Managed Care Program Annual Report (MCPAR) for New York: 2023-24 HIV Special Needs Plan (HIVSNP)

Due date	Last edited	Edited by	Status
09/27/2024	09/30/2024	Anesa Brkanovic	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

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.	NYS DOH - OHIP: Division Of Health Plan Contracting and Oversight (DHPCO)
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	bmcfhelp@health.ny.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Anesa Brkanovic
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	anesa.brkanovic@health.ny.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	09/30/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	04/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	03/31/2024
A6	**Program name** Auto-populated from report dashboard.	2023-24 HIV Special Needs Plan (HIVSNP)

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 438.71See 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	New York State Medicaid Managed Care Alternative Services and Settings - In Lieu of Services (ILS) (ny.gov)

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.	7,657,192
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.	No PI activities were performed during the reporting period.
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).	Sections: 19.5; 19.6; 22.7; 23.3
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	Pursuant to 42 CFR 438.608(c)(3), the 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, as reported to SDOH pursuant to Section 18.5(a)(viii)(G) or Section 22.5(b)(ix) of this Agreement, within sixty (60) days of identification, or receipt of notice, of such payments.
BX.5	**State overpayment reporting monitoring**	The Office of the Medicaid Inspector General (OMIG) can perform audits of financial reports

	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.	filed by Contractors after SDOH reviews and accepts the Contractor's report. If the audit determines that the Contractor's filed report contained misstatements of fact, causing the Contractor and/or other Contractors to receive an inappropriate capitation rate, the OMIG will recover any and all overpayments. The Contractor will be entitled to the audit rights afforded to providers in Section 517.5 and Section 517.6 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York. Nothing in this section shall limit SDOH, OMIG, or any other auditing entity from the development of alternative audit and/or recovery rights for time periods prior to the contract period, during the contract period, or subsequent to the contract period, or limit other remedies or rights available to SDOH, OMIG, or any other auditing entity relating to the timeliness, completeness and/or accuracy of the Contractor's reporting submission.
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).	New York State Department of Health (NYSDOH) has taken a proactive approach to improve the quality control of monthly Medicaid enrollments and premium payments. The NY Medicaid program operates through two enrollment systems, the Welfare Management System (WMS) and the New York State of Health (NYSOH), as well as multiple disenrollment channels. With multiple systems, a small percentage of discrepancies can occur, resulting in conflicting enrollments or incorrectly denied payments. To address these issues, NYSDOH has implemented an automated process that identifies discrepancies to produce a password-protected report that is shared with individual health plans. These monthly reports help health plans to promptly review and take corrective actions, ensuring the accuracy of Medicaid enrollment while ensuring that health plans are paid for their services. This proactive approach has been effective in addressing enrollment conflicts and payment disputes in a timely manner, benefiting both health plans and NYSDOH. Additionally, the Office of Medicaid Inspector General does periodic audits to identify improper payments, including if a member was deceased, incarcerated or disenrolled.

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 §455.104 and required by 42 CFR 438.602(g)(3).	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	https://www.health.ny.gov/health_care/managed_care/reports/docs/cy2021_encounter_data_audit.pdf

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 your response. 'N/A' is not an acceptable response.

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/managed_care/providers/docs/mmc_fhp_hiv-snp_harp_model_contract.pdf
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	16,520

	month during the reporting year (i.e., average member months).	
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 the reporting year' as your response. 'N/A' is not an acceptable response.	There were no major changes to the population or benefits during the reporting year' as your 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 section references, not page numbers.	18.5 (iv) Reporting Requirements

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 NYS implemented the OSDS encounter submission format during the reporting period and instructed plan to hold back encounter data during OSDS implementation (April 2023) until such time new system was ready to collect data (May 2023). This encounter submission hold led to some encounters being submitted outside the 15 day requirement for reporting.

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.	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.
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 MCO, PIHP or PAHP receives the appeal.	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 Appendix F.2(4)(a)(ii) and (iii) of the Model Contract

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.	Appendix F.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 insufficient or no providers available to serve the population. Some providers are unwilling to comply with the provisions of the 21st Century Cures Act and enroll with the state's Medicaid program. Providers may be unwilling to accept Medicaid reimbursement rates or to contract with Managed Care plans.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	MCPs submit their provider networks on a quarterly basis. Network adequacy is reviewed at the county level. MCPs receive 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. NYS will issue Statement of Deficiencies to MCPs in relation to identified gaps and require MCPs to submit Corrective Action Plans to address gaps in network adequacy. Where networks are inadequate, authorizations for out-of-network access are required. Additionally, MCPs work with NYS collaboratively to assess and assure provider market data is accurate.

