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STANDARD CONTRACT FORM

This form is jointly issued and published by the Office of the Comptroller, the Executive Office for Administration and Finance, and the Operational Services Division as the default contract for all Commonwealth Departments when another form is not prescribed by regulation or policy. The Commonwealth deems void any changes made on or by attachment (in the form of addendum, engagement letters, contract forms or invoice terms) to the terms in this published form or to the Standard Contract Form Instructions and Contractor Certifications, the Commonwealth Terms and Conditions, the Commonwealth Terms and Conditions for Human and Social Services or the Commonwealth IT Terms and Conditions which are incorporated by reference herein. Additional non-conflicting terms may be added by Attachment. Contractors are required to access forms at macomptroller.org/forms or mass.gov/lists/osd-forms.

CONTRACTOR INFORMATION

Contractor Legal Name Fallon Community Health Plan, Inc. **d/b/a**

Legal Address As entered on Form W-9 or Form W-4: One Mercantile Street, Suite 400, Worcester, MA 01608

Contract Manager Name Deborah Daviau

Phone 508-368-9489 **Email** Deborah.Daviau@fallonhealth.org **Fax** 508-368-9550

Vendor Code VC 6000230412

Vendor Code Address ID AD 001
e.g. "AD001". Note: The Address ID must be set up for Electronic Funds Transfer (EFT) payments.

COMMONWEALTH INFORMATION

Department Executive Office of Health and Human Services **MMARS Code** EHS

Contract Manager Name Daniel Cohen

Business Mailing Address One Ashburton Place, 5th Fl., Boston, MA 02108

Billing Address If Different

Phone 617-573-1710 **Email** Daniel.cohen@mass.gov **Fax**

MMARS Doc ID(s)

RFR/Procurement or Other ID Number 15LCEHSSCORFA

○ NEW CONTRACT

Procurement or Exception Type (Check one option only)

- ☐ **Statewide Contract** (OSD or an OSD-designated department.)
- ☐ **Collective Purchase** (Attach OSD approval, scope, and budget.)
- ☐ **Department Procurement** - Includes all Grants 815 CMR 2.00. (Attach Solicitation Notice or RFR, and Response or other procurement supporting documentation.)
- ☐ **Emergency Contract** (Attach justification for emergency, scope, and budget.)
- ☐ **Contract Employee** (Attach Employee Status Form, scope, and budget.)
- ☐ **Interim Contract with new Contractor** (Attach justification for Interim Contract and updated scope/budget.)
- ☐ **Other Procurement Exception** (Attach authorizing language, legislation with specific exemption or earmark, and exception justification, scope, and budget.)

◉ CONTRACT AMENDMENT

Current Contract End Date *PRIOR* to Amendment December 31, 2025 **Amendment Amount** Or Enter "No Change" No Change

Amendment Type (Check one option only. Attach details of amendment changes.)

- ☑ **Amendment to Date, Scope, or Budget** (Attach updated scope and budget.)
- ☐ **Interim Contract with Current Contractor** (Attach justification for Interim Contract and updated scope/budget.)
- ☐ **Contract Employee** (Attach any updates to scope or budget.)
- ☐ **Other Procurement Exception** (Attach authorizing language/justification and updated scope/budget.)

TERMS AND CONDITIONS

The Standard Contract Form Instructions and Contractor Certifications and the following document are incorporated by reference into this Contract and are legally binding (Check ONE option):

◉ Commonwealth Terms and Conditions ○ Commonwealth Terms and Conditions for Human and Social Services ○ Commonwealth IT Terms and Conditions

COMPENSATION (Check ONE option.)

The Department certifies that payments for authorized performance accepted in accordance with the terms of this Contract will be supported in the state accounting system by sufficient appropriations or other non-appropriated funds, subject to intercept for Commonwealth owed debts under 815 CMR 9.00.

◉ Rate Contract (No Maximum Obligation). (Attach details of all rates, units, calculations, conditions or terms and any changes if rates or terms are being amended.)

○ Maximum Obligation Contract. Total maximum obligation for total duration of this contract (or new total if contract is being amended):

PROMPT PAYMENT DISCOUNTS (PPD)

Commonwealth payments are issued through Electronic Funds Transfer (EFT) 45 days from invoice receipt. See Prompt Pay Discounts Policy.

