NASUAD
National Association of States United for Aging and Disabilities

AN ANALYSIS OF TITLE VI – TRANSPARENCY AND PROGRAM INTEGRITY

Summaries of Key Provisions in the "Patient Protection and Affordable Care Act" (HR 3590) as amended by the "Health Care and Education Reconciliation Act of 2010" (HR 4872), as of August 18, 2010

Initiative	Summary	Important Dates	Participants
NURSING HOME TRANSPARENCY			
Nursing Facilities Required Disclosures (HR 3590, Sec. 6101)	Facilities are required to disclose extensive information regarding the entities who own, control, or manage the facility. The facility must disclose information regarding "each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity." The disclosure also must address corporate structures, by including organizational information that describes the legal interrelationships between the entities and real persons that own or manage the facility.	March 23, 2010: Upon enactment, this information is available upon request to the federal and state governments, and each state's long-term care ombudsman program. March 23, 2012: Within two years of enactment, the Secretary will publish final regulations implementing these provisions. Facilities will have 90 days after the Secretary publishes these regulations to report the required information	A facility is either a skilled nursing facility or a nursing facility. Thus, skilled nursing facilities (SNFs) and nursing facilities (NFs) will be required to disclose information relating to ownership, organizational structure and management of the facility.
Nursing Facility Compliance and Ethics Programs (HR 3590, Sec. 6102)	Facilities must implement an operational compliance and ethics program that is effective in preventing and detecting criminal, civil and administrative violations, and which also promotes quality of care. These programs must comply with relevant federal regulations, which will be promulgated by the Secretary.	March 23, 2012: Within two years of enactment, the Secretary will issue regulations for an effective program March 23, 2013: Within three years of enactment, each facility's ethics program must be in operation	A facility is either a skilled nursing facility or a nursing facility. At a minimum, in operating the compliance and ethics programs, the SNF or NF must ensure (1) That the programs are overseen by managerial staff with sufficient authority (2) That the facility's standards are effectively communicated to employees and other agents (3) That reasonable

			steps are taken by the facility to achieve compliance with its standards (4) That monitoring and discipline is adequate, and (5) That the facility responds appropriately to any offenses.
Quality Assurance and Performance Improvement Program (HR 3590, Sec. 6102)	The Secretary must establish and implement a quality assurance and performance improvement program (QAPI) for facilities. The program will establish standards and provide technical assistance on the development of best practices to meet those standards.	December 31, 2011: The Secretary will establish and implement the QAPI program by this date Within one year after the Secretary releases the regulations: Each facility must submit its plan for compliance	A facility is either a skilled nursing facility or a nursing facility. Thus, the QAPI program applies to both SNFs and NFs, requiring these entities to submit to CMS a plan to implement the best practices and meet the standards established by the Secretary and set forth under the QAPI program.
Nursing Home Compare Website (HR 3590, Sec. 6103)	The health care reform law requires that the following additional information be posted on CMS's Nursing Home Compare website: (1) Staffing data for each facility, including the hours of care provided per resident per day, information on staffing turnover and tenure, and discussions of how staffing affects quality and how different resident needs might demand different staffing levels (2) Links to state Internet websites with information regarding state survey and certification programs (3) Links to state-issued inspection reports, with information on how those reports should be interpreted (4) The standardized complaint form (5) Instructions on how to file a complaint with the survey agency or the state long-term care ombudsman program (6) Summary information on the number, type, severity, and outcome of substantiated complaints against a facility (7) The number of adjudicated instances of criminal violations by a nursing facility or its employees that	March 23, 2011: Within one year of enactment, the website must include the newly required information	To improve the timeliness of the Nursing Home Compare website's information, states must provide inspection information to CMS at the same time that the information is presented to the affected facilities. In turn, CMS must update the information on Nursing Home Compare as quickly as possible upon receiving this data from the state, but must at least update the site quarterly.

