TN Division of TennCare | LTSS

Attestation of Compliance for Eligibility to Receive Enhanced Home and Community Based Services (HCBS) Federal Medical Assistance Percentage (FMAP) Funding and Other Rate Increases based on Targeted State Appropriations

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. Recurring funding will be provided through targeted State appropriations. In addition, provider rates are being further increased based on state budget approval to support additional wage increases for frontline direct support professionals (DSPs) working in TennCare's home- and community-based services programs, including CHOICES, Employment and Community First CHOICES, and the 1915(c) Waivers operated by DIDD. The below attestation is confirmation that my 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. I further affirm that I will maintain documentation to demonstrate my agency's compliance with TennCare requirements, and cooperate fully with all 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/or state appropriations, and to only 1) submit claims or requests for payment of these federal and/or state funds; and 2) accept payment of these federal and/or state 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 federal and/or state payments received.

- ☐ I acknowledge that any federal or state 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 Act.

Attestation Type	
☐ **Initial** ☐ **Annual Renewal** ***(annual renewals are due no more than 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.