Contractors requesting **accelerated** payments must identify a PPD as follows: Payment issued within: 10 days % PPD. 15 days % PPD. 20 days % PPD. 30 days % PPD.

If PPD percentages are left blank, identify reason:

☐ **Statutory/legal** ☐ **Ready Payments** (M.G.L. c. 29, § 23A) ☑ **Agree to standard 45-day cycle** ☐ **Only initial payment**

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT

Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attach all supporting documentation and justifications.

Amendment 5 to the SCO 3rd Amended and Restated Contract: adds nursing facility care coordination language to comply with Marster Settlement requirement, at CMS' suggestion updates the Frail Elder Waiver appendix to remove the waiver document itself and direct readers to access the waiver on the CMS website, adds new Appendix Q, which memorializes updated MDS-HC Supplemental instructions.

SUPPLIER DIVERSITY PROGRAM (SDP) PLAN

Does the Supplier Diversity Program apply? ○ **YES** If YES, the Contractor's annual SDP commitment for this Contract is

◉ **NO** If NO, and the department is an Executive Department, enter the appropriate exemption: Insurance

ANTICIPATED START DATE (Complete ONE option only.)

The Department and Contractor certify for this Contract, or Contract Amendment, that Contract obligations:

◉ 1. may be incurred as of the Effective Date (latest signature date below) and **no** obligations have been incurred **prior** to the Effective Date.

○ 2. may be incurred as of , **20** , a date **LATER** than the Effective Date below and **no** obligations have been incurred **prior** to the Effective Date.

○ 3. were incurred as of , **20** , a date **PRIOR** to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.

CONTRACT END DATE

Contract performance shall terminate as of December 31 , **20** 25 , with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

CERTIFICATIONS

Notwithstanding verbal or other representations by the parties, the **"Effective Date"** of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified above, subject to any required approvals. The Contractor certifies that they have accessed and reviewed all documents incorporated by reference as electronically published and the Contractor makes all certifications required under the Standard Contract Form Instructions and Contractor Certifications under the pains and penalties of perjury, and further agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein according to the following hierarchy of document precedence, the applicable Commonwealth Terms and Conditions, this Standard Contract Form, the Standard Contract Form Instructions and Contractor Certifications, the Request for Response (RFR) or other solicitation, the Contractor's Response (excluding any language stricken by a Department as unacceptable, and additional negotiated terms, provided that additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

AUTHORIZING SIGNATURE FOR THE CONTRACTOR

Signature and date must be captured at time of signature.

Signature Signed by: Manuel Lopes 40A055E4FDD245E... **Date** 3/12/2025

Print Name Manny Lopes **Print Title** President and CEO

AUTHORIZING SIGNATURE FOR THE COMMONWEALTH

Signature and date must be captured at time of signature.

Signature Mike Levine **Date** 03/17/2025

Print Name Mike Levine **Print Title** Assistant Secretary for MassHealth

AMENDMENT 5
TO THE
THIRD AMENDED AND RESTATED CONTRACT
FOR SENIOR CARE ORGANIZATIONS
BY AND BETWEEN
THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
AND
FALLON COMMUNITY HEALTH PLAN, INC.

WHEREAS, the Executive Office of Health and Human Services (EOHHS) and Fallon Community Health Plan, Inc. (the Contractor) entered into the Third Amended and Restated Contract for Senior Care Organizations (the Contract), effective September 18, 2023, and amended effective December 28, 2023 (Amendment #1), September 17, 2024 (Amendment #2), December 12, 2024 (Amendment #3), and December 19, 2024 (Amendment #4) to provide medical services to MassHealth members enrolled in the Contractor's Senior Care Options (SCO) plan; and

WHEREAS, in accordance with **Section 5.10** of the Contract, EOHHS and the Contractor wish to amend the Contract to update certain financial requirements and certain program requirements, effective upon execution.

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the parties agree as follows:

1. **Section 2.3** is hereby amended by adding a new **Section 2.3.E.8**, as follows:

   "Effective January 1, 2025, the Contractor shall document Enrollee consent to enroll in Senior Care Options in accordance with all applicable rules and guidance and as further directed by EOHHS. The Contractor may accept enrollment requests telephonically or by obtaining the member's signature on an enrollment form, including with an electronic signature."