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Access measure total count: 4

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 4

C2.V.2 Measure standard

See Medicaid Model Contract Section 15
health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv_snp_model_contract.pdf

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	County	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

2 / 4

C2.V.2 Measure standard

dictionary.pdf (ny.gov)
https://www.health.ny.gov/health_care/managed_care/adequacy_standards.htm

C2.V.3 Standard type

Network Adequacy

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
All required provider types specific to approved lines of business in accordance with the applicable data dictionary provide by the Provider Network Data System	County	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

3 / 4

C2.V.2 Measure standard

Referral by NYS Bureau of Consumer Services for assessment of specific network providers where questions about adequacy arise.

C2.V.3 Standard type

Network Adequacy

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
All required provider types specific to approved lines of business in accordance with the applicable data dictionary provide by the Provider Network Data System	County	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access

C2.V.8 Frequency of oversight methods

As needed through referral by other state agencies, advocates or complaints field with other Bureaus

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 4 / 4

C2.V.2 Measure standard

Identification and validation of providers that have been recorded on a federal or state exclusion list.

C2.V.3 Standard type

Service fulfillment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
All required provider types specific to approved lines of business in accordance with the applicable data dictionary provide by the Provider Network Data System	County	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

Quarterly

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

Beginning December 2024, this section must be completed for programs that include MCOs

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	No

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.,** 8,747 **Metro Plus Health Care Inc.,** 4,446 **VNS Choice** 3,403
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.,** 0.11% **Metro Plus Health Care Inc.,** 0.06% **VNS Choice** 0.04%
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.,** 0.15% **Metro Plus Health Care Inc.,** 0.08% **VNS Choice** 0.06%

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.,** 92% **Metro Plus Health Care Inc.,** 95% **VNS Choice** 96%
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 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.	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** N/A **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.,** 04/01/2022 **Metro Plus Health Care Inc.,** 04/01/2022 **VNS Choice** 04/01/2022
N/A	Enter the end date.	**AmidaCare Inc.,** 03/31/2023 **Metro Plus Health Care Inc.,** 03/31/2023 **VNS Choice** 03/31/2023

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.,** " Section 18.5 (a) (iv) of the Model Contract -- page 179: 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.,** " Section 18.5 (a) (iv) of the Model Contract -- page 179: 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** " Section 18.5 (a) (iv) of the Model Contract -- page 179: 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 (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	**AmidaCare Inc.,** 96.91% **Metro Plus Health Care Inc.,** 99.5% **VNS Choice** 92%

	submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	
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.,** 99.86% **Metro Plus Health Care Inc.,** 100% **VNS Choice** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

> ⚠ **Beginning June 2025, Indicators D1.IV.1a-c must be completed. Submission of this data before June 2025 is optional; if you choose not to respond prior to June 2025, enter "N/A".**

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.,** 636 **Metro Plus Health Care Inc.,** 219 **VNS Choice** 77
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. If you choose not to respond prior to June 2025, enter "N/A".	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** N/A **VNS Choice** N/A
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. If you choose not to respond prior to June 2025, enter "N/A".	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** N/A **VNS Choice** N/A

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. If you choose not to respond prior to June 2025, enter "N/A".	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** N/A **VNS Choice** N/A
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.,** 0 **Metro Plus Health Care Inc.,** 57 **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 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).	**AmidaCare Inc.,** 3 **Metro Plus Health Care Inc.,** 9 **VNS Choice** 47
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	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0

	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 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.,** 421 **Metro Plus Health Care Inc.,** 205 **VNS Choice** 0

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.,** 19 **Metro Plus Health Care Inc.,** 11 **VNS Choice** 37
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 service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**AmidaCare Inc.,** 211 **Metro Plus Health Care Inc.,** 146 **VNS Choice** 1
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.,** 10 **Metro Plus Health Care Inc.,** 17 **VNS Choice** 0
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.,** 412 **Metro Plus Health Care Inc.,** 73 **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.,** 2 **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** 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.	**AmidaCare Inc.,** 1 **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.,** 0 **Metro Plus Health Care Inc.,** 2 **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.,** 85 **Metro Plus Health Care Inc.,** 150 **VNS Choice** 7
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, including diagnostic and laboratory services. 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.,** 57 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 3
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** 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".	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** 1 **VNS Choice** 0
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan	**AmidaCare Inc.,** 1 **Metro Plus Health Care Inc.,**

