Managed Care Program Annual Report (MCPAR) for New York: HIV Special Needs Plan (HIV SNP)

Due date	Last edited	Edited by	Status
09/27/2025	09/30/2025	Dajana Trapanese	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Selected

	Indicator	Response
	Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If "No", please complete the following questions under each plan.	Plan to submit on 12/15/2025

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	New York
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Susan Montgomery
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	NYS-MCPAR@health.ny.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Dajana Trapanese
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	dajana.trapanese@health.ny.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	09/30/2025

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	04/01/2024
A5b	**Reporting period end date** Auto-populated from report dashboard.	03/31/2025
A6	**Program name** Auto-populated from report dashboard.	HIV Special Needs Plan (HIV SNP)

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Indicator	Response
Plan name	AmidaCare Inc., Metro Plus Health Care Inc., VNS Choice

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	Enrollment Broker (NY Medicaid Choice)

Add In Lieu of Services and Settings (A.9)

Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

Indicator	Response
ILOS name	

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	7,647,192
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	5,767,869

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	State Medicaid agency staff Other state agency staff State actuaries EQRO Proprietary system(s)
BIII.2	**HIPAA compliance of proprietary system(s) for encounter data validation** Were the system(s) utilized fully HIPAA compliant? Select one.	Yes

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter “No PI activities were performed during the reporting period” as your response. “N/A” is not an acceptable response.	The Office of the Medicaid Inspector General conducts a number of reviews to address payment risks between the state and plans, including: • MLTC Eligibility Reviews: Audits that identify instances where Managed Long-Term Care Plans are not providing long-term services and supports and recovers capitation payments accordingly. • Enhanced Nursing Home Rate Code Reviews: These audits identify instances where a Plan was paid an enhanced capitated payment for a member permanently placed in a nursing home, but the member either was not permanently placed in the nursing home or the Plan failed to pay the nursing home for the month in question. • Reviews of Supplemental Maternity and Newborn Payments to Managed Care Plans: When a baby is born, the Plan receives a supplemental payment due to the cost of the birth. OMIG conducts regular reviews to ensure these payments are proper. • Reviews of Low Birthweight Supplemental Maternity Payments: When a baby is born with a low birth weight, they often require significant medical services to support the baby’s wellbeing. Due to these increased costs, the Plan receives an enhanced supplemental maternity payment for these low-birth-weight babies. OMIG conducts an audit reviewing these payments to ensure they were properly paid. • Audit of Encounter Data for Reported Payments Improperly Made for Managed Care Recipients in the Restricted Recipient Program • OMIG's Recovery Audit Contractor (RAC) was involved in two Managed Care audits that focused on PI activity, Same Plan (Code 7) For the Same Plan audits, RAC recovers the capitation payment from the plan when an enrollee is simultaneously enrolled or in receipt

of Comprehensive Third-Party Health Insurance coverage under another product offered by the Plan (or a parent, subsidiary, or sister entity). • Different Plan (Code 8) - For the Different Plan, the RAC recovers the capitation payment from the plan when an enrollee is simultaneously enrolled or in receipt of Comprehensive Third-Party Health Insurance coverage through a different plan. • OMIG's Division of Medicaid Investigations has seen a significant increase in the volume of FWA referrals from plans of Fiscal Intermediary (FI), Consumer Directed Personal Assistance Program (CDPAP) services of suspected fraud for services not rendered due to a member not being present in their service location for the dates of service of the Medicaid paid claims. Some of the common received FWA allegations in which FIs submitted claims and were paid for services not rendered were for the period in which members were hospitalized, deceased, and when members/caregivers were incarcerated. • MLTC Eligibility Reviews: Audits that identify instances where Managed Long-Term Care Plans are not providing long-term services and supports and recovers capitation payments accordingly. • Enhanced Nursing Home Rate Code Reviews: These audits identify instances where a Plan was paid an enhanced capitated payment for a member permanently placed in a nursing home, but the member either was not permanently placed in the nursing home or the Plan failed to pay the nursing home for the month in question. • Reviews of Supplemental Maternity and Newborn Payments to Managed Care Plans: When a baby is born, the Plan receives a supplemental payment due to the cost of the birth. OMIG conducts regular reviews to ensure these payments are proper. • Reviews of Low Birthweight Supplemental

