

# HCBS Capacity Building Funding Opportunity Frequently Asked Questions (FAQ)

## Providers and Services Eligible for Funding

1. Which services are included in the opportunity? Which services are excluded?
  - a. Almost all home and community-based CHOICES, Employment and Community First (ECF) CHOICES, 1915(c), Katie Beckett and OPTIONS services, including residential and day services, are eligible for the funding opportunity, except the following:
    - PERS (Personal Emergency Response Systems)
    - PEST (Pest Control Services)
    - Home Delivered Meals
    - Minor Home Modifications
    - Independent Support Coordinator (ISC) agencies
  - b. OPTIONS providers that wish to apply for the funding opportunity must be credentialed by either the MCOs or DDA to provide services for CHOICES, ECF CHOICES, 1915(c), and/or Katie Beckett programs.
2. Can providers of behavior services apply for funding?
  - a. Providers of HCBS that include behavior services may submit an application. For ECF CHOICES, this includes
    - Specialized Consultation and Training,
    - Intensive Behavioral Family Centered Treatment, Stabilization, and Supports (IBFCTSS), and
    - Intensive Behavioral Community Transition and Stabilization Services (IBCTSS).
  - b. For 1915(c), it includes Behavior Services and Behavioral Respite.
3. Can providers of 1915(c) only services apply for funding?
  - a. Providers currently only serving members in the 1915(c) HCBS waivers may submit an application. As with all provider submissions, the application should provide a detailed description of the assessed need and how it will be addressed by the proposed initiative.
4. Is it possible to receive funding for activities that are not service-related, such as childcare assistance for staff?
  - a. Yes. Activities that are not directly service-related may be approved for funding, if the provider is able to justify that it will support their ability to expand capacity. For example, funds to provide staff childcare assistance may be considered a

workforce recruitment and/or retention initiative.

5. Can new providers apply if they are not yet contracted with an MCO?
  - a. No. Providers must be contracted with at least one MCO to apply.
6. Can funds be used to acquire agencies in other geographic areas?
  - a. No. Funds may not be used to acquire other agencies or sites, as this is considered a capital expenditure. Additionally, purchasing existing agencies or sites does not support the goal of expanding capacity to serve new or additional members.
7. Are Independent Support Coordinator (ISC) agencies eligible to apply for funding?
  - a. Funding may not be used to expand ISC services; however, if an ISC agency also provides eligible HCBS through the CHOICES, ECF CHOICES, and/or Katie Beckett programs, the agency may apply for funds to expand those services.
8. Can funds be used to provide training to direct support professionals (DSPs)/paid caregivers?
  - a. Yes. Funds may be used for workforce training and development. These efforts are vital to building capacity to serve members by improving workforce retention and preparing DSPs and paid caregivers to support member with varying level of care needs. It is important to remember that all funding awards are non-recurring, so if there will be ongoing costs related to the training (e.g., maintaining certifications or training new staff members after the end of the funding period), those costs will be the provider's responsibility.
9. Can funds only be used to expand to new service areas or add new service types?
  - a. No. Capacity building is not just about expansion of available locations or services. It also includes strengthening the workforce to reduce turnover, increasing capacity to serve members with higher level of care needs, reduce existing service initiation delays, and improving the quality and person-centeredness of currently offered services. Providers are encouraged to consider broader opportunities for capacity building, such as training and development, increased use of technology, improved case management systems, and agency certifications/accreditations.
10. Are providers that are contracted with an MCO, but not currently serving any TennCare members, eligible to receive funding?
  - a. Yes. All providers that have active credentials and are contracted with at least one MCO are eligible to receive funding. The Needs Assessment section of the provider's application should describe any factors or barriers impacting their ability to serve current TennCare members and Project Plans should focus on how funds will be used to begin accepting member referrals.
11. During the informational session, it was stated that some providers may need to be credentialed with DDA in order to expand their services. What is DDA and how do I know if I need to be credentialed with them?
  - a. DDA is the TN Department of Disability and Aging (formerly known as the Department of Intellectual and Developmental Disabilities, or DIDD). DDA is

responsible for credentialing providers for the following programs:

- ECF CHOICES,
- 1915(c) HCBS waivers,
- Katie Beckett Parts A and B,
- CHOICES providers that also provide ECF CHOICES, 1915(c), and/or Katie Beckett services.

