A Summary of the Patient Protection and Affordable Care Act (P.L. 111-148) and Modifications by the Health Care and Education Reconciliation Act of 2010 (H.R. 4872)

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (H.R. 3590, P.L. 111-148), which was passed by the Senate on December 24, 2009 and by the House on March 21, 2010. Following closely on its heels was the Health Care and Education Reconciliation Act of 2010, which makes changes to the Patient Protection and Affordable Care Act. The reconciliation bill was passed by both houses of Congress on March 25, 2010 and signed into law by the President on March 30, 2010. This Policy Brief presents an analysis of the Patient Protection and Affordable Care Act, covering those elements that provide support for the continuum of care for seniors. The Health Care and Education Reconciliation Act of 2010 modified a few provisions in the health reform law specific to the continuum of care, and these modifications are noted where relevant.

The organizing framework for this analysis includes the following concepts about the continuum of care: 1) support the rebalancing of the long-term services and supports (LTSS) available to seniors toward home and community-based services; 2) improve the coordination of health and supportive services, especially for those with chronic illnesses; 3) improve access to medications and reduce the cost burden on seniors; 4) reinforce the existing workforce and establish initiatives to grow the workforce that serves seniors, including direct care workers; and 5) strengthen quality and consumer protections for seniors.

	The Patient Protection and Affordable Care Act (Public Law 111-148)	Health Care and Education Reconciliation Act of 2010 (H.R. 4872)
Dates Introduced & Passed	*Announced: November 18, 2009; Passed by Senate: December 24, 2009; Passed by House: March 21, 2010; Signed into Law: March 23, 2010*	*Introduced March 18, 2010; Passed by House: March 21, 2010; Passed by Senate with Revisions: March 25, 2010; Revised Bill Passed by House: March 25, 2010; Signed into Law: March 30, 2010*
1. Bolstering Supportive Services Delivered at Home and in the Community		
Community Living Assistance Services and Supports (CLASS) plan	Establishes a new public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. • Financed by voluntary payroll deductions or contributions from all eligible adults • Those eligible to enroll are actively employed (including self-employed) adults age 18 and older • Automatic enrollment with an opt-out option; if an employer does not elect to deduct and withhold premiums on behalf of an employee, an alternate payment mechanism will be available for an eligible individual • 5-year vesting period • Enrollees will be eligible for benefits after meeting specified disability criteria (functional and/or cognitive impairment that is expected to last for 90 days or more and is certified by a licensed health care practitioner) • Upon determination of eligibility, a cash benefit will be paid based on functional ability, averaging not less than $50 per day, with no lifetime or aggregate limit • Secretary is required to establish premiums to ensure solvency for 75 years	No changes made.

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	• Medicaid enrollees receiving home and community-based services (HCBS) or Program for All Inclusive Care of the Elderly (PACE) would retain 50 percent of their cash benefit while living in the community • Medicaid enrollees in institutions would retain 5 percent of their cash benefit • Premium subsidies would be available for eligible individuals ages of 18 to 22 who are full-time students while working or for any individual with income below the poverty line • Self-employed individuals could enroll • The CLASS program will be treated in the same manner as a qualified long-term care insurance policy • No taxpayer funds (e.g., Federal funds from any source other than from premiums collected in the CLASS program) will be used to pay benefits under this provision. • The Secretary must establish an eligibility assessment system by January 1, 2012 and designate the benefit plan by October 1, 2012. (Title VIII, Sec. 8002)	
Community First Choice Option	Establishes a Medicaid State Plan Option to provide a community-based attendant services and supports benefit to those who meet the state's nursing facility clinical eligibility standards. • Provides 6 percentage point increase in FMAP to States choosing this option • States would be authorized to provide community transitions support (e.g., rent/utility deposits, first month's rent and utilities, bedding, basic kitchen supplies) to institutionalized individuals who meet the eligibility criteria. • Effective start date was October 1, 2010. (Title II, Subtitle E, Sec. 2401)	The Reconciliation Bill changed the implementation start date to October 1, 2011. (Title I, Subtitle C, Sec. 1205)
Removal of Barriers to Providing Home and Community-Based Services	Amends Section 1915(i) of the Social Security Act to remove barriers to providing HCBS by giving States the option to provide more types of HCBS through a State Plan amendment to individuals with higher levels of need, rather than through waivers. • Requires "State-wideness" of the HCBS State Plan benefit • Prohibits States from setting caps on the number of individuals who receive coverage for the benefit • Enables States to target benefits to individuals with selected conditions if the State wishes • Individuals receiving coverage under the State Plan are grandfathered into services if the criteria for eligibility are modified for as long as their condition meets the previous criteria. • Effective on the first day of the first fiscal year quarter that begins after the date of enactment of this Act. (Title II, Subtitle E, Sec. 2402)	No changes made.
Money Follows the Person Rebalancing Demonstration	Extends the Money Follows the Person Rebalancing Demonstration, originally authorized in the DRA, through September 30, 2016. Modifies eligibility rules, which originally required that individuals reside in facility for not less than 6 months, by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days. Amendments effective 30 days after enactment of this Act. (Title II, Subtitle E, Sec. 2403)	No changes made.