Maternity Payments: When a baby is born with a low birth weight, they often require significant medical services to support the baby's wellbeing. Due to these increased costs, the Plan receives an enhanced supplemental maternity payment for these low-birth-weight babies. OMIG conducts an audit reviewing these payments to ensure they were properly paid. • Audit of Encounter Data for Reported Payments Improperly Made for Managed Care Recipients in the Restricted Recipient Program • OMIG's Recovery Audit Contractor (RAC) was involved in two Managed Care audits that focused on PI activity, Same Plan (Code 7) For the Same Plan audits, RAC recovers the capitation payment from the plan when an enrollee is simultaneously enrolled or in receipt of Comprehensive Third-Party Health Insurance coverage under another product offered by the Plan (or a parent, subsidiary, or sister entity). • Different Plan (Code 8) - For the Different Plan, the RAC recovers the capitation payment from the plan when an enrollee is simultaneously enrolled or in receipt of Comprehensive Third-Party Health Insurance coverage through a different plan. • OMIG's Division of Medicaid Investigations has seen a significant increase in the volume of FWA referrals from plans of Fiscal Intermediary (FI), Consumer Directed Personal Assistance Program (CDPAP) services of suspected fraud for services not rendered due to a member not being present in their service location for the dates of service of the Medicaid paid claims. Some of the common received FWA allegations in which FIs submitted claims and were paid for services not rendered were for the period in which members were hospitalized, deceased, and when members/caregivers were incarcerated.

BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Section 18.5 (a)(viii)(G) The Contractor shall report to SDOH and OMIG within sixty (60) days after it identifies or has received notice of any capitation payments or other payments in excess of amounts specified in the contract and shall return such overpayments to SDOH. §§ 19.5 and 19.6 OMIG may recover overpayments caused by Contractor submission of misstated reports and/or misstated encounter data. Section 22.7 The State has the right to recover overpayments as a result of any investigation, audit or action commenced by the NYS Attorney General, SDOH, OMIG and OSC. Where the contractor has previously recovered overpayments form a participating provider, said overpayment recovery shall not be recovered from Participating provider for any previously recovered identifiable overpayments that are subject to a further investigation. When contractor has recovered overpayments, the contractor retains recoveries. However, where the contractor recovers an overpayment in violation of its obligation to report potential fraud, waste and abuse to the State, the contractor is required to remit the full amount recovered to the State. Also, the contractor does not retain an overpayment it recovers on behalf of the OMIG or SDOH where OMIG or SDOH require the contractor to recover the overpayment owed to the Medicaid program. Section 23.3 Contractor shall return, and shall require its subcontractors to return, to SDOH

		any capitation payments or other payments in excess of amounts specified in this Agreement within sixty (60) days of identification, or receipt of notice, of such payments.
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard selected in indicator B.X.2.	Sections 18.5, 19.5, 19.6, 22.7 and 23.3
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	18.5(a)(viii)(F)(3)- Provider Investigative Report- all overpayments identified or recovered from Participating or Non-Participating Providers, specifying the overpayments due to potential fraud, and shall keep or return such overpayments in accordance with Section 22.7 of this Agreement- for mainstream, reports are monthly. The plans submissions timeliness is tracked. The timeliness, completeness and accuracy of these reports are evaluated as part of OMIGs Managed Care Program Integrity Reviews.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	Upon processing an enrollment or disenrollment, Plans are notified via an 834 Client Enrollment file from the State. This file indicates a change, addition, or removal of a member. Plans can also request this file to audit their records. Plans also receive transactions files from the State's BSS entity Maximus of enrollments and terminations. If an inappropriate payment for an enrollee is identified by the Department, the Plan is notified to correct any errors/self-report the error to the Office of the Medicaid Inspector General (OMIG). If after 60 days, the

		Department notices action has not been taken then the overpayment is reported to OMIG. The Department of Health and OMIG collaborate with the local districts on the retroactive disenrollment process. This initiative identifies instances where a change in an enrollee's circumstances renders them no longer eligible for Medicaid managed care, and the plan has already received capitation payments for months subsequent to the enrollee's change in circumstance. The local districts issue notifications to the Plans and OMIG identifying the reason for the disenrollment, and OMIG monitors to ensure the Plan voids in response. Should the Plan fail to void, OMIG issues a follow-up audit recovering the inappropriately paid capitation payments. In addition, OMIG issues standalone, statewide reviews of recovery scenarios related to changes in an enrollee's circumstances, including reviews recovering capitation payments for individuals who were: • Incarcerated • Deceased • Residing in another state
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No

BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as	No such audits were conducted during the reporting year" as your response

	your response. “N/A” is not an acceptable response.	

Topic XIII. Prior Authorization

> ⚠ **Beginning June 2026, Indicators B.XIII.1a-b–2a-b must be completed. Submission of this data before June 2026 is optional.**

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?**	Not reporting data

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	MEDICAID MANAGED CARE/ FAMILY HEALTH PLUS/ HIV SPECIAL NEEDS PLAN/ HEALTH AND RECOVERY PLAN MODEL CONTRACT March 1, 2024
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	03/01/2024
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)

C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Dental Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	5,028,357
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter "There were no major changes to the population or benefits during	There were no major changes to the population or benefits during the reporting year" as your response

	the reporting year" as your response. "N/A" is not an acceptable response.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract	18.5 (iv) Reporting Requirements

	section references, not page numbers.	
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Model Contract 18.5 (iv)G; and State's Social Services Law Sec. 364 j(32)
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with “N/A” if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter “The state did not experience any barriers to collecting or validating encounter data during the reporting year” as your response. “N/A” is not an acceptable response.	The state did not experience any barriers to collecting or validating encounter data during the reporting year

