Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Clinical Standards and Quality/Survey & Certification Group

Nationwide Program for National and State Background Checks

for

Direct Patient Access Employees of Long Term Care Facilities and Providers

Ninth Announcement CFDA # 93.506

Funding Opportunity Number: CMS-1A1-13-002

Competition ID: CMS-1A1-13-002-017299

Applications will be accepted on a flow basis and acted on every 30 days

Background Check Questions and Answers Available at:
https://www.cms.gov/SurveyCertificationGenInfo/Downloads/backgroundcheckqanda.pdf

May 2013

TABLE OF CONTENTS

CHAPTER		PAGE
Executive Summary		3
Timetable		4
I.	Funding Opportunity Description	5
II.	Award Information	6
III.	Eligibility Information	7
IV.	Application and Submission Criteria	8
V.	Application Review Information	16
VI.	Award Administration Information	19
VII.	Agency Contact	21

APPENDICES

Appendix 1 - Statutory Provisions, Section 6201 of the Affordable Care Act of 2010
Appendix 2 - Program Narrative Requirements/Components of a Background Check Program
Appendix 3 - Sample Work Plan and Timeline
Appendix 4 - Sample Flow Diagram
Appendix 5 - Sample Budget Forms
Appendix 6 - Section 307 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003
Appendix 7 - Definitions Applicable to this Solicitation
Appendix 8 - Resource Information Related to Non-Federal Match
Appendix 9 - Application Submission Checklist

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) is inviting proposals from States and U.S. territories to be considered for inclusion in the legislatively mandated National Background Check Program.

CMS is conducting a nationwide program that will identify efficient, effective and economical procedures for long term care facilities and providers to conduct background checks on prospective direct patient/resident access employees. Eligible facilities and providers include skilled nursing facilities, nursing facilities, home health agencies, hospice care providers, long-term care hospitals, personal care service providers, adult day care providers, residential care providers, assisted living facilities, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) and other entities that provide long-term care services, as specified by each participating State.

The State Office of the Governor, State Medicaid Agency, or the State Survey Agency may apply for funding under this grant opportunity. CMS will accept only one application per State; therefore we encourage State offices and agencies to work collaboratively to develop one application packet when deemed appropriate. If more than one application is received for one State, CMS reserves the right to determine which application to select. Successful applicants will receive a Notice of Award (NOA) from the CMS Grant Management Officer approximately 60 days after the application due date. Grantees will receive funding through a 36-month project/budget period.

In order to participate in this nationwide program, a State must guarantee that it will make available non-Federal funds to cover a portion of the cost to be incurred by the State to carry out the Program in their State. The participating State must make available non-Federal contributions as a condition of receiving the Federal match under this Agreement. CMS will provide Federal grant funds to each *newly* participating State that enters into this Agreement with CMS at a rate which will be three times the amount that the State guarantees, not to exceed $3 million dollars in Federal funds from the beginning of the award period through a 36-month project/budget period. CMS will provide Federal grant funds to each *previously* participating State that enters into this agreement with CMS at a rate that will be three times the amount that the State guarantees, not to exceed $1.5 million dollars in Federal funds from the beginning of the award period through a 36-month project/budget period.

This grant is not competitive. All States submitting an application that is scored by the Federal technical evaluation panel at 70.2 out of the possible 101 points or greater shall receive a grant. Applications that score below 70.2 points will not be included as grantees. In addition to the minimum score all applicants must meet all statutory requirements as described in section 6201 of the Patient Protection and Affordable Care Act (Affordable Care Act).

TIMETABLE

MILESTONE	**DATE**
Grant Applications Due to CMS	Applications will be reviewed every 30 days.
Grant Awards – Successful applicants will receive a Notice of Award (NOA) signed and dated by the CMS Grants Management Officer, Office of Acquisition and Grants Management. The Notice Of Award will be sent through the U.S. Postal Service.	Approximately 60 days after application due date.

I. FUNDING OPPORTUNITY DESCRIPTION

1. Introduction

Title VI, Subtitle B, Part III, Subtitle C, section 6201 of the Affordable Care Act directs the Secretary of Health and Human Services (HHS), to establish a nationwide program to identify efficient, effective, and economical procedures for long term care facilities and providers to conduct background checks on a statewide basis on all prospective direct patient access employees. A copy of Section 6201 of the Affordable Care Act of 2010 is included as Appendix 1.

CMS is inviting proposals from all States and U.S. territories to be considered for inclusion in this National Background Check Program. Federal matching funds are available to all States and U.S. territories that meet the requirements described in section 6201 of the Affordable Care Act and that provide an application that is scored at 70.2 out of a possible 101 points by the Federal review panel. The national program will be evaluated by the HHS Office of Inspector General (OIG). CMS has awarded a technical support contract to support the States that are selected to participate in the program. This program announcement provides States information concerning application procedures, policy considerations, and criteria to be used in reviewing applications and selecting States.

2. Background

Since the Omnibus Budget Reconciliation Act passed in 1987, long term care patient abuse, neglect and misappropriation of funds have been identified as a widespread problem for millions of Americans receiving long term care services. Protecting this vulnerable population continues to be a national challenge. Over the years, Congress has initiated several measures to address this challenge. CMS established regulations that prohibit long term care facilities and providers from employing individuals found guilty of abuse, neglect, or misappropriation of patient funds. In 1998 Congress enacted Public Law 105-277 which allows long term care facilities to request the Federal Bureau of Investigation (FBI) search its fingerprint database for criminal history matches. During 2003-2007 CMS piloted a program to evaluate the effectiveness of conducting background checks on prospective employees of long term care facilities and providers who had direct access to patients. The pilot supported the importance of background screening which included fingerprinting for individuals who have direct access to patients of nursing facilities, skilled nursing facilities, home health agencies, hospice care providers, long term care hospitals, long term care residential care providers (including assisted living facilities), personal care services providers, adult day care services providers, intermediate care facilities for individuals with intellectual disabilities and all other long term care providers. The pilot evaluation final report can be found at: https://www.cms.gov/reports/downloads/White8-2008.pdf

3. Key Requirements for State Participation in the National Background Check Program

The specific requirements that applicant States must meet are in accordance with the legislative language and can be found in their entirety in Appendix 1 of this document.

Participating States must guarantee non-Federal funds to cover a portion of the cost to conduct the program in their State. CMS will provide a three-to-one match for State funds to each grantee. The participating State must require fingerprint checks as part of the criminal background check for all direct patient access employees. The participating State must have a plan to implement the program (a) statewide and (b) in all long term care entities specified in section 6201 of the Affordable Care Act. States may phase-in the program over a multi-year period, and the phase-in may be accomplished by geographical location, provider type, or other factors determined by the State. NOTE: Key provider types identified by CMS must be phased-in by the time periods identified in section B.3 of Appendix 3 of this solicitation.

Participating States must ensure background checks include checks of State criminal history records for all relevant States, and the records of any proceedings that may contain disqualifying information (such as licensing and disciplinary boards and State Medicaid Fraud Control Units). According to the stipulations in section 6201, the participating State must require providers to search the abuse registries of all known States in which the employee lived. The background checks must include FBI fingerprint checks. The State must describe and test methods to reduce duplication of fingerprinting including "rap back" capabilities which will include a provision for State law enforcement departments to immediately inform the State of any criminal offenses by the employee that occur following the pre-employment background check. The "rap back" provision requires the State to immediately notify the provider when law enforcement notifies the State that an employee is convicted after the pre-employment background check. Participating States must have a procedure for (1) monitoring provider compliance with the National Background Check Program; (2) providing privacy and security safeguards; and (3) providing an independent dispute/appeal process.

II. AWARD INFORMATION

Funding for this Program shall become effective upon CMS' issuance of Notice of Award. Grants will be awarded to every State that meets the terms of agreement as described in this solicitation. This includes submission of an application that meets all provisions of the Law and scores at least 70.2 out of 101 possible points from the Federal technical panel review. The estimated total amount available for all awards is approximately $140 million. Individual State grant funding will range between $1.5million and $3 million. The anticipated number of awards combined from all solicitations is up to 54 and the expected duration of support is up to 3 years. States will have 36 months from the grant period start date to implement their program. Although

CMS will fully fund grant awards under this program, CMS shall impose drawdown restrictions, as necessary to ensure State program pre-approved milestones are met.

III. ELIBIBILITY INFORMATION

1. Eligible Applicants

States may apply for funding under this grant opportunity. By "State" we refer to the definition provided under 45 CFR 74.2 as "any of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State exclusive of local governments." By "territory or possession" we mean Guam, the U.S. Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands. A State's Office of the Governor, State Medicaid Agency, or State Survey Agency may apply for funding under this grant opportunity. Any previously-awarded State that received less than the maximum permitted may at any time request an increase up to the maximum allowed by law provided that (a) the State submits a proposed modification to their plan that details and justifies the increase, (b) the State provides the requisite matching funds from acceptable sources, (c) CMS will evaluate the proposals on a flow basis; and (d) CMS reserves the right to fund less than requested.

2. Federally Matched Funding and State Guarantee Requirements

The National Background Check Program legislation mandates States must guarantee they will make available non-Federal funds to cover a portion of the cost to be incurred to carry out the background check program in their State. State funding may be from any source; such as State funds, local funds, bona-fide donations, or health care-related taxes that qualify as permissible sources of the non-Federal share in order to obtain Federal Medicaid matching funds. Funding requirements are specified in 42 CFR 433 subpart B, except that sections 42 CFR 433.53(b) and §433.70 will not apply to this background check program. For example, any provider-related donations must be determined to be bona fide in accordance with Section 1903(w)(2) of the Social Security Act and 42 CFR 433.54. CMS reserves the right to grant exceptions to the limitations on non-Federal share sources if the agency determines it is in the best interest of the public. Please refer to Appendix 9 for more details.