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Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment	Requires States to apply spousal impoverishment rules to beneficiaries who receive HCBS. This provision would apply for a five-year period beginning on January 1, 2014. (Title II, Subtitle E, Sec. 2404)	No changes made.
Funding to Expand State Aging and Disability Resource Centers	Appropriates to the Secretary of HHS $10 million for each of FYs 2010 through 2014 to carry out Aging and Disability Resource Center (ADRC) initiatives provided in the Older Americans Act. (Title II, Subtitle E, Sec. 2405)	No changes made.
Sense of the Senate Regarding Long-Term Care	Expresses the *Sense of the Senate* that during the 111th Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need, in the community as well as in institutions. (Title II, Subtitle E, Sec. 2406)	No changes made.
Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes	Creates the State Balancing Incentive Payments Program with new financial incentives for States to shift Medicaid beneficiaries out of nursing homes and into home and community-based services. • Eligible States are those that spend less than 50 percent of total expenditures for LTSS on services in the home or community • The Secretary may determine among the States that apply and qualify which will participate • Qualifying States with less than 25 percent of total LTSS expenditures for HCBS will receive a 5 percentage point increase in FMAP; States with 25-50 percent will receive a 2 percentage point increase • As part of this provision, States may increase the income eligibility for HCBS • Requires qualifying States to establish a statewide "No wrong door – single entry point system" to enable consumer to access LTSS • Requires qualifying States to develop case management services to assist in the development of a service plan for beneficiaries and for family caregivers; also provide case management to support the transition from institutional to community-based services • Allocates up to $3 billion for Medicaid HCBS. (Title X, Subtitle B, Part I, Sec. 10202)	No changes made.
2. Improving Coordination of Health Care and Supportive Services		
Building Infrastructure for Program and Policy Development		
Medicaid and CHIP Payment and Access Commission (MACPAC)	Clarifies the topics to be reviewed by the Medicaid and CHIP Payment and Access Commission (MACPAC) including: • Medicaid and CHIP enrollment and retention processes, coverage policies, quality of care, how interactions of policies between Medicare and Medicaid affect access to services, payments, and dually-eligible individuals, and additional reports of State specific data • Authorizes $11 million to fund MACPAC for FY2010. (Title II, Subtitle J, Sec. 2801)	No changes made.
Improved Coordination and Protection for Dual Eligibles	Requires the Secretary to establish a Federal Coordinated Health Care Office (CHCO) within the Centers for Medicare and Medicaid Services (CMS) by March 1, 2010. The purpose of the CHCO will be to bring together officials of the Medicare and Medicaid programs to: • More effectively integrate benefits under those programs, and • Improve the coordination between the federal and state governments for individuals eligible for	No changes made.

