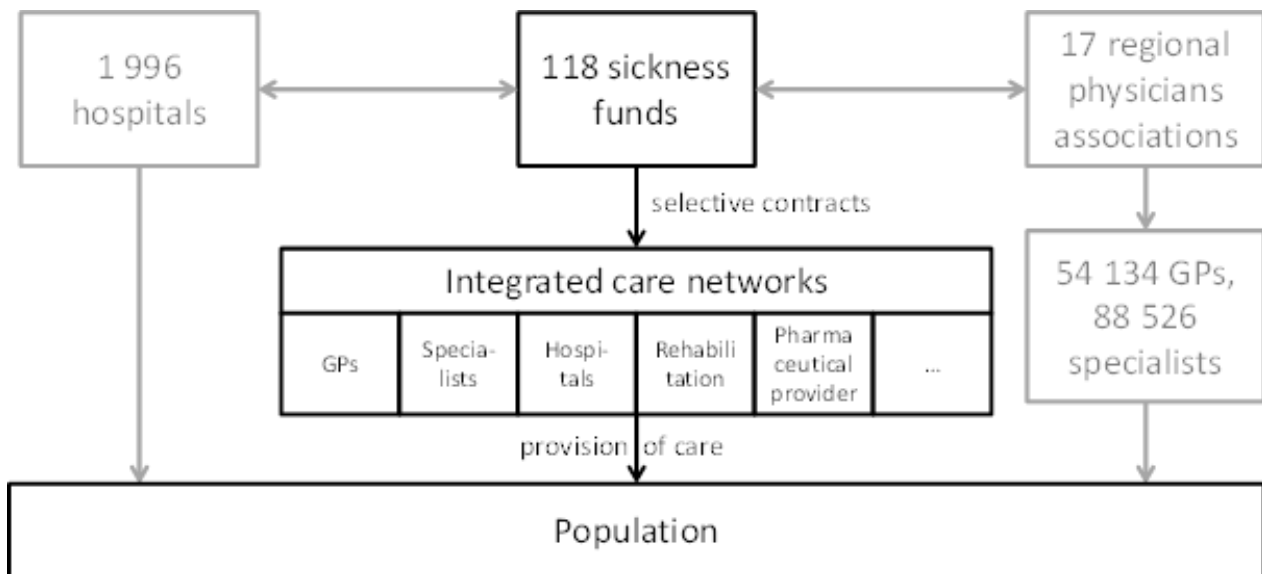
One of the main problems of the two separated budgets for the in- and outpatient sector is the resulting lack of cooperation between the sectors. As there is no common budget for both sectors, incentives to realise savings in the other sector on cost of one's own budget are low. For example, outpatient physicians have little incentives to increase efforts on prevention of hospital admissions because gains of this additional effort are realized in the inpatient sector. To foster collaboration and to optimise outcomes across sectors, the Federal government introduced integrated care programmes which are described in the next sections.

3. Integrated care

At least two health providers from two different sectors have to collaborate within a programme to qualify as integrated care, it, *e.g.*, inpatient and outpatient sector, and/or at least two different specialties, *e.g.*, general practitioners (GP) and cardiologists (see Figure 2). In- and outpatient care providers, rehabilitation facilities, nursing homes, as well as pharmaceutical and medical technology companies can also become contracting partners and/or members of an integrated care network. The contacts themselves allow for a high degree of freedom. The respective parties are free to negotiate payment schemes (fee-for-service, case-based budget, capitation, risk sharing, etc.), the provision of care (setting, in- and outpatient delivery, new and innovative health technologies, etc.), and the evaluation of the integrated care programme. Taking part in an integrated care programme is voluntary for all: providers, sickness funds, and patients. Besides the promise of better quality of care, enrolees can be incentivised by reductions in co-payments and bonus payments. Bonus payments are made, for example, if a patient complies with the proposed treatment pathway within the integrated care programme (*e.g.*, lump sum payment of EUR 80 per year).

Integrated care aims to increase the efficiency and quality in the SHI system by allowing for and fostering collaboration of providers of different healthcare sectors. By the end of 2011, there were about 6 340 integrated care programmes with about 1 926 133 enrolees nationwide. The budget of sickness funds for these contracts amounted to about EUR 1.35 billion. About 45% of this budget was spent on inpatient care, 35% was spent on outpatient care and 10% was spent on pharmaceuticals (Deutscher Bundestag, 2012).

Figure 2. Integrated care services



Source: Authors' compilation

4. The historical development and outlook

Integrated care was introduced on 1 January 2000 by a coalition of the Social Democratic Party of Germany (SPD) and the Green Party in alignment with several other models which aimed to liberalise provision of care. The government intended to target four deficiencies present in the standard delivery of care: First, it introduced market prices in a highly regulated and monopolistic outpatient market by allowing price negotiations between payers and providers; second, it allowed for individually tailored delivery of care, *i.e.*, under consideration of the population's needs or other regional characteristics; third, it allowed to intensify cross-sectoral cooperation; and fourth, it aimed to increase competition on quality although this was not further defined.