	were committed inside the facility or, of those crimes, were instances of abuse or exploitation, and (8) A consumer rights page that explains the facility-specific information that is available to consumers, including tips on choosing a nursing facility, along with consumer rights information and a state-specific description of the services available through the long-term care ombudsman program.		
Review of the Nursing Home Compare Website (HR 3590, Sec. 6103)	The Secretary must establish a process to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on Nursing Home Compare, and to make necessary revisions.	March 23, 2011: Within one year of enactment, the Secretary will review and modify the Nursing Home Compare website	In performing the review, CMS must consult with state long-term care ombudsman programs, consumer advocacy groups, and provider stakeholder groups.
State Websites (HR 3590, Sec. 6103)	The Nursing Home Compare website will link to individual state websites. Each state must maintain a consumer-oriented website providing useful information to consumers regarding all SNFs NFs in the state, including, for each facility: Form 2567 state inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and other information as appropriate. If possible, the Secretary will include this information on the Nursing home compare website.	March 23, 2011: Within one year of enactment, the Secretary will ensure that this information is included on the Nursing Home Compare website	The Secretary will provide the states with guidance regarding how states can establish electronic links to From 2567 State Inspection Forms (or successor forms), complaint investigation reports, and a facility's plan of correction or other response to such Form 2567 reports on the state website that provides information on SNFs and NFs.
Special Focus Facility Program (HR 3590, Sec. 6103)	In a provision which amends the Nursing Home Reform Law of 1987 (42 USC Sec. 1395) to reflect current procedures, the Secretary is directed to develop a special focus facility program. Under the program, the Secretary will identify nursing facilities that have substantially failed to meet the requirements of the Social Security Act, including the Nursing Home Reform	March 23, 2010: These provisions were effective upon enactment	The Secretary will identify those facilities that have repeatedly been out of compliance, and such facilities will be inspected at least once every six months under the program.

	Law of 1987. To enforce these requirements at the designated facilities, the Secretary will conduct surveys of each facility in the program at least once every six months.		
SNF Expenditure Reporting (HR 3590, Sec. 6104)	Within 30 months of enactment, SNFs must separately report, and make publicly available upon request, expenditure information, arrayed by specified functional accounts (direct care, indirect care, capital assets and administrative service costs). For cost reporting periods beginning two or more years after enactment, skilled nursing facilities must report direct care staff expenditures separately, breaking out registered nurses, licensed nurses, nurse aides, and other medical and therapy staff members.	Within 30 months of enactment: expenditure information is to be publicly available on request March 23, 2012: Within two years of enactment, skilled nursing facilities must report expenditures for wages and benefits for direct care staff separately	SNFs will be required to separately report expenditures for direct care staff, indirect care services, capital assets and administrative services.
Standardized Complaint Form (HR 3590, Sec. 6105)	The Secretary will develop a standardized complaint form to be used by residents, or anyone acting on their behalf, in filing a complaint with a state survey and certification agency as well as with a state long-term ombudsman program with respect to a facility.	March 23, 2011: Within one year of enactment, these provisions will become effective	The state must make the form available upon request to a resident of the facility, and to any person acting on the resident's behalf.
Complaint Resolution Process (HR 3590, Sec. 6105)	Each state must develop a complaint resolution process to ensure that the legal representative of a resident, or other responsible party, is not denied access to the resident or otherwise retaliated against if they have complained about the quality of care provided by the facility, or about other issues relating to the facility.	March 23, 2011: Within one year of enactment, these provisions will become effective	The state must establish a complaint resolution process, which must include (1) accurate tracking of complaints received, (2) notification to the complainant that the complaint has been received, (3) investigation procedures, and (4) deadlines for responding to the complaint and for notifying the complaining party of the outcome of the investigation.

Ensuring Accurate Staffing Data (HR 3590, Sec. 6106)	The Secretary will require SNFs and NFs to electronically submit to CMS their direct care staffing levels, including information with respect to agency and contract staff, based on payroll and other verifiable data. Also, to put the information in context, the information must include resident census data and information on residents' care needs, as well as information on employee turnover and tenure, and on the hours of care provided by each category of certified employees.	March 23, 2012: Within two years of Enactment, these requirements will become effective.	Facilities will submit this data using a format to be developed by CMS, and the reported levels must specify the category of work a certified employee performs, such as a registered or licensed nurse.
GAO Study of the Five-Star Quality Rating System (HR 3590, Sec. 6107)	The Comptroller General will conduct a study of the currently operational Five Star Quality Rating system. The study will address how the system is being implemented, problems with implementation, and suggestions for improvement.	March 23, 2012: Within two years of enactment, the report must be submitted to Congress, along with recommendations for legislative and administrative action	Since December 2008, CMS has been using a Five Star Quality Rating System, assigning each nursing home that participates in Medicare or Medicaid a rating from one to five stars. This information is available on the Nursing Home Compare website, and the rating itself is based on the facility's inspection records, staffing levels, and the facility's record on certain clinical measures.
Civil Money Penalties: Reductions for Self-Reported Violations (HR 3590, Sec. 6111)	CMS is authorized to reduce a civil money penalty (CMP) levied against SNFs or NFs by up to 50 percent if the facility self-reports the violation, and subsequently corrects the deficiency within ten days.	March 23, 2011: Within one year of enactment, this provision will become effective	These reductions for self-reporting SNFs and NFs are not available if a penalty for the same violation had been reduced under this procedure within the preceding year, or if the penalty were imposed for a deficiency that had caused a pattern of harm, immediately jeopardized a resident's health or safety, or caused a resident's death.
Civil Money	The Secretary will issue regulations that provide a	March 23, 2011: Within one year of	Both skilled nursing facilities and nursing