	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".	0 **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.,** N/A **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 not cover skilled nursing services, enter "N/A".	**AmidaCare Inc.,** 4 **Metro Plus Health Care Inc.,** 7 **VNS Choice** 6
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.,** 1 **Metro Plus Health Care Inc.,** 8 **VNS Choice** 39
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that	**AmidaCare Inc.,** 66 **Metro Plus Health Care Inc.,**

	were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	26 **VNS Choice** 15
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** N/A
D1IV.7j	**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-i paid primarily by Medicaid, enter "N/A".	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** 53 **VNS Choice** 9

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**AmidaCare Inc.,** 21 **Metro Plus Health Care Inc.,** 4 **VNS Choice** 3
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.,** 2 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
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** 0
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 of the enrollee) during the reporting year prior to reaching a decision.	**AmidaCare Inc.,** N/A **Metro Plus Health Care Inc.,** 1 **VNS Choice** 0

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.,** 3 **Metro Plus Health Care Inc.,** 14 **VNS Choice** 2
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.,** 1 **Metro Plus Health Care Inc.,** 13 **VNS Choice** 2

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.,** 215 **Metro Plus Health Care Inc.,** 24 **VNS Choice** 136
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.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 8
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.,** 8 **Metro Plus Health Care Inc.,** 3 **VNS Choice** 48
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	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0

	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 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.	**VNS Choice** 2
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.	**AmidaCare Inc.,** 214 **Metro Plus Health Care Inc.,** 22

See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**VNS Choice** 122

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.,** 10 **Metro Plus Health Care Inc.,** 0 **VNS Choice** N/A
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, including diagnostic and laboratory services. 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.,** 71 **Metro Plus Health Care Inc.,** 0 **VNS Choice** N/A
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 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".	**AmidaCare Inc.,** 3 **Metro Plus Health Care Inc.,** 0 **VNS Choice** N/A
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	**AmidaCare Inc.,** 15 **Metro Plus Health Care Inc.,**

	mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	1 **VNS Choice** N/A
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.,** 13 **Metro Plus Health Care Inc.,** N/A **VNS Choice** N/A
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.,** 2 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 1
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.,** 8 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 11
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	**AmidaCare Inc.,** 30 **Metro Plus Health Care Inc.,** 8

	not cover this type of service, enter "N/A".	**VNS Choice** 9
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.,** 11 **Metro Plus Health Care Inc.,** 0 **VNS Choice** N/A
D1IV.15j	**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-i paid primarily by Medicaid, enter "N/A".	**AmidaCare Inc.,** 9 **Metro Plus Health Care Inc.,** 21 **VNS Choice** 115

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.,** 43 **Metro Plus Health Care Inc.,** 1 **VNS Choice** 6
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.,** 26 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 3

D1IV.16c	**Resolved grievances related to 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.,** 9 **VNS Choice** 21
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.,** 35 **Metro Plus Health Care Inc.,** 1 **VNS Choice** 4
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 communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**AmidaCare Inc.,** 16 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 88

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.,** 5 **Metro Plus Health Care Inc.,** 10 **VNS Choice** 1
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** 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.	**AmidaCare Inc.,** 8 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal**	**AmidaCare Inc.,** 3 **Metro Plus Health Care Inc.,**

	(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).	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 the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**AmidaCare Inc.,** 0 **Metro Plus Health Care Inc.,** 0 **VNS Choice** 0
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.,** 0 **Metro Plus Health Care Inc.,** 3 **VNS Choice** 13

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: 31

Complete

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

1 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

56.02

Metro Plus Health Care Inc.,

61.22

VNS Choice

67.95

Complete

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

2 / 31

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, 01/01/2022 - 02/31/2022

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.,

53.03

Metro Plus Health Care Inc.,

48.39

VNS Choice

67.06

Complete

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

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, 01/01/2022 - 12/31/2022

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.,

59.35

Metro Plus Health Care Inc.,

22.41

VNS Choice

31.82

Complete

D2.VII.1 Measure Name: Breast Cancer Screening

4 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure

Measure results

AmidaCare Inc.,

61.61

Metro Plus Health Care Inc.,

72.11

VNS Choice

72.98

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening

5 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

68.33

Metro Plus Health Care Inc.,

83.20

VNS Choice

76.92

Complete

D2.VII.1 Measure Name: Chlamydia Screening (Ages 21-24)