2. **Section 2.4** is hereby amended by adding a new **Section 2.4.A.17**, as follows:

   "17. Nursing Facility Care Coordination

   a. For Enrollees receiving nursing facility services, the Contractor shall:

      1) Conduct an in-person comprehensive assessment;

      2) Monitor and modify as necessary the Enrollee's ICP to include all specialized services, behavioral health, and rehabilitative services identified in the PASRR evaluation, as well as other needs identified through the comprehensive assessment;

3) Make any necessary referrals and coordinate those referrals for the provision of the services identified in the ICP; and

4) Offer an in-person visit monthly and complete an in-person visit with Enrollees receiving nursing services quarterly (and make phone calls/telehealth visits as appropriate between in-person visits).”

2. **Section 2.18.O** is hereby amended by striking it in its entirety and replacing it as follows:

“O. For services provided by Behavioral Health Urgent Care provider sites, the Contractor shall establish rates at or above 100% of the MassHealth-equivalent rates as specified by EOHHS, effective for dates of service on or after August 1, 2025, or a date to be further specified by EOHHS.”

3. **Appendix P** is hereby amended by striking it in its entirety and replacing it with **Appendix P** attached hereto.

4. Effective April 1, 2025**, Appendix Q** is hereby added as a new appendix attached hereto.

APPENDIX P: FRAIL ELDER WAIVER

The term “Frail Elder Waiver” as used in this contract shall refer to the most recent CMS-approved §1915 (c) HCBS Frail Elder Waiver application document, as it may be amended from time to time. For reference, the most recent CMS-approved Frail Elder Waiver is available on the CMS website at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html as MA Frail Elder Waiver.

EOHHS shall provide the Contractor any future CMS-approved amendments to the Frail Elder Waiver outside of this Contract. Each CMS-approved amendment to the Frail Elder Waiver does not require an amendment to this Contract’s **Appendix P**. Nevertheless, the Contractor is responsible for referring to the most updated CMS-approved version of the Frail Elder Waiver and complying with its requirements.

APPENDIX Q: MDS-HC 2.0 Supplemental Instructions

MASSHEALTH MDS-HC 2.0 SUBMISSION
SUPPLEMENTAL INSTRUCTIONS FOR SCO PLANS
Office of Long Term Services and Supports

Introduction:
Section 1 and Appendix M of the SCO contract require the Minimum Data Set – Home Care (MDS-HC) assessment to be completed by a Registered Nurse (RN) and submitted electronically to the Executive Office of Health and Human Services (EOHHS). Completion of the MDS-HC accomplishes two key objectives. First, it establishes the correct Rating Category for SCO enrollees as Nursing Home Certifiable (NHC), Community Behavioral Health (CBH), or Community Other in the Medicaid managed care payment system. Second, it serves as a core component of the member's Health Risk Assessment (HRA) and a basis for the member's individualized care plan.

The Contractor must ensure that documentation in the MDS-HC and Request for Services (RFS) document is accurate and up to date. When the Contractor determines that the member has improved, declined, or has had any other significant change in their condition, the Contractor must submit an updated MDS-HC to reflect the change in the member's clinical status. In addition, member individualized care plans and documentation in the member's plan file must support the member's need for care, as documented in and aligned with the MDS-HC. Upon request by MassHealth, the Contractor must be able to produce documentation that demonstrates the member's specific skilled need(s) and/or activity of daily living needs.

A member's individualized care plan must at a minimum include specific assessments, goals, interventions, who is providing the service, and their frequency. This specifically includes documenting, in the care plan, when informal support, such as relatives living in the home, are providing care to meet a member's skilled and/or ADL need(s). The care plan must specify whether a skilled service is being provided by a registered nurse, therapist or other caregiver. When a skilled need is being provided by a caregiver, the frequency and nature of the supervision provided by the registered nurse or therapist overseeing the delivery of the skilled services must be documented in the care plan. The care plan shall also document if any skill training has been provided to the caregiver.

