

Department of Health

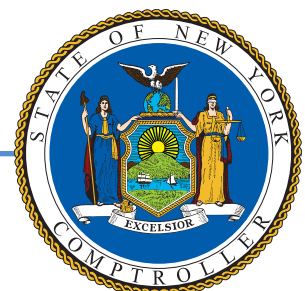
Medicaid Program: Oversight of Managed Care Provider Networks

Report 2023-S-20 | October 2025

OFFICE OF THE NEW YORK STATE COMPTROLLER

Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability



Audit Highlights

Objective

To determine if the Department of Health (DOH) has provided adequate oversight of Medicaid managed care provider networks to ensure cost efficiency and access to adequate in-network care. The audit covered the period from January 2023 through December 2023.

About the Program

DOH administers New York's Medicaid program. Most of the State's Medicaid members receive their services through managed care. DOH is responsible for ensuring that managed care organizations (MCOs) maintain and monitor a network of providers supported by written agreements that is sufficient to provide timely and adequate access to all services covered under the contract. If the provider network cannot provide services, the member can go out of network. MCOs are required to submit their provider network to DOH quarterly using the Provider Network Data System (PNDS) for assessment of its adequacy. This information is used to generate a deficiency report identifying areas where the MCO lacks enough providers in certain counties. MCOs are given an opportunity to dispute deficiencies and provide supporting information to have the deficiency removed. DOH reviews the MCO's responses and updates the status of the deficiency. At the conclusion of this process, the remaining deficiencies are compiled into a quarterly Statement of Agreement (SOA) for each MCO.

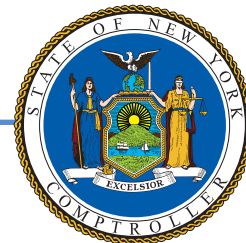
Key Findings

We found that DOH lacked sufficient oversight of managed care provider networks. We determined that, in many instances, DOH did not follow its internal PNDS Review Guidance. SOAs contained inaccurate deficiencies, and deficiency statuses were not always updated so it was unclear whether DOH took the additional steps needed to complete its quarterly network adequacy review. Additionally, we found records that appear to have been incorrectly labeled as "excluded" from the network adequacy process, which could result in incomplete SOAs.

We also found that DOH does not provide MCOs with adequate guidance regarding the deficiency review process or out-of-network provider payments, which may expose the Medicaid program to increased expenses. Furthermore, despite having access to the SOA data, DOH officials do not use this information to identify patterns or areas for improvement or to provide any other oversight of the network adequacy process.

Key Recommendations

- Improve monitoring and controls over the provider network adequacy process to ensure network deficiencies are reported timely and accurately, including issuing guidance detailing MCO responsibilities within the deficiency review process.
- Evaluate the provider network deficiencies identified in SOAs and take steps to improve MCO provider networks.



Office of the New York State Comptroller Division of State Government Accountability

October 22, 2025

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. McDonald:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Oversight of Managed Care Provider Networks*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

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Glossary of Terms

Term	Description	Identifier
DOH	Department of Health	<i>Auditee</i>
MCO	Managed care organization	<i>Key Term</i>
OMH	Office of Mental Health	<i>Agency</i>
PNDS	Provider Network Data System	<i>Key Term</i>
SOA	Statement of Agreement	<i>Key Term</i>

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. During the State fiscal year ended March 31, 2025, New York's Medicaid program had approximately 8.4 million members and Medicaid claim costs totaled about \$93 billion (comprising \$49.2 billion in fee-for-service health care payments and \$43.8 billion in managed care premium payments). The federal government funded about 55.7% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 44.3%.

The Department of Health (DOH) administers the Medicaid program in New York State. DOH uses two methods to pay for Medicaid services: fee-for-service and managed care. Under the fee-for-service method, DOH, through its Medicaid claims processing and payment system (eMedNY), pays Medicaid-enrolled providers directly for services delivered to Medicaid members. Under the managed care method, DOH makes monthly premium payments to managed care organizations (MCOs) for each enrolled Medicaid member and, in turn, the MCOs arrange for the provision of health care services and reimburse providers for those services.