6 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

79.71

Metro Plus Health Care Inc.,

N/A

VNS Choice

N/A

Complete

D2.VII.1 Measure Name: Colorectal Cancer Screening (Ages 50-75)

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

56.09

Metro Plus Health Care Inc.,

66.42

VNS Choice

60.25

Complete

D2.VII.1 Measure Name: Colorectal Cancer Screening (Ages 46-49)

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

28.44

Metro Plus Health Care Inc.,

32.23

VNS Choice

27.70

Complete

D2.VII.1 Measure Name: Colorectal Cancer Screening (Ages 46-75)

9 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

52.44

Metro Plus Health Care Inc.,

62.38

VNS Choice

57.48

Complete

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

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

51.26

Metro Plus Health Care Inc.,

75.72

VNS Choice

62.34

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

Standardized National Measure set

Measure results

AmidaCare Inc.,

97.07

Metro Plus Health Care Inc.,

95.04

VNS Choice

97.41

Complete

D2.VII.1 Measure Name: Flue vaccination

12 / 31

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0039

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

Standardized National Measure Set

Measure results

AmidaCare Inc.,

64.54

Metro Plus Health Care Inc.,

69.95

VNS Choice

73.59

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness Within 7 days

13 / 31

D2.VII.2 Measure Domain

Behavioral health care

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

3489

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized National measure set

Measure results

AmidaCare Inc.,

55.81

Metro Plus Health Care Inc.,

41.38

VNS Choice

46.81

Complete

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

14 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure set

Measure results

AmidaCare Inc.,

41.44

Metro Plus Health Care Inc.,

29.13

VNS Choice

34.31

Complete

D2.VII.1 Measure Name: Follow-Up After High-Intensity Care for Substance Use Disorder Within 7 Days

15 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure set

Measure results

AmidaCare Inc.,

45.99

Metro Plus Health Care Inc.,

38.85

VNS Choice

44.26

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

34.76

Metro Plus Health Care Inc.,

46.15

VNS Choice

33.33

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness Within 7 Days (Ages 18-64)

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

32.52

Metro Plus Health Care Inc.,

42.55

VNS Choice

29.55

Complete

D2.VII.1 Measure Name: Getting Care Needed

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

74.46

Metro Plus Health Care Inc.,

79.91

VNS Choice

82.10

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Substance Use Disorder Treatment - Initiation of SUD - Total - Total

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

10.20

Metro Plus Health Care Inc.,

13.08

VNS Choice

12.04

Complete

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

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, 01/01/2022 - 12/31/2022

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.,

31.39

Metro Plus Health Care Inc.,

28.44

VNS Choice

34.34

Complete

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

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

40.97

Metro Plus Health Care Inc.,

41.67

VNS Choice

34.06

Complete

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

22 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

21.65

Metro Plus Health Care Inc.,

18.73

VNS Choice

23.10

Complete

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

23 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

48.42

Metro Plus Health Care Inc.,

71.05

VNS Choice

71.50

Complete

D2.VII.1 Measure Name: Pharmacotherapy for Opioid Use Disorder

24 / 31

D2.VII.2 Measure Domain

Behavioral health care

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

3175

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

20.77

Metro Plus Health Care Inc.,

24.07

VNS Choice

25.00

Complete

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

25 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

75.55

Metro Plus Health Care Inc.,

76.05

VNS Choice

78.72

Complete

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

26 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

78.63

Metro Plus Health Care Inc.,

87.50

VNS Choice

82.95

Complete

D2.VII.1 Measure Name: Statin Therapy for Patients with Cardiovascular Disease - Adherent (F 40-75)

27 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

84.21

Metro Plus Health Care Inc.,

86.67

VNS Choice

75.76

Complete

D2.VII.1 Measure Name: Statin Therapy for Patients with Cardiovascular Disease - Adherent (M 21-75)

28 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

76.34

Metro Plus Health Care Inc.,

88.10

VNS Choice

87.27

Complete

D2.VII.1 Measure Name: Use of Pharmacotherapy for Alcohol Use Disorder

29 / 31

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

The percentage of individuals with any encounter associated with alcohol use or dependence, with at least 1 prescription for appropriate pharmacotherapy at any time during the measurement year.