CMS will provide Federal grant funds to each *newly* participating State that enters into this agreement with CMS at a rate that will be three times the amount that the State guarantees, not to exceed $3 million dollars in Federal grant funds for the 36-month award period starting with the grant period start date. Due to grants beginning on a flow basis, grant funding and grant period start dates will vary. States that participated in the *pilot* background check program under Section 307 of the Medicare Modernization Act, and are now entering into this agreement with CMS will receive Federal grant funds at a

rate that will be three times the amount that the State guarantees not to exceed $1.5 million dollars.

3. **Foreign and international organizations are not eligible to apply under this solicitation.**

4. **Faith based organizations are not eligible to apply under this solicitation.**

IV. APPLICATION and SUBMISSION CRITERIA

1. Address to Request Application Package

An electronic application package for this program announcement is available at www.grants.gov. Applicants may request an application package by sending an email to Background_Checks@cms.hhs.gov. Please be sure to include the name, mailing address and phone number of a contact person for the agency requesting an application. Please note that only one application request will be accepted per State.

NOTE: Although the application may be downloaded from the CMS website, applications must be electronically submitted to CMS through www.grants.gov.

2. Content and Form of Application Submission

Each application must include all contents described below, in the order indicated, and in conformance with the following specifications:

- Use 8.5 x 11" pages with 1" top, bottom and side margins;
- Font not smaller than 12-point and an average character density not greater than 14 characters per inch;
- Abstract may be single-spaced but no more than one page;
- Double-space (no more than 3 lines per vertical inch);
- Paginate *all* pages of the narrative; and
- The Program Narrative portion of the application is limited to 40 pages*.

*The following items are not included in the Program Narrative portion of the application and, therefore, they do not count toward the total page limit:

- Applicant's Title Page and Cover Letter;
- Standard Forms from the Application Forms Kit;
- Letters of Agreement and Endorsement;
- Program Abstract;
- Budget Narrative/Justification and resources;
- Budget Forms; and
- Appendices.

(a) Required Content of the Application

A complete proposal consists of the following materials organized in the listing sequence indicated (see Appendix 10 for an application submission checklist).

- Applicant's Title Page and Cover Letter
- Standard Forms from the Grant Application Package
- A letter of endorsement from the Governor or State Survey Agency Director, etc.
- Program Abstract
- Program Narrative (see Appendix 3 for content)
- Budget Narrative/Justification
- Budget Forms
- Required Appendices
- Attachments (e.g., Letters of Agreement and Support)

Applicant's Title Page and Cover Letter

A letter from the applicant identifying the Agency serving as the lead organization, indicating the title of the program, the principal contact person, amount of funding requested, and the names of all other State entities involved in the design, implementation of the program, and a point of contact for each. The letter should indicate that the submitting Agency has clear authority to oversee and coordinate the proposed activities and is capable of convening a suitable working group of all relevant partners.

Standard Forms from the Grant Application Package

The following standard forms must be completed and enclosed as part of the proposal.

Grant Application Package

SF 424:	Application for Federal Assistance
SF 424A:	Budget Information
SF 424B:	Assurances – Non-Construction Programs

SF LLL: Disclosure of Lobbying Activities
Additional Assurances and Certifications
Key Contacts

Letters of Endorsement and Support

CMS advises all applicants to include a limited number of additional letters of support from key stakeholders. These letters will not be counted toward the narrative's page limitation and should be included as attachments.

Program Abstract

The one-page abstract should serve as a succinct description of the proposed program and should include:

- The overall goals of the program;
- A description of how the grant will be used; and
- Budget allocations as follows:
  - Total budget for 36-month project/budget period
  - Total Federal funds requested

Program Narrative

The program narrative should (1) Provide a concise and complete description of the proposed program; (2) Contain all information necessary for the review panelists to fully understand the proposed program; (3) Address the components of a background check program, (current infrastructure, use of grant funds, work products and timeline and staffing); and(4) Application narrative must not exceed 40 pages. See Appendix 3 for a detailed description of information that should be included in the program narrative.

Budget Narrative/Justification and Resources

The designated lead agency is solely responsible for the fiscal management of the program, and as such is responsible for providing the narrative/justification as well as aggregate numbers for the budget recorded on Standard Form 424 (SF 424). Application for Federal Assistance, must include allocations for each set of proposed activities and tasks. Additionally, allocations should distinguish the proportion of grant funding designated for each grant activity and task.

The budget must clearly delineate funds which will be administered directly by the lead agency and funds which will be subcontracted to other partners. The State's application must specifically identify the amount and source of projected funding to meet the non-financial recipient contribution that is identified in Item 15 (Estimated Funding) on SF 424.

Budget Forms

Include the following as distinct line items on the budget forms that will accompany State proposals:

- Management Staffing Expenses
- Other Staffing Expenses
- Cost for Fingerprint Collection
- Fees for Fingerprint Searches (distinguish FBI fees from State fees)
- Fees for Registry Searches (if any)
- Identify and justify fees paid to other agencies in addition to those previously identified
- Information Systems Software Costs
- Information Systems Hardware Costs

Sample Budget Forms can be found in Appendix 6 of this solicitation.

Required Appendices

- Key Staff Qualifications: Include a brief biographical sketch or resume of key staff describing their qualifications.

- Visual Map or Diagram: Include a flow diagram or process map of the current background check process in use (if any), and a revised flow diagram that is illustrative of how the Program will function. A sample Flow Diagram is located in Appendix 5 of this document.

(b) Data Universal Numbering System (DUNS)

Beginning October 1, 2003, applications are required to have a Dun and Bradstreet (DUNS) number to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access the following website: www.dunandbradstreet.com or call 1-866-705-5711.

Your assigned DUNS number should be entered in Item 5 (applicant name and address) on Form SF-424 (Application for Federal Assistance) with the annotation "DUNS" followed by the DUNS number that identifies the applicant. The name and address in the application should be exactly as given for the DUNS number.

(c) Matching Requirement – Non-Federal Funds

Federal legislation stipulates for States to participate in this nationwide program, the State must guarantee that it will make available non-Federal funds to cover a portion of the cost to be incurred to carry out the background check program in its State. Funds may either be provided directly through State revenues (including provider taxes or certification fees) or through donations. All donations must be in accordance with section 1903(w)(2) of the Social Security Act 42 CFR 433.54. Note: Applicant fees may *not* be charged to persons participating in a Medicaid program who self-directs their own care, or to the applicants of such self-directed care employers. CMS will provide matched funding to each *newly* participating State that enters into this Agreement with CMS. Matched funding will be three times the amount the State guarantees not to exceed $3 million dollars.

CMS will provide matched funding to each *previously* participating State that conducted their statewide Background Check Program. CMS' matching funds will be three times the amount the State guarantees not to exceed $1.5 million dollars. Appendix 9 of this document contains additional information with regard to non-Federal sources of funds.

(d) Indirect Cost Rate Agreement (if applicable)

If indirect costs are included in the budget, a copy of the approved Indirect Cost Rate Agreement must be submitted with the application and uploaded in Grants.gov as an attachment.

3. Submission Dates and Times

All grant applications must be submitted electronically through http://www.grants.gov. All applications will receive an automatic time stamp upon submission and applicants will receive an automatic e-mail reply acknowledging the application's receipt.

Note: Grants.gov may take up to 2 days to validate your application as accepted or rejected.

Applications submitted by facsimile (fax) transmission, email or postal mail will not be accepted.

4. Intergovernmental Review

This grant is not subject to Executive Order 12372 concerning "Intergovernmental Review of Federal Programs".

5. Funding Restrictions

(a) Grant funds <u>may</u> be used for any of the following:

- Costs of data collection and transmission, which may include the costs of dedicated computers, software, necessary IT support, and data transmission costs as they relate to the National Background Check Program.

- Costs of electronic fingerprint collection and transmittal systems.

- Costs of rap-back systems that reduce the need for repeated full background checks of individuals by providers.

- Personnel costs, which may include program support staff and contracts for collaboration with staff working in the long term care industry and/or consultants with expertise in background investigation and tracking. Please note the program must include a lead point of contact and program manager for the State, whose salary may or may not be paid through the use of grant funds.

- Travel costs as they pertain to the administration and implementation of the grant. Examples of allowable travel costs may include costs associated with data collection and program implementation with rural providers and travel to the CMS Background Check conferences. Federal travel regulations and cost limits will govern reimbursement for travel expenditures. Travel costs should be built into the State's budget application.

- Direct costs of conducting background checks (e.g., fees paid to law enforcement). State funds used in an existing program may be used as the State matching funds required in this solicitation provided the increased Federal funds provide for reasonable expansion and improvement of the background check program. Proposals that include an existing program without reasonable expansion or improvement will not be approved.

- Training costs for State agencies, providers and human resources personnel participating in the implementation of the National Background Check Program Training costs must be specified with detail in the grant budget.

- Indirect and overhead costs will be allowed at the State's approved rate.

(b) Grant funds may <u>not</u> be used for any of the following:

- To provide direct services to individuals except as explicitly permitted under the grant solicitation.

- To match any other Federal funds.

- To provide services, equipment, or supports that are already the legal responsibility of another party under Federal law (e.g., Nurse Aid Registry for the job categories currently required) or under any Federal civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.

- To provide infrastructure for which Federal Medicaid matching funds are available at the 90/10 matching rate, such as certain Medicaid Management Information System improvements.

6. Other Submission Requirements

All applications must be submitted electronically through www.grants.gov.