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident", as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	A definition for Critical Incident is not in the current mainstream/HARP/HIV SNP quarterly report instructions. A proposed definition might be: "Critical Incident: An event involving an Enrollee which has, or may have, an adverse effect on the health, life, safety, or welfare of the Enrollee." "An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed)
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	The managed care plans are required to make a determination for a standard appeal within 30 days of receipt of the appeal per section F.2(4)(a)(i) of the Model Contract.
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the	The managed care plans are required to make a determination for an expedited appeal within two business days of receipt of necessary information but no later than seventy-two hours of the date of receipt of the appeal per section F.2(4)(a)(ii) and (iii) of the Model ContractAppendix F.2(4)(a)(ii) and (iii) of the Model Contract

	MCO, PIHP or PAHP receives the appeal.	
C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	2019F.2(a)(v) For action appeals reviewed under the standard timeframe the contractor must send written notice to the enrollee, and the provider when appropriate, within (2)two business days of the Action Appeal determination, and not later than 30 days of the receipt of the Action Appeal or, if review has been extended as provided in 4)iii) above, not later than the date the extension expires

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	The diverse geography of New York (rural versus urban) presents challenges in areas of the state where there are not enough, or any providers available to serve the population. Providers willing to comply with the provisions of the 21st Century Cures Act and enroll with the state's Medicaid program have presented challenges. Reimbursement rates to providers have historically always presented challenges in recruiting and sustaining MCPs provider networks.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	NYS staff review MCP provider networks on a quarterly basis. Network adequacy is determined at the county level and each quarter, after the reviews are complete, MCPs are provided a report identifying where network inadequacies are identified. Subsequently, MCPs are responsible for providing NYS with a response as to the measures they are employing to help mitigate gaps in their provider networks. Additionally, MCPs work with NYS collaboratively to assess and assure provider market data is accurate

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	www.nymedicaidchoice.com
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	Phone, Internet, Email, TTY, In-Person Appointments
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	New York Medicaid Choice enrollment broker conducts research to identify the source of the issue prior to reporting their findings to the state. Additionally, the New York Medicaid Choice enrollment broker will touch base with the consumer and or their authorized representative to gather details and assess risk; House an effective data reporting system regarding enrollments, disenrollments, exemptions, transfers, outreach and education activities and complaints and grievances. Respond to internal research and analysis needs, or research requests from the state and routinely monitor available data to preempt problems that impact the program, and report problems and potential solutions to the state.

C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	The state reviews monthly reports to determine if all performance measures were met as well as routinely monitors the quality management plan. Set performance standards for the program functions and periodically assess through the Internal Quality Assurance Program and through weekly, monthly and ad-hoc required reporting, regularly scheduled required meetings, and through consumer surveys.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	Yes
C1XII.5	**Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?** (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	**Did the State or MCOs complete the most recent parity analysis(es)?**	Other, specify – Both
C1XII.7a	**Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?** (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	No
C1XII.8	**When was the last parity analysis(es) for this program completed?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the	08/14/2022

	state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	
C1XII.9	**When was the last parity analysis(es) for this program submitted to CMS?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	03/14/2022
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	Yes
C1XII.10b	**In the last analysis(es) conducted, describe all deficiencies identified.**	"QTLs: Two QTL issues were identified with Partial Hospitalization (PH) and HARP HCBS. The State's analysis also revealed that neither the MCOs nor the State are actively imposing either of these limitations, additionally limitations can be exceeded for HCBS. Another QTL issue was identified within the Medicaid model contract for failing the Substantially All test for smoking cessation counseling sessions. State Plan Amendments were

submitted to address the limits for PH and smoking cessation counseling. NQTLs: The State conducted a review of all active MCOs and their compliance with 19 different NQTLs. This was done in three phases. During the first phase, MCOs failed to demonstrate compliance with MHPAEA for prior authorization, concurrent review, medical necessity criteria, and formulary design due to incomplete submissions and not providing substantive comparative analysis. In Phase 2, the NQTL workbooks exhibited minimal improvement in submission quality, with most MCOs failing to demonstrate compliance with MHPAEA. Many submissions were unresponsive to the prompts, incomplete, and/or did not provide substantive comparative analyses for coding edits, out of network coverage standards, and reimbursement. Additionally, one plan was in violation of MHPAEA after disclosing practices demonstrating that strategies used when determining reimbursement rates for MH/SUD services were not comparable to the strategies used in determining reimbursement rates for M/S services in the inpatient, outpatient, and emergency care benefit classifications. Phase 3 demonstrated similar results to Phases 1 and 2, as most MCO submissions lacked comprehensive responses and did not provide substantive comparative analyses for five of the ten NQTLs tested; retrospective review, outlier review, experimental/investigational determinations, fail first, and provider credentialing. Additionally, the Phase 3 analysis revealed that four plans violated MHPAEA for imposing treatment limitations on retrospective review and/or outlier review. "

