Division of TennCare | LTSS

Attestation of Compliance for Eligibility to Receive Enhanced Home and Community Based Services (HCBS) Federal Medical Assistance Percentage (FMAP) Funding for Providers

Enhanced HCBS FMAP Funds are dollars being used within Tennessee's Home and Community Based Services (HCBS) Programs—CHOICES, Employment Community First CHOICES (ECF), and 1915(c) Waiver Programs—to increase access to HCBS, strengthen the HCBS workforce, and build provider capacity to meet the needs of individuals receiving HCBS in these programs. This time-limited funding provided under Tennessee's American Rescue Plan Act (ARPA) Federal Medical Assistance Percentage (FMAP) Initial Spending Plan allows providers to be eligible for payments upon meeting custom/specific quality metrics related to the completion of competency-based training that are anticipated to improve the quality of service delivery and quality of life of those receiving services. The below attestation is confirmation that your agency will comply with all applicable requirements pertaining to eligibility for 1) the submission of claims or requests for payment of these federal funds, and 2) the receipt of these federal funds as prescribed by TennCare in written memos, protocols, or other communication. You further affirm to maintain documentation to demonstrate your agency's compliance with TennCare requirements and cooperate fully with all reporting and/or evaluation requirements, audits, or other requests for documentation related to these payments.

Attestation:

- ☐ I understand that it is my responsibility to review eligibility requirements for each of the increased funding opportunities made available through federal Enhanced HCBS FMAP funding, and to only 1) submit claims or requests for payment of these federal funds; and 2) accept payment of these federal funds if eligibility requirements are met.
- ☐ I commit, as an Officer or Delegate Official, that complete documentation of compliance with these requirements will be maintained, and that records will be available upon request for auditing and validation of compliance for all ARPA FMAP payments received.
- ☐ I commit, as an Officer or Delegate Official, that Direct Support Professionals (DSPs) and/or Front Line Supervisors (FLSs) participants will register for the E-Badge Academy through the TennCare provided Formstack Reporting Tool (DSPs) or Formstack Reporting Tool (FLSs).
- ☐ I understand, as an Officer or Delegate Official, that the provider agency may seek reimbursement up to $1000 for the cost of a nationally approved training once the National Association for Direct Support Professional (NADSP) has certified DSP achievement of the tiers.
- ☐ I understand, as an Officer or Delegate Official, that as a condition of receiving these quality incentive payments (i.e. directed quality bonus incentive payment to HCBS providers, DSPs, FLSs, and training reimbursement), the provider will agree to provide data to help evaluate the efficacy of the approach in increasing satisfaction and quality (for the person supported as well as the workforce), and in improving workforce recruitment and retention.
- ☐ I acknowledge, as an Officer or Delegate Official, that the funding is time-limited and will not be funded through ARPA funds past March 31, 2025.
- ☐ I acknowledge that any Enhanced HCBS FMAP funding accepted by my agency for which eligibility requirements are not met is subject to recoupment, and that any such funding received, or any claims or requests for such funding for which eligibility requirements are not met is subject to potential False Claims Act violations.
- ☐ I am a part of senior leadership within the provider agency with authority to sign on behalf of the agency.

☐ I understand if there are any indications that any provider agency engaging in activities to maximize incentive payments through fraudulent means will be reported to the TennCare Office of Program Integrity, the TBI, and Tennessee Attorney General's office for an investigation related to violation of the False Claims

Attestation Type	
☐ **Initial** ☐ **Annual Renewal** ***(annual renewals are due 365 days from the date on the initial attestation)***	
Provider Information	
Name:	**Provider Medicaid Identification:**
Tax Identification Number:	**Date of Attestation:**
Address:	
Printed name of signature:	
Title:	
Date:	
Authorized signature:[1]	

[1] A scanned, imaged, electronic, photocopy or stamp of the above signature shall have the same force and effect as an originally executed signature.