



Summary of S. 1781

The Reduce Emergency Department Utilization through Coordination and Empowerment Act (REDUCE Act)

October 2009

Purpose: To create a demonstration program that will allow service providers to be reimbursed by Medicaid for coordinated care management and community support services. The program targets Medicaid beneficiaries with complex medical and behavior health conditions who frequently rely on emergency health care services.

What is a Demonstration Program? The federal Centers for Medicare and Medicaid Services (CMS) administers the Medicaid program. CMS often offers demonstration program opportunities to a limited number of states to evaluate new service and financing models, including evaluating the cost-effectiveness of the new models. CMS submits a report of outcomes to Congress, which also contain recommendations for legislative and administrative actions, with the goal of improving the Medicaid program nationwide.

Participating States: States can apply to participate by submitting an application. These applications are evaluated independently and will be approved until the limit of 10 is reached.

Program Duration: 5 years

Cost to States: In the first two years, the federal government will pay 100 percent of costs. In years 3, 4, and 5, the federal share is 75 percent, and the state share is 25 percent.

Target Population: Medicaid eligible adults who are over 19, have been diagnosed with multiple chronic conditions, and frequently use emergency health, hospital, and other inpatient health services are eligible.

Qualifying Chronic Conditions: Qualifying chronic conditions include but are not limited to asthma, cancer, chronic obstructive pulmonary disease, diabetes, HIV/AIDS, liver disease, post-traumatic stress disorder, renal failure, rheumatologic disease, severe mental illness, substance use disorder, thromboembolic disease, traumatic brain injury resulting in cognitive impairment, and other chronic medical conditions that have been identified by a state and approved by the federal Department of Health and Human Services (HHS).

States Are Required to:

- Create individualized care plans that include the integration of primary care and behavioral health services, either through co-location of services or multi-disciplinary teams. These plans must be developed with input from the client.

- Provide a projection of the number of targeted Medicaid beneficiaries they expect to serve, including data on how they have engaged with the health system and who might be at risk of frequently and inappropriately using health services.
- Create a strategy for outreach.
- Establish criteria for selecting appropriate health care providers.
- Include a plan to continue services for program participants after the demonstration program ends.

States’ Criteria for Determining an Individual’s Eligibility:

- The number and severity of chronic conditions, co-occurring behavioral health disorders, or substance use disorders.
- Functional impairments.
- Care and support needs.
- Recent utilization of emergency or inpatient care in a hospital or similar facility.
- Other factors as determined by the State.

Collecting Savings: Participating states may develop arrangements with participating health providers that allow these providers to keep any financial savings generated by implementing the demonstration program.

Potential Providers: The legislation lists safety-net hospitals, community health centers, community mental health centers, and health provider coalitions (defined in the legislation) as potential providers. These providers must have the ability to share data with multiple institutions in order to adequately identify frequent users.

Services Covered in the Benefits Package: States will provide the HHS Secretary with a comprehensive list of services they plan to provide under this program. The bill includes the following language to ensure that services outside a state’s Medicaid plan can be included in the benefits package: *“Upon request by the State and subject to approval by the Secretary, a participating State may provide additional services under the demonstration program that are not covered under the State plan upon showing that such services will reduce avoidable utilization of health services by targeted Medicaid beneficiaries.”*

Evaluation and Report: Throughout the duration of the program, participating states must evaluate whether the demonstration programs reduce avoidable hospitalizations or institutional admissions, Medicaid expenditures, and use of emergency health services, and whether they improve overall health. The results of the evaluations should prescribe which future Medicaid programs should be established to address the care of individuals with complex medical and behavioral health needs.

A report of the evaluation results is due one year after completion of the demonstration program. The bill authorizes \$15 million for evaluation of the program within each state.

Total Cost of Program: The bill authorizes \$150 million over five years, which is an average of \$30 million a year.