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	benefits under both Medicare and Medicaid (dual eligibles) to ensure that dual eligibles have full access to the items and services to which they are entitled. • The goals of the CHCO are: o Provide dual eligibles full access to benefits to which they are entitled under Medicare and Medicaid; o Simplify the process by which dual eligibles access services; o Improve the quality of health and long-term care services for dual eligibles; o Increase dual eligibles understanding of and satisfaction with coverage; o Eliminate regulatory conflicts between Medicare and Medicaid; o Improve care continuity for dual eligibles; o Eliminate cost shifting between Medicare and Medicaid and among related health care providers; and o Improve the quality of performance of providers under Medicare and Medicaid. • Specific responsibilities include: o Provide States, Special Needs Plans, and providers with education and tools to align Medicare and Medicaid benefits; o Support State efforts to coordinate and align acute and long-term care services for dual eligibles; o Provide support for coordination, contracting and oversight by States and CMS with respect to integrating Medicare and Medicaid; o Consult and coordinate with MedPAC and MACPAC regarding relevant policies; o Study the provision of drug coverage for new full-benefit dual eligibles and monitor and report total annual expenditures, outcomes and access to benefits for dual eligibles; and o Submit an Annual Report to Congress with recommendations for legislation to improve care coordination and benefits for dual eligibles. • Effective March 1, 2010. (Title II, Subtitle H, Sec. 2602)	
Establishment of Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS)	Establishes within CMS a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare as well as payment reform models. Successful models can be expanded nationally. Requires the Secretary to focus on models that both improve quality and reduce costs. Effective January 1, 2011. (Title III, Subtitle A, Part 3, Sec. 3021)	No changes made.
Demonstration Programs and New Delivery Models		
Accountable Care Organizations	Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time. • ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others)	No changes made.

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	• ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program. • Offers the Secretary the flexibility to consider a partial capitation model (where the ACO is at financial risk for some, but not all, services) or other payment models, including those used by private payors. • Shared savings program effective January 1, 2012. (Title III, Subtitle A, Part 3, Sec. 3022)	
Medical Homes	Creates a program to establish and fund the development of community health teams to support the development of medical homes for persons with chronic conditions by increasing access to comprehensive, community-based, coordinated care. Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016. (Title III, Part 3, Subtitle F, Sec. 3502) Provides States the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination. Provides states taking up the option with 90 percent FMAP for two years. Effective January 1, 2011. (Title II, Subtitle I, Sec. 2703)	No changes made.
Independence at Home Demonstration Program	Creates a new demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes. Effective January 1, 2012. (Title III, Subtitle A, Part 3, Sec. 3024)	No changes made.
Implementation of Medication Management Services in Treatment of Chronic Disease	Establishes a new program to implement medication therapy management (MTM) services provided by licensed pharmacists as part of a collaborative approach to the treatment of chronic diseases with the aim of improving quality of care and reducing overall costs of care in the treatment of such diseases. Requires an annual comprehensive medication review by a licensed pharmacist or other qualified provider and follow-up interventions based on the findings of the annual review. Also requires the prescription drug plan sponsor to have a process in place to assess the medication use of individuals who are risk but not enrolled in the MTM program, including individuals who have experienced a transition in care. Plans must also enroll beneficiaries who qualify on a quarterly basis with an opt-out provision. Effective May 1, 2010. (Title III, Part 3, Subtitle F, Sec. 3503)	No changes made.
Community-Based Care Transitions Program	Provides funding to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission. Effective January 1, 2011. (Title III, Subtitle A, Part 3, Sec. 3026)	No changes made.
Medicare Hospice Concurrent Care Demonstration Program	Directs the Secretary to establish a three-year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare covered services during the same period of time. The demonstration would be conducted in up to 15 hospice programs in both rural and urban areas and would evaluate the impacts of the demonstration on patient care, quality of life and spending in the Medicare program. (Title III, Subtitle B, Part 3, Sec. 3140)	No changes made.
Patient Navigator Program	Reauthorizes demonstration programs to provide patient navigator services within communities to assist patients in overcoming barriers to health services. Program facilitates care by assisting individuals in coordinating health services and provider referrals; and assists community	No changes made.