- b. DDA is also responsible for credentialing all Community Living Supports (CLS) and Community-Living Supports – Family Model (CLS-FM) providers, including CLS or CLS-FM for CHOICES members only. Additional information about [DDA credentialing](#) can be found on the DDA website.

12. When expanding capacity for existing services or offering new services, will providers need to obtain the additional required credentials, licenses, and/or certifications prior to submitting the application?

- a. Providers proposing initiatives that will require additional credentials, licensures, and/or certifications do not need to have completed the process prior to submitting the funding opportunity application. However, the application should explain where the provider is in the process and the anticipated timeline for obtaining all applicable credentials, licensures, and/or certifications. For providers that are not applying this year but are interested in applying in 2026, we encourage them to begin applying for additional credentials, licensures, and/or certifications over the next year in preparation for the next funding cycle.

13. Are home health providers eligible to apply for the funding opportunity?

- a. Funding may not be used to expand home health services; however, if a home health agency also provides eligible HCBS, the agency may apply for funds to expand those services.

14. Can funds be used to increase pay rates to recruit and/or retain staff with higher qualifications and experience?

- a. As awarded funds are non-recurring, however, funds may be used for one-time bonuses or incentives if the provider's application is able to demonstrate how they will promote sustained or increased capacity.

15. Since HCBS programs do not include medical services, can funds be used to recruit and train staff with nursing or other health care credentials?

- a. With members allowed to enlist providers for Self-Direction of Health Care Tasks (SDHCT) beginning in July 2025, we recognize the potential benefit of recruiting and training of DSPs with nursing or other health care credentials and will allow funds for this purpose. As previously stated, all awarded funds are nonrecurring, so providers should consider potential ongoing costs associated with any recruitment or training initiatives. Additionally, applications that include initiatives aimed at recruiting and training nursing or other health care staff should detail how the proposal will help build capacity to serve new members, reduce or prevent service initiation delays, and or improve quality of services.

16. Can funds be used to expand current program and/or service capacity, such as a building or acquiring larger space, increasing staff, or purchasing additional curriculum or

resource materials?

- a. Funds cannot be used for capital expenditures, which includes the purchase of additional land or facilities, construction of new buildings on currently owned property, and construction of additional space or usable square footage at existing sites.
  - b. Additionally, as awarded funds are non-recurring, providers should consider ongoing costs that may be associated with any proposed initiative, including leasing spaces, increasing staff, and purchasing additional materials, and provide details in their application for how they will fund those expenses after the end of the funding period.
17. Can funds be used to purchase or lease vehicles for member transportation or mobile recruitment or training resources?
- a. Funds cannot be used to purchase or lease vehicles. However, funds can be used to make modifications to provider-owned vehicles in order to provide member transportation or serve as a mobile resource for DSP/caregiver recruitment and training.
18. Can funds be used to purchase assistive devices to have in a training room for new caregivers or ongoing training (e.g., use of Hoyer lifts, sit to stand lifts, etc.)?
- a. Funds cannot be used to purchase assistive devices for training only. Training on use of assistive devices and/or assisting with lifts/transfers should be individual-specific, taking place with the member and using the specific equipment available in their environment.
19. During the informational session, it was stated that the addition of new slots in ECF CHOICES and CHOICES Group 3 was one of the drivers for capacity building. Are funding applications limited to expanding services for these populations, or can proposals be aimed at expanding services for CHOICES Group 2 as well?
- a. Funds may be used to build capacity for both current and future ECF and/or CHOICES members, regardless of their enrollment group. The goals of the funding opportunity are to support the availability of services for existing members as well as expand the provider network for future HCBS recipients.

