



Annual Attestation of Compliance: Employee Education about Medicaid False Claims, per Federal Deficit Reduction Act of 2005, Section 6032

I, acting on behalf of the entity named below, and authorized to so act, after diligent inquiry, hereby attest that said entity complies with the requirements under 42 U.S.C. §1396a(a)(68), enacted under Section 6032 of the Deficit Reduction Act of 2005 (the Act), and MassHealth regulations at 130 CMR 450.205(F)(1), and 130 CMR 450.223(C)(7).

I understand that said Act requires all entities that receive at least \$5 million dollars in Medicaid payments annually to educate employees at all associated locations about federal and state laws concerning false claims and whistleblower protections. I further understand that the Act requires as a condition of receiving such payments that the entity must

- establish written policies for all employees of the entity and contractors that provide detailed information about federal and state false claims laws, penalties for submitting false claims and statements, whistleblower protections, and the role of the laws in preventing and detecting fraud, waste, and abuse;
- include as part of such written policies detailed information about the entity's policies and procedures for detecting and preventing fraud, waste, and abuse in federal health care programs; and
- include in any employee handbook, if one exists, a specific discussion of such laws, whistleblower protections, and the entity's policies and procedures for detecting fraud, waste, and abuse.

I further attest that access to such information is available as follows (check all that apply):

- through electronic communications (please provide your website address);
- printed and included in employee handbooks (please provide a copy of printed information);
- printed and posted in easily accessible areas (please provide a copy of printed information); or
- other (please describe and attach additional documentation if needed): _____

Providers with multiple sites:

If you have multiple locations, complete this form and attach a listing of all locations. This information must include the name, tax identification number, and address of each separate facility.

Mail or fax this form, and all additional documentation, to the following address.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Compliance and Program Integrity Unit
100 Hancock Street
Quincy, Massachusetts 02171
Fax: 617-847-1245

Person responsible for publication/distribution and contact information:

Name: _____ Title: _____
Contact Phone: _____ Contact E-mail: _____

I certify under the pains and penalties of perjury that the information on this form and any attached statement I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties and criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Signature of Authorized Representative : _____ Date: _____

(Signature and date stamps, or the signature of anyone other than a person legally authorized to act on behalf of the legal entity, are not acceptable.)

Print Name: _____ Print Title: _____

Print Name of Entity: _____