(a) Grants.gov Registration in Brief

1. Your organization will need to obtain a DUNS Number. The DUNS number is a nine-digit identification number that uniquely identifies business entities. Obtaining a DUNS number is easy and free of charge. To obtain a DUNS number, access the following Website: www.dunandbradstreet.com or call 1-866-705-5711. It may take up to two business days to obtain a DUNS Number.
2. Ensure that your organization is registered with the System for Award Management (SAM)* at www.sam.gov. Registering an account with SAM is a separate process from submitting an application. Applicants are encouraged to register early. Therefore, registration should be completed in sufficient time to ensure that it does not impair your ability to meet required submission deadlines

   *Applicants were previously required to register with the CCR. However, SAM has integrated the CCR and 7 other Federal procurement systems into a new, streamlined system. If an applicant has an active record in CCR, there will be an active record in SAM. Nothing more is needed unless a change in the business circumstances requires updates to the Entity record(s) in order for the applicant to be paid, receive an award, or to renew the Entity prior to expiration. Please consult the SAM website listed above for additional information.

3. Authorized Organizational Representative: The Authorized Organizational Representative (AOR) who will officially submit an application on behalf of the organization must register with Grants.gov for a username and password. AORs must complete a profile with Grants.gov using their organization's DUNS Number to obtain

their username and password, at http://grants.gov/applicants/get_registered.jsp. AORs must wait at least one business day after registration in SAM before entering their profiles in Grants.gov. **Applicants should complete this process as soon as possible after successful registration in SAM to ensure this step is completed in time to apply before application deadlines.**

4. When an AOR registers with Grants.gov to submit applications on behalf of an organization, that organization's E-Biz point-of-contact will receive an e-mail notification. The e-mail address provided in the profile will be the e-mail used to send the notification from Grants.gov to the E-Biz POC with the AOR copied on the correspondence.
5. The E-Biz POC must then login to Grants.gov (using the organization's DUNS number for the username and the special password called "M-PIN") and approve the AOR, thereby providing permission to submit applications.
6. The AOR and the DUNS must match. If your organization has more than one DUNS number, be sure you have the correct AOR for your application. Please note that there can be more than one AOR for an organization.
7. Any files uploaded or attached to the Grants.Gov application must be PDF file format and must contain a valid file format extension in the filename. Even though Grants.gov allows applicants to attach any file format as part of their application, CMS restricts this practice and only accepts PDF file formats. Any file submitted as part of the Grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process. In addition, the use of compressed file formats such as ZIP, RAR, or Adobe Portfolio will not be accepted. The application must be submitted in a file format that can easily be copied and read by reviewers.
8. At any time, you can track your AOR status by going to the applicant login page at http://www.grants.gov/track.

(b) Submit Your Application Early!

CMS strongly encourages applicants to submit early to ensure resubmission time if your application is rejected due to errors. An applicant containing errors or omissions can require protracted time to correct the errors and/or to solicit help from Grants.gov. Note: Validation or rejection of your application by Grants.gov may take up to 2 business days after submission. Please consider this in developing your submission timeline.

For issues including, but not limited to downloading the application, retrieving your password, or assistance with error messages, please contact Grants.gov directly at 1-800-518-4726 or support@grants.gov . Hours of Operation: Monday-Friday, 7:00 a.m. to 9:00 p.m., Eastern Time, closed on Federal Holidays. Please have the following information available when contacting grants.gov to help expedite your inquiry:

- Funding Opportunity Number (FON)
- Name of Agency You Are Applying To
- Specific Area of Concern

V. APPLICATION REVIEW INFORMATION

1. Criteria

CMS uses the following criteria to evaluate all applications for inclusion in the Program. Only States whose application is scored at 70.2 out of a possible 101 points or greater will be accepted as grantees. In addition to the minimum score all applicants must meet all statutory requirements as described in section 6201 of the Affordable Care Act.

The total score for the criteria below is 101 points.

(a) Background and Areas for Improvement or Expansion of Current Program (10 Points)

1. The application evidences a clear, comprehensive description of the current system in the State to conduct background screening for health care employees.

2. The application evidences the strengths and weaknesses of the current system, and identifies opportunities for improvement of the current system, explaining why such changes are important.

(b) Goals/Objectives (3 points)

1. The application evidences clear goals and objectives that relate in a meaningful way to the issues and opportunities identified in the immediate preceding section.

2. The application evidences goals and objectives that are reasonable and will be effective in accomplishing the purpose of the grant.

3. The application addresses how the background check process will not create barriers to job application that significantly reduce the available workforce for direct patient access positions.

(c) Components and Methodology of the Background Check Program (38 points)

1. The application reflects a strong understanding of the scope, complexity and required components of a background check program.

2. The application fully addresses each component of the background check program and represents a sufficiently substantive undertaking in terms of design and scope; that the proposal is likely, together with accepted applications of other States, to test the major hypotheses for this national program.

3. The application fully incorporates provisions for “rap back” capability by the State.

4. The application evidences effective uses of technology and other approaches that are effective in "low tech" environments.

5. The methodology and design of the State program is coherent and well-conceived.

(d) Work Plan and Flowchart (5 points)

1. The application includes a work plan that documents: goals and objectives, reasonable benchmarks, milestones, timeframes, measurable outcomes and products; and identifies the responsible parties to accomplish the goals of the program. As a tool to assist applicants in developing their proposal and to facilitate CMS' review panel process, CMS recommends applicants use the Sample Work Plan and Timeline (see Appendix 4) to formulate their Work Plan.

2. The application includes a work flow diagram or process map of the current background check process in use (if any), and a revised flow diagram that is illustrative of how the Program will function. A sample Flow Diagram can be found in Appendix 5.

(e) Key Personnel (5 points)

1. The application evidences that key program staff are qualified and possess the experience and skills necessary to design, implement and evaluate the program within the available timeframe.

2. The application evidences a single point of contact for the program known as the Principal Investigator (PI) or Project Director (PD), and that person will be available and dedicated to the effort. The PI/PD must be clearly identified in the application.

3. The application evidences that key program staff have direct professional experience with conducting or overseeing a background check program.

(f) Collaboration among State Agencies (10 Points)

1. The application evidences collaboration and coordination amongst State entities (e.g., State survey agency, State law enforcement agencies, single State Medicaid agency, etc.) that will be required for a successful Program.

(g) Involvement of Providers and Stakeholders (10 Points)

1. The application evidences the involvement of consumer and provider interest groups in the design and implementation of the national program.

2. Describes partnerships with public and private organizations that possess expertise in workforce issues pertaining to direct patient access workers in long-term care facilities or providers.

3. Promotes partnerships with public and private organizations that represent people of any age who receive long-term care services.

(h) Budget Narrative/Justification and Resources (20 Points)

1. The application evidences a reasonable and detailed budget.

2. The application evidences budgeted costs that are reasonable in relation to the proposed objectives, design, and significance.

3. The application evidences that the budget follows the requirements stated in the program announcement and specifically does not use grant funds to supplant existing funds.
4. The budget demonstrates a logical interface between current resources and the anticipated grant funding.

2. Review and Selection Process

The review and selection process occurs in two parts. Upon timely receipt by CMS, all applications will be screened to assure that the application is complete. Applicants may be requested to provide additional information during the review process.

A panel of Federal experts will conduct the application reviews. The panelists will review the applications to determine if the proposed Background Check Program meets the requirements of the solicitation. Panelists will score the applications based on the review criteria set forth in Section V of this document. Applications not attaining a minimum score of 70.2 out of a possible 101 points will be considered unacceptable.

Final award decisions will be made by the Director of the Survey and Certification Group, within the Office of Clinical Standards and Quality (OCSQ) after consideration of the comments and recommendations of the technical review panel.

CMS reserves the right to offer a funding level that differs from the requested amount, and to negotiate with the applicant regarding the appropriate scope and intensity of effort that would be appropriate and commensurate with the final funding level.

3. Anticipated Announcement and Award Dates

Awards to those States submitting successful applications will be made on or about the date specified in the timetable.

VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

Successful applicants will receive via email an official Notice of Award (NOA), signed by the CMS Grants Officer that will set forth the amount of the award, the Terms and Conditions of the award, and other State specific pertinent information. The NOA is a legal document issued to notify the grantee that an award has been made and that funds may be requested from the HHS payment system. Grantees are considered to have accepted the grant and its Terms and Conditions as soon as funds are drawn down from the Payment Management System.

2. Administrative and National Policy Requirements

The following standard requirements apply to applications under this solicitation.

- Specific administrative and policy requirements of applicants, as outlined in 45 CFR 92, and OMB Circulars A-102, A-87, and A-133 apply to this grant opportunity.

- Civil Rights - All Grantees receiving awards under these grant programs must meet the requirements of:
  i. Title VI of the Civil Rights Act of 1964;
  ii. Section 504 of the Rehabilitation Act of 1973;
  iii. The Age Discrimination Act of 1975;
  iv. Hill-Burton Community nondiscrimination provisions; and
  v. Title II, Subtitle A, of the Americans with Disabilities Act of 1990.

This funding opportunity with CMS will include the *Health and Human Services (HHS) Grants Policy Statement* at **http://www.hhs.gov/grantsnet/adminis/gpd/index.htm** and may also include additional specific grant "special" terms and conditions. Potential applicants should be aware that special requirements could apply to grant awards based on the particular circumstances of the effort to be supported of deficiencies identified in the application by the review panel or CMS.

3. Reporting

As a condition for accepting funding under this grant program, States are required to comply with the following reporting requirements:

(a) Grantees must agree to fully cooperate with any Federal evaluation of the program and provide quarterly or semi-annually any required program progress and financial reports in a form prescribed by CMS (including the SF-425, Federal Financial Report). These reports are designed to outline how grant funds were used and to describe program progress, as well as barriers and measurable outcomes. CMS will provide a format for reporting.