Under Section 4.4.B of the SCO contract, MassHealth has the right to audit the Contractor's for their adherence to the guidance provided within this document. Where the Contractor fails to meet the requirements provided below, MassHealth may reallocate members to their appropriate rating category as well as issue financial sanctions. **Question 5 of the RFS must be completed for all MDS-HCs.** For MDS-HC documents submitted on or after January 1, 2025, MassHealth will review Question 5 of the RFS to ensure that it documents which criteria specified in 130 CMR 456.409 the Contractor is relying to demonstrate NHC eligibility. Failure to

document the specific daily skilled need under 130 CMR 456.409(A) (path 1); or failure to document the specific three needed services under 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C) (path 2), may result in MassHealth reallocating the member to the Community Other rating category AND recouping the difference between the Community Other payment level and the NHC payment level, retroactive to the date of the MDS-HC submission.

A. Nursing Home Certifiable (NHC):

For NHC, the information provided in the MDS-HC must establish that the member meets the state's nursing facility clinical eligibility criteria found in the MassHealth Nursing Facility Regulation 130 CMR 456.409.

130 CMR 456.409: Clinical Eligibility Criteria

To be assigned to the NHC rating category a member must be clinically eligible for nursing facility services. There are two paths to establish clinical eligibility for nursing facility services.

Path 1, the member must require one or more skilled services listed in 130 CMR 456.409(A) **daily**; or

Path 2, the member must have a medical or mental condition requiring a combination of at least three services from 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C).

(A) Skilled Services (Path 1) – one skilled service daily (130 CMR 456.409(A))

Skilled services must be performed by or under the supervision of a registered nurse or therapist. Skilled services consist of the following:

(1) intravenous, intramuscular, or subcutaneous injection, or intravenous feeding.

(2) nasogastric-tube, gastrostomy, or jejunostomy feeding.

(3) nasopharyngeal aspiration and tracheostomy care. However, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services.

- For SCO NHC, to rely on this subsection for skilled care, the nurse must document the specific tracheostomy care needed in the member's plan.

(4) treatment and/or application of dressings when the physician or PCP has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions).

(5) administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema).

(6) skilled-nursing observation and evaluation of an unstable medical condition (observation must, however, be needed at frequent intervals throughout the 24 hours; for example, for arteriosclerotic heart disease with congestive heart failure).

(7) skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery and safety.

(8) insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter (a urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled-nursing care). However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled-nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection).

- For SCO NHC, the Contractor must be able to produce the documentation demonstrating the need for the urethral catheter upon request by MassHealth.

(9) gait evaluation and training administered or supervised by a registered physical therapist at least five days a week for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame. The member must require these services in an institutional setting.

- For SCO NHC, because these services require an institutional setting, the Contractor may not rely on (9) to demonstrate a skilled need for the NHC rating category determination.

(10) certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical-therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record).

- For SCO NHC, the Contractor must be able to produce the physical therapy notes upon request by MassHealth.

(11) hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications.

(12) physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician or PCP and be designed to achieve specific goals within a given time frame.

- For SCO NHC, the Contractor must be able to produce the therapy notes and physician or PCP documentation upon request by MassHealth.

(B) Assistance with Activities of Daily Living - (Path 2) 130 CMR 456.409(B)

Assistance with activities of daily living includes the following services:

(1) bathing when the member requires either direct care or attendance or constant supervision during the entire activity;

(2) dressing when the member requires either direct care or attendance or constant supervision during the entire activity;

(3) toileting, bladder or bowel, when the member is incontinent of bladder or bowel function day and night, or requires scheduled assistance or routine catheter or colostomy care;

(4) transfers when the member must be assisted or lifted to another position;

(5) mobility/ambulation when the member must be physically steadied, assisted, or guided in ambulation, or be unable to propel a wheelchair alone or appropriately and requires the assistance of another person; and

(6) eating when the member requires constant intervention, individual supervision, or direct physical assistance.

- Activities of Daily Living (ADLs) must be documented accurately in the MDS-HC, RFS, and Member’s Care Plan and other supporting Documentation.

(C) Nursing Services. (Path2) - 130 CMR 456.409(C)

Nursing services, including any of the following procedures performed at least three times a week, may be counted in the determination of medical eligibility under path 2.