Since its introduction, requirements for integrated care contracts were readjusted several times (see Table 1). Although introduced in 2000, substantial uptake of integrated care contracts started not before 2004. Following the very low uptake of integrated care, the government firstly abolished the need for approval from the physicians' associations, which was regarded as an obstacle by sickness funds and independent providers. Secondly, it introduced a generous start-up financing to foster integrated care. From 2004 to 2008, sickness funds could withhold up to 1% of the in- and outpatient budget which amounted to up to EUR 680 million per year to finance new integrated care models. In addition, the strategic focus was broadened from a purely population-based focus to a more comprehensive understanding of population that also allowed establishing intervention-specific models. During this time, the number of contracts and participating enrolees increased quickly. In 2008, about 6% of all enrolees participated in an integrated care programme. However, at the same time, integrated care was marked by few contracts covering a large share of enrolees with a comparatively low financial volume. Out of the total of 6 400 contracts, 32 accounted for more than 90% of all enrolees, but only 17% of all expenditures for integrated care programmes (Grothaus, 2009).

Table 1. From integrated care to special care

	Jan 2000	Jan 2004/Jan 2007	Apr 2007/Jan 2011	Jul 2015
Legal basis	<ul style="list-style-type: none"> Health Care Reform Act [GKV-Gesundheitsreformgesetz] 	<ul style="list-style-type: none"> Health Care Modernization Act [GKV-Modernisierungsgesetz] Physician Amendment Act [Vertragsarztrechtsänderungsgesetz] 	<ul style="list-style-type: none"> Competition Reinforcement Act [GKV-Wettbewerbsstärkungsgesetz] Pharmaceutical Market Restructuring Act [Arzneimittelmarktneuordnungsgesetz (AMNOG)] Health Care Provision Act [GKV-Versorgungsstrukturgesetz] 	<ul style="list-style-type: none"> Health Care Strengthening Act [GKV-Versorgungsstärkungsgesetz]
Key elements	<ul style="list-style-type: none"> Introduces ICPs as cross-sectoral modes of care (population and indication based programs) Provides framework agreement between the National Association of SHI Physicians and the seven National Associations of Sickness Funds Regulates content, reimbursement, quality standards and budget adjustment Requires obligatory ICP approval of the Regional Associations of SHI Physicians (RASHIP) 	<ul style="list-style-type: none"> Removes need for framework agreement Introduces start-up funding for period 2004 to 2006 Prolongs start-up funding for the period 2007 to 2008 Offers free disposition of start-up funding between all eligible contract partners 	<ul style="list-style-type: none"> Restricts disposition of start-up funding to out- and inpatient care in 2007 Introduces necessity for pre-approval of the ICPs by the Federal Insurance Authority in 2012 	<ul style="list-style-type: none"> Removes necessity for cross-sectoral design of ICPs Introduces need to demonstrate economic viability after four years Integrates previously separately regulated 'structure contracts' (§73a SGB V) and 'special outpatient physician care' (§73c SGB V) into the integrated care framework Removes necessity for pre-approval of ICPs by the regulatory agency
Eligible ICN partners	<ul style="list-style-type: none"> Networks of general practitioners, specialist physicians, and dentists Other outpatient providers incl. their networks RASHIPs Hospitals Rehabilitation facilities Alliances of the above-mentioned partners 	<ul style="list-style-type: none"> Allows contracts with individual general practitioners, specialist physicians, and dentists Excludes RASHIPs as eligible contract partner Added outpatient clinics as eligible partners in 2004 	<ul style="list-style-type: none"> Added long-term care facilities and their payers (long-term care funds) as eligible partners in 2007 Added pharmaceutical companies and manufacturers of medical devices as eligible partners in 2011 	<ul style="list-style-type: none"> Reintroduces RASHIPs as eligible contract partners
Budget adjustment	<ul style="list-style-type: none"> Adjustment of in- and outpatient budgets necessary based on number of patients to stabilize contribution rates 	<ul style="list-style-type: none"> Waived adjustment of in- and outpatient budget for period 2004-2008 	<ul style="list-style-type: none"> Introduces necessity for budget adjustment based on number of patients and risk structure from 2009 	<ul style="list-style-type: none"> Simplifies the adjustment procedure by allowing a general flat budget adjustment and allows waiving adjustment if efforts exceed benefit of adjustment
Financial incentives	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Allows start-up funding of up to EUR 680 m p.a. (sickness funds are allowed to withhold up to 1% of the in- and outpatient budget) 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Reintroduces start-up funding of up to EUR 300 m p.a. for the period 2016-2019 (sub-committee of federal joint committee decides on start-up funding)

Source: Milstein, R. and C. R. Blankart (forthcoming).

After the cessation of the start-up financing end of 2008, the growth of integrated care contracts decreased and only financially sustainable programs that effectively improved quality and efficiency of care have remained. In 2008 and 2009, around 1 440 out of 6 400 contracts were terminated, while about 1 300 new contracts were completed (see Table 2) (Deutscher Bundestag, 2012). A survey among sickness funds identified two main reasons for the termination: first, higher costs and second, a lack of patient participation (Deutscher Bundestag, 2012). Since the cessation of the start-up financing, sickness funds as well as providers got more selective on contracting for integrated care.