Penalties: Independent Informal Dispute Resolution Process (HR 3590, Sec. 6111)	facility upon which a CMP has been imposed with an opportunity to participate in a new independent informal dispute resolution process prior to the collection of the penalty. If a per diem penalty has been assessed, the penalty will not be imposed until this resolution process has concluded.	enactment, this provision is effective	facilities upon which CMPs have been imposed would be eligible to participate in this independent informal dispute resolution process, not later than 30 days after the imposition of the penalty.
Civil Money Penalties: Escrow Account (HR 3590, Sec. 6111)	The new law gives the Secretary the authority to issue regulations providing for the collection and subsequent placement of civil money penalties into an escrow account. The CMP may be put into an escrow account on either the date the informal dispute resolution process is completed, or 90 days after the penalty is imposed, whichever is earlier. The collected amounts may be kept in the escrow account pending the resolution of any subsequent appeals.	March 23, 2011: Within one year of enactment, this provision will become effective	Both skilled nursing facilities and nursing facilities upon which CMPs have been imposed would be subject to the collection and placement of such amounts into an escrow account.
Civil Money Penalties: Appeals (HR 3590, Sec. 6111)	If a SNF or NF successfully appeals a CMP, the amount placed in escrow, plus interest, will be returned to the facility. If all of the facility's appeals are unsuccessful, the Secretary may provide that some of the amount collected be used to support activities that benefit residents.	March 23, 2011: Within one year of enactment, this provision will become effective	Activities that benefit residents include, but are not limited to: the protection of residents when facilities close, the promotion of resident and family councils, and facility improvement initiatives approved by CMS. Such facility improvement initiatives include the joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, and the appointment of temporary management firms.
National Independent Monitor Demonstration	The Secretary, will develop, test, and implement a two-year pilot program. Under the demonstration, an independent monitor will contract with the Secretary to	March 23, 2011: Within one year of enactment, the demonstration project will be implemented. The demonstration project	To participate in the program, chains must submit applications and be selected. The selection process will be based in part on

Project (HR 3590, Sec. 6112)	oversee interstate and intrastate chains of SNFs and NFs.	will run for two years, starting within one year from the enactment of the health care reform law	evidence that a number of the chain's facilities are experiencing significant problems with quality of care. If selected, the chain will be responsible for the cost of a monitor, who will conduct periodic reviews and perform root cause quality and deficiency analysis of the chain.
Notification of Facility Closure (HR 3590, Sec. 6113)	Facility administrators must submit to the Secretary, the state long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending facility closure at least 60 days prior to the closure, and, in the case of a government decertification, at a time specified by the Secretary. Additionally, the facility must not admit any new residents on or after the written notification is submitted.	March 23, 2011: Within one year of enactment, the administrator of a nursing facility must provide written notification of the facility's closure	The facility's notice must include a plan to transfer and relocate the facility's residents that has been approved by the state. The state, in turn, will ensure that all the residents have been successfully relocated to another facility or an alternative home and community base setting before the facility closes.
National Demonstration Projects in Nursing Homes (HR 3590, Sec. 6114)	The Secretary will conduct two demonstration projects: (1) one for the development of best practices in SNFs and NFs that are involved in the culture change movement, and (2) another for the development of best practices in SNFs and NFs for the use of information technology to improve resident care.	March 23, 2011: Within one year of enactment, the demonstration projects must commence, and they must conclude within three years after commencement.	The Secretary will award one or more competitive grants to facility-based settings for the development of best practices with respect to the demonstration project involved. Each demonstration project must consider the special needs of residents with cognitive impairment, including dementia.
Dementia and Abuse Prevention Training (HR 3590, Sec. 6121)	Required training in facilities must include training in dementia care and abuse prevention. Also, in a clarification, the minimum training requirements for nurse aides now explicitly apply to persons who provide services through an agency or under contract with the	March 23, 2011: Within one year of enactment, these provisions will become effect	Facilities that are required to provide this training include both skilled nursing facilities and nursing facilities.