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	organizations in helping individuals receive better access to care, providing information on clinical trials, and conducting outreach to health disparity populations. Authorizes $3.5 million for FY2010 and allocating funds as needed for FY2011 through FY2015. (Title III, Part 3, Subtitle F, Sec. 3510)	
Payment Reform – Bundling	Directs the Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. • Covers Medicare beneficiaries who are hospitalized for one of ten conditions (a mix of chronic and acute) • Requires the Secretary to establish this program by January 1, 2013 for a period of five years • Before January 1, 2016, the Secretary is also required to submit a plan to Congress to extend the pilot program if doing so will improve patient care and reduce spending. (Title III, Subtitle A, Part 3, Sec. 3023) Establishes a demonstration project, in up to eight States, to study the use of bundled payments for hospital and physicians services under Medicaid. The demonstration will begin by January 1, 2012 through December 31, 2016. (Title II, Subtitle I, Sec. 2704)	No changes made.
Extension of Special Needs Plan (SNP) Program	Extends the SNP program through December 31, 2013 and requires SNPs to be National Committee for Quality Assurance (NCQA) approved. • Allows HHS to apply a frailty payment adjustment to fully-integrated, dual-eligible SNPs that enroll frail populations • Requires HHS to transition beneficiaries to a non-specialized Medicare Advantage plan or to original fee-for-service Medicare who are enrolled in SNPs that do not meet statutory target definitions and requires dual-eligible SNPs to contract with State Medicaid programs beginning 2013 • Also requires an evaluation of Medicare Advantage risk adjustment for chronically ill populations. (Title III, Subtitle C, Sec. 3205)	No changes made.
Medicare Senior Housing Plans	Allows demonstration plans that serve residents in continuing care retirement communities to operate under the Medicare Advantage program. Effective January 1, 2010. (Title III, Subtitle C, Sec. 3208)	No changes made.
New Benefits Supporting Care Coordination		
Medicare Coverage of Annual Wellness Visit	Provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services. • Such services would include a comprehensive health risk assessment • A personalized prevention plan would take into account the findings of the health risk assessment and include elements such as: a five- to ten-year screening schedule; a list of identified risk factors and conditions and a strategy to address them; and health advice and referral to education and preventive counseling or community-based interventions to address modifiable risk factors such as physical activity, smoking, and nutrition. • Effective January 1, 2011. (Title IV, Subtitle B, Sec. 4103)	No changes made.

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3. Improve Medicare Part D Access and Reduce the Medication Cost Burden		
Reduction or Elimination of the Coverage Gap in Medicare Part D	Increases the initial coverage limit in the standard Part D benefit by $500 for 2010, thus decreasing the time that a Part D enrollee would need to be in the coverage gap. This provision applies only to 2010; the initial coverage limit for subsequent years will be separately determined. (Title III, Subtitle D, Sec. 3315)	This section was repealed by the Reconciliation Bill. (Title I, Subtitle B, Sec. 1101)
Medicare Coverage Gap Discount Program	Requires drug manufacturers to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010. (Title III, Subtitle D, Sec. 3301)	This section is further amended to include: • Provides a $250 rebate to Medicare beneficiaries who reach Part D coverage gap in 2010 (Effective January 1, 2010) • Gradually phases down the coinsurance rate in the Medicare Part D coverage gap from 100 percent to 25 percent by 2020 • For brand name drugs, requires pharmaceutical manufacturers to provide a 50 percent discount on prescriptions filled in the coverage gap (Effective January 1, 2011), in addition to federal subsidies of 25 percent of the brand-name drug cost by 2020 (Phased in beginning January 1, 2013) • For generic drugs, provides federal subsidies of 75 percent of generic drug cost by 2020 for prescriptions filled in coverage gap (Phased in starting in 2011) (Title I, Subtitle B, Sec. 1101)
Improved Assistance to Low-Income Subsidy (LIS) Beneficiaries	The following sections improve access to Medicare Part D plans for LIS beneficiaries and beneficiary outreach and education activities. • Allows Part D plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark to absorb the cost of the difference between their bid and the LIS benchmark in order to remain a $0 premium LIS plan. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3303) • Allows the surviving spouse of an LIS-eligible couple to delay LIS redetermination for one year after the death of a spouse. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3304) • Requires HHS, beginning in 2011, to transmit formulary and coverage determination information to subsidy-eligible beneficiaries who have been automatically reassigned to a new Part D low-income subsidy plan. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3305) • Provides $45 million for outreach and education activities to State Health Insurance Programs, Administration on Aging, Aging Disability Resource Centers and the National Benefits Outreach and Enrollment beginning FY2009. (Title III, Subtitle D, Sec. 3306)	No changes made.