C1XII.11a	**As of the end of this reporting period, have these deficiencies been resolved for all plans?**	No
C1XII.11b	**If deficiencies have not been resolved, select all that apply.**	Other, specify – The State is currently pursuing enforcement actions following the Phase I, II, and III Focus Surveys, due to the repeat noncompliance with parity reporting across NQTLs. While the enforcement actions are still taking place, the State is in the process of conducting MHPAEA Compliance Virtual Focus Surveys as a follow up to the outcome of the Phase I, II, and III Focus Survey. The survey includes the review of updated, completed workbooks, specific in-operation NQTL requests, and the evaluation of the MCO's implementation of the approved POCs associated with the previously issued citations. Any identified deficiencies may result in a citation and the potential for further enforcement action. Preliminary results indicate that several of the previously identified areas of noncompliance have been resolved.
C1XII.12a	**Has the state posted the current parity analysis(es) covering this program on its website?** The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single	Yes

	state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	
C1XII.12b	**Provide the URL link(s).** Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.	https://www.health.ny.gov/health_care/managed_care/reports/docs/compliance_report_3-22.pdf,https://www.health.ny.gov/health_care/managed_care/reports/docs/compliance_report_3-21.pdf,https://www.health.ny.gov/health_care/managed_care/reports/docs/2019-04-18_rpt.pdf,https://www.health.ny.gov/health_care/managed_care/reports/focused_surveys/mental/index.htm

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**AmidaCare Inc.,** 9,263 **Metro Plus Health Care Inc.,** 4,445 **VNS Choice** 3,608
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**AmidaCare Inc.,** 0.12% **Metro Plus Health Care Inc.,** 0.06% **VNS Choice** 0.05%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**AmidaCare Inc.,** 0.16% **Metro Plus Health Care Inc.,** 0.08% **VNS Choice** 0.06%
D1I.4: Parent	**Organization: The name of the parent entity that**	**AmidaCare Inc.,**

controls the Medicaid Managed Care Plan. If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not controlled by a separate entity, please report the managed care plan name in this field.	AmidaCare Inc. **Metro Plus Health Care Inc.,** New York City Health and Hospitals Corporation **VNS Choice** Visiting Nurse Service of New York

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**AmidaCare Inc.,** 89.61% **Metro Plus Health Care Inc.,** 96.42% **VNS Choice** 95.83%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**AmidaCare Inc.,** Program-specific statewide **Metro Plus Health Care Inc.,** Program-specific statewide **VNS Choice** Program-specific statewide
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** N/A

	or Group VIII expansion enrollees? If so, describe the populations here. Enter “N/A” if not applicable. See glossary for the regulatory definition of MLR.	**VNS Choice** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**AmidaCare Inc.,** Yes **Metro Plus Health Care Inc.,** Yes **VNS Choice** Yes
N/A	Enter the start date.	**AmidaCare Inc.,** 04/01/2021 **Metro Plus Health Care Inc.,** 04/01/2021 **VNS Choice** 04/01/2021
N/A	Enter the end date.	**AmidaCare Inc.,** 03/31/2022 **Metro Plus Health Care Inc.,** 03/31/2022 **VNS Choice** 03/31/2022

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**AmidaCare Inc.,** The Contractor shall prepare and submit encounter data twice a month, as specified by SDOH, to SDOH through SDOH's designated Fiscal Agent. Unless otherwise directed by SDOH, encounter data shall not be submitted to the SDOH, or its designee, more than 15 days from the date of adjudication of the corresponding claim. **Metro Plus Health Care Inc.,** The Contractor shall prepare and submit encounter data twice a month, as specified by SDOH, to SDOH through SDOH's designated Fiscal Agent. Unless otherwise directed by SDOH, encounter data shall not be submitted to the SDOH, or its designee, more than 15 days from the date of adjudication of the corresponding claim. **VNS Choice** The Contractor shall prepare and submit encounter data twice a month, as specified by SDOH, to SDOH through SDOH's designated Fiscal Agent. Unless otherwise directed by SDOH, encounter data shall not be submitted to the SDOH, or its designee, more than 15 days from the date of adjudication of the corresponding claim.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions	**AmidaCare Inc.,** 90.74% **Metro Plus Health Care Inc.,** 99%

	(submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**VNS Choice** 94%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**AmidaCare Inc.,** 86.02% **Metro Plus Health Care Inc.,** 100% **VNS Choice** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**AmidaCare Inc.,** 2,299 **Metro Plus Health Care Inc.,** 147 **VNS Choice** 102
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.	**AmidaCare Inc.,** 159 **Metro Plus Health Care Inc.,** 50 **VNS Choice** 74