	facility.		
Criminal Background Checks (HR 3590, Sec. 6201)	The Secretary will establish a nationwide background check program in order to conduct checks on prospective direct patient access employees. The optional grant program will be conducted through agreements made between CMS and states, and a single state agency must be responsible for coordinating these background checks. The programs will receive federal funding, in the form of grants from CMS, but with a non-federal match from each state. Participating states will receive a federal match of three times the amount of the state match, which may be comprised solely of donations from public or private entities.	For fiscal years 2010 through 2012: Up to $160 million is appropriated for this program	Participating states will be required, among other things, to monitor compliance with the nationwide program, develop an appeals process and designate a single state agency to focus on oversight. The checks will be used for nursing facilities, home health agencies, hospice agencies, long-term care hospitals, adult day health care providers, assisted living facilities providing a level care determined by CMS, and other appropriate care providers determined by the state.
COMPARATIVE EFFECTIVENESS RESEARCH			
Patient Centered Outcomes Research Institute (HR 3590, Sec. 6301)	The new law establishes the Patient Centered Outcomes Research Institute (PCORI), a private, non-profit entity. The PCORI will focus on prioritizing and funding comparative effectiveness research (CER), and will establish and execute a national CER agenda. In addition, there will be public comment periods to allow the general public to provide feedback to the Institute on proposed priorities and other key decisions.	March 23, 2010: These provisions were effective upon enactment	A variety of entities are eligible to enter into contracts with the Institute for the management of funding and to conduct research, including federal agencies, academic institutions, and private research organizations. The Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH) will receive priority funding consideration.
PCORI Governing Board (HR 3590, Sec. 6301)	The PCORI will be guided by a Board of Governors, to be appointed by the Comptroller General for six year terms. The Board will represent a broad range of perspectives, and will collectively have scientific	September 23, 2010: Within six months of enactment, the Comptroller General is required to make appointments to the Governing Board	The Board of Governors will include the directors of NIH and AHRQ, patient advocates, consumer representatives, physicians, nurses, hospitals, private

	expertise in clinical health sciences research. The Board will carry out the duties of the Institute.		payers, drug and device industries, quality improvement organizations, and other federal and state health agencies.
PCORI Methodology Committee (HR 3590, Sec. 6301)	A standing methodology committee will work to develop and improve the science and methods of comparative clinical effectiveness research. The committee will either directly, or contract out to develop and update methodological standards for research.	September 23, 2011: Within 18 months of the establishment of the Institute, the committee will develop and update methodological standards for research	The 15-member committee will be composed of experts in comparative effectiveness methods, biostatisticians, epidemiologists, health services researchers, and other experts.
MEDICARE AND MEDICAID PROGRAM INTEGRITY			
Provider Screening (HR 3590, Sec. 6401, as amended by Sec. 10603 and HR 4872 Sec. 1304)	To address enrollment fraud, the Secretary will establish procedures for screening providers and suppliers participating in Medicare, Medicaid and CHIP before granting billing privileges. The Secretary has the authority to set different levels of screening depending on the type of provider or supplier. The screenings will include a licensure check, and may include criminal background checks, fingerprinting, site visits, and database checks. .	September 19, 2010: Within 180 days of enactment, the Secretary will establish procedures under which the screening is to be conducted March 23, 2011: The enhanced screening procedures will be effective for providers or suppliers not enrolled as of the date of enactment, March 23, 2010 March 23, 2012: The enhanced screening will be effective for providers or suppliers enrolled as of the date of enactment, March 23, 2010	An application fee of $500 in 2010 for institutional providers and suppliers will be imposed to cover the costs of screening, with a percentage increase equal to the change in the consumer price index for each subsequent year. The Secretary may waive the fee on a case-by-case basis if the imposition of the application fee would result in hardship, or would impede beneficiary access to care as to a state Medicaid program.
Provider Disclosures (HR 3590, Sec. 6401)	Providers or suppliers enrolling or re-enrolling in Medicare, Medicaid or CHIP will be required to disclose any current or previous affiliations with a provider or supplier that (1) has uncollected debt, (2) has had payments suspended (3) has been excluded from	March 23, 2011: Beginning on this date, providers and suppliers undergoing a new enrollment or enrollment revalidations must disclose this additional information	The Secretary may deny a provider or supplier enrollment if a previous affiliation poses an undue risk of fraud, waste or abuse to Medicare, Medicaid or CHIP.