According to federal regulations (42 CFR § 438.206) and the MCO Model Contract, DOH is responsible for ensuring that MCOs maintain and monitor a network of providers supported by written agreements that is sufficient to provide timely and adequate access to all services covered under the MCO Model Contract. If the provider network cannot provide services, the member is allowed to go out of network for as long as the MCO provider network is unavailable. DOH has developed guidelines for MCOs that define the minimum requirements for network adequacy by county, county surrounding area, and provider type (e.g., primary care providers, specialists, pharmacies).

DOH uses the Provider Network Data System (PNDS), a software provided by Quest Analytics, to collect data needed to evaluate provider networks. Each quarter, MCOs are required to self-report their provider networks to DOH to determine their adequacy. The information reported by each MCO is used by PNDS to identify available providers in each county. Quest Analytics then uses this information to generate a deficiency report identifying areas where the MCO lacks sufficient providers to meet network requirements. DOH reviews this report to ensure it contains valid deficiencies and then shares it with the MCO. The MCOs are given an opportunity to dispute deficiencies and submit supporting information to have the deficiencies removed. DOH reviews the MCO's responses and updates the status of the deficiency to one of nine possible statuses (e.g., "resolved," "issuer dispute – deficiency removed" or "issuer dispute – deficiency retained"). At the conclusion of this process, the remaining deficiencies are compiled into a quarterly Statement of Agreement (SOA) for each MCO. The SOAs specify deficiencies by county and provider specialty. MCOs have 10 days to sign the SOA, agreeing to allow members access to non-participating providers for the specialties in the specified counties until the network requirements are satisfied.

Audit Findings and Recommendations

We found that DOH does not have sufficient oversight of managed care provider networks. The data used to assess network adequacy is self-reported by MCOs and often has accuracy issues, which can lead to incorrect conclusions that a provider network is either adequate or has deficiencies. DOH relies on the data system vendor, Quest Analytics, to investigate and correct many of these inaccuracies, stating that DOH has no input on the logic or data processes within PNDS, as it is strictly a user of the data. We reviewed deficiency reports and SOAs from each quarter of 2023 for nine MCOs. We found that, in many instances, DOH did not follow its internal PNDS Review Guidance, SOAs contained inaccurate deficiencies, and it was unclear whether DOH took the necessary additional steps to complete its quarterly network adequacy review. Additionally, we identified records that likely were incorrectly labeled as “excluded” from the network adequacy process. These inaccuracies in SOAs mean that DOH and MCOs lack clarity on which counties, regions, and specialties actually have deficiencies needing improvement, and this hampers DOH’s ability to identify the MCOs most in need of improvement.

Although MCOs are given an opportunity to dispute deficiencies, DOH often does not respond timely, and deficiencies frequently remain on reports and SOAs for multiple quarters. This forces MCOs to re-review and comment on the deficiencies each quarter. Moreover, DOH provides insufficient guidance to MCOs about the deficiency review process and out-of-network provider payments, which may expose the Medicaid program to increased expenses. Furthermore, even though DOH has access to the SOA data, officials do not utilize this information to identify patterns, target areas for improvement, or provide any other oversight of the network adequacy process.

Inadequate Oversight of the Network Adequacy Process

Data Issues

Because provider network information is self-reported by each MCO, there are often issues with the data used to create the deficiency reports that lead to false deficiencies. This can be due to issues with how the information is cross-walked from the MCO to DOH or because MCOs provide incorrect information. For example, when an MCO submits its network data to PNDS, the provider information must align with the data fields used by DOH; otherwise, it may not be properly loaded into PNDS. Additionally, if an MCO submits incorrect address information for an in-network provider, PNDS may incorrectly record this provider as in network and available for all MCOs to contract with when assessing MCOs’ network adequacy. Consequently, the other MCOs may be assessed for a deficiency until the information is corrected. In such cases, each MCO must repeatedly provide proof that the provider does not operate at that location. DOH may take steps to confirm this information but does not reach out to the MCO that reported the incorrect information. Instead, DOH is supposed to mark the provider as “suspect” in PNDS and relies on its vendor to take the appropriate steps to investigate and remove the

provider from its data moving forward. DOH has stated it has no input on the logic or data processes within PNDS, as it is strictly a user of the data, and relies on its vendor to supply accurate information.