Table 2. Number of contracts, participants and expenditure 2008-2011

Year	No of registered contracts	Enrolees participating	Expenditures [EUR million]
2008	6 400	1 661 283	1 225
2009	6 262	1 635 270	1 224
2010	6 374	1 771 949	1 353
2011	6 339	1 926 133	1 352

Source: Deutscher Bundestag (2012).

In July 2015, integrated care was integrated in the broader framework of special care which now covers most of the different historically grown forms of selective contracting. Besides unifying the different types of selective contracting, i.e., structure contracts (§ 73a SGB V), special outpatient physician care (§ 73c SGB V), and integrated care (§§ 140a-d SGB V), the Federal government introduced start-up financing for innovative projects (EUR 225m p.a.) and health services research (EUR 75m p.a.).

5. Special care in context with other innovative forms of care

In Germany, several innovative forms of the delivery of care have been introduced since the beginning of the twenty-first century and now co-exist with the standard delivery of care. They differ in their requirements, contract partners and design. These innovative forms can be differentiated by the sectors involved, as some forms were implemented to foster collaboration within one sector whereas others should foster cooperation between sectors. However, they all have in common that participation of patients is voluntary and financial and non-financial incentives may apply. Examples from the in- and outpatient sector as well as one cross-sectoral form of delivery of care are presented in Table 3.

GP-centred care (§ 73b SGB V) has introduced a gatekeeping system into the German SHI system. The GP becomes the main actor within this program who guides the patient through the healthcare system. All sickness funds are legally obliged to offer such a program to their enrolees. Usually, sickness funds contract with a major part of the GPs in a region, but not necessarily with all. Reimbursement is negotiated between regional GP networks and the sickness funds. Patients are (non-)financially incentivized to join GP-centred care. If they take part at this programme they are obliged to first consult the GP whenever they seek treatment.

Disease-Management-Programs (DMPs) as defined in § 137f SGB V are an example of another cross-sectoral form of care. The DMPs refer to structured patient pathways for the management of currently six chronic diseases (extension to 10 chronic diseases is in discussion). Within these programs, the patients follow a structured pathway that is managed by a distinguished physician (often a GP), who manages their care path and refers them to specialists whenever necessary. The structured guidelines are binding and developed by the Federal Joint Committee (Gemeinsamer Bundesausschuss). In return, physicians receive an additional remuneration for providing DMP-related services. Depending on the sickness fund, patients can receive financial or non-financial incentives, which vary among sickness funds.

Table 3. Overview on several innovative forms in the delivery of care

	Standard delivery of care	Integrated care/special care	Disease-management-programs	GP-centred care	Outpatient care in hospitals	Pilot projects on innovative forms
Source of law (SGB V)	§ 72	§ 140a	§ 137f	§ 73b	§ 116b para.2, para.3 no.2	§§ 63-65
Available since	1911	2000/2015	2002	2004	2004	2011
Voluntary for:						
• SHI funds		X	X		X	X
• Providers		X	X	X	X	X
• Enrolees		X	X	X	X	X
Core features	Comprehensive delivery of outpatient care for the entire population, collective agreements between sickness funds and providers	Coordinated delivery of care across sectors and/or disciplines	Coordinated structured care pathway for chronic diseases, integration of in- and outpatient care	GP acts as gate keeper, coordinated patient pathways	Continuous in- and outpatient delivery of care by hospitals	Pilot projects to experiment with inter-disciplinary and cross-sectoral deliveries of care, limited to 8 years
Contracting partners	Sickness funds, physicians' associations	Sickness funds, providers and their networks	Sickness funds, physicians' associations, hospitals	Sickness funds, physician networks, physicians' associations	Sickness funds, hospitals	Physicians' associations, associations of pharmacists and sickness funds
Payment methods	FFS	Negotiable: global budget, capitation, DRGs, FFS, P4P, bundles, etc.	FFS + P4P for process indicators	Negotiable: usually FFS + P4P for process indicators	FFS	Negotiable: Global budget, capitation, DRGs, FFS, P4P, bundles, etc.
Adjustment of budget for standard delivery of care		X		X		X
Evaluation mandatory		X	X			X

Source: Based on Schreyögg (2014) and Deutscher Bundestag (2007, 2012).

6. Contract partners and contract types

Originally, the political intention of integrated care programmes was to foster the collaboration of providers of different healthcare sectors. To date, most contracts involve in- and outpatient care, while other providers are less represented. SHI physicians (both general practitioners and specialists), outpatient clinics (Medizinisches Versorgungszentrum), acute and rehabilitation hospitals, nursing homes, pharmaceutical companies, producers of health technological devices as well as networks or legal entities of the aforementioned health providers can be contract partners. Management companies of the above mentioned contract partners are also eligible to contract with sickness funds. In 2008, 64% of all contracts included outpatient providers, while hospitals served as contract partners in 54% (Grothaus, 2009). Pharmaceutical companies, producers of health technological devices and rehabilitation facilities are involved in 13%, 11%, and 1% of all contracts, respectively (Deutscher Bundestag, 2012). It seems that most integrated care contracts either combine different groups of physicians or combine in- and outpatient care (Grothaus, 2009). However, there is no information on existing combinations and their shares.