	participating in a federal health program or (4) has had billing privileges revoked.		
Integrated Data Repository (HR 3590, Sec. 6402)	CMS must complete development of a comprehensive Integrated Data Repository (IDR), which will allow federal regulators to correlate claims and payment data across and within public programs to identify fraud. To be included in this IDR are claims and payment data from (1) Medicare (Parts A, B, C and D), (2) Medicaid, (3) CHIP, (4) health-related programs administered by the Departments of Veterans Affairs (VA) and (5) Defense (DOD), (6) the Social Security Administration (SSA) and (7) the Indian Health Service (IHS).	March 23, 2010: These provisions were effective upon enactment	The Secretary must allow DOJ access to this data, and must enter into data-sharing agreements with the Commissioner of Social Security, the Secretaries of the VA and DOD, and the Director of HIS to help identify fraud, waste and abuse.
Reporting and Returning Overpayments (HR 3590, Sec. 6402)	Medicare and Medicaid overpayments must be reported and returned within 60 days from the date of identification, or by the date that the corresponding cost report is due, if applicable.	March 23, 2010: These provisions were effective upon enactment	Any provider, supplier or Medicaid managed care organization must report and return an overpayment to HHS, the state, an intermediary, a carrier, or a contractor, as appropriate.
Provider Payment Suspension (HR 3590, Sec. 6402)	Medicare and Medicaid payments to a provider may be suspended pending investigation of a "credible allegation" of fraud against the provider, unless the Secretary determines that there is good cause not to suspend such payments.	March 23, 2010: These provisions were effective upon enactment	The Secretary will consult with the Inspector General at HHS in determining whether there is a credible allegation of fraud against a provider or supplier.
Health Care Fraud and Abuse Control Account (HR 3590, Sec. 6402)	This section increases funding for the Health Care Fraud and Abuse Control Account (HCFAC) by $10 million each year for ten years.	For each of fiscal years 2011- 2020: An additional $10 million is appropriated to the Health Care Fraud and Abuse Control Account	The law permanently indexes amounts appropriated from the HCFAC Fund to HHS, OIG, the FBI, and the Medicare Integrity Program, and applies inflation adjustments to the HCFAC and to the Medicaid Integrity Program.

Medicare and Medicaid Integrity Programs (HR 3590, Sec. 6402)	The Medicaid Integrity Program and Program contractors must provide the Secretary and the HHS Office of Inspector General with performance statistics, including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment for such activities.	FY 2011: Beginning with FY 2011, not later than 180 days after the end of each FY, the Secretary will submit a report to Congress regarding this data	The Secretary will conduct periodic evaluations of these contractors at least once every three years.
Medicaid Management Information System (HR 3590, Sec. 6402)	Authorizes the Secretary to withhold the federal matching payment to states for medical assistance expenditures whenever a state does not report enrollee encounter data in a timely manner to the state's Medicaid Management Information System (MMIS).	January 1, 2011: The Secretary may withhold the federal matching payment to states	Currently, unless waived by the Secretary, states are required to use the MMIS for operating state mechanized claims processing and information retrieval.
Maximum Period of Submission of Medicare Claims (HR 3590, Sec. 6404)	This section amends the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims from three calendar years to one calendar year after the date of service. Additionally, this section mandates that all claims for services furnished prior to January 1, 2010 must be filed with the appropriate Medicare claims processing contractor no later than December 31, 2010.	January 1, 2010: Services furnished on or after this date will be affected. December 31, 2010: Claims for services provided before January 1, 2010 must be submitted by this date	This new rule affects all physicians, providers and suppliers submitting claims to Medicare contractors, fiscal intermediaries, Part A/B Medicare administrative contractors, and/or regional home health intermediaries for services provided to Medicare beneficiaries.
Physician Documentation Requirements HR 3590, Sec. 6406	Authorizes the Secretary to disenroll, for up to one year for each act, a Medicare enrolled physician or supplier that fails to maintain and, upon request, provide access to, written documentation relating to written orders or requests for payment for DME, certifications for home health services, or referrals for other items and services ordered by such provider, physician or supplier under Medicare, as specified by the Secretary.	January 1, 2010 : This provision applies to orders, certifications, and referrals made on or after this date	Medicare enrolled physicians, suppliers or providers failing to maintain and produce the necessary documentation may be disenrolled from Medicare for up to one year for each such act.