(b) Grantees must also agree to respond to requests that are necessary for the evaluation of the National Background Check Program grant efforts to satisfy the statutory requirements for the Federal evaluation enumerated in Section 6201 of the Affordable Care Act. Grantees must also provide data on key elements of their Background Check Program grant activities. Grant activities will include detailed information on the number of background checks requested by various providers; information gathered in the course of background checks and employment decisions made based on gathered information and decision rationale; and whether prospective employees challenged the results of adverse decisions and the outcomes of these challenges. Grantee reporting will also include cost accounting information of sufficient quality to allow reliable calculation of the costs of the various components of the background checks programs.

(c) Following the awarding of the grant, grantees must submit an operational protocol. The operational protocol must describe in detail the policies and procedures the State will follow during the program period. The operational protocol should detail the responsibilities of the providers included in the program; the State government personnel and any additional responsible parties (e.g., contractors) involved in the program. Those who receive grant awards will be provided further detail outlining the expected contents of the operational protocol prior to or during the first grantee meeting.

VII. AGENCY CONTACT

For questions regarding forms and related materials, please contact:

CMS National Background Check Program
Centers for Medicare & Medicaid Services
Center for Clinical Standards and Quality/Survey & Certification Group
Mail Stop: C2-21-16
7500 Security Boulevard
Baltimore Maryland, 21244-1850

E-mail: Background_Checks@cms.hhs.gov

or

OAGMGrantsBaltimore@cms.hhs.gov

Appendix 1

Statutory Provisions

Affordable Care Act of 2010 (section 6201)

Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers

SEC. 6201. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.

(**a) IN GENERAL**.—The Secretary of Health and Human Services (in this section referred to as the "Secretary"), shall establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the ''nationwide program''). Except for the following modifications, the Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsection (b)(3)(A) and (b)(6), respectively, of such section 307:

(1) AGREEMENTS.— H. R. 3590—604

(A) NEWLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under such subsection (c)(1), but only in the case where such agreement did not require the State to conduct background checks under the program established under subsection (a) of such section 307 on a Statewide basis;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain State and national criminal history background checks on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize a search of State-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee previously resided in that State, State criminal history records, the records of any proceedings in the State that may contain disqualifying information about prospective employees (such as proceedings conducted by State professional licensing and disciplinary boards and State Medicaid Fraud Control Units), and Federal criminal history records, including a fingerprint check using the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation;

(B) require States to describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability by the State such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted H. R. 3590—605 with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department, the department will immediately inform the State and the State will immediately inform the long term care facility or provider which employs the direct patient access employee of such conviction; and

(C) require that criminal history background checks conducted under the nationwide program remain valid for a period of time specified by the Secretary.

(4) STATE REQUIREMENTS.—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the nationwide program;

(B) have procedures in place to—

(i) conduct screening and criminal history background checks under the nationwide program in accordance with the requirements of this section;

(ii) monitor compliance by long-term care facilities and providers with the procedures and requirements of the nationwide program;

(iii) as appropriate, provide for a provisional period of employment by a long-term care facility or provider of a direct patient access employee, not to exceed 60 days, pending completion of the required criminal history background check and, in the case where the employee has appealed the results of such background check, pending completion of the appeals process, during which the employee shall be subject to direct on-site supervision (in accordance with procedures established by the State to ensure that a long-term care facility or provider furnishes such direct on-site supervision);

(iv) provide an independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the nationwide program, including the specification of criteria for appeals for direct patient access employees found to

have disqualifying information which shall include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevancy of the particular disqualifying information with respect to the current employment of the individual;

(v) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a H. R. 3590—606 prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(III) immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(IV) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section;

(vi) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(vii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(viii) describe and test methods that reduce duplicative fingerprinting, including providing for the development of ‘‘rap back’’ capability such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee’s fingerprints match the prints on file with the State law enforcement department—

(I) the department will immediately inform the State agency designated under clause (v) and such agency will immediately inform the facility or provider which employs the direct patient access employee of such conviction; and

(II) the State will provide, or will require the facility to provide, to the employee a copy of the results of the criminal history background check conducted with respect to the employee at no charge in the case where the individual requests such a copy.

(5) PAYMENTS.—

(A) NEWLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(A)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a

particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $3,000,000.

(B) PREVIOUSLY PARTICIPATING STATES.— H. R. 3590—607

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i) except that in no case may the payment amount exceed $1,500,000.

(6) DEFINITIONS.—Under the nationwide program:

(A) CONVICTION FOR A RELEVANT CRIME.—The term ‘‘conviction for a relevant crime’’ means any Federal or State criminal conviction for—

(i) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7); or

(ii) such other types of offenses as a participating State may specify for purposes of conducting the program in such State.

(B) DISQUALIFYING INFORMATION.—The term ‘‘disqualifying information’’ means a conviction for a relevant crime or a finding of patient or resident abuse.

(C) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ‘‘finding of patient or resident abuse’’ means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a Federal agency that a direct patient access employee has committed—

(i) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

(ii) such other types of acts as a participating State may specify for purposes of conducting the program in such State.

(D) DIRECT PATIENT ACCESS EMPLOYEE.—The term ‘‘direct patient access employee’’ means any individual who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the State for purposes of the nationwide program. Such term does not include a volunteer unless the volunteer has duties that are equivalent to the duties of a direct patient access employee and those duties involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(E) LONG-TERM CARE FACILITY OR PROVIDER.—The term ‘‘long-term care facility or provider’’ means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act: H. R. 3590—608

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))).

(ii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 396r(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395x(dd)(1))).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv))).

(vi) A provider of personal care services.

(vii) A provider of adult day care.

(viii) A residential care provider that arranges for, or directly provides, long-term care services, including an assisted living facility that provides a level of care established by the Secretary.

(ix) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(x) Any other facility or provider of long-term care services under such titles as the participating State determines appropriate.

(7) EVALUATION AND REPORT.—

(A) EVALUATION.—

(i) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program.

(ii) INCLUSION OF SPECIFIC TOPICS.—The evaluation conducted under clause (i) shall include the following:

(I) A review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing agencies, to conduct background checks of direct patient access employees under the nationwide program and identification of the most appropriate, efficient, and effective procedures for conducting such background checks.

(II) An assessment of the costs of conducting such background checks (including start up and administrative costs).

(III) A determination of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for long-term care facilities or providers.

(IV) An assessment of the impact of the nationwide program on reducing the number of incidents of neglect, abuse, and misappropriation of resident property to the extent practicable.

(V) An evaluation of other aspects of the nationwide program, as determined appropriate by the Secretary.

(B) REPORT.—Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall H. R.

3590—609 submit a report to Congress containing the results of the evaluation conducted under subparagraph (A).

(b) FUNDING.—

(1) NOTIFICATION.—The Secretary of Health and Human Services shall notify the Secretary of the Treasury of the amount necessary to carry out the nationwide program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(2) TRANSFER OF FUNDS.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1) Such amount shall remain available until expended.

(B) RESERVATION OF FUNDS FOR CONDUCT OF EVALUATION.—

The Secretary may reserve not more than $3,000,000 of the amount transferred under subparagraph (A) to provide for the conduct of the evaluation under subsection (a)(7)(A).

Appendix 2

Program Narrative Requirements

For Required Components of a Background Check Program

Please address each of the following topics in your program narrative, in the sequence as outlined below. The program narrative should not exceed 40 pages and should use the outline structure below (e.g., A.1, A.2 …B.1, B.2, etc.). Please do not rely on Appendices to describe key details of your program. Appendices will not be used in the rating process.

A. Current System

1. **Description of Current System:** Describe the current system in your State to conduct background screening for healthcare employees. Include a description of the following:

   (a) ***Nurse Aide Registry:*** Describe the current process for checking the Nurse Aid Registry, and other registries maintained by the State or professional organizations (e.g., Board of Nursing);
   (b) ***Other Background Check Systems:*** Describe the types of providers (e.g., provider types in addition to nursing homes) and the types of employees (e.g., nurse aides, dietary, security, housekeeping, therapists, etc.) being screened. Additionally state whether only new applicants are required to undergo background checks, or current employees as well;
   (c) ***Management:*** Identify the agency that has overall responsibility for managing the current background check system
   (d) ***Definitions:*** Define the State's utilization of "disqualifying information" (e.g. definition of abuse, definition of neglect, etc.);
   (e) ***Fee Schedule:*** Describe the fee schedule (if any) used to charge providers or applicants for conducting the background screening (e.g., who is charged what amount, for what, and whether there is any system of reimbursing those who pay fees, such as reimbursing providers through the State's rate-setting mechanisms or reimbursing applicants who are hired);
   (f) ***Authority:*** Describe the State authority under which your current system operates. Include the legal or regulatory citations that indicate where the pertinent authority is codified in State law or regulation;
   (g) ***Evaluations and Research:*** Provide citations (article(s) and publication name(s), investigator(s) name(s); and the article's page numbers) and a description of any evaluations or research that have been conducted on the State's background check system(s);
   (h) ***Rap-back Systems:*** Identify whether the State currently has a rap-back system and, if so, describe how the system currently works (see part B.6.c of this Appendix for a description);
   (i) ***Additional Information:*** Include references and any established web address by which additional information may be obtained.

2. **Issues and Opportunities**: Briefly describe the strengths and weaknesses of the current system, as relevant to this national program. Identify opportunities for improvement of the current system and why such changes are important in your State. Examples include expansion of scope (e.g., extension to additional providers), expansion of employee coverage (e.g., adding additional types of workers), improving intensity of checking mechanisms (e.g., adding FBI checks where only State checks are currently preformed), improving efficiency (e.g., streamlining the fingerprint capture process), improving worker access and convenience (e.g., adding fingerprinting sites, reducing stigma or inconvenience), improving compliance rates on the part of providers, etc.