Sickness funds and health providers are free in negotiating their agreements as the § 140a SGB V framework does not describe any contractual prerequisites or characteristics. In practice however, four basic types of integrated care contracts can be identified that vary in their objectives.

First, there are contracts which are mainly used for competition purposes by the sickness funds. Main purpose of those programmes is to attract healthy individuals with an attractive risk structure (resulting in positive contributions from the risk structure compensation scheme). Services provided are tailored to the clients' demands but often lack of scientific evidence. However, although all of those contracts fulfil the minimum requirements of integrated care, they are in critique to hardly foster intersectoral co-operation in reality. Second, there are contracts that aim at realizing savings (rebates) in turn for higher volumes. For example, sickness fund may direct patients to a provider network that in turn offers discounts or additional services. While this approach certainly is beneficial in terms of cost containment, improvement of quality of care is discussed controversially. Third, contracts aiming to shift delivery of care from the inpatient to the outpatient sector. Those contracts shall shift simple surgeries, e.g., tonsillectomy or hernia repair, from an inpatient to an outpatient setting with the same outcome at a cheaper price. Fourth, integrated care contracts aiming to improve the provision and management of care. Those contracts often aim to increase efficiency and quality of care by implementing binding evidence-based guidelines for a multidisciplinary team of providers from different sectors.

7. Financing and cash flows

There are two different ways to reimburse healthcare providers within a special care contract. First, sickness funds can reimburse all services to contracting physicians. This requires a reduction in the global outpatient budget by the amount that should be covered by the standard care that is paid to the physicians' associations (inpatient care budgets do not have to be adjusted because the payment is done on a case basis). Second, sickness funds may reimburse outpatient providers with an add-on payment to the reimbursement that is paid by the physicians' associations. The latter payment method is far more accepted and established as problems resulting from adjusting the standard outpatient budget of the physicians' associations are minimized (Schwinger and Nolting, 2010). Therefore, it is not surprising that the majority of all contracts that involve outpatient care use add-on payments to the existing fee schedule and therefore

do not cause any budget adjustments. These add-on payments are normally granted as a fixed sum per patient treated, i.e. EUR 20 per patient for whom additional documentation has been provided.

The type of reimbursement itself differs by contract as it can be individually negotiated. Thus, rates differ from standard rates and are assumed to be more attractive for physicians. Fee-for-service, capitation, global budgets, or mixed forms are among the commonly used reimbursement forms. Pay for performance (P4P) agreements are also implemented in these kinds of contracts as this is one of the options to introduce value-based healthcare in the German SHI system. P4P can offer the contracting partners more flexibility on the design of the incentive structure, but also bears risks for both sides. It is common to combine different schemes and to impose ceiling amounts. However, due to the confidentiality of the contracts and the large heterogeneity, there is no comprehensive overview on payment methods used.