(1) any physician-ordered skilled service specified in 130 CMR 456.409(A).

- For SCO NHC, the Contractor must refer to Section A above and skilled service must occur at least three times a week.

(2) positioning while in bed or a chair as part of the written care plan.

(3) measurement of intake or output based on medical necessity.

- For SCO NHC, the Contractor must document the medical need for intake and output measurement in the member's care plan.

(4) administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions.

(5) staff intervention required for selected types of behavior that are generally considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers; or requiring a consistent staff one-to-one ratio for reality orientation when it relates to a specific diagnosis or behavior as determined by a mental-health professional.

(6) physician- or PCP -ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals.

(7) physician- or PCP -ordered licensed registered nursing observation and/or vital-signs monitoring, specifically related to the written care plan and the need for medical or nursing intervention.

(8) treatments involving prescription medications for uninfected postoperative or chronic conditions according to physician or PCP orders, or routine changing of dressings that require nursing care and monitoring.

- For SCO NHC, the Contractor must be able to produce the physician/PCP documentation upon request by MassHealth.

Data entered in the MDS-HC regarding skilled needs and skilled services must be clinically consistent and aligned with diagnoses listed in MDS-HC Section J.

For all initial or change-in-status MDS-HC submissions the skilled services may be in place at the time of assessment or must be in the process of being placed to meet those needs recorded in the MDS-HC. Services must be in place and documented in the care plan within 30 days. If, after 30 days, services are not in place, then the Contractor must submit a new MDS-HC that accurately reflects the services that are in place.

In contrast, for MDS-HC submissions related to reassessments, the skilled services must be in place. The skilled need(s) must be being performed per 130 CMR 456.409 (A) daily (path 1), or the member must have a medical or mental condition requiring a combination of at least three services that are actually being provided from 130 CMR 456.409 (B) and (C), including at least one of the nursing services listed in (C) at least three times per week (path 2). Support for the member's skilled need(s) must be documented in the member's care plan. If the member can fully and independently meet their skilled need(s), the member does not meet NHC level of care criteria.

B. Community Behavioral Health (CBH):

Information in the MDS-HC may not indicate NHC criteria as stated above and may indicate one

or more actively treated behavioral health diagnoses that meet CBH rating category. Behavioral health diagnoses must be confirmed in the member's medical records and must be chronic and ongoing. ICD-10 coding must be accurate and documented in the MDS-HC.

C. Community Other (CO):

Information in the MDS-HC may not indicate NHC criteria or CBH criteria as listed above. Those members will be included in the Community Other rating category.

REQUEST FOR SERVICES (RFS)

Question 5 on the RFS must be completed for all MDS-HCs submitted. MassHealth uses this field to understand which criteria specified in 130 CMR 456.409 the plan is relying upon to demonstrate NHC eligibility. The Contractor must document the specific daily skilled need under 130 CMR 456.409(A) (path 1); OR document the specific three needed services under 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C) (path 2) .

- To access the drop-down free-text writing space for RFS Question 5, you must enter "YES" to Question #5, regardless of whether or not a significant change in condition has (or has not) occurred.
- Question #5: Has the member or applicant experienced a significant change in condition in the last 30 days? Answer: "YES" and Text Box will become available. There is no other way to access the drop-down free-text writing field other than by entering 'YES" to Question #5.
- Question #5 on the RFS must include any skilled nursing needs and/or ADLs documented in the MDS-HC.
    - Examples:
        1. A member is assessed on the MDS-HC to require physical assistance with bathing, and dressing, and requires daily assistance with administration of oral medications for monitoring of dosage, frequency, or adverse reactions.
            a. In the RFS Question #5, the RN must document the specific Nursing Facility regulation subsection. *"Member requires physical assistance with bathing (B1), dressing (B2), and oral medication management (C4).*
        2. A member is assessed on the MDS-HC to require daily physical assistance with insulin injections.
            a. In the RFS Question #5, the RN must document the specific Nursing Facility regulation subsection. *"Member requires daily physical assistance with subcutaneous injection (A1)."*