B. Proposed Program for this Solicitation

1. **Brief Synopsis:** Provide a brief synopsis of the proposed system, *including* the goals to be accomplished.

2. **Single State Agency:** Section 6201(A)(4)(B)(v) of the Affordable Care Act requires the designation of a single State agency responsible for:
   - Overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider);
   - Overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks;
   - Immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and
   - In the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section.

   Please identify the Single State Agency, how the background check program will be staffed, and provide an organizational chart identifying the agency in relation to other relevant State agencies and State law enforcement agencies.

3. **Provider Types:** Complete following the Provider Types chart to describe the scope of your proposed program.

   In the Facility or Provider Type column, the following definitions apply:

   - HCBS or HCBS-W refers to the home and community-based service (HCBS) waivers in Medicaid under sections 1915(c) or section 1915(i) State home and community based services of the Social Security Act.
   - Assisted Living refers to any definition adopted by a State under State law or regulation.

   In the Number of Providers Statewide, column, estimate the number of discrete employing agencies. For group living environments, count the number of different facility locations (e.g., a chain of 10 nursing facilities in 10 different address locations

would count as 10 locations). For home health agencies and personal care agencies, count the number of employing agencies rather than the number of branch locations (e.g., a home health agency with five branches would count as one). If you are including providers who are employees of individuals self directing their services, provide the number of individuals within the State who are acting as employers of record for self-directed services.

The column designated Required Yes/No, indicate the provider types for which participation in the background check program will be required and the approximate timetable for the provider's inclusion in the program. Certain provider types must be included in order for a State to be selected for a grant under this solicitation. Such provider types are denoted by a "Yes" in the chart. States may choose the extent to which other provider types will be required from the start of the award period through a 36-month budget period. Please note, however:

- Section 6201 Subtitle C of the Affordable care Act requires CMS to ensure "the inclusion of a variety of long term care facilities or providers".
- The inclusion of more provider types may increase funding options and the likelihood of a State being awarded a grant, (providing all conditions of the federal legislation and grant solicitation are successfully met).
- CMS is permitting some State discretion in the selection of certain provider types due to the probability of trade-off between (a) comprehensiveness of coverage and (b) the speed of implementation, effectiveness of the checking systems, extent of provider education and compliance, and time available. Consequently, the extent of provider inclusion is weighted heavily in CMS' scoring criteria, as is other factors such as coherency and feasibility of the State's program design.

The Phase In Plan Dates, column requires the description of two dates: first, the date particular provider types will begin to phase in the requirement; and secondly, the date all providers in the provider category will be required to comply fully with the background check system.

Provider Types Chart

	Facility or Provider Type	No. of Providers Statewide	Required Yes/ No	Phase-In Plan Dates		Explain
				Start Date* (Mo.+ Year)	Completely In, Statewide	
A. Group Living Environments	A.1. Skilled Nursing Facilities/Nursing Facilities		**Yes**			
	A.2. Long Term Care Hospitals, Swing Beds		**Yes**			
	A.3. ICFs/IIDs		**Yes**			
	A.4. Psychiatric Hospitals					
	A.5. Hospices		**Yes**			
	A.6. Assisted Living Facilities		**Yes**			
	A.7. HCBS or PACE Group Homes Over 8 Beds*		**Yes**			
	A.8. HCBS or PACE Group Living - Other (Define)*					
	A.9. Other Living Arrangements (Define)					
B. Community Programs	B.1. Home Health Agencies		**Yes**			
	B.2. Personal Care Agencies - Medicaid State Plan		**Yes**			
	B.3. Personal Care Agencies - HCBS-W or S. 1115					
	B.4. Self-Directed Personal Care		**On** Request**			
	B.5 Treatment Foster Homes for Children					
	B.6. Case Management Agencies - Medicaid					
	B.7. Hospices		**Yes**			
	B.8. Other					

* *If currently covered through an existing background check program, enter "Existing" and explain in the column provided.*

***Background checks must be provided only at the request of the person self-directing the care (i.e., the employer), and provided at no cost to the employer or applicant.*

4. **Employment Agencies**: Describe the specific role (if any) employment agencies (including temporary agencies) will have in your program.

5. **State Authority:** Describe whether additional State authority (via law or regulation) will be needed to (a) require the identified providers to participate in the proposed program (and thereby assure that all new individuals hired by those providers undergo background checks); (b) provide protection for applicants against misuse of background check information, as specified in section 307 (b)(4)(A) of the MMA; and (c) protect providers against liability as specified in s. 307(b)(4)(B) of the MMA.

   If new authority is not required, please describe how existing authority is adequate to meet the requirements of section 6201 of the Affordable Care Act of 2010, and section 307 of the MMA of 2003; and provide appropriate legal citations for such authority.

   If additional authority will be required, please describe (a) the form you expect such authority to take (e.g., law or regulation), (b) the nature of the additional authority required (e.g., requiring provider participation, protecting applicants, protecting providers, etc.), (c) the strategy and timetable you expect for gaining such authority; and (d) the current status of preparation and planning for adoption of the additional authority.

6. **The Five Primary Processes:** Please describe in detail each of the five processes identified below associated with conducting background checks.

   a. **Collection of Fingerprints**: Section 6201 of the Affordable Care Act establishes this national background check program be carried out under similar terms and conditions as the pilot program under section 307 of the MMA Act of 2003. Section 307 (b)(2)(A)(iv) of said Act specifies an applicant's State and national criminal history records must be obtained through a 10-fingerprint check that utilizes State criminal history records and the Integrated Automated Fingerprint Identification System (IAFIS) of the Federal Bureau of Investigation (FBI). Applicants must provide a description detailing how the proposed program will collect a prospective employee's set of rolled or inked fingerprints to be used to check State and Federal criminal records. Your description must address each of the following:

      i. ***Technology:*** Describe the technology you will use to collect fingerprints (e.g., live scan or hard card mailed, hard card scanned, etc.) If live scan technology is not currently used, describe the State's plan to phase in such technology (required).
      ii. ***Collection Agencies:*** Who will be authorized to collect the fingerprints?
      iii. ***Locations:*** Where will the collection of fingerprints occur? How many such sites currently exist or are projected? How far will applicants typically need to travel if the collection sites are not at the provider?
      iv. ***Transmittal Methods:*** How will the fingerprints be transmitted to the agency conducting the State criminal history check and the IAFIS at the FBI?

b. **Records Check –** Provide a description of how your proposed program will complete the check of registries and State and national criminal histories. Descriptions must address each of the following:

   i. ***Databases Checked:*** What registries and databases will be checked at the State level, and how is this accomplished?
   ii. ***State Checking:*** Describe the process for completing the State level criminal records check, including the agencies involved and responsibilities of each agency, time allocated, findings transmittal, etc.
   iii. ***Checking with FBI:*** Describe the process for completing the national criminal records check through the IAFIS.
   iv. ***Checking Sequences:*** In what sequence will the above required (items i – iii) checks be completed?
   v. ***Elimination of Unnecessary Checks***: The State must, in accordance with section 307(b)(1)(B), permit providers to terminate background checks at any stage based on disqualifying information. If the background check process is stopped once disqualifying information has been obtained, how will cessation be communicated to all involved entities?
   vi. ***Costs and Fees:*** What are the costs associated with each level of check (i.e., State registries, State criminal records, FBI national records)? What (if any) charges does the State propose to levy to job applicants or providers for (a) State checks, (b) FBI checks?
   vii. ***Lifespan of Checks:*** Please describe the time period during which a completed background check with no disqualifying information will remain valid without requiring a new background check if the applicant seeks another long term care position. We would expect this time period to vary with the extent to which the State has a functioning rap-back system (see below). In a State with a fully functional rap-back system, we would typically expect the background check to remain valid for 2-4 years, while a State without such a system may limit the validity to a few months for existing direct patient access employees, and require a new check with every new employment application.

c. **Rap-Back System:** Please describe the State's plan to utilize an existing rap-back system, or to develop and test such a system if one does not already exist. Each participating State is required to develop and test a rap-back system by which State law enforcement departments immediately inform the State of any criminal convictions against the employee that occur following the pre-employment background check. In turn a rap back system provides for the State to immediately notify the provider when law enforcement notifies the State that an employee is convicted of a crime after the pre-employment background check.

d. **Fitness Determination:** Describe the process that will be used to make the determination whether a job applicant is qualified or disqualified according to the criteria identified by the State. Your description must address each of the following:
   i. ***Definition:*** Define disqualifying information as the State interprets it when making a fitness determination (e.g., how are abuse and neglect, etc.) If the

Federal definitions are not used, and are there other categories of State-defined disqualification?

ii. ***Agency:*** Who is responsible for making the fitness determination (e.g., a State agency making the decision or the provider)?

iii. ***Categories of State Communication:*** If the fitness determination is made at the State level, please describe how the determination is made, and if any criminal history information is passed on to the requesting provider. To illustrate, will it be a yes/no communication to providers (red light, green light), or will providers have some discretion (e.g. red light, yellow light, green light), or will providers receive criminal history information to make their own fitness determination?

iv. ***Timeliness:*** What is the length of time allowed for completion of the fitness determination? When does the time begin?

v. ***Missing Dispositions***: How will your program handle missing dispositions, and how will missing dispositions factor into the fitness determination?

vi. ***Provisional Employment:*** Each participating State is required to provide a provisional period of employment for a long-term care facility or provider direct patient access employee. The provisional period may, not to exceed 60 days, pending completion of the required criminal history background check; and in the case where the employee has appealed the results of such background check. Pending the completion of the appeals process, the employee shall be subject to direct on-site supervision (in accordance with procedures established by the State to ensure that a long-term care facility or provider furnishes such direct on-site supervision). Please describe how your program will provide provisional supervision features, including:

