Medicaid Care Management Services Contract
Exhibit N
Liquidated Damages Matrix (Draft)

Liquidated damages shall be assessed based on the violation or non-compliance set forth in this Matrix. While Exhibit O measures compliance in a specific timeframe, typically monthly or quarterly, the liquidated damages shall be assessed based on the timeframe below. For example, if the MCO fails to meet a monthly requirement set forth in Exhibit O, and according to this Exhibit the liquidated damages are assessed weekly, then the liquidated damages shall be assessed for each week within the month that was found to be in violation.

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
1. LEVEL 1 MCO action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of member(s); reduces members' access to care; and/or the integrity of the managed care program	1.1 Failure to substantially provide medically necessary covered services	$25,000 per each failure
	1.2 Discriminating among members on the basis of their health status or need for health care services	$100,000 per violation
	1.3 Imposing arbitrary utilization management criteria, quantitative coverage limits, or prior authorization requirements prohibited in the contract	$25,000 per violation
	1.4 Imposing on members premiums or charges that are in excess of the premiums or charges permitted by DHHS	$10,000 per violation (DHHS will return the overcharge to the member)
	1.5 Continuing or recurring failure to meet minimum Primary Care and Prevention Focused Model of Care general requirements (Section 4.10)	$25,000 per week of violation
	1.6 Continuing or recurring failure to meet minimum behavioral health (mental health and substance use disorder) requirements, including the full continuum of care for members with substance use disorders	$25,000 per week of violation
	1.7 Continuing or recurring failure to meet or failure to require their network providers to meet the network adequacy standards established by DHHS (without an approved exception) or timely member access to care standards in Section 4.7.4.6	$1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan; $100,000 per day for failure to meet the requirements of the approved Corrective Action Plan
	1.8 Misrepresenting or falsifying information furnished to CMS or to DHHS or a member	$25,000 per violation

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	1.9 Failure to comply with the requirements of Section 5.3 (Program Integrity) of the contract	$10,000 per month of violation (for each month that DHHS determines that the MCO is not substantially in compliance)
	1.10 Continuing or recurring failure to resolve member appeals and grievances within specified timeframes	$25,000 per violation
	1.11 Failure to submit timely, accurate, and/or complete encounter data records in the required file format *(For submissions more than 30 calendar days late, DHHS reserves the right to withhold 5% of the aggregate capitation payments made to the MCO in that month until such time as the required submission is made)*	$5,000 per day the submission is late
	1.12 Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness)	$25,000 per violation
	1.13 Failure to adhere to the Preferred Drug List requirements	$25,000 per violation
	1.14 Continued noncompliance and failure to comply with previously imposed remedial actions issued in accordance with Section 5.5 (Remedies) and/or intermediate sanctions from a Level 2 violation	$25,000 per violation
	1.15 Continued or recurring failure to comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR part 438, subpart K, which prohibits discrimination in the delivery of mental health and substance use disorder services and in the treatment of members with, at risk for, or recovering from a mental health or substance use disorder	$50,000 per violation for continuing failure
	1.16 Continued or recurring failure to meet the requirements for minimizing psychiatric boarding	$5,000 per day for continuing failure

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	1.17 Failure to ensure non-emergency medical transportation (NEMT) driver services and vehicle safety requirements conform with Section 4.1.9.3; 4.1.9.8.1.1 - 4.1.9.8.1.7	$25,000 per violation
	1.18 Failure to deliver or recover a confirmed NEMT ride, resulting in disruption to a Covered Service (Section 4.1.9.8.1.8	$5,000 per violation for the first five occurrences; $7,000 for each additional violation
	1.19 In-network provider not enrolled with NH Medicaid	$1,000 per provider not enrolled; $500 per additional day provider is not suspended once MCO is notified of non-enrollment, unless good cause is determined at the discretion of DHHS
	1.20 Failure to notify a member of DHHS senior management within twelve (12) hours of a report by the Member, Member's relative, guardian or authorized representative of an allegation of a serious criminal offense against the Member by any employee of the MCO, its Subcontractor or a Provider	$50,000 per violation
	1.21 Two or more Level 1 violations within a contract year	$75,000 per occurrence
2. LEVEL 2 MCO action(s) or inaction(s) that jeopardize the integrity of the managed care program but does	2.1 Failure to meet readiness review timeframes or address readiness deficiencies in a timely manner as required under the Agreement	$5,000 per violation (DHHS reserves the right to suspend enrollment of members into the MCO until deficiencies in the MCO's readiness activities are rectified)
	2.2 Failure to maintain the privacy and/or security of data containing protected health information (PHI) which results in a breach of the security	$100,000 per violation

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not necessarily jeopardize member(s) health, safety, and welfare or access to care.	of such information and/or timely report violations in the access, use, and disclosure of PHI	
	2.3 Failure to meet prompt payment requirements and standards	$25,000 per violation
	2.4 Failure to cost avoid, inclusive of private insurance, Medicare or subrogation, at least 1% of paid claims in the first year of the contract, 1.2% in the second year, and 1.5% in contract years 3, 4, and 5; or failure to provide adequate information to determine cost avoidance percentage as determined by DHHS	$50,000 per violation
	2.5 Failure to cost avoid claims of known third party liability (TPL)	$250 per member and total claim amount paid that should have been cost avoided
	2.6 Failure to collect overpayments for waste and abuse in the amount of 0.06% of paid claim amounts in the first year of the contract, 0.08% in the second year, and 0.10% in years 3, 4, and 5	$50,000 per violation
	2.7 Failure to refer at least 20 potential instances of subcontractor or provider fraud or abuse to DHHS annually	$10,000 unless good cause determined by Program Integrity
	2.8 EQR reports with “not met” findings that have been substantiated by DHHS	$10,000 per violation
	2.9 Using unapproved beneficiary notices, educational materials, and handbooks and marketing materials, or materials that contain false or materially misleading information	$5,000 per violation
	2.10 Failure to comply with member services requirements (including hours of operation, call center, and online portal)	$5,000 per day of violation
	2.11 Member in pharmacy “lock-in” program not locked into a pharmacy and no documentation as to waiver or other excuse for not being locked in	$500 per member per occurrence and total pharmacy claims amount paid while not locked-in