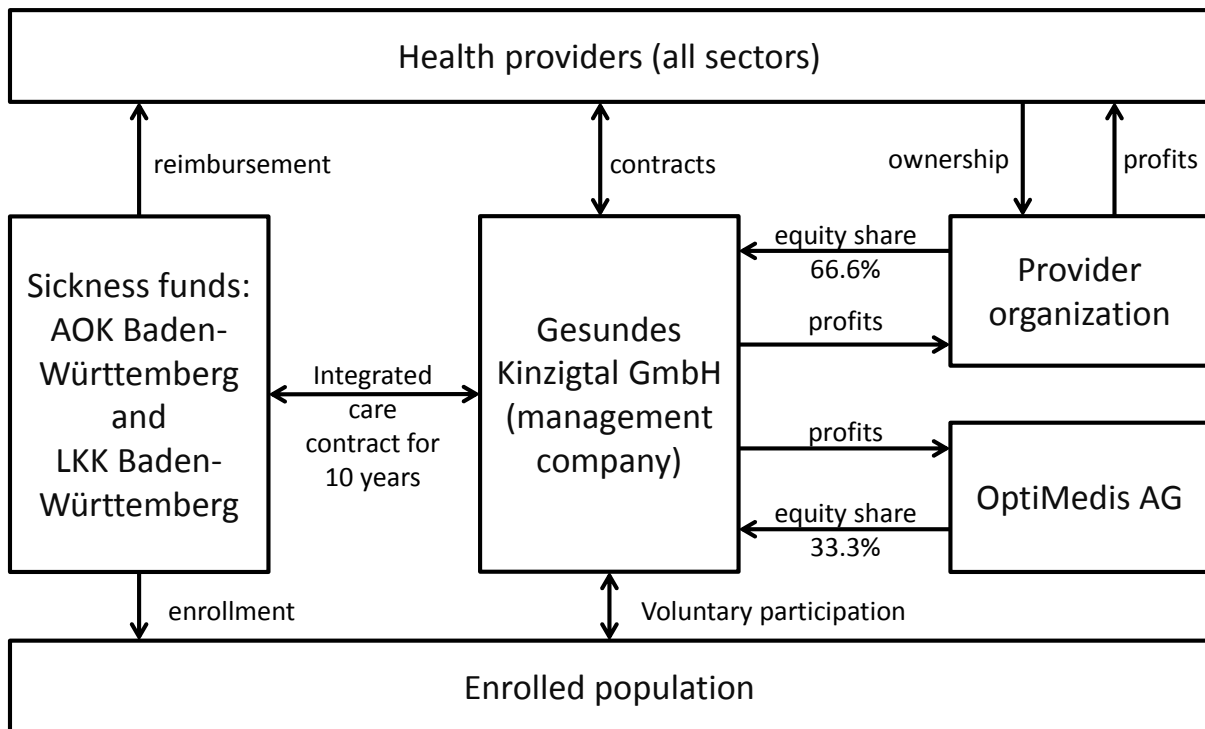
8. Case studies

To date, there are only a few evaluations of integrated care contracts publically available, and also unpublished internal evaluations are scarce. According to a survey from 2012, only 5% of all sickness funds responded that they evaluate all of their programs, 22% evaluate most, 56% some, and 17% never evaluate their integrated care programs. However, even if evaluations were performed, only one sickness fund declared to always publish the results. Almost 80% responded that they sometimes publish and 21% answered that they never publish their results (Deutscher Bundestag, 2012). If evaluations were available, most of them show a reduction in financial expenditure and an increase in patients' compliance and/or health outcomes. In the next sections, case studies from two evaluated and successful integrated care models are presented. *Gesundes Kinzigtal* is population-based and *Cardio-Integral* is a large scale intervention-specific program to improve management of patients with cardiovascular diseases.

8.1 Gesundes Kinzigtal

A prominent example of integrated care that has received a high degree of public attention is the population-based integrated care program “*Gesundes Kinzigtal*”. Two sickness funds, the AOK Baden-Württemberg and the LKK Baden-Württemberg, concluded a contract with the management company “*Gesundes Kinzigtal GmbH*”. Two thirds of the management company belongs to the providers who also bring medical know-how into the company. One third belongs to the *OptiMedis AG*, a management company which mainly provides health science, administrative know-how, and data management and – analysis (see Figure 4). In 2015, several in- and outpatient acute and rehabilitation clinics and more than 70 physicians participated in the program representing more than 60% of all providers in the region. In 2014, about half of the population (approx. 33 000 individuals) is eligible to take part in the program and about 10 000 enrolees have joined (Hildebrandt et al. 2015). Enrolees of both sickness funds can voluntary join the program for free and leave the program on a quarterly basis without stating any reasons. There are no large financial incentives for participants, as *Gesundes Kinzigtal* wants to attract new enrolees by better quality and not by financial incentives. Non-financial and small financial incentives include tailored prevention and sports programs, vouchers for gyms, reduction in co-payments in smoking cessation programs, and 10€-vouchers to spend for *Gesundes Kinzigtal* partners or charities.

Figure 3. Organization of Gesundes Kinzigtal

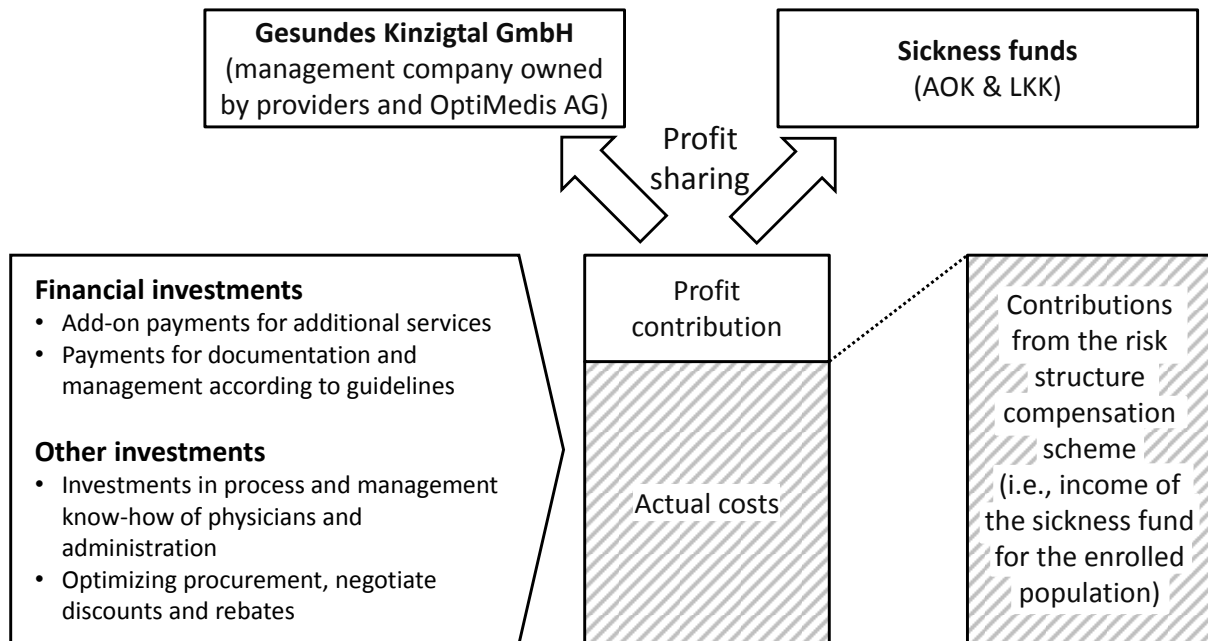


Source: based on Hildebrandt (2013).