Required face to face encounters HR 3590, Sec. 6407, as amended by Sec. 10605	Requires a physician or other permitted practitioner certifying or re-certifying home health services or ordering DME to have a face-to-face encounter with a patient, including through telehealth, during the preceding six months, or other reasonable timeframe determined by the Secretary. This section also authorizes the Secretary to apply the same face-to-face encounter requirement to other items and services under Medicare, based upon a finding that doing so would reduce the risk of fraud, waste, and abuse. The Secretary is also authorized to apply the face-to-face requirement to physicians making certifications for home health services under Medicaid.	January 1, 2010: These provisions are effective for home health certifications March 23, 2010: These provisions are effective for DME orders	In the case of home health services, the face-to-face encounter may also be conducted by a nurse practitioner, a clinical nurse specialist, a physician assistant, or a certified nurse-midwife. In the case of DME, the face-to-face encounter may also be conducted by a nurse practitioner, a clinical nurse specialist, or a physician assistant.
Civil Money Penalties for False Statements or Delaying Inspections (HR 3590, Sec. 6408)	Provides for enhanced civil monetary penalties for submission of false claims data under a federal health care program, and imposes financial penalties for failure to grant the OIG timely access to documents, for the purpose of audits, investigations, evaluations, or other statutory functions.	January 1, 2010: This provision is effective with respect to acts committed on or after this date	Individuals who knowingly make, use, or cause to be made or used, any false statement to a federal health care program would be subject to a CMP of $50,000 for each violation, and such acts are grounds for permissive exclusion from further participation in federal health care programs.
Enhanced Civil Money Penalties for MA and Part D plans (HR 3590, Sec. 6408)	This section imposes sanctions and CMPs on Part C Medicare Advantage plans or Part D plans that (1) enroll individuals in an MA or Part D plan without their consent (2) transfer an individual from one plan to another for the purpose of earning a commission, (3) fail to comply with marketing requirements and CMS guidance or (4) employ or contract with an individual or entity that commits a violation.	January 1, 2010: These enhanced penalties are effective	Penalties for Part C and Part D plans that misrepresent or falsify information would be increased to up to three times the amount claimed by a plan or plan sponsor, based on the misrepresentation or falsified information.

Expansion of the Recovery Audit Contractor Program to Medicaid (HR 3590, Sec. 6411)	Expands the Recovery Audit Contractor Program (RAC) program to Medicaid by amending state plans to require states to contract with one or more RACs to identify underpayments and overpayments and recoup overpayments for Medicaid.	December 31, 2010: States must have programs contracting with recovery audit contractors by this date	States are required to contract with RACs by December 31, 2010 for their Medicaid plans.
Expansion of the Recovery Audit Contractor Program to Medicare (HR 3590, Sec. 6411)	Expands the RAC program to Medicare Parts C and D by requiring the Secretary to contract with RACs to, among other things, ensure that each Part C Medicare Advantage plan and each Part D prescription drug plan has an anti-fraud plan in effect, and to review the effectiveness of such a plan.	December 31, 2010: HHS must contract with RACs for Medicare Parts C and D by this date	HHS must contract with RACs by December 31, 2010 for Medicare Parts C and D.
Medicaid provider participation (HR 3590, Sec. 6501)	Providers are to be terminated from participation in Medicaid if the entity has been terminated by Medicare or another state Medicaid program, unless either: (1) the Secretary waives the exclusion, or (2) such an exclusion would impose a hardship on the ability of individuals to receive benefits.	January 1, 2011: These provisions will be effective	States must terminate provider participation under Medicaid if the provider has been terminated by Medicare or another state Medicaid program.
Expanded MSIS reporting (HR 3590, Sec. 6504)	This section amends state requirements for electronic transmission of claims data consistent with the Medicaid Statistical Information System (MSIS) to also require data elements that the Secretary determines are necessary for program integrity, oversight and administration.	January 1, 2010: This provision applies to data submitted beginning on this date	States must submit expanded data elements under MSIS, as determined by the Secretary of HHS, that is necessary for program integrity, oversight and administration
Prohibition on Medicaid payments	Payments for any items or services provided under the Medicaid state plan or under a waiver may not be made	January 1, 2011: These provisions will be effective	Prohibits states from making payments for Medicaid services to entities or financial