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	2.12 Continued noncompliance and failure to comply with previously imposed remedial actions issued in accordance with Section 5.5 (Remedies) and/or intermediate sanctions from a Level 3 violation	$25,000 per week of violation
	2.13 Failure to suspend or terminate providers when instructed by DHHS	$500 per day of violation
	2.14 Failure to timely process 98% of clean and complete provider credentialing applications	$1,000 per delayed application
	2.15 Failure to meet any performance standards in the contract which may include, but not necessarily be limited to: 2.15.1 Care Coordination and Care Management measures (Sections 4.11.3.4, 4.11.5.7); 2.15.2 Claims processing (Sections 4.20.1.4, 4.20.1.5, 4.20.3.2, 4.20.4.2, 4.20.5.2); 2.15.3 Call center performance (Sections 4.4.4.2.3.1, 4.4.4.2.3.2, 4.4.4.2.3.3, 4.15.4.1.3.1, 4.15.4.1.3.2, 4.15.4.1.3.3); 2.15.4 Non-emergency medical transportation (Sections 4.1.9.8.59.); 2.15.5 Service authorization processing (Sections 4.2.3.6.1, 4.8.4.2.1.1, 4.8.4.3.1, 4.8.4.3.5); and 2.15.6 Childhood Lead Testing Requirements (Section 4.8.2.3.2)	$1,000 per violation
	2.16 Failure to meet 99% of claims financial accuracy requirements (Section 4.19.3.1), and 95% of post service authorization processing requirements (Section 4.8.4.3.5)	$1,000 per violation
	2.17 Two or more recurring Level 2 violations within a contract year	$50,000 per occurrence
	2.18 Failure to comply with subrogation timeframes established in RSA 167:14-a	$15,000 per occurrence

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3. LEVEL 3 MCO action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program.	3.1 Failure to submit to DHHS within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories, provider agreements, etc. requiring DHHS review and/or approval or as requested by an audit	$10,000 per violation
	3.2 Failure to submit to DHHS within the specified timeframes all required plans, documentation, and reporting related to the implementation of Alternative Payment Model requirements	$10,000 per week of violation
	3.3 Failure to implement and maintain required policies, plans, and programs	$500 per every one-week delay
	3.4 Failure to comply with provider relations requirements (including hours of operation, call center, and online portal)	$10,000 per violation
	3.5 Failure to report subrogation settlements that are under 80% of the total liability (lien amount)	$10,000 per violation
	3.6 Failure to enforce material provisions under its agreements with Subcontractor	$25,000 per violation
	3.7 Failure to submit and obtain DHHS review and approval for applicable Subcontracts	$25,000 per violation
	3.8 Failure to comply with ownership disclosure requirements	$10,000 per violation
	3.9 Continued noncompliance and failure to comply with previously imposed remedial actions issued in accordance with Section 5.5 (Remedies) and/or intermediate sanctions from a Level 4 violation	$25,000 per week of violation
	3.10 Failure to meet minimum social services and community care requirements, as described in Section 4.11.7 (Provider-Delivered Care	$10,000 per violation

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	Coordination and Integration with Social Services and Community Care) of the contract, with respect to unmet resource needs of members	
	3.11 Failure to ensure that clinicians conducting or contributing to a comprehensive assessment are certified in the use of New Hampshire's CANS and ANSA, or an alternative evidenced based assessment tool approved by DHHS within the specified timeframe	$10,000 per violation
	3.12 Two or more Level 3 violations within a contract year	$100,000 per occurrence
4. LEVEL 4 MCO action(s) or inaction(s) that inhibit the efficient operation the managed care program.	4.1 Submission of a late, incorrect, or incomplete, measure, report or deliverable (excludes encounter data and other financial reports). The violation shall apply to resubmissions that occur in contract years following the initial submission due date.	$1,000 for each of the first ten occurrences each contract year; $5,000 for each additional occurrence in same contract year. The number of occurrences in a contract year shall be the aggregate of all issues subject to liquidated damages in this Section 4.1.
	4.2 Failure to submit timely, accurate, and/or complete files to NH CHIS per NH Code of Administrative Rules, Chapter Ins 4000	$2,500 per day the submission or resubmission is late
	4.3 Failure to comply with timeframes for distributing (or providing access to) beneficiary handbooks, identification cards, provider directories, and educational materials to beneficiaries (or potential members)	$5,000 per violation
	4.4 Failure to meet minimum requirements requiring coordination and cooperation with external entities (e.g., the New Hampshire Medicaid Fraud Control Unit, Office of the Inspector General) as described in the contract	$5,000 per violation
	4.5 Failure to comply with program audit remediation plans within required timeframes	$5,000 per occurrence

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	4.6 Failure to meet staffing requirements	$5,000 per violation
	4.7 Failure to ensure provider agreements include all required provisions	$10,000 per violation

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