Providers continue to be remunerated by the reimbursement scheme of the physicians’ association for services that belong to the standard delivery of care. Additional services, which are not covered under the standard benefit basket, but deemed necessary by the two sickness funds and the management company, are covered additionally on a fee-for-service basis. In addition, providers are able to profit from the eventual success of the management company as they hold a substantial part of the equity.

The management company itself has concluded a profit-sharing agreement with the sickness funds (see Figure 5). The aim is to save money on the long run by providing a better quality of care. Profit contributions per patient are “virtually” calculated and equal the difference between actual costs and contributions of the risk-structure compensation scheme (from the sickness fund’s perspective, this equals the income per patient after risk adjustment) (see also Pimperl et al., 2014). The morbidity-adjusted contribution per patient from the risk-structure compensation scheme should equal the expected health expenditure and amounts on average to about EUR 2 600 per individual. If the actual costs are lower, e.g. EUR 2 200, the realized savings of EUR 400 are split between the sickness fund and the management company (Hildebrandt *et al.*, 2010). Llano (2013) estimates the realized savings to amount to about 10-15% of the provider’s income.

Figure 4. Cash flows in the Gesundes Kinzigtal program



Source: based on Hildebrandt (2013).

The Gesundes Kinzigtal program is subject to an independent evaluation to prevent under- or over-provision, risk selection, or other undesired effects. The evaluation is coordinated by an institute based at the department of medical sociology at University of Freiburg. Until now, first evaluations are promising and the stakeholders expect to provide more positive results in the future when earlier made health investments pay off. For example, prevalence of fractures due to osteoporosis is with 26 percent substantially lower than in the control group with 36 percent (Hildebrandt, 2015). Gesundes Kinzigtal is also well received by both enrolees and providers according to a survey from 2012/13. More than 90% of all surveyed enrolees and more than 80% of all surveyed providers stated that they would join Gesundes Kinzigtal again (Busse and Stahl, 2014). Financial results are also positive: for the first three years, the profit, i.e., the difference between the contribution a sickness fund receives for an enrolee and their actual cost, amounted EUR 151 per enrolee per year (Busse and Stahl, 2014). These savings were increased to EUR 170 per enrolee per year which equals savings of 7.4 percent in 2013 (Gesundes Kinzigtal, 2014).

By now, Gesundes Kinzigtal has launched about 20 sub-programs, e.g., a program for heart disease, a program for rheumatism, a program for psychiatric diseases to improve care and realise savings compared to the control population (Pimperl et al., 2015, Struckmann et al., 2015). Those programs are continuously evaluated. However, one has to take into account that all evaluations suffer from a small sample size although Gesundes Kinzigtal belongs to the largest population-based integrated care programmes (Siegel et al., 2011). For example, the sub-program heart disease for patients aged 55 and above has demonstrated positive results. After four years, results show a substantial reduction in mortality (survival participants: 89% vs. control 80%). Furthermore, costs of participants increased at a slower pace over the period from 2005 to 2010 (7% vs. 19.3%) (Hildebrandt et al., 2012). Another sub-programme aiming at empowering older people to lead an independent life focussing on physical activity and nutrition (Mnich et al., 2013)

yielded mixed to positive results. The evaluation was conducted as a pre-post comparison of 468 people. According to the evaluation, nutrition behaviour improved whereas physical activity did not. However, health-related quality of life did not change over the treatment period of 12 months (Mnich *et al.*, 2013). A more recent study based on 5 411 enrolees using propensity score matching shows that *Gesundes Kinzigtal* overall reduces the total amount of life years lost by 635 life years lost compared to the control group (Schulte *et al.*, 2014). Also, more recent results indicate positive developments regarding population health, patient experience, and cost-effectiveness (Hildebrandt *et al.* 2015).