outside of the US (HR 3590, Sec. 6505)	to any financial institution or entity located outside the United States.		institutions outside the United States.
Collection of Overpayments due to fraud (HR 3590, Sec. 6506)	This section extends the time under which states can recover overpayments before a federal adjustment is made from 60 days to one year, in the case of fraud. If recovery of overpayments does not occur within one year due to a judgment being under appeal, no adjustment will be made to state payments until 30 days after the judgment is finalized.	March 23, 2010: This section applies to overpayments discovered on or after this date	The Secretary will issue regulations requiring states to correct federally identified overpayments of an ongoing or recurring nature with the new Medicaid Management Information System (MMIS).
Mandatory State use of national correct coding initiative (HR 3590, Sec. 6507)	Requires states to incorporate compatible methodologies of the National Correct Coding Initiative used for Medicare and other methodologies identified by the Secretary to promote proper coding.	September 1, 2010: The methodologies will have been identified October 1, 2010: Claims filed on or after this date must incorporate these methodologies	The Secretary will be responsible for identifying Initiative methodologies compatible with Medicaid claims, and for identifying methodologies that should be incorporated into Medicaid claims for which no Medicare coding methodologies have been established, and for notifying states of these methodologies and how to incorporate them into Medicaid claims.
ELDER JUSTICE ACT			
Elder Justice Coordinating Council (HR 3590, Sec. 6703)	Establishes an Elder Justice Coordinating Council within HHS to make recommendations to the Secretary on the coordination of activities of HHS, DOJ, and other relevant federal, state, local, and private agencies and entities relating to elder abuse, neglect, and exploitation and other crimes against elders.	March 23, 2012: Within two years after the enactment, and every two years after that, the Council will submit a report to Congress describing the Council's activities, accomplishments, challenges and recommendations. There are authorized to be appropriated such sums as are necessary to carry out this section.	The Council will be comprised of the Secretary of HHS, the Attorney General, and the head of each federal department or agency that has responsibilities or administers programs relating to elder abuse, neglect and exploitation.

Advisory Board on Elder Abuse, Neglect and Exploitation (HR 3590, Sec. 6703)	Establishes an Advisory Board on Elder Abuse, Neglect and Exploitation. The Board is to create both short and long-term multidisciplinary strategic plans for the development of the field of elder justice, and to make recommendations to the Elder Justice Coordinating Council.	September 23, 2011: Within 18 months after the enactment, the Board will develop a report to Congress and the Elder Justice Coordinating Council. There are authorized to be appropriated such sums as are necessary to carry out this section.	The Advisory Board is to be composed of 27 members appointed by the Secretary from among members of the general public with expertise in elder abuse, neglect, exploitation prevention, detection, treatment, intervention, or prosecution.
Elder Abuse, Neglect and Exploitation Forensic Centers (HR 3590, Sec. 6703)	Establishes a grant program to establish and operate stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, abuse, neglect and exploitation.	FY11: $4 million is authorized FY 12: $6 million is authorized FY13: $8 million is authorized FY14: $8 million is authorized	The Secretary will award four grants to institutions of higher education to establish and operate stationary forensic centers. Six of the grants will be awarded to appropriate entities to establish and operate mobile forensic centers.
Enhancement of Long-Term Care (HR 3590, Sec. 6703)	The Secretary will provide eligible entities with grants to enhance long-term care staffing through training and recruitment incentives for individuals seeking or maintaining employment in long-term care, either in a facility or a community based long-term care entity.	FY11: $20 million is authorized FY12: $17.5 million is authorized FY13: $15 million is authorized FY14: $15 million is authorized	Eligible entities include (1) long-term care facilities and (2) community based long-term care entities, the latter of which will be defined by the Secretary.
Grants to enhance the provision of APS (HR 3590, Sec. 6703)	Authorizes the first dedicated federal funding stream for state and local Adult Protective Services (APS) offices that investigate reports of the abuse, neglect, and exploitation of elders. The Secretary will award grants to states for the purposes of enhancing APS provided by state and local governments.	FY11 – FY14: $100 million per year for four years, $400 million total is authorized for adult protective services	The APS grants will be awarded to states. In coordination with the Department of Justice, grantee states must collect and disseminate data relating to elder abuse.
State APS Demonstration Programs	The Secretary is authorized to award grants to states for the purposes of conducting demonstration programs that test training modules developed to	FY11 – FY14: $25 million annually for four years, $100 million total, is authorized for state demonstration grants to test a variety	Eligible entities for these grants include states submitting applications in accordance with the Secretary's