- Criteria for allowing provisional employment;
- Limitations of length of provisional employment;
- Levels of supervision and conditions of employment, this may vary by provider type or category of employee; and
- Special considerations given to supervision requirements for small rural providers or home health agencies.

e. **Integrity**

i. ***Error Checks:*** Describe the system you will use to ensure the validity of the background check results. Include both internal processes (passive, automatic process that do not require special effort by any actor) and those that are complaint driven (active process dependent on an internal or external actor noticing a problem and having the wherewithal to bring it to management's attention).

ii. ***Appeals:*** Please explain the process a prospective employee may use to appeal the results of a background check. Include the types of appeals allowed; the timeframe for filing appeals; time allowed for resolution once an appeal has been filed; how appeals are processed; and any relation to periods of provisional employment. An example is the process prescribed under federal law relative to nurse aides at 42 CFR 483.156 (c)(1)(iv)(D). Section 6201 of the Affordable Care Act requires that the State "provide an

independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the nationwide program, including the specification of criteria for appeals for direct patient access employees found to have disqualifying information which shall include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevancy of the particular disqualifying information with respect to the current employment of the individual."

iii. ***Rehabilitation:*** Explain if the State program allows rehabilitation of individuals with previous convictions for disqualifying behaviors, and if yes, what criteria will be used to evaluate an individual's fitness for employment.

iv. ***Compliance monitoring:*** How will your State monitor compliance to ensure all providers and facilities included in the program are conducting the background checks on prospective employees as required?

v. ***Enforcement and Feedback:*** What penalties or enforcement actions will be used against facilities or providers that may be non-compliant? What mechanisms will be in place to facilitate feedback from providers?

vi. ***Unintended Negative Effects:*** Describe the features of your State's program that are designed to prevent or limit negative, unintended results, such as impairment to the recruitment of prospective, qualified workers into long term care? Examples include making it easy to provide fingerprints, avoiding stigma, promoting the value of a positive finding on the background checks, avoiding costs to the applicant, etc.

7. **Education and Technical Assistance Plan:** Describe the method your State will use to communicate the requirements of the proposed program to both the provider community and potential employees. Include methods to provide ongoing technical assistance to facilities and providers as necessary to ensure successful implementation of the program.

8. **Management:** Describe the program's management and staffing plan, addressing staffing requirements for each component of the program. Include staff responsibilities and qualifications necessary to carry out stated responsibilities. Provide in the State's application Appendix an organizational chart showing the relationships amongst major actors in the system.

9. **Partnerships and Collaboration:** Describe how your State will partner and collaborate with other State entities and stakeholders to ensure successful implementation of the proposed program.

10. **Evaluation:** States that are selected for inclusion in this national program must agree to participate in the national evaluation. Participation includes your agreement to collect and transmit data as requested by CMS throughout the duration of the program.

C. Financing Plan

1. **Systems Infrastructure:** Describe the types of equipment, information systems and additional infrastructure that will be necessary to implement the proposed program. Please note that any equipment costs may not exceed 25% of the total budget, and each application must have a plan to transition to electronic live scan technology if such capability does not exist currently.

2. **Finance Narrative:** Describe the method that will be used to pay for the variable costs of conducting the program (e.g., fees paid, by whom, to whom, what rate, and for what purpose(s)). Include a copy of your fee schedule (if applicable). In particular, describe whether your State expects applicants to pay any portion of the cost and if so, (a) the percent the applicant will pay, (b) the expected dollar amount of the fee the applicant will pay for each background check, and (c) whether any or all of the paid fees will be returned to the applicant in the event there is no disqualifying information and the applicant is hired.

3. **Budget Forms for Expenditures:** Please include the following as distinct line items on the budget forms that will accompany your proposal:

   a. Management staffing
   b. Other staffing
   c. Collection of fingerprints
   d. Fees to be paid for checking of registries (if any)
   e. Fees to be paid for checking of fingerprints at the State level
   f. Fees to be paid for checking of fingerprints with the FBI
   g. Fees paid to other agencies of services beyond those identified above, and explain
   h. Information systems software
   i. Information systems hardware
   j. Prevention Programs (optional); This budget line item, assumes the remainder of the State's application is funded. In other words, include here only those *additional* costs directly associated with the prevention program (e.g., do not assume the need for an additional program administrator, etc., unless the State deems such cost to be necessary even if the rest of the State's program is funded).

4. **Budget Chart for Non-Federal Match**: For each source of non-Federal funds that the State plans to use, please describe the total expected multi-year amount from Award date through the 36-month period, and summarize the method of administration.

Budget Chart for Non-Federal Funds Match Through Year 3*

1	Source of Non-Federal Funds	Expected Expenditures				Summary - Administration and Methods by Which Funds will be Raised
		Year 1	Year 2	Year 3	Total Multi-Year Period	
2	State Funds (without provider taxes)					
3	Provider taxes					
4	Certification fees paid by applicants					
5	Donations					
6	Local Funds					
7	Other					
	TOTAL					

*States have the option of expending funds through a 36-month budget period, but it is not required.

5. **Narrative for Non-Federal Match:** For each source, please explain how the non-Federal match meets the criteria for funds that typically qualifies as matching for Federal financial participation in Medicaid, as specified in 42 CFR 433 subpart B (except for sections 42 CFR 433.53(b) and 433.70 since those sections do not apply here). See Appendix 9 for an explanation.

6. **Relationship to Other Funding:** If the total amount of Federal plus matching State funds (aggregate annual amount of such other funds that are not included in the budget table above) under this solicitation is not expected cover the full cost of the program, please explain any other funding that the State plans to use to support the statewide background check program. For example, some States with existing background check

programs have built background checks into their Medicaid program, and charge providers for the cost of the background checks but also recognize such costs in their rate-setting for the providers as a cost of doing business. Appendix 9 of this solicitation provides some background on the regulations concerning matching funds under Medicaid.

Appendix 3

Sample Work Plan and Timeline

The grant application must include a program work plan and timeline. All of the program's goals must be included in the work plan. The completed work plan will not be counted towards the 40 page narrative limitation. Table headings are explained below to guide you in completing the work plan and timeline.

Table Headings

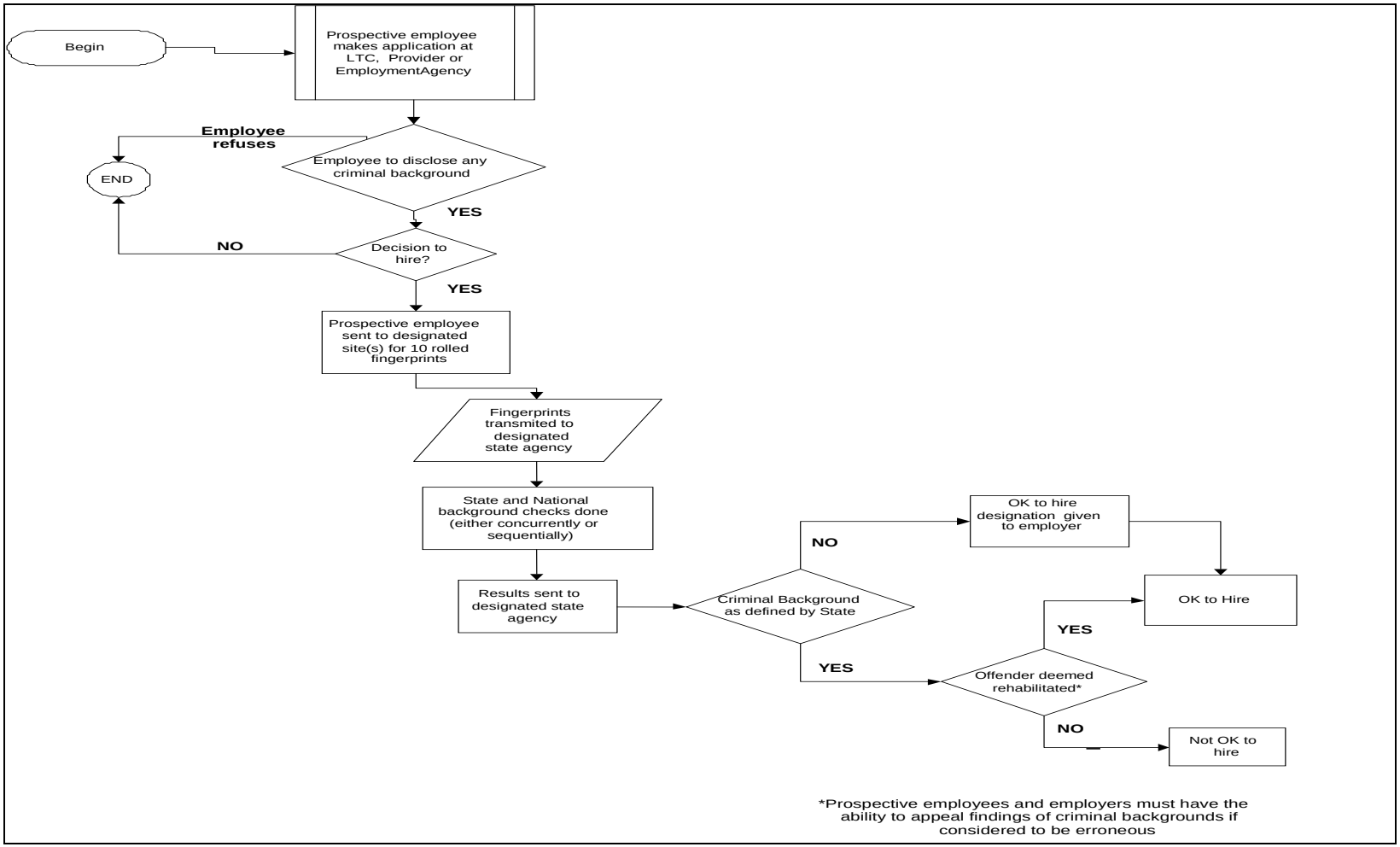
Goal(s):	What are the goals specific to your State's program?
Major Activities:	How will your State realize the stated goal(s)? (There may be multiple activities for more than one goal.)
Specific Tasks:	What are the specific tasks required to accomplished each activity?
Lead Person:	Who is responsible for ensuring program activities are completed (e.g., program director or subcontractor)? Identify the primary person by name, if possible, with responsibility for the specific activity.
Timeline:	What are the dates for starting and completing the activity? Please specify by quarters (e.g., 1st Quarter, 2nd – 5th Quarter), the beginning and anticipated completion dates of the activity.
Products:	What tangible products will be produced?