## **Funding Opportunity Applications**

1. What is the timeline for the application and award process?
  - a. Applications will be released to providers that attended the mandatory training sessions held at the end of July. The target date for releasing the application is September 1, 2025. Providers will have thirty (30) days to submit a completed application. The timeline for award notifications is fluid based on the number of applications received; however, the goal is that all applicants to be notified if their project was funded by the end of 2025.
2. Can we use a grant writer to develop our funding opportunity application?
  - a. Providers are welcome to use a grant writer to help develop their application; however, the associated cost will be the provider's responsibility and cannot be

reimbursed through the funding opportunity.

3. Will providers that are contracted with more than one MCO need to submit their application to each MCO?
  - a. No. Providers will submit their application to the MCO contact assigned to the region in which their initiative will be implemented. If a provider's initiative will be implemented in more than one region, their application should be submitted to the BlueCare contact.
4. If a provider is proposing multiple initiatives, should a separate application be submitted for each?
  - a. No. Providers should include all proposed initiatives in one application. However, that does not mean that a provider will be awarded funds for all proposed initiatives in an application.
5. Is the "Expansion Credentialing Application" from DDA the same as the application for this funding opportunity?
  - a. No. DDA's Expansion Credentialing Application is for existing providers to become credentialed for additional services and/or programs. This is unrelated to the HCBS Capacity Building Funding Opportunity. The funding opportunity application will be released in August to providers that attended one of the mandatory training sessions.
6. Can providers apply for funds in Year 1 for projects that will take five years to implement?
  - a. While applications may be submitted for multi-year initiatives, we encourage providers to consider the potential complications of a proposal that will take three to five years to implement. These may include changes in provider leadership, state or federal requirements, member population or level of care needs, and/or service usage. Providers planning a multi-year initiative may consider using a phased- implementation approach and applying for funds in subsequent years for each phase.
7. Do providers with applications approved in Year 1 need to reapply each year for additional funding?
  - a. Whether a provider approved in Year 1 needs to reapply in subsequent years for additional funding is based on 1) the activities and timeframe outlined in the provider's approved application and 2) the provider's desire to expand the initiative or undertake additional capacity building activities.
  - b. For example, if a provider's Year 1 application proposes an initiative that will take two years to implement, and the initiative is fully approved, the provider will not need to apply for additional funds in Year 2. However, if a provider's Year 1 application proposes an initiative that takes one year or less to implement and, after completion, they decide to expand or replicate the activities at additional sites, the provider would need to apply for additional funds in Year 2. There is no guarantee of funds in later years.
  - c. Providers that complete their approved initiatives and do not wish to participate in any additional capacity building activities are not required to reapply in

subsequent years.

8. If a provider does not apply for funding in Year 1, can they apply in a subsequent year?
  - a. Yes. Providers that do not apply in Year 1 may apply in any subsequent funding year. Additionally, providers that apply in Year 1, but are not awarded funding, may reapply when the funding opportunities are reopened in Years 2 through 5.
9. Can two or more provider organizations submit a joint/collaborative application?
  - a. No. Each provider organization must submit separate applications for their initiatives to ensure effective oversight of implementation and reporting. If a provider wants to enlist the services of another provider organization to assist in implementing an initiative—for example, as a subcontractor—the primary provider organization would need to identify and describe the role of the supporting provider in the application. In this situation, the primary (applying) provider would be responsible for meeting all implementation and reporting requirements.
10. Will the number of new members a provider serves this year improve the likelihood of being approved for funding in 2026? For example, if a provider accepts more new members, will their 2026 funding application be given preference?
  - a. Each year’s funding awards will be determined based solely on the strength, quality, and feasibility of the proposed initiative. No preferences will be given based on the size of the organization or the number of new members the provider accepted in the previous year.
11. Will providers have the opportunity to correct or add to a submitted application if it was denied funding due to missing or incomplete information?
  - a. No. All funding award decisions are final, and providers will not have the opportunity to amend their proposal to provide additional information if it was denied. Providers that are not awarded funding are strongly encouraged to make any corrections or additions to their application in order to apply for a future year of funding.