D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.	**AmidaCare Inc.,** 10 **Metro Plus Health Care Inc.,** 93 **VNS Choice** 10
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.	**AmidaCare Inc.,** 87 **Metro Plus Health Care Inc.,** 4 **VNS Choice** 18
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**AmidaCare Inc.,** 6 **Metro Plus Health Care Inc.,** 12 **VNS Choice** 4
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** 56 **VNS Choice**

	service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	96
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 7

	first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**AmidaCare Inc.,** 238 **Metro Plus Health Care Inc.,** 134 **VNS Choice** 11
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**AmidaCare Inc.,** 8 **Metro Plus Health Care Inc.,** 8 **VNS Choice** 90
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a	**AmidaCare Inc.,** 254 **Metro Plus Health Care Inc.,** 23 **VNS Choice** 101

service.
(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).

D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 29 **VNS Choice** 1
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**AmidaCare Inc.,** 2,040 **Metro Plus Health Care Inc.,** 95 **VNS Choice** 0
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**AmidaCare Inc.,** 5 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance**	**AmidaCare Inc.,** 0

	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**AmidaCare Inc.,** 1,084 **Metro Plus Health Care Inc.,** 86 **VNS Choice** 0
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**AmidaCare Inc.,** 1,153 **Metro Plus Health Care Inc.,** 49 **VNS Choice** 1
D1IV.7c	**Resolved appeals related to inpatient behavioral health services**	**AmidaCare Inc.,** 3

	Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.	**Metro Plus Health Care Inc.,** 2 **VNS Choice** 0
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter “N/A”.	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 2 **VNS Choice** 0
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter “N/A”.	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** 2 **VNS Choice** N/A
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** 6 **VNS Choice**

	not cover skilled nursing services, enter “N/A”.	7
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter “N/A”.	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** 36 **VNS Choice** 82
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter “N/A”.	**AmidaCare Inc.,** 59 **Metro Plus Health Care Inc.,** 39 **VNS Choice** 0
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter “N/A”.	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0

D1IV.7k:	**Resolved appeals related to durable medical equipment (DME) & supplies** Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter “N/A”.	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 12
D1IV.7l:	**Resolved appeals related to home health / hospice** Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter “N/A”.	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.7m:	**Resolved appeals related to emergency services / emergency department** Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter “N/A”.	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.7n:	**Resolved appeals related to therapies**	**AmidaCare Inc.,** 0

	Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.	**Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.7o	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-n paid primarily by Medicaid, enter “N/A”.	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.	**AmidaCare Inc.,** 36 **Metro Plus Health Care Inc.,** 8 **VNS Choice** 8
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**AmidaCare Inc.,** 4 **Metro Plus Health Care Inc.,** 5 **VNS Choice** 2
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**AmidaCare Inc.,** 2 **Metro Plus Health Care Inc.,** 1 **VNS Choice** 3
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf	**AmidaCare Inc.,** 6 **Metro Plus Health Care Inc.,** 1

	of the enrollee) during the reporting year prior to reaching a decision.	**VNS Choice** 2
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**AmidaCare Inc.,** 5 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**AmidaCare Inc.,** 5 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 1

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**AmidaCare Inc.,** 138 **Metro Plus Health Care Inc.,** 40 **VNS Choice** 109
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**AmidaCare Inc.,** 15 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 1
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**AmidaCare Inc.,** 7 **Metro Plus Health Care Inc.,** 13 **VNS Choice** 47

D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 1

	of the reporting year, the state can enter “N/A” in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**AmidaCare Inc.,** 217 **Metro Plus Health Care Inc.,** 40 **VNS Choice** 108

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter “N/A”.	**AmidaCare Inc.,** 8 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.	**AmidaCare Inc.,** 15 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 21
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that	**AmidaCare Inc.,** 7 **Metro Plus Health Care Inc.,**

	were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	0 **VNS Choice** 0
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	**AmidaCare Inc.,** 25 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 2
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter “N/A”.	**AmidaCare Inc.,** 8 **Metro Plus Health Care Inc.,** N/A **VNS Choice** 1
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter “N/A”.	**AmidaCare Inc.,** 3 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0

D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**AmidaCare Inc.,** 7 **Metro Plus Health Care Inc.,** 2 **VNS Choice** 16
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**AmidaCare Inc.,** 26 **Metro Plus Health Care Inc.,** 9 **VNS Choice** 11
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**AmidaCare Inc.,** 14 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.15k	**Resolved grievances related to durable medical equipment (DME) & supplies** Enter the total number of grievances resolved by the plan	**AmidaCare Inc.,** 104 **Metro Plus Health Care Inc.,**

	during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter “N/A”.	38 **VNS Choice** 0
D1IV.15l	**Resolved grievances related to home health / hospice** Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter “N/A”.	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.15m	**Resolved grievances related to emergency services / emergency department** Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0