Measure results

AmidaCare Inc.,

25.85

Metro Plus Health Care Inc.,

21.72

VNS Choice

19.90

Complete

D2.VII.1 Measure Name: Use of Spirometry Testing in the Assessment and Diagnosis of COPD

30 / 31

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0577

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

13.19

Metro Plus Health Care Inc.,

12.50

VNS Choice

18.52

Complete

D2.VII.1 Measure Name: Viral Load Suppression

31 / 31

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

HEDIS

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

standardized national measure sets

Measure results

AmidaCare Inc.,

76.76

Metro Plus Health Care Inc.,

82.48

VNS Choice

84.52

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. Include any pending or unresolved actions.

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: 5

Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 5

D3.VIII.2 Plan performance issue

Focus survey, SD/D supplies and treatments

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

2

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

06/28/2023

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

Yes, remediated 05/31/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 5

D3.VIII.2 Plan performance issue

Focus Survey , MHPAEA Compliance

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

3

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

01/17/2024

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

Yes, remediated 09/30/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

3 / 5

D3.VIII.2 Plan performance issue

Encounter data submission

D3.VIII.3 Plan name

AmidaCare Inc.,

D3.VIII.4 Reason for intervention

Failing to submit timely encounter data pursuant to SSL 364(j)

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$4,750.41

D3.VIII.7 Date assessed

10/01/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

4 / 5

D3.VIII.2 Plan performance issue

Encounter Submission

D3.VIII.3 Plan name

Metro Plus Health Care Inc.,

D3.VIII.4 Reason for intervention

Failing to submit complete encounter data pursuant to SSL 364(j)

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$27,589.55

D3.VIII.7 Date assessed

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

04/01/2023

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

5 / 5

D3.VIII.2 Plan performance issue

Encounter Submission

D3.VIII.3 Plan name

AmidaCare Inc.,

D3.VIII.4 Reason for intervention

Failing to submit complete encounter data pursuant to SSL 364(j)

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$50,913.74

D3.VIII.7 Date assessed

04/01/2023

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

No, no remediation

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.,** 6 **Metro Plus Health Care Inc.,** 40 **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.,** 8 **Metro Plus Health Care Inc.,** 83 **VNS Choice** 19
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**AmidaCare Inc.,** 0.88:1,000 **Metro Plus Health Care Inc.,** 83:1,000 **VNS Choice** 0.6:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**AmidaCare Inc.,** 8 **Metro Plus Health Care Inc.,** 6 **VNS Choice** 8

D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**AmidaCare Inc.,** 8:1,000 **Metro Plus Health Care Inc.,** 0.6:1,000 **VNS Choice** 0.02:1,000
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**AmidaCare Inc.,** Makes referrals to the State Medicaid Agency (SMA) only **Metro Plus Health Care Inc.,** Makes referrals to the Medicaid Fraud Control Unit (MFCU) only **VNS Choice** Makes referrals to the SMA and MFCU concurrently
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.,** 5 **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.,** 2 **Metro Plus Health Care Inc.,** Not applicable **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 unduplicated referrals.	**AmidaCare Inc.,** Not applicable **Metro Plus Health Care Inc.,** Not applicable **VNS Choice** 2
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	**AmidaCare Inc.,** 0.22:1,000 **Metro Plus Health Care Inc.,** 0.5:1,000 **VNS Choice** 0.06:1,000
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.,** 04/01/2022 **Metro Plus Health Care Inc.,** 04/01/2022 **VNS Choice** 04/01/2024
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.,** 03/31/2023 **Metro Plus Health Care Inc.,** 03/31/2023 **VNS Choice** 03/31/2025

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.,** $611,146 **Metro Plus Health Care Inc.,** $105,635.40 **VNS Choice** $1,078,424.33
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 as defined in MLR reporting under 438.8(f)(2))	**AmidaCare Inc.,** $525,670,697 **Metro Plus Health Care Inc.,** $265,705,998 **VNS Choice** $115,224,612
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**AmidaCare Inc.,** Monthly **Metro Plus Health Care Inc.,** Promptly when plan receives information about the change **VNS Choice** Weekly

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

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