## **Award Determinations and Funding**

1. Are the funding awards considered “loans” (i.e., will they need to be paid back)?
  - a. No. Funding awards are not loans and will not need to be paid back for implemented initiatives. However, providers may be required to return some or all awarded funds if they do not meet implementation and/or reporting requirements.
2. How long does the funding determination/approval process take?
  - a. While the timelines have not been finalized, we anticipate that providers will have approximately 30 days to develop and submit their proposals after the application has been released. The MCOs intend to communicate funding determinations to providers within 30 – 45 days of the close of the application period. However, this timeline may be impacted by the volume and complexity of submitted applications so the MCOs can ensure all proposals are thoroughly reviewed and

fairly scored.

3. How will the MCOs determine which provider applications/proposals will be funded?
  - a. Each MCO will independently review every provider application and score them using a jointly developed scoring rubric. After finishing the independent reviews, the MCOs will meet to discuss the scores and determine which proposals will be funded and the amount to be awarded.
4. Will the MCOs consider factors other than the proposal application when making funding determinations? For example, does a provider's previous compliance or quality monitoring scores factor into the decision?
  - a. The strength, quality, and feasibility of the proposal application, as determined by the scoring rubric, are the only factors considered for funding determinations. However, maintaining quality and compliance are crucial to provider and member success. If your agency participates in the DDA Quality Monitoring Survey, we encourage you to consider your most recent report when developing your proposal. If your agency does not currently participate in the Quality Monitoring Survey, you may want to review the current survey tool and related resources on the [Quality Monitoring page](#) of DDA's website.
5. How will the funding amounts awarded to providers be determined? Could they receive more or less than requested?
  - a. Funding awards will be based on the amounts requested in the provider's application and will never be more than the proposed budget. However, funding awards may be less than the request amount if the MCOs choose not to fund all elements of a provider's proposed initiative(s).
6. If the approved funding awards do not total the allocated \$10 million, will the remaining funds roll over to the next year?
  - a. The state is aiming to use all allocated funds during each award year; however, at this time, it is anticipated that any unallocated funds in a funding period will be rolled over for use in the following year.
7. Are providers required to contribute matching funds or provide money upfront?
  - a. No. Providers are not required to provide money upfront or match the funds they are awarded for approved initiatives. However, for initiatives that a provider intends to carry on long-term, such as implementation of an electronic case management system, the provider's application will need to describe how ongoing implementation will be funded.
8. Can providers begin expansion initiatives prior to approval of funding awards?
  - a. Yes. Providers that have the resources are encouraged to begin expansion initiatives prior to approval of funding awards. However, there is no guarantee of funding and awarded funds cannot be used to reimburse the provider for expenses accrued prior to the funding approval date. Providers that wish to begin expansion initiatives immediately should develop their application and budget to focus on activities in later stages of the project.
9. What is the maximum amount a provider can apply for?
  - a. There is no maximum amount on which a provider may request; however, the annual cap for total funding awards is \$10 million per year for each of the five

years. It is also important to note that providers may not be awarded the full amount requested in their application. MCOs have the authority to approve partial funding based on strength and feasibility of the proposal as well as number of proposals submitted for funding.

10. How many providers will receive funding each year? Will there be a certain number of awards per program (e.g. CHOICES, ECF)
  - a. There are not a set minimum or maximum number of providers that will receive funding each year and there is not a set number of awards per program. Many factors may impact the number of providers that receive funding including, but not limited to, the number and quality of proposals received, the appropriateness of proposals in meeting capacity building goals, and the amount of funds requested and approved for individual initiatives.
11. What if my application is not successful?
  - a. Providers that did not receive approval for their proposed initiatives are welcome to reapply in a future funding year.