Name of Program:
State:
Organization:

Goal(s):															
Measurable Outcomes:															
Major Activities	**Specific Tasks**	**Lead Person**	**Timeline (Start and End Date by Quarter)**												**Products**
			1	2	3	4	5	6	7	8	9	10	11	12	
1.															
2.															
3.															

Appendix 4 Sample Flow Diagram

The Proposal should provide a visual map or "flow diagram" of the minimum requirements of a successful State application. See diagram below.



Appendix 5

Budget Justification

Sample Format

Object Class Category	Federal Funds	Non-Federal Cash	Justification
Management Staffing			
Other Staffing			
Fringe Benefits			
Travel			
Collection of Fingerprints			
Fees for Checking Registries			
Fees for Checking of Fingerprints against State criminal records repository			

Object Class Category	Federal Funds	Non-Federal Cash	Justification
Fees for Checking of Fingerprints against FBI criminal records repository (if necessary)			
Fees paid to other Agencies beyond those identified above (e.g., to obtain missing dispositions or other necessary information)			
Information Systems Software			
Information Systems Hardware			
Supplies			
Other Indirect Charges (please specify)			
TOTAL			

Appendix 6

Statutory Language for the 2003-2007 Pilot

Medicare Modernization Act of 2003 (sec 307)

Note- this language is included here only as a reference document, since section 6201 of the new Affordable Care Act states that the background check program should be conducted in a manner similar to the pilot program previously conducted under the MMA.

SEC. 307. PILOT PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES OR PROVIDERS.

(a) AUTHORITY TO CONDUCT PROGRAM.—The Secretary, in consultation with the Attorney General, shall establish a pilot program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees.

(b) REQUIREMENTS.—

(1) IN GENERAL.—Under the pilot program, a long-term care facility or provider in a participating State, prior to employing a direct patient access employee that is first hired on or after the commencement date of the pilot program in the State, shall conduct a background check on the employee in accordance with such procedures as the participating State shall establish.

(2) PROCEDURES.—

(A) IN GENERAL.—The procedures established by a participating State under paragraph (1) should be designed to—

(i) give a prospective direct access patient employee notice that the long-term care facility or provider is required to perform background checks with respect to new employees;

(ii) require, as a condition of employment, that the employee—

(I) provide a written statement disclosing any disqualifying information;

(II) provide a statement signed by the employee authorizing the facility to request national and State criminal history background checks;

(III) provide the facility with a rolled set of the employee's fingerprints; and

(IV) provide any other identification information the participating State may require;

(iii) require the facility or provider to check any available registries that would be likely to contain disqualifying information about a prospective employee of a long-term care facility or provider; and

(iv) permit the facility or provider to obtain State and national criminal history background checks on the prospective employee through a 10- fingerprint

check that utilizes State criminal records and the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation.

(B) ELIMINATION OF UNNECESSARY CHECKS.— The procedures established by a participating State under paragraph (1) shall permit a long-term care facility or provider to terminate the background check at any stage at which the facility or provider obtains disqualifying information regarding a prospective direct patient access employee.

(3) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

(A) IN GENERAL.—A long-term care facility or provider may not knowingly employ any direct patient access employee who has any disqualifying information.

(B) PROVISIONAL EMPLOYMENT.—

(i) IN GENERAL.—Under the pilot program, a participating State may permit a long-term care facility or provider to provide for a provisional period of employment for a direct patient access employee pending completion of a background check, subject to such supervision during the employee's provisional period of employment as the participating State determines appropriate.

(ii) SPECIAL CONSIDERATION FOR CERTAIN FACILITIES AND PROVIDERS.—In determining what constitutes appropriate supervision of a provisional employee, a participating State shall take into account cost or other burdens that would be imposed on small rural long-term care facilities or providers, as well as the nature of care delivered by such facilities or providers that are home health agencies or providers of hospice care.

(4) USE OF INFORMATION; IMMUNITY FROM LIABILITY.—

(A) USE OF INFORMATION.—A participating State shall ensure that a long-term care facility or provider that obtains information about a direct patient access employee pursuant to a background check uses such information only for the purpose of determining the suitability of the employee for employment.

(B) IMMUNITY FROM LIABILITY.—A participating State shall ensure that a long-term care facility or provider that, in denying employment for an individual selected for hire as a direct patient access employee (including during any period of provisional employment), reasonably relies upon information obtained through a background check of the individual, shall not be liable in any action brought by the individual based on the employment determination resulting from the information.

(5) AGREEMENTS WITH EMPLOYMENT AGENCIES.—A participating State may establish procedures for facilitating the conduct of background checks on prospective direct patient access employees that are hired by a long-term care facility or provider through an employment agency (including a temporary employment agency).

(6) PENALTIES.—A participating State may impose such penalties as the State determines appropriate to enforce the requirements of the pilot program conducted in that State.

(c) PARTICIPATING STATES.—

(1) IN GENERAL.—The Secretary shall enter into agreements with not more than 10 States to conduct the pilot program under this section in such States.

(2) REQUIREMENTS FOR STATES.—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the pilot program;

(B) have procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the pilot program; and

(C) agree to—

(i) review the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(ii) immediately report to the entity that requested the criminal history background checks the results of such review; and

(iii) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1128E of the Social Security Act 11 (42 U.S.C. 1320a–7e), report the existence of such conviction to the database established under that section.

(3) APPLICATION AND SELECTION CRITERIA.—

(A) APPLICATION.—A State seeking to participate in the pilot program established under this section, shall submit an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) SELECTION CRITERIA.—

(i) IN GENERAL.—In selecting States to participate in the pilot program, the Secretary shall establish criteria to ensure—

(I) geographic diversity;

(II) the inclusion of a variety of long-term care facilities or providers;

(III) the evaluation of a variety of payment mechanisms for covering the costs of conducting the background checks required under the pilot program; and

(IV) the evaluation of a variety of penalties (monetary and otherwise) used by participating States to enforce the requirements of the pilot program in such States.

(ii) ADDITIONAL CRITERIA.—The Secretary shall, to the greatest extent practicable, select States to participate in the pilot program in accordance with the following:

(I) At least one participating State should permit long-term care facilities or providers to provide for a provisional period of employment pending completion of a background check and at least one such State should not permit such a period of employment.

(II) At least one participating State should establish procedures under which employment agencies (including temporary employment agencies) may contact the State directly to conduct background checks on prospective direct patient access employees.

(III) At least one participating State should include patient abuse prevention training (including behavior training and interventions) for managers and employees of long-term care facilities and providers as part of the pilot program conducted in that State.

(iii) INCLUSION OF STATES WITH EXISTING PROGRAMS.—Nothing in this section shall be construed as prohibiting any State which, as of the date of the enactment of this Act, has for conducting background checks on behalf of any entity described in subsection (g)(5) from being selected to participate in the pilot program conducted under this section.

(d) PAYMENTS.—Of the amounts made available under subsection (f) to conduct the pilot program under this section, the Secretary shall—

(1) make payments to participating States for the costs of conducting the pilot program in such States; and

(2) reserve up to 4 percent of such amounts to conduct the evaluation required under subsection (e).

(e) EVALUATION.—The Secretary, in consultation with the Attorney General, shall conduct by grant, contract, or inter- agency agreement an evaluation of the pilot program conducted under this section. Such evaluation shall—

(1) review the various procedures implemented by participating States for long-term care facilities or providers to conduct background checks of direct patient access employees and identify the most efficient, effective, and economical procedures for conducting such background checks;

(2) assess the costs of conducting such background checks (including start-up and administrative costs);

(3) consider the benefits and problems associated with requiring employees or facilities or providers to pay the costs of conducting such background checks;

(4) consider whether the costs of conducting such background checks should be allocated between the Medicare and Medicaid programs and if so, identify an equitable methodology for doing so;

(5) determine the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for such facilities or providers;

(6) review forms used by participating States in order to develop, in consultation with the Attorney General, a model form for such background checks;

(7) determine the effectiveness of background checks conducted by employment agencies; and

(8) recommend appropriate procedures and payment mechanisms for implementing a national criminal background check program for such facilities and providers.

(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out the pilot program under this section for the period of fiscal years 2004 through 2007, $25,000,000.

(g) DEFINITIONS.—In this section:

(1) CONVICTION FOR A RELEVANT CRIME.—The term ‘‘conviction for a relevant crime’’ means any Federal or State criminal conviction for—

(A) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7); and

(B) such other types of offenses as a participating State may specify for purposes of conducting the pilot program in such State.

(2) DISQUALIFYING INFORMATION.—The term ''disqualifying information'' means a conviction for a relevant crime or a finding of patient or resident abuse.