8.2 Cardio-Integral

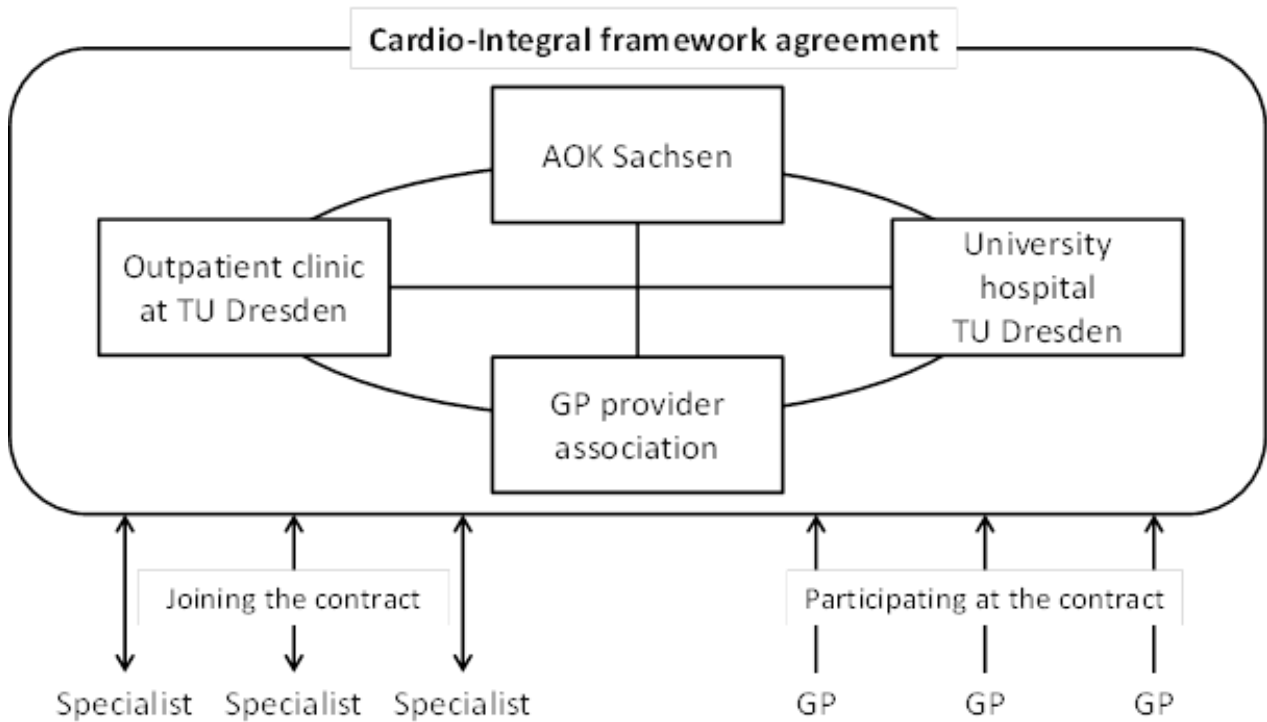
Cardio-Integral, an integrated care program in the state Saxony, targets patients with cardiovascular diseases and is similarly structured as the DMP for coronary heart disease. In 2010, the network designed by the sickness fund AOK Sachsen comprised about 50 000 enrolees, 1 207 GPs, and 91 specialists with a budget of EUR 2.4 million. The treatment was designed to follow a structured pathway, which is coordinated by both a GP and a cardiologist. If necessary, the enrolee is referred to another in- or outpatient specialist for invasive treatment.

The patients' pathway depends on the disease's severity. Less severe cases are supervised and monitored by the GP. More severe cases are treated by invasive cardiologists and then transferred to non-invasive cardiologists and/or GPs for follow-up. In both cases, the GP enrolls the patient in the disease-management programme on heart failure. The GP also supervises the patient's adherence and coordinates the care pathway with non-invasive cardiologists.

All providers are incentivized by bonus payments for certain process measures, such as regular documentation, or regular check-ups. GPs receive the bonus payment for the treatment of GPs within the disease-management programme. In addition, GPs receive a flat-sum bonus payment of EUR 10 to 20 per patient if the patient is compliant. The GP can also earn EUR 20 per patient for the preparation of invasive treatment. Cardiologists receive a flat-sum bonus payment of EUR 30 for the first consultation and EUR 20-80 per patient treated within the Cardio-Integral programme. All bonus payments per patient can be charged on a quarterly, half-year, or yearly basis depending on the service.

The Cardio-Integral framework agreement is concluded between the AOK Sachsen, the GP provider association, the outpatient clinic of the university hospital, and the university hospital itself in the state capital Dresden. Specialists can explicitly join while GPs can only participate in the contract (see Figure 5). However, both provider groups have to meet certain requirements, *e.g.*, provide technical equipment and prove a certain quality.

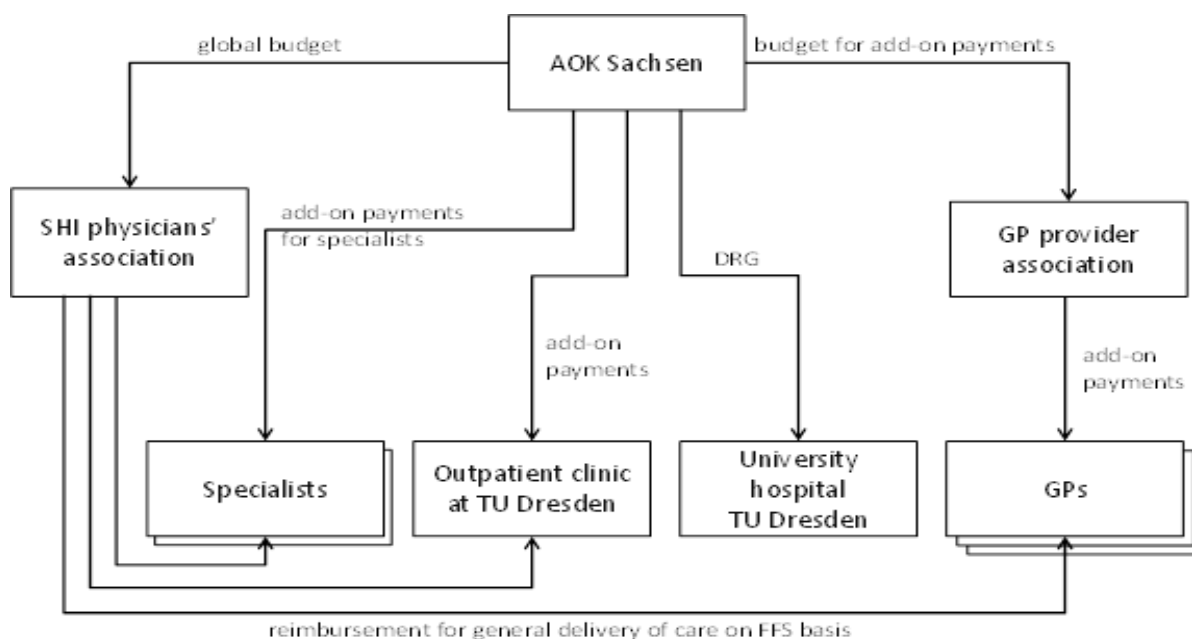
Figure 5. Organization of Cardio-Integral