## **Provider Initiative Implementation**

1. What are the implementation and reporting requirements?
  - a. All applications are required to provide detailed information about implementation of the proposed initiative, including budgets, milestones for completion, and outcome measures. MCOs will conduct regular check-ins with, and request quarterly reports from, providers that are awarded funds to ensure milestones are being met, outcomes are achieved, and expenditures align with the approved budget.
2. If a provider's application proposes to expand in two locations, could the task be split between the first of the year and the middle of the year?
  - a. Yes, if the submitted proposal describes the timeline/milestones for starting and completing each of the expansion projects.
3. What metrics will be used to determine whether a funded initiative is successful?
  - a. The metrics for success will be defined by the provider in the evaluation plan section of the approved project proposal.

## **Technical Assistance and Support**

1. Can MCOs assist providers in developing their proposals?
  - a. The MCOs cannot assist individual providers in developing their proposals. Since the MCOs are reviewing the applications and making award determinations, this would be a conflict of interest. However, the MCOs will provide technical

assistance through dedicated office hours, email support, and data sharing.

2. What kind of assistance can providers receive at the MCO office hours?
  - a. During the office hours, providers can receive technical assistance on specific questions related to current and future network needs, credentialing and contracting processes for expanding services, allowable uses for funding, and the requirements outlined in the Request for Application. Additionally, as the office hours are open meeting sessions, they provide an opportunity to connect with other providers and brainstorm ideas for building network capacity. The MCOs cannot assist providers with developing their proposals or drafting their application during the office hours sessions.
3. Can a provider schedule a private session with the MCO instead of attending the open office hours?
  - a. Due to the number of providers anticipated to apply for this funding opportunity, the MCOs are unable to schedule private sessions with providers to provide technical assistance.
4. If a provider has questions about whether their proposal is compliant with the HCBS Final Rule, including the Settings Requirements, who can they ask?
  - a. Questions about applicability and/or compliance with the HCBS Final Rule, including the Settings Requirements, can be discussed with the MCOs during office hours. If questions cannot be resolved during office hours, providers may reach out to Amanda Yanez, Director of QAI Policy, Planning, and Programs with TennCare LTSS, at [Amanda Yanez](#).
5. Is additional information available related to the quality monitoring topics and indicators?
  - a. Additional information about the quality monitoring topics and indicators, including the survey tools and other resources, can be found on the [Quality Monitoring page of the DDA website](#).
6. Are fee schedules/rate information available for each of the services?
  - a. Yes. To obtain a copy of the fee schedules or rate information, please reach out to Provider Relations Team at each MCO.
7. What data will be included on the provider dashboards that were shared during the informational sessions? Is there a link available to access the dashboards?
  - a. There is not a shareable link to the provider data dashboards; however, county- and regional-level profiles were made available via email to providers that attended the mandatory training. Providers that did not receive the files may request the data at the scheduled MCO Office Hours, or by emailing the MCO contact for the provider's region.
  - b. The provider data profiles will display data to support decisions for expansion proposals, including numbers of 1) credentialed providers; 2) members on the ECF CHOICES waitlist; and 3) members interested in Employment Services. The profiles will also identify the top three services experiencing initiation delays.
8. Is a regional breakdown available of members that will be enrolling from the waitlist so that providers assess capacity and prepare for new referrals?
  - a. Yes. MCOs will be able to provide data about member locations by region, county, and zip code after the mandatory training sessions, as well as by email to

the MCO regional contact. Please note that the data provided should be considered projections. While we strive for the data to be as accurate as possible, there may be some minor fluctuations in the number of members and/or types of services needed in a certain area due to relocations, changing service needs, and/or disenrollments.