D1IV.15n	**Resolved grievances related to therapies** Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter “N/A”.	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.15o	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-n paid primarily by Medicaid, enter “N/A”.	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**AmidaCare Inc.,** 48 **Metro Plus Health Care Inc.,** 3 **VNS Choice** 9
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**AmidaCare Inc.,** 20 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 2

D1IV.16c	**Resolved grievances related to network adequacy or access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**AmidaCare Inc.,** 11 **Metro Plus Health Care Inc.,** 3 **VNS Choice** 46
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**AmidaCare Inc.,** 19 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 7
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 17

	communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**AmidaCare Inc.,** 11 **Metro Plus Health Care Inc.,** 12 **VNS Choice** 2
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**AmidaCare Inc.,** 1 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation**	**AmidaCare Inc.,** 0

	Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**AmidaCare Inc.,** 1 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0

	the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**AmidaCare Inc.,** 27 **Metro Plus Health Care Inc.,** 22 **VNS Choice** 26

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Quality & performance measure total count: 25

Complete

D2.VII.1 Measure Name: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

1 / 25

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

1879

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

54.96

Metro Plus Health Care Inc.,

68.29

VNS Choice

63.27

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management-84 days and 180 days (Composite)

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0105

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

The percentage of adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications. The two components of this measure - effective Acute and Continuous Phase Treatments are weighted and combined to calculate the final rate.

Measure results

AmidaCare Inc.,

52.01

Metro Plus Health Care Inc.,

47.31

VNS Choice

73.38

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio (Ages 19-64)

3 / 25

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

The percentage of adults 19–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. State-specific age stratification.

Measure results

AmidaCare Inc.,

48.05

Metro Plus Health Care Inc.,

50.00

VNS Choice

35.60

Complete

D2.VII.1 Measure Name: Breast Cancer Screening - Electronic

4 / 25

Complete

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

2372

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

standardized national measure

Measure results

AmidaCare Inc.,

60.51

Metro Plus Health Care Inc.,

77.94

VNS Choice

68.39

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening

5 / 25

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0032

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

56.67

Metro Plus Health Care Inc.,

80.78

VNS Choice

67.54

Complete

D2.VII.1 Measure Name: Chlamydia Screening (Ages 16-24)

6 / 25

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0033

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

79.10

Metro Plus Health Care Inc.,

73.81

VNS Choice

N/A

Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure

7 / 25

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0018

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

62.04

Metro Plus Health Care Inc.,

75.18

VNS Choice

68.30

Complete

D2.VII.1 Measure Name: Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Using Antipsychotic Meds

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

1932

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

95.82

Metro Plus Health Care Inc.,

99.20

VNS Choice

92.86

Complete

D2.VII.1 Measure Name: Follow-up After Emergency Department Visit for Substance Use Within 7 Days

9 / 25

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3488

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

34.41

Metro Plus Health Care Inc.,

41.67

VNS Choice

28.49

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness Within 7 Days

10 / 25

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

41.14

Metro Plus Health Care Inc.,

54.17

VNS Choice

35.29

Complete

D2.VII.1 Measure Name: Getting Care Needed

11 / 25

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

0006

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

76.89

Metro Plus Health Care Inc.,

78.62

VNS Choice

78.43

Complete

D2.VII.1 Measure Name: Initiation and Engagement in SUD Dependence Treatment (Composite)

12 / 25

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0004

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

The percentage of new episodes of substance use disorder that result in treatment initiation or engagement. The two components of this measure (Initiation Phase and Contiuation Phase) are weighted and combined to calculate the final rate.

Measure results

AmidaCare Inc.,

26.36

Metro Plus Health Care Inc.,

34.23

VNS Choice

35.92

Complete

D2.VII.1 Measure Name: Initiation of Pharmacotherapy Upon New Episode of Opioid Use Disorder

13 / 25

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

The percentage of individuals who initiate pharmacotherapy with at least 1 prescription or visit for opioid treatment medication within 30 days following an index visit with a diagnosis of opioid dependence.

Measure results

AmidaCare Inc.,

30.85

Metro Plus Health Care Inc.,

37.39

VNS Choice

20.61

Complete

D2.VII.1 Measure Name: Kidney Health Evaluation for Patients With Diabetes (Total)

14 / 25

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

N/A

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

39.78

Metro Plus Health Care Inc.,

51.20

VNS Choice

34.93

Complete

D2.VII.1 Measure Name: Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control

15 / 25

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0059

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

25.06

Metro Plus Health Care Inc.,

16.55

VNS Choice

29.69

Complete

D2.VII.1 Measure Name: Eye Exam for Patients With Diabetes

16 / 25

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0055

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

47.93

Metro Plus Health Care Inc.,

68.37

VNS Choice

64.06

Complete

D2.VII.1 Measure Name: Rating of Health Plan

17 / 25

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

0006

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

75.91

Metro Plus Health Care Inc.,

77.99

VNS Choice

74.81

Complete

D2.VII.1 Measure Name: Statin Therapy for Patients with Cardiovascular Disease - Adherent