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Elimination of Part D Cost-Sharing for Selected Non-Institutionalized Dual Eligible Individuals	Eliminates Part D cost sharing for people receiving care under a home and community-based waiver who would otherwise require institutional care. (Title III, Subtitle D, Sec. 3309)	No changes made.
4. Enhancing and Revitalizing the Health and Supportive Service Workforce		
Demonstration Project to Address Health Professions Workforce Needs	• Establish a demonstration program to offer low income individuals the opportunity to obtain training and education for occupations in the health care field that are expected to experience labor shortages or be in high demand. • Requires the Secretary to establish demonstration programs in up to 6 States for no less than 3 years through competitive grants for purposes of developing core competencies, pilot training curricula, and develop certification programs for personal and home care aides. • Appropriates $85 million for 5 years (FY 2010-2014), no more than $5 million per year (FY 2010-2012) allocated for the personal and home care aide demonstration (Title V, Subtitle F, Sec. 5507)	No changes made.
Training Opportunities for Direct Care Workers	Establishes grants to eligible entities to provide advanced training opportunities for direct care workers employed in long-term care settings (including nursing homes, assisted living facilities, intermediate-care facilities, and home and community-based settings). • Funds are to be allocated in the form of tuition or fee support for eligible individuals • A condition of receiving assistance is that participating individuals agree to work in the fields of geriatrics, disability services, long term services and supports, or chronic care management for at least 2 years following completion of training • This provision authorizes $10 million for FY 2011-2013 for these grants. (Title V, Subtitle D, Sec. 5302)	No changes made.
Expanding Physician Assistants' Role in Medicare	Authorizes physician assistants to order skilled nursing facility care. This provision is effective starting January 1, 2011. (Title III, Subtitle B, Part 1, Sec. 3108)	No changes made.
Payment Incentives for Selected Primary Care Services	Increases the Medicare payment rate by 10 percent to primary care practitioners for primary care services. • Primary care practitioners are those with a family, internal, geriatric, or pediatric medicine and for whom primary care services account for at least 60 percent of allowed charges (Effective FY 2011-2016). (Title V, Subtitle F, Sec. 5501)	No changes made.
Geriatric Education and Training; Career Awards; Comprehensive Geriatric Education	Authorizes $10.8 million for FY 2011 to FY 2014 for geriatric education centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools, direct care workers, and family caregivers. • Funds are allocated to develop curricula and best practices in geriatrics focusing on mental health, medication safety, and communication skills in dementia care • These funds also expand the geriatric career awards to advanced practice nurses, clinical social workers, pharmacists, and psychologists; create a parallel geriatrics career incentive award program for Master's level candidates; and establish traineeships for individuals who are	No changes made.

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	preparing for advanced education nursing degrees in geriatric nursing. (Title V, Subtitle D, Sec. 5305)	
Health Workforce Evaluation and Assessment	• Establishes a national commission tasked with reviewing health care workforce and projected workforce needs. The overall goal of the Commission is to provide comprehensive, unbiased information to Congress and the Administration about how to align Federal health care workforce resources with national needs. Congress will use this information when providing appropriations to discretionary programs or in restructuring other Federal funding sources. Appointments to be made by September 20, 2010. (Title V, Subtitle B, Sec. 5101) • Codifies existing national center and establishes several state and regional centers for health workforce analysis to collect, analyze, and report data related to Title VII (Public Health Service Act) primary care workforce programs. The centers will coordinate with State and local agencies collecting labor and workforce data and coordinate and provide analyses and reports on Title VII to the Commission. Authorizes $7.5 million for each fiscal year 2010 through 2014 to carry out activities of the National Center. Also authorizes $4.5 million for each fiscal year 2010 through 2014 to carry out the activities of the state and regional centers. (Title V, Subtitle B, Sec. 5103)	No changes made.
5. Strengthening Quality and Consumer Protections		
Improving Transparency of Information on Skilled Nursing Facilities, Nursing Facilities, and Other Long-Term Care Facilities		
Required Disclosure of Ownership and Additional Disclosable Parties	Requires skilled nursing facilities (SNFs) and nursing facilities (NFs) to disclose information on ownership and facility organizational structure and requires the Secretary of HHS to develop a standardized format for such information within two years of date of enactment. Final regulations must be promulgated within 2 years following the enactment of this Act. Information will be publicly available one year following the publication of final regulations. (Title VI, Subtitle B, Part 1, Sec. 6101)	No changes made.
Accountability Requirements for SNFs and NFs	Requires SNFs and NFs to operate compliance and ethics programs on or after the date that is 36 months after enactment. Directs the Secretary to develop a quality assurance and improvement program for SNFs and NFs no later than December 31, 2011. (Title VI, Subtitle B, Part 1, Sec. 6102)	No changes made.
Nursing Home Compare Medicare Website	Directs the Secretary to publish the following information on the Nursing Home Compare Medicare website: standardized staffing data, links to state internet websites regarding state survey and certification programs, the model standardized complaint form, a summary of substantiated complaints, and the number of adjudicated instances of criminal violations by a facility or its employee. Each informational element shall be published on the website one year after the date of enactment of the relevant subsection of the bill. (Title VI, Subtitle B, Part 1, Sec. 6103)	No changes made.
Reporting of Expenditures	Requires SNFs to separately report expenditures for direct care staffing services, indirect care services, capital assets, and administrative costs on cost reports for cost reporting periods. • Requires Secretary to redesign the SNF cost report to meet the needs of this section no later than 1 year following enactment • Effective on or after two years following redesign of the cost report. (Title VI, Subtitle B, Part 1, Sec. 6104)	No changes made.