In some instances, such as for hospice providers, PNDS did not accurately identify the provider service area. This could cause PNDS to list providers as operating in counties where they do not actually operate. As a result, MCO deficiency reports can have incorrect deficiencies, and MCOs are then responsible for reviewing these deficiencies and providing explanations to DOH for any disagreements with the assessment. In some instances, MCOs stated they had provided information to DOH in 2020 explaining the issues with hospice providers, but DOH took no actions to resolve the problem. During the audit, DOH officials stated there were no plans to update PNDS to correctly reflect which counties hospice providers serve.

Excluded Status

There are certain services that DOH excludes from its deficiency review process for various reasons, such as the service not currently being used for network adequacy or the service being reviewed separately for network adequacy by the Office of Mental Health (OMH).

In quarter four of 2023, there were 685 instances of “excluded” status on the deficiency reports for the nine MCOs reviewed that appear to have been incorrectly labeled as “excluded.” This includes 32 different specialties (e.g., optometry and podiatry). Based on the exclusion lists provided by DOH and OMH, along with the PNDS Data Dictionary—which lists the provider specialties included in DOH’s network adequacy process—it is likely these 685 instances should have been sent to MCOs as deficiencies for review but were not due to the incorrect “excluded” status. DOH attributed some of these errors to a PNDS system issue that caused the “excluded” status to be carried over each quarter. Additionally, we compared a list of services DOH said were excluded due to OMH review with a list of services OMH actually reviews and found DOH’s list to be incomplete.

DOH reported that it has updated its review process to require all “excluded” records to be reviewed for accuracy each quarter. However, this review will only be effective if DOH is using current and accurate information about which specialties should have an “excluded” status in PNDS. When inaccurate information is used, services may be incorrectly included in or excluded from DOH’s network adequacy process, which can affect the accuracy of the SOAs.

Inaccurate Deficiencies

We reviewed deficiency reports and SOAs for each quarter of 2023 for the nine MCOs. Our review identified instances—such as a provider specialty and county—where MCOs were cited for deficiencies incorrectly or where deficiencies remained on the MCOs’ SOAs despite MCO comments explaining why these deficiencies were incorrect. For example:

-
- We identified a record listed as a deficiency even though the MCO did not operate in the specified county. Although the MCO provided this information after the deficiency first appeared, the deficiency remained on its SOAs for quarters two through four of 2023. Overall, for 2023, we found 249 deficiencies on SOAs where this MCO did not operate in the listed county.
 - We identified 75 records marked as “data error” that still appeared on SOAs, even though DOH’s internal PNDS Review Guidance states records with this label should not be included on an SOA.
 - We found a record indicating the MCO had already contracted with the only available provider in the area, so it would not be a deficiency. However, the deficiency still appeared on the MCO’s SOA in the second quarter of 2023.
 - DOH’s internal PNDS Review Guidance indicates that if no providers are available in a county or surrounding area for a particular specialty, the record should automatically be set to a status of “issue resolved,” and not included on an SOA. However, we found 72 records where no providers for a specialty were located in the county or surrounding area, but the status was not appropriately set to “issue resolved,” causing these records to appear on SOAs.
 - We identified one record where an MCO was cited as having a deficiency because it contracted with one less opioid treatment program specialty than was required in the county. The MCO determined this to be a PNDS error, as there were no additional providers in the county. Despite this, the deficiency was still included on the SOAs for three quarters of 2023.

There is the potential that additional deficiencies were inaccurately included on the SOAs, as it was often unclear whether DOH had taken the necessary additional steps to finalize its review. Of the 17,202 records we reviewed, 12,608 were not updated with a status indicating DOH’s determination. (Note: this includes 236 of the 249 deficiencies in 2023 where the MCO did not operate in the specified county as noted above.) Further, 2,140 of the 12,608 records without an assigned status contained comments from the MCO expressing disagreement. It is unclear why these records have not been updated with the appropriate status. However, because DOH’s internal PNDS Review Guidance states the status must be updated, it is evident DOH is not enforcing this process. According to DOH, the assigned status can affect whether a deficiency is included on the SOA, so it is imperative that DOH updates these records with the necessary information.

Inaccurate SOAs result in DOH and MCOs not knowing which counties, regions, and specialties actually have deficiencies that need to be addressed, which reduces DOH’s ability to identify which MCOs are most in need of improvement. Despite having access to SOA data, DOH officials do not use this information to detect patterns or areas for improvement or to provide any other oversight of the network adequacy process.