(3) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ''finding of patient or resident abuse'' means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a Federal agency that a direct patient access employee has committed—

(A) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

(B) such other types of acts as a participating State may specify for purposes of conducting the pilot program in such State.

(4) DIRECT PATIENT ACCESS EMPLOYEE.—The term ''direct patient access employee'' means any individual (other than a volunteer) that has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider, as determined by a participating State for purposes of conducting the pilot program in such State.

(5) LONG-TERM CARE FACILITY OR PROVIDER.—

(A) IN GENERAL.—The term ''long-term care facility or provider'' means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act) (42 U.S.C. 1395i–3(a)).

(ii) A nursing facility (as defined in section 1919(a) in such Act) (42 U.S.C. 1396r(a)).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act) (42 U.S.C. 1395x(dd)(1)).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act) (42 U.S.C. 1395ww(d)(1)(B)(iv))

(vi) A provider of personal care services.

(vii) A residential care provider that arranges for, or directly provides, long-term care services.

(viii) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act) 42 U.S.C. 1396d(d)).

(B) ADDITIONAL FACILITIES OR PROVIDERS.—
During the first year in which a pilot program under this section is conducted in a participating State, the State may expand the list of facilities or providers under subparagraph (A) (on a phased-in basis or otherwise) to include such other facilities or providers of long-term care services under such titles as the participating State determines appropriate.

(C) EXCEPTIONS.—Such term does not include—

(i) any facility or entity that provides, or is a provider of, services described in subparagraph (A) that are exclusively provided to an individual pursuant to a self-directed arrangement that meets such requirements as the

participating State may establish in accordance with guidance from the Secretary; or

(ii) any such arrangement that is obtained by a patient or resident functioning as an employer.

(6) PARTICIPATING STATE.—The term ‘‘participating State’’ means a State with an agreement under subsection (c)(1).

Appendix 7

Definitions Applicable to this Solicitation

Any Available Registries – means state based databases, in addition to a nurse aide registry, that identifies those who have been approved by state requirements to provide care to residents or patients in long-term care facilities or by providers of long-term care services. These registries may include, but are not limited to those, which list physicians, nurses, psychologists, and other professionals who are considered direct access employees. In addition, other registries or databases may include Medicare Exclusion Database (MED), Fraud Investigation Database (FID), Healthcare Integrity and Protection Data Bank (HIPDB), or National Practitioner Data Bank (NPDB).

Background Check – means the process by which the State appointed agency, the provider, or employer conducts a legislatively approved investigation and with written approval of a direct access employees' personally provided information at the time of application for employment.

Centers for Medicare & Medicaid Services (CMS) – is the Federal agency that administers the Medicare program, and works in partnership with the States to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. CMS is responsible for the administrative standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and quality standards in health care facilities through its survey and certification activity.

Conviction for a Relevant Crime – means any Federal or State criminal conviction for any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a – 7); and such other types of offenses a participating State may specify for purposes of conducting the demonstration program in that State.

Direct Patient Access Employee – means any individual that has *access* to a resident, patient or client of a long-term care facility or provider through employment or through a contract with such facility or provider. Examples of direct patient access employees include, but are not limited to, nursing, housekeeping, dietary, pharmacy, and administrative staff.

Patient – (for the purpose of this solicitation) means any patient, resident or client of a long term care facility or provider.

Employment Agency – an organization that provides temporary, part-time, or permanent staff to a requesting facility or provider organization.

Fitness Determination – a decision made by either the State appointed agency, the provider, or employer to either offer a position of employment or deny a position of employment based on the information obtained

Livescan and Cardscan – automated devices for generating and transmitting digitized fingerprint images. Livescan devices capture fingerprint images directly from subjects' fingers, which are

rolled onto glass scanning plates. Cardscan devices scan and digitize standard inked fingerprint cards and can transmit electronic images with related textual data to remote sites for printout or direct use.

National Criminal History Background Check – means the criminal history record system maintained by the Federal Bureau of Investigation based on fingerprint identification, through its Integrated Automated Fingerprint Identification System (IAFIS) and the utilization of State criminal records or other methods of positive identification.

Nurse Aid Registry – means a federally mandated database that requires states to establish and maintain a registry which contains information on individuals who have successfully completed a nurse aide training and competency evaluation program in accordance with Federal requirements and who have been found competent to function as a nurse aide.

Rap-Back System – means a rap-back system that provides the capability by which State law enforcement departments can monitor the legal status of individuals who have had a previous background check and can immediately inform the State of any criminal convictions against the employee that occur following the pre-employment background check. In turn a "rap back" system provides capability for the State to immediately notify the provider when law enforcement notifies the State that an employee is convicted of a disqualifying offense after the pre-employment background check.

Rehabilitation – means the reestablishment of an individual's character following a conviction of a crime as defined by State statute or regulation. Rehabilitation may be demonstrated by the passage of time and by examining an individual's activities and lifestyle.

Set of Fingerprints – means a rolled or flat impression of a prospective direct access employee's 10 fingers.

Appendix 8

Resource Information Related to Non-Federal Share

Section 6201 of the Affordable Care Act specifies that Federal funding for States to implement the national background check initiative requires a 25% non-Federal match. In judging the acceptability of the non-Federal match CMS will generally apply the same criteria as is used in Medicaid. Where some of the limitations of Medicaid do not apply, CMS notes those exceptions in the body of the solicitation and also reserve the right to make other exceptions to the limitations if CMS judges any such exceptions to be in the best interests of the public.

Medicaid law and regulations permit a variety of options for use as the source of the non-Federal share, such as:

- State tax revenue,
- Local tax revenue,
- Health care-related taxes, and
- Bona Fide Donations.

Regulations at 42 CFR 433 subpart B identify the basic requirements, except that sections 42 CFR 433.53(b) and §433.70 do not apply to this background check program.

CMS has received questions regarding the use of fees as a source of non-federal match. CMS is therefore including this Appendix to offer additional information with regard to some of the options and limits that apply.

Health care-related taxes that are broad-based, uniform, imposed on a permissible class of services and that do not result in hold harmless violations are used by States as the non-Federal share for a variety of Medicaid services. Licensing and certification fees imposed on health care providers are considered health care-related taxes and can represent another revenue source often employed by States. CMS notes that licensing and certification fees imposed on health care providers may qualify as a permissible source for the non-Federal share if they meet the requirements of 42 CFR 433. Certification fees can apply to providers, and/or to classes of workers. CMS does not encourage the use of fees that potential employees must pay, as the fees may have the unintended effect of discouraging job applicants. Nonetheless, CMS recognizes the limitations of State budgets, and also observes some States that have used job applicant fees have mitigated the potential discouragement effect by returning some, or all, of the fee in the event the applicant has no disqualifying information and is hired by a long term care employer.

Certification fees can apply to a particular provider class and can vary between those provider classes. For example, the fee for a personal care agency may be different than the fee for a home health agency. For purposes of the background check program, CMS will consider as a distinct class any provider type identified in 42 CFR 433.56 or, if not listed in 42 CFR 433.56, any provider grouping distinctly identified in the Provider Types Chart in section B.3 of Appendix 3 of this solicitation.

Certification fees may also apply to all affected individuals of a class. For example, a State could charge a background check certification fee for all individuals applying for positions in a nursing home, and a different fee for all applicants seeking employment in a home health agency. But within each provider type, the fee must be uniformly applied (e.g., all nursing home applicants must be charged the same amount, unless a waiver is obtained).

In each case, the criteria identified in 42 CFR 433.56 (a)(19) apply. The "fee must be broad based and uniform or the State must receive a waiver of these requirements", the payer of the fee cannot be held harmless and "the aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program."

CMS will also consider requests for some variation to the broad-based and uniformity requirements (42 CFR 433.56(a)(19)(i) in the case of a State wishing to maintain some variation in the fees within a provider class based on good cause. For example, a State may wish to charge lower fees to applicants in certain rural or low income areas, or a State may wish to phase-in application of the fee based on geographic areas.

Federal regulations specify if a licensing and certification fee for providers is not more than $1,000 annually and the total amount raised by the State from the fees is used in the administration of the licensing or certification program, waivers of the broad-based and uniformity requirements will be automatically granted. In the case of a geographical area phase-in, the fee may not immediately apply statewide but would apply to all providers (or all individual applicants to those providers) in the particular area included in the background check program, in accordance with a published phase-in timetable identifying the geographical boundaries and the timetable for inclusion.

CMS also notes that the provisions of 42 CFR 433 do not preclude a State from charging applicants a fee and then returning some or all of the fee to applicants who had no disqualifying information and who are subsequently hired by the long term care provider. The returned funds, however, cannot count as non-Federal matching funds. A State could set its fee schedule in such a way that it anticipates returning some of the fees to applicants and then counts only the net remaining collections as non-Federal matching funds. Also note, if fees are not collected from certain providers, the fee would not be broad-based and may require a waiver. If this is the case, CMS is available to work directly with each State to design and implement a fee that is in accordance with all applicable requirements.

Appendix 9

Application Submission Checklist

_____ Applicant's Title Page and Cover Letter

_____ Standard Forms from Grant Application Package (Grants.gov)

_____ Letters of Agreement and Support from the Governor or State Survey Agency Director, etc.

_____ Program Abstract

_____ Project Narrative

_____ Work Plan and Flowchart

_____ Budget Narrative/Justification

_____ Budget Forms

_____ Attachments (Letters of Agreement and Support)

_____ Required Appendices

_____ Biographical Sketch/Resume (upload in Grants.gov as an attachment)

_____ Indirect Cost Rate Agreement (if applicable)

Please see Section IV *Required Application and Submission Information Contents* for detailed information on the application submission requirements.

Appendix 10

THIS APPENDIX IS RESERVED