Source: based on Rössl (2013)

All participating outpatient providers, *i.e.*, the specialists, the GPs, and the outpatient clinic, continue to be reimbursed by the physicians' association on a fee-for-service basis. Similarly, the university hospital continues to be reimbursed by DRGs. However, all outpatient providers are eligible for add-on payments. Specialists and the outpatient clinic receive those payments directly from AOK Sachsen, while the participating GPs receive add-on remuneration from the GP provider association (see Figure 6).

Figure 6. Cash flows in the Cardio-Integral program



Source: based on the Cardio-Integral contract

Providers' reaction to the program has been predominantly positive: more than 70% of 195 surveyed GPs and specialists judged the program to be good or excellent (Werblow and Karmann, 2012). Cooperation between physicians as well as financial incentives were important drivers for the providers' motivation. The 2011-based survey also showed that satisfaction of participating enrollees (n=387) improved with their own health status. The patients also acknowledged the better cooperation between GP and cardiologist. However, from a process perspective, a substantial reduction in waiting times could not be achieved (compared to other countries, waiting times are a minor problem in the German healthcare system). The health-economic evaluation showed that the program saved on average EUR 95.70 per patient per year mainly because of lower hospital admissions. Initial costs that were induced by intensive treatment and diagnostics or readjustment of the drug therapy are offset after about 4.5 years (Werblow and Karmann, 2012). However, similar to most integrated care projects, it remains difficult to differentiate the effects from the Cardio-Integral program and the existing DMP on cardiovascular diseases. Less severe cases within Cardio-Integral programme are treated according to the structured pathway of the according DMP. The only two additions of Cardio-Integral for less severe cases are the coordination with a cardiologist and the increased financial incentive for the GP. Furthermore, Cardio-Integral explicitly aims at enrolling more patients into a DMP.

9. Discussion and conclusion

After a substantial uptake in integrated care initiatives because of the generous start-up funding during the time from 2004 to 2008, growth substantially decreased in the following years. The lack of funding was not the only reason why uptake slowed down. First of all, one has to mention that providers as well as payers had too high expectations from integrated care programs. Sickness funds and providers often

overestimated the number of participants and underestimated the management effort that was needed to make the program successful. Furthermore, the contracting parties often anticipated a higher impact on quality and efficiency from the measures taken within the program. Instead, unexpected adverse effects often led to lower efficiency gains. For example, the promising approach to shift the delivery of care from the inpatient in the outpatient sector, led to the practice that hospitals acquired other inpatient cases to reach internal bed occupancy targets.

The difficult adjustment procedure of the global outpatient care budget for services that are usually covered by the standard outpatient care represents another challenge (Deutscher Bundestag, 2012). First, sickness funds have to calculate the value of the substituted services, adjust the global budget, and then the physicians' associations have to break down this amount to the individual budget of each physician, which is even more difficult. Therefore, integrated care models that fully substitute services met the resistance of the physicians' associations and are very scarce. Today, most contracts only reimburse additional services, e.g., not reimbursed health technologies, better documentation, or the achievement of quality targets, while the largest part of services are financed through the reimbursement scheme of the physicians' association. This avoids the problem of budget adjustments and clearly indicates the participating physicians that they work for additional and not reallocated money. As a result, the original aim to break the monopoly of the physicians' associations and to increase competition between outpatient providers could only be partially achieved.

Nevertheless, special care contracts are still regarded as an important element to foster competition and quality in the German SHI system. With the introduction of special care, the coalition of Christian Democratic Union (CDU), Christian Social Union (CSU), and SPD, which was elected in 2013, has further consolidated the different frameworks. With the reintroduction of the obligatory formal assessment of the efficiency as well as reintroduction of the mandatory and facilitated budget adjustment, the coalition has successfully implemented their coalition agreement (CDU, CSU and SPD, 2013).

Despite remaining challenges, the special care model has now evolved to an important alternative to the provision of standard care in the German healthcare system. Special care programs allow for a large flexibility to link providers of different sectors, introduce new payment models, or efficiently provide access to new health technologies. If properly designed, special care programs define evidence-based patient pathways that reduce double examinations, unnecessary hospital stays, complications, and achieve substantial cost savings at similar or better quality of care. However, nowadays many evaluations are old, of mixed quality, unpublished, unreviewed, or do not exist at all. With mandatory assessment, health care decision makers will be enabled to identify best practices or to single out components that make the programmes even more successful.

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