18 / 25

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

83.85

Metro Plus Health Care Inc.,

75.00

VNS Choice

80.39

Complete

D2.VII.1 Measure Name: Viral Load Suppression

19 / 25

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

2082

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

The percentage of members 2 years of age and older confirmed HIV-positive who had a HIV viral load less than 200 copies/mL at last HIV viral load test

Measure results

AmidaCare Inc.,

78.03

Metro Plus Health Care Inc.,

81.21

VNS Choice

84.41

Complete

D2.VII.1 Measure Name: Adult Immunization Status Influenza (Ages 19-65) - Electronic

20 / 25

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

3620

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

38.51

Metro Plus Health Care Inc.,

54.67

VNS Choice

55.10

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (Total) 21 / 25

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1516

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

48.80

Metro Plus Health Care Inc.,

69.11

VNS Choice

51.56

Complete

D2.VII.1 Measure Name: Colorectal Cancer Screening (Total)-Electronic

22 / 25

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0034

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

53.31

Metro Plus Health Care Inc.,

67.79

VNS Choice

59.25

Complete

D2.VII.1 Measure Name: Customer Service

23 / 25

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

AmidaCare Inc.,

89.04

Metro Plus Health Care Inc.,

86.19

VNS Choice

87.83

Complete

D2.VII.1 Measure Name: Depression Screening and Follow-Up for Adolescents and Adults (Combo)

24 / 25

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0418

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

The percentage of members 12 years or older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. The two components of this measure (Depression Screening and Follow-Up on Positive Screen) are weighted and combined to calculate the final rate.

Measure results

AmidaCare Inc.,

29.24

Metro Plus Health Care Inc.,

33.06

VNS Choice

0.00

Complete

D2.VII.1 Measure Name: Medical Assistance with Tobacco Cessation (Composite)

25 / 25

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0028

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

The percentage of members 18 years of age and older who indicated that they current smokers or tabacco users and were provided medical assistance with smoking and tobacco use cessation. The three components of this measure(Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications and Discussing Cessation Strategies) are weighted and combined to calculate the final rate.

Measure results

AmidaCare Inc.,

73.30

Metro Plus Health Care Inc.,

76.56

VNS Choice

78.75

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Sanction total count: 16

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 16

D3.VIII.2 Plan performance issue

Target Survey, UR, Contract Oversight, QA

D3.VIII.3 Plan name

VNS Choice

D3.VIII.4 Reason for intervention

Annual Operational Survey

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/28/2025

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 12/31/2025

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 16

D3.VIII.2 Plan performance issue

Comprehensive, UR, BH, Contract Oversight

D3.VIII.3 Plan name

AmidaCare Inc.,

D3.VIII.4 Reason for intervention

Annual Operational Survey

Sanction details

D3.VIII.5 Instances of non-compliance

7

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/18/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 12/31/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

3 / 16

D3.VIII.2 Plan performance issue

Comprehensive, UR, Non-UR

D3.VIII.3 Plan name

Metro Plus Health Care Inc.,

D3.VIII.4 Reason for intervention

Annual Operational Survey

Sanction details

D3.VIII.5 Instances of non-compliance

6

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/27/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 12/01/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

4 / 16

D3.VIII.2 Plan performance issue

Focus Survey, Member Services

D3.VIII.3 Plan name

Metro Plus Health Care Inc.,

D3.VIII.4 Reason for intervention

EQRO Survey for Requirement of 1115 CMS Waiver

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/04/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 10/01/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

5 / 16

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name

VNS Choice

Focus Survey, Member Services

D3.VIII.4 Reason for intervention

EQRO Survey for Requirement of 1115 CMS Waiver

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/28/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 07/19/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

6 / 16

D3.VIII.2 Plan performance issue

Focus Survey, Member Services

D3.VIII.3 Plan name

AmidaCare Inc.,

D3.VIII.4 Reason for intervention

EQRO Survey for Requirement of 1115 CMS Waiver

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/28/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 05/01/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

D3.VIII.2 Plan performance issue

Focus Survey, Provider Access and Availability

D3.VIII.3 Plan name

AmidaCare Inc.,

D3.VIII.4 Reason for intervention

EQRO Survey for Requirement of 1115 CMS Waiver

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/23/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 08/30/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

8 / 16

D3.VIII.2 Plan performance issue

Focus Survey, Provider Directory

D3.VIII.3 Plan name

AmidaCare Inc.,

D3.VIII.4 Reason for intervention

EQRO Survey for Requirement of 1115 CMS Waiver

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/23/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 08/30/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

9 / 16

D3.VIII.2 Plan performance issue

Focus Survey, Provider Access and Availability

D3.VIII.3 Plan name

Metro Plus Health Care Inc.,

D3.VIII.4 Reason for intervention

EQRO Survey for Requirement of 1115 CMS Waiver

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/23/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 10/31/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