SOA Timeliness

We reviewed the SOAs for each quarter of 2023 for the nine MCOs and found 20 of 36 (56%) were not signed by the MCO. Of the 16 SOAs that were signed, none were signed by their due date. In fact, it took an average of 106 days for these documents to be signed and returned to DOH. While DOH officials stated there may be slight delays in this process due to the MCO's CEO being temporarily unavailable or PNDS system updates, we found situations where the SOA remained unsigned for over a year. When we asked MCOs why they did not sign the documents, they said it was an oversight and there was miscommunication between them and DOH. In some cases, the MCO stated that it took DOH over a year to follow up about the missing signatures. When DOH does not receive signed SOAs, DOH lacks assurance that the MCO agrees with the deficiency and will allow members to go out of network.

Lack of Communication Regarding the Network Adequacy Process

Although MCOs are given an opportunity to dispute deficiencies and provide supporting information, DOH does not respond timely, and deficiencies often remain on deficiency reports and resulting SOAs for multiple quarters. This requires MCOs to re-review them and provide comments to dispute the deficiency each quarter. We contacted four MCOs to discuss the network adequacy process. They reported that even after an MCO submits information to DOH showing a record is not a deficiency, it still appears on the deficiency reports in the following quarters. One MCO reported that DOH recently started reviewing disputes from a year ago, and the reports still show a deficiency even though it has been confirmed that a provider is unavailable. Additionally, although the deficiency reports have a specific field for comments where the MCO and DOH are expected to correspond, DOH allows offline conversations to occur, which are not documented as part of this process. DOH officials stated that such offline conversations are rare.

Furthermore, when reviewing deficiency reports, we discussed with DOH a deficiency that the MCO had confirmed was incorrect by calling the provider listed in PNDS and finding the provider did not offer services under the specialty and county listed. DOH officials stated that the MCO did not provide the necessary supporting documentation to challenge the deficiency, so the deficiency would be included in the SOA. However, through our discussions with the MCOs, we found they were unaware of this requirement. The MCOs said their understanding was that they could provide additional documentation to support their position if they chose to, but it was not required.

In response to our audit, DOH stated it has begun making improvements to monitor and control the provider network adequacy process and to ensure excluded services are correctly recorded.

Out-of-Network Payment

When a Medicaid member receives out-of-network care, the MCO must pay the provider for the services for as long as the MCO cannot offer the service through a participating provider. During our discussions with MCOs, we found there was no consistent payment method when a member is allowed to go out of network, and DOH provides no guidance on acceptable payments. In some cases, the provider agrees to accept Medicaid rates; other times, the MCO negotiates an acceptable rate with the provider, which could be higher than the Medicaid rate. Because MCO premium payments are primarily based on the cost of medical services, this situation may expose the Medicaid program to increased expenses. As such, it is critical DOH improve oversight of the network adequacy process to ensure member access to in-network providers.

Recommendations

1. Improve monitoring and controls over the provider network adequacy process to ensure network deficiencies are reported timely and accurately, including issuing guidance detailing MCO responsibilities within the deficiency review process.
2. Develop a complete and accurate list of specialties that are excluded from the quarterly network adequacy process, including collaborating with OMH, to ensure all services are appropriately reviewed for network adequacy.
3. Evaluate the provider network deficiencies identified in SOAs and take steps to improve MCO provider networks.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine if DOH has provided adequate oversight of Medicaid managed care provider networks to ensure cost efficiency and access to adequate in-network care. The audit covered the period from January 2023 through December 2023.

To accomplish our objective and assess related internal controls, we interviewed officials from DOH and MCOs and analyzed MCO deficiency reports and SOAs from January 2023 through December 2023 for nine MCOs. We also examined DOH's relevant policies and procedures as well as the MCO Model Contract and applicable federal laws and regulations.

We used a non-statistical sampling approach to provide conclusions on our audit objective and to test internal controls and compliance. We selected judgmental samples. However, because we used a non-statistical sampling approach for our tests, we cannot project the results to the population. Our samples, which are discussed in detail in the body of our report, include:

- A judgmental sample of nine of 18 MCOs that made up over 90% of the capitation payments for mainstream, HIV/Special Needs Plans, and Health and Recovery Plans from 2020–2023. For each MCO, we reviewed all the deficiency reports and SOAs for January 2023 through December 2023.
- A judgmental sample of four of the nine MCOs that had the most instances of being the only MCO in a county with a deficiency. We contacted each of the four MCOs to understand the network adequacy process from their perspective.