3. A member is assessed on the MDS-HC to require assistance with bathing, dressing, toileting, and transferring. They have a gastrostomy tube and require daily physical assistance with feeding.
    a. In the RFS Question #5, the RN must document the specific Nursing Facility regulation subsection. *"Member requires physical assistance with bathing (B1), dressing (B2), toileting (B3), transferring (B4) and requires daily assistance with gastrostomy tube feedings (A2)."*

4. A member is assessed on the MDS-HC to have complicated heart failure with frequent decompensations and has a family caregiver who monitors heart rate, weight, blood pressure, and O2 sats on a daily basis with close skilled RN oversight.
    a. In the RFS Question #5, the RN must document the specific Nursing Facility regulation subsection. *"Member requires monitoring of heart rate, weight, blood pressure, and O2 sats on a daily basis with close skilled RN oversight (A7) to ensure care is achieving its purpose."*

- Keep the information provided in Question #5 concise, clear, and specific.
- If the member is on the Frail Elder Waiver (FEW), please note "FEW" in Question 5.

ADDITIONAL AREAS REQUIRING SPECIAL ATTENTION FOR SCO SUBMISSIONS:

- Any MDS-HC assessment with a date 90 days prior or greater when submitted will not be accepted.

- All MDS's must be submitted by 2:00 p.m. on the last business day of the month. Submissions occurring after 2:00 p.m. will be assigned to the specific rating category for capitation purposes at the close of the following month.

- There are only 3 MDS-HC assessment codes in Section A.2 that SCO uses:
    - 1. Initial;
    - 3. Routine assessment at fixed intervals (e.g., reassessments); and
    - 6. Change-in-Status.

- MDS-HC reassessments must be submitted annually.

- Change-in-Status MDS-HC submissions should occur whenever a member has a significant change in condition.

- Regarding Department of Developmental Services (DDS) Waiver Members: A person who is enrolled as a DDS Waiver Member cannot enroll in SCO unless the person first disenrolls from the DDS Waiver program.

- Section CC Referral Items states *"Complete at Intake Only";* **Please disregard this statement and complete this section for all MDS-HC assessments.**
    - In section CC.1 "Date case opened/reopened": Please enter the date of original enrollment to the SCO program.
    - The remaining questions in Section CC must be answered in relation to the current assessment.

- Section G Informal Supports

  Read and answer question G.1.e carefully
    - Enter Code "1" if answer is NO
    - Enter Code "0" if answer is YES

  Do not reverse these codes, e.g. do not use a zero "0" code to indicate "NO".

- Section J Disease Diagnoses
    - RN must provide accurate diagnosis information in its entirety.
    - A drop-down box in section J.2 is provided for RN to choose diagnoses and the related ICD-10 codes.
    - If J.1.s "Any psychiatric diagnosis" has been coded, RN must enter a detailed diagnosis in section J.2 "Other current or more detailed diagnoses" and include the related ICD-10 code.
    - If J.1.y "Diabetes" has been coded, RN must enter a detailed diagnosis in section J.2 "Other current or more detailed diagnoses" and include the related ICD-10 code.

- Section P Service Utilization
    - Section P.1 Formal Care must indicate the need and/or care provided to the member.
    - Section P.2 Special Treatments, Therapies, Programs must be completed as applicable.
    - There must be documentation in the member's plan record to support the member's skilled need(s).

- Section Q Medications
    - Every MDS submission must include a complete medication list.
    - Section Q.5 must include Name, Dose, Form, Number taken and Frequency for each medication taken including PRNs and over the counter (OTC) medications.

- Section R Assessment Information
    - Section R.1.a-R.1.c must be signed and dated by the RN upon completion of the MDS-HC.
    - The MDS-HC must be completed in its entirety and include all required information.
    - The RN is the assessment coordinator who holds the legal responsibility to make sure the MDS-HC assessment is accurate and up to date with the member's current medical status prior to signing.
    - All other signatures in section R: All dates must be before the RN signature date. It is not acceptable for other valid signatures to have dates after the signature date of the RN responsible for completing the assessment.

Members who Transfer between SCO Plans

If the member is transferring from one SCO Plan to another, the RN at the accepting SCO Plan must complete a new MDS-HC assessment.

- Section CC.1 Date case opened/re-opened – enter as transfer date.
- Section A.2 Type of Assessment – enter as Initial.
- Submit the transfer MDS-HC as an Initial Assessment.