(HR 3590, Sec. 6703)	detect or prevent elder abuse, financial exploitation, and other matters relating to the detection or prevention of elder abuse.	of methods to improve APS.	requirements.
Grants to support the Long-Term Care Ombudsman Program Grants (HR 3590, Sec. 6703)	The law authorizes the Secretary to make grants to eligible entities for the purposes of (1) improving the capacity of the ombudsman programs to respond to and resolve complains (2) conducting pilot programs with state long-term care ombudsman offices, and (3) providing support for ombudsman programs, such as through the establishment of a National Long-Term Care Ombudsman Resource Center.	FY11: $5 million is authorized FY12: $7.5 million is authorized FY13: $10 million is authorized FY14: $10 million is authorized	Eligible entities must have relevant expertise and experience in abuse and neglect in long-term care facilities or long-term care ombudsman programs.
Grants to support Long-Term Care Ombudsman Training Programs (HR 3590, Sec. 6703)	The Secretary will establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and state long-term care ombudsman programs	FY11 – FY14: $10 million annually for four years, $40 million total, is authorized for ombudsman training programs	These programs will improve the ombudsman training for both national and state organizations.
National Training Institute for Surveyors (HR 3590, Sec. 6703)	The Secretary is authorized to contract with an entity to establish and operate National Training Institute for federal and state surveyors. This Institute will provide and improve the training of surveyors with respect to investigating allegations of abuse, neglect, and misappropriation.	FY11 – FY14: $12 million is authorized to carry out this section, for the four year period	The entity with whom the Secretary contracts will, among other things, (1) assess the roles of surveyors within state agencies, (2) evaluate surveyor competency and recommend improvements, (3) conduct surveyor trainings, (4) distribute best practices, (5) evaluate state complaint intake systems, and (6) operate a back-up system to state intake systems.
Grants to State	The Secretary is authorized to make grants to state	FY11 – FY14: $5 million annually for four	Grantees will use these awards to, among

Survey Agencies (HR 3590, Sec. 6703)	agencies that perform surveys of SNFs and NFs.	years, $20 million total, is authorized to carry out this section	other things, optimize the collaboration between local authorities, consumers and providers, including (1) the grantee state agency (2) the state long-term care ombudsman (3) local law enforcement agencies, (4) advocacy and consumer organizations, (5) state aging units, (6) area agencies on aging, and (7) other appropriate entities.
Reporting Crimes to Law Enforcement (HR 3590, Sec. 6703)	Requires the immediate reporting to law enforcement of crimes in long-term care facilities that annually receive at least $10,000 in federal funding, which includes virtually all nursing facilities and some assisted living facilities. If there is a reasonable suspicion of a crime committed against a resident of a long-term care facility, a report must be made to CMS and to law enforcement, within 24 hours, or within two hours if the crime resulted in serious bodily injury.	March 23, 2010: These provisions were effective upon enactment	The owner or operator of each long-term care facility that receives federal funds under the Social Security Act will be responsible for determining if the facility received at least $10,000 in such federal funds during the preceding year. If so, the owner must notify each individual who is an owner, operator, employee, manager, agent or contractor of the long-term care facility of that individual's obligation to comply with the reporting requirements.
National Nurse Aide Registry (HR 3590, Sec. 6703)	The Secretary will conduct a study on establishing a national nurse aide registry. The study will include, among other things, an evaluation of who should be included in the registry, how such a registry would comply with privacy laws, how data would be collected, and how the functions of the registry would be coordinated with the nationwide background checks.	September 23, 2011: Within 18 months of enactment, CMS must submit a report on the study. Funding for the study will not exceed $500,000	After receiving the report, the appropriate Senate and House Committees will, as they deem appropriate, take action based on the report's recommendations.

Please note that NASUAD's analysis of The Affordable Care Act will be updated as additional information becomes available.