We obtained the PNDS files and assessed the reliability of that data by reviewing existing information, interviewing officials knowledgeable about the system, and tracing to and from source data. We determined that the data in these files was sufficiently reliable for the purposes of this report.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties could be considered management functions for the purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of DOH's oversight and administration of managed care provider networks.

Reporting Requirements

We provided a draft copy of this report to DOH officials for their review and formal comment. We considered DOH's comments in preparing this report and have included them in their entirety at the end of the report. In their response, DOH officials generally concurred with the audit recommendations and indicated that certain actions have been and will be taken to address them. Our response to one DOH remark is included in the report's State Comptroller's Comment, which is embedded in DOH's response.

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Agency Comments and State Comptroller's Comment



**Department
of Health**

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

October 15, 2025

Christopher Morris, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Christopher Morris:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit 2023-S-20 entitled, "Medicaid Program – Oversight of Managed Care Provider Networks."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink that reads "Johanne E. Morne". The signature is written in a cursive, flowing style.

Johanne E. Morne, M.S.
Executive Deputy Commissioner

Enclosure

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**Department of Health Comments on the
Office of the State Comptroller's
Draft Audit Report 2023-S-20 entitled, "Medicaid Program – Oversight
of Managed Care Provider Networks"**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2023-S-20 entitled, "Medicaid Program – Oversight of Managed Care Provider Networks."

General Comments:

Audit Scope, Objective, and Methodology, Page 11, 3rd Paragraph

We used a non-statistical sampling approach to provide conclusions on our audit objectives and to test internal controls and compliance. We selected judgmental samples. However, because we used a non-statistical sampling approach for our tests, we cannot project the results to the population.

Department Response - OSC Use of A Judgmental Sample

Judgmental sampling is based on a found problem. It doesn't accurately measure how many problems you have or how widespread they are. This method involves selecting specific cases based on the auditor's judgment rather than using a statistically valid, random sample. Such an approach is inherently prone to selection bias, meaning that, as the Report acknowledges, the resulting findings cannot be generalized to the broader population and may overstate the prevalence of any identified issues.

State Comptroller's Comment – DOH's statement is misleading. Random and judgmental samples are routinely used and widely accepted to reach audit conclusions. In this case, for example, our main sample included all 2023 deficiency reports and SOAs for the nine MCOs that received 93% of the Medicaid capitation payments from 2020–2023 for mainstream, HIV/Special Needs Plans, and Health and Recovery Plans. As noted in the audit report, the sample reviews were supplemented with reviews of regulations, policies, and procedures and the MCO Model Contract; interviews with various DOH officials; assessments of internal controls; and data analysis to reach audit conclusions and recommendations.

Audit Recommendation Responses:

Recommendation #1

Improve monitoring and controls over the provider network adequacy process to ensure network deficiencies are reported timely and accurately, including issuing guidance detailing MCO responsibilities within the deficiency review process.

Response #1

The Department has begun implementing improvements to monitoring and controls over the provider network adequacy process to ensure quarterly network deficiencies are being completed by Managed Care Organizations timely and accurately and reviewed by Department staff in a timely manner. The Department will remind Managed Care Organizations of their responsibilities to complete the deficiency review process. The Department will continue to track completion and follow up with Managed Care Organizations not meeting required due dates.

Recommendation #2

Develop a complete and accurate list of specialties that are excluded from the quarterly network adequacy process, including collaborating with OMH, to ensure all services are appropriately reviewed for network adequacy.

Response #2

In 2024, The Department started working with The Office of Mental Health to confirm the list of excluded services. The Department will continue to work with other partners to ensure excluded services are updated. This will better ensure there is a complete and accurate list.

Recommendation #3

Evaluate the provider network deficiencies identified in SOAs and take steps to improve MCO provider networks.

Response #3

The Department is committed to using the tools and recourses available to ensure that network adequacy standards are enforced for all Managed Care Organizations in New York State. The Department is exploring options and best practices as to how to proceed.

Contributors to Report

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