

## Attachment 18 – Liquidated Damages

Failed Deliverable	Penalty
Readiness Review	MLTC will conduct a formal review of the MCO's readiness to implement all required services described in this RFP. Should the MCO fail the review, MLTC may assess damages of \$5,000 for each calendar day until such time as MLTC certifies that the MCO has met all readiness requirements.
Date of Implementation	Should the MCO fail to begin full operations on the contract start date, and should MLTC determine that the MCO is responsible for the delay, MLTC may assess damages of \$10,000.00 per calendar day for each day beyond the contract start date that the MCO fails to begin full operations.
Network Performance Requirement	The MCO must have a contracted provider network in place and submit the required attestation of network sufficiency 90 calendar days prior to the contract start date. A penalty of \$1,000.00 shall be assessed, at MLTC' discretion, per calendar day for each day that the provider network is not adequate to meet the service needs of the covered populations as described in Section X - Provider Network and the attestation of network sufficiency has not been received.
Employment of Key Personnel	The MCO must meet all key personnel requirements specified in Section X of this RFP. MLTC may assess a penalty of \$1,000 per day, per position, for each day after the 30 allowed calendar days that a key position remains unfilled by a qualified person approved by MLTC.
Excessive Reversals on Appeal	If the MCO exceeds 10% of member appeals overturned upon final appeal over a 12-month period (January-December or the first twelve months that the contract is in effect), a penalty of \$25,000 may be imposed for every additional overturned appeal. This penalty may also be assessed for each occurrence in which the MCO does not provide the medical services or requirements set forth in an administrative decision by MLTC or a state fair hearing.
Ongoing and Ad Hoc Reporting	As detailed in Attachment 6, MLTC may assess a penalty of \$1,000 for each calendar day that a report is late, inaccurate, includes less than the required copies, or is not in the approved format.

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<p>Encounter Data</p>	<p>\$10,000 per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications required by MLTC.</p> <p>\$10,000 per calendar day for each day encounter data is received after the due date, for failure to correct and resubmit encounter data that was originally returned to the MCO for correction because submission data was in excess of the 5% error rate threshold, until acceptance of the data.</p> <p>\$10,000 per return of re-submission of encounter data that was returned to the MCO, as submission data was in excess of the 5% error rate threshold, for correction and was rejected for the second time.</p> <p>\$10,000 per calendar day for inability to reconcile financial statement of medical expenses paid with the total dollars submitted through encounter data for that quarter within 10% for 2017 and 5% for 2018.</p> <p>\$10,000 per occurrence of medical record review by MLTC or its designee where the MCO or its provider(s) denotes provision of services which were not submitted in the encounter data regardless of whether or not the provider was paid for the service that was documented.</p>
<p>Claims Processing</p>	<p>90% of all clean claims must be paid within 15 business days of the date of receipt. If not met, subject to \$5,000 for the each month that an MCO's claims performance percentages by claim type fall below the performance standard.</p> <p>99% of all clean claims must be paid within 60 calendar days of the date of receipt. If not met, subject to \$5,000 for the each month that an MCO's claims performance percentages by claim type fall below the performance standard.</p>
<p>Pharmacy Claims Processing</p>	<p>90% of all clean claims must be paid within 7 calendar days of the date of receipt. If not met, subject to \$5,000 for the each month that an MCO's claims performance percentages by claim type fall below the performance standard.</p> <p>99% of all clean claims must be paid within 14 calendar days of the date of receipt. If not met, subject to \$5,000 for the each month that an MCO's claims performance percentages by claim type fall below the performance standard.</p>
<p>PCP Assignment</p>	<p>\$5,000 per calendar day for failure to assign a PCP within one month of the effective date of enrollment until the assignment is made.</p>

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Member Services	\$5,000 per calendar day for failure to provide member services functions from 8 a.m. to 5 p.m. central time, Monday through Friday, to address nonemergency issues encountered by members, and 24 hours a day, 7 days a week to address emergency issues encountered by members.
Provider Services	\$5,000 per calendar day for failure to furnish provider services functions from 7 a.m. to 8 p.m. central time, Monday through Friday, to address nonemergency issues encountered by members, and 24 hours a day, 7 days a week to address emergency issues encountered by members and for failure to handle emergent provider issues on a 24 hours a day, 7 days a week basis.
<b>Intermediate Sanctions</b>	
Per 42 CFR 438.704(b)(1): A maximum of \$25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or health care providers; failure to comply with physician incentive plan requirements; marketing violations.	
Per 42 CFR 438.704(b)(2): A maximum of \$100,000 for each determination of discrimination; misrepresentation or false statements to CMS or the State or any such action or inaction that the State deems a violation that merits a fine consistent with this section.	
Per 42 CFR 438.704(b)(3): A maximum of \$15,000 for each member the State determines was not enrolled because of a discriminatory practice (subject to the \$100,000 overall limit above) or any such action or inaction that the State deems a violation that merits a fine consistent with this section.	
Per 42 CFR 438.704(c): A maximum of \$25,000 or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program; or any such action or inaction that the State deems a violation that merits a fine consistent with this section. The State must deduct from the penalty the amount of overcharge and return it to the affected enrollee(s).	