10 / 16

D3.VIII.2 Plan performance issue

Focus Survey, Provider Directory

D3.VIII.3 Plan name

Metro Plus Health Care Inc.,

D3.VIII.4 Reason for intervention

EQRO Survey for Requirement of 1115 CMS Waiver

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/23/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 10/31/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

11 / 16

D3.VIII.2 Plan performance issue

Focus Survey, Provider Access and Availability

D3.VIII.3 Plan name

VNS Choice

D3.VIII.4 Reason for intervention

EQRO Survey for Requirement of 1115 CMS Waiver

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/23/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 08/16/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

12 / 16

D3.VIII.2 Plan performance issue

Focus Survey, Provider Directory

D3.VIII.3 Plan name

VNS Choice

D3.VIII.4 Reason for intervention

EQRO Survey for Requirement of 1115 CMS Waiver

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/23/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 08/16/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

13 / 16

D3.VIII.2 Plan performance issue

Focus Survey, MHPAEA Compliance

D3.VIII.3 Plan name

AmidaCare Inc.,

D3.VIII.4 Reason for intervention

Per 42 CFR Parts 438, 440, and 457 addressing application of MHPAEA requirements

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

D3.VIII.8 Remediation date non-compliance was corrected

01/17/2024

Yes, remediated 06/01/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

14 / 16

D3.VIII.2 Plan performance issue

Focus Survey, MHPAEA Compliance

D3.VIII.3 Plan name

VNS Choice

D3.VIII.4 Reason for intervention

Per 42 CFR Parts 438, 440, and 457 addressing application of MHPAEA requirements

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/12/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 03/31/2025

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

15 / 16

D3.VIII.2 Plan performance issue

Focus Survey, BH Key Staffing

D3.VIII.3 Plan name

VNS Choice

D3.VIII.4 Reason for intervention

Failure to notify the State of Adult and/or Children BH Key Staff Departure at Plan

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/12/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 04/02/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

16 / 16

D3.VIII.2 Plan performance issue

Focus Survey, Government Rate Payment Compliance

D3.VIII.3 Plan name

AmidaCare Inc.,

D3.VIII.4 Reason for intervention

Failure to pay required Government rates for BH services

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/06/2024

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 07/17/2024

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**AmidaCare Inc.,** 3 **Metro Plus Health Care Inc.,** 43 **VNS Choice** 3
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**AmidaCare Inc.,** 11 **Metro Plus Health Care Inc.,** 70 **VNS Choice** 16
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**AmidaCare Inc.,** 2 **Metro Plus Health Care Inc.,** 6 **VNS Choice** 23
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program	**AmidaCare Inc.,** Makes referrals to the SMA and MFCU concurrently

	integrity referrals to the state? Select one.	**Metro Plus Health Care Inc.,** Makes referrals to the Medicaid Fraud Control Unit (MFCU) only **VNS Choice** Makes referrals to the State Medicaid Agency (SMA) only
D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**AmidaCare Inc.,** Not applicable **Metro Plus Health Care Inc.,** 7 **VNS Choice** Not applicable
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made.	**AmidaCare Inc.,** Not applicable **Metro Plus Health Care Inc.,** Not applicable **VNS Choice** 14
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals.	**AmidaCare Inc.,** 11 **Metro Plus Health Care Inc.,** Not applicable **VNS Choice**

		Not applicable
D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**AmidaCare Inc.,** 11/20/2024 **Metro Plus Health Care Inc.,** 01/01/2024 **VNS Choice** 01/01/2024
D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**AmidaCare Inc.,** 03/01/2025 **Metro Plus Health Care Inc.,** 12/31/2024 **VNS Choice** 12/31/2024
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount** From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**AmidaCare Inc.,** $35,979.28 **Metro Plus Health Care Inc.,** $893,758.80 **VNS Choice** $339,262.55
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue	**AmidaCare Inc.,** $0 **Metro Plus Health Care Inc.,** $0

	as defined in MLR reporting under 438.8(f)(2))	**VNS Choice** $127,574,456
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**AmidaCare Inc.,** Weekly **Metro Plus Health Care Inc.,** Promptly when plan receives information about the change **VNS Choice** Promptly when plan receives information about the change

Topic XI: ILOS

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if “Yes”, which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter “0” for utilization.

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**AmidaCare Inc.,** No ILOSs were offered by this plan **Metro Plus Health Care Inc.,** No ILOSs were offered by this plan **VNS Choice** No ILOSs were offered by this plan

Topic XIII. Prior Authorization

Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage

> ⚠ **Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".**

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Not reporting data

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Enrollment Broker (NY Medicaid Choice)** Enrollment Broker
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Enrollment Broker (NY Medicaid Choice)** Enrollment Broker/Choice Counseling

Section F: Notes

Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to “Review & submit.”

Number	Indicator	Response
F1	**Notes (optional)**	Not answered