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Standardized Complaint Form	Directs the Secretary to develop a standardized complaint form for use by residents or a person acting on a resident's behalf in filing complaints with a State survey and certification agency and a State long-term care ombudsman program. • States would also be required to establish complaint resolution processes. • Effective one year after the date of enactment of this Act. (Title IV, Subtitle B, Part 1, Sec. 6105)	No changes made.
Ensuring Staffing Accountability	Requires the Secretary to develop a program for facilities to report staffing information in a uniform format based on payroll data, and to also take into account services provided by any agency or contract staff. Effective two years after the date of enactment of this Act. (Title IV, Subtitle B, Part 1, Sec. 6106)	No changes made.
GAO Study and Report on Five-Star Quality Rating System	Requires the Government Accountability Office to conduct a study on the Five-Star Quality Rating System which would include an analysis of the systems implementation and any potential improvements to the system. A Report to Congress is due two years after the date of enactment of this Act. (Title IV, Subtitle B, Part 1, Sec. 6107)	No changes made.
National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes	Requires the Secretary to conduct two facility-based demonstration projects that would develop best practice models in two areas: • To identify best practices in facilities that are involved in the "culture change" movement, including the development of resources where facilities may be able to access information in order to implement culture change; and • To develop best practices in information technology that facilities are using to improve resident care. • The demonstration projects shall be implemented no later than one year following the date of enactment of this Act. The demonstration projects shall be conducted for a period not to exceed three years. (Title IV, Subtitle B, Part 2, Sec. 6114)	No changes made.
Dementia and Abuse Prevention Training	Permits the Secretary to require SNFs and NFs to conduct dementia management and abuse prevention training in pre-employment training programs, and, if the Secretary determines appropriate, as part of ongoing training. Effective one year after the date of enactment of this Act. (Title IV, Subtitle B, Part 3, Sec. 6121)	No changes made.
Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers	Establishes a national program for long term care facilities and providers to conduct screening and criminal and other background checks on prospective direct access patient employees. Authorizes an amount not to exceed $160 million for the period FY2010 to FY2012. (Title IV, Subtitle C, Sec. 6201)	No changes made.
Other Quality Provisions		
Elder Justice	Establishes advisory capacity and grants to further elder justice providing for the following: • An Elder Justice Coordinating Council within the Office of the Secretary that will make recommendations to the Secretary, coordinating with the Department of Justice and other	No changes made.

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	relevant federal, state, local, and private agencies and entities related to elder abuse, neglect, exploitation and other crimes against elders • Establishes an Advisory Board on Elder Abuse, Neglect and Exploitation to create strategic plans around elder justice in long-term care • Grants to eligible entities to establish elder abuse, neglect and exploitation forensic centers • Awards grants and carry out activities that provide greater protection to those individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities. (Title VI, Subtitle H, Sec. 6703)	

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