Health Plan Name	Aetna Better Health of Illinois - ABHIL	2023
Link to list of Prior Authorization requirements for Healthcare Services		
Link to formulary with prior authorization requirements for Pharmaceuticals		
Total # of prior authorization requests for physical health services	**If a physical health Rx is covered by the medical benefit, it should be in this number.** ***Include initial requests and not extensions.** ***Do not include voids and withdrawals.** ***This should be unique prior authorization requests. If there are multiple requests for the same service and same member, that counts as 1 request.** ***This should be reported at the authorization level rather than service level.** ***Use the decision dates for reporting timeframe.** ***For dental and transportaton, include authorizations that are within the medical benefit and require a PA. Exclude services under dental benefit, non-urgent transportation, and HCBS.**	**175,565**
Total # of prior authorization requests denied for physical health services	**If a physical health Rx is covered by the medical benefit, it should be in this number.** ***This should be the last decision made before appeal.** ***This should be reported at the authorization level rather than service level.** ***Denials for physical health should be inclusive of medical necessity denials and administrative denials.** ***Overturned appeals count as a denial.** ***Plans should use the same specifications for partial approvals as the QBRs.**	**15,966**

Total # of prior authorization denials for physical health compared to total # of services provided (ratio)	**This should be total volume of denials/total covered services via claim counts.** ***Compare authorization denial volume counts to covered services via claim counts.** ***Report the total number of covered services in the reporting period by reporting total claim counts (paid and partially paid claims).** ***To break out BH vs PH vs Pharmacy, use the logic you currently use for HFS claim reporting.** ***Use HFS MPR Handbook for reference on HFS claim reporting.**	**3.9%**
Percentage of claims payments for physical health services with PA compared to all claim payments (%)	**This should be a comparison to all services covered even if there wasn't a PA required. This column is to point out a lot of drugs are covered without PA.** ***Include a %.** ***Count claims rather than service lines.**	**12.9%**
Total # of prior authorization requests for behavioral health services	**If a behavioral health Rx is covered by the medical benefit, it should be in this number.** ***Include initial requests and not extensions.** ***Do not include voids and withdrawals.** ***This should be unique prior authorization requests. If there are multiple requests for the same service and same member, that counts as 1 request.** ***This should be reported at the authorization level rather than service level.** ***Use the decision dates for reporting timeframe.**	**15,020**

Total # of prior authorization requests denied for behavioral health services	**If a behavioral health Rx for BH is covered by the medical benefit, it should be in this number.** ***This should be the last decision made before appeal.** ***This should be reported at the authorization level rather than service level.** ***Denials for behavioral health should be inclusive of medical necessity denials and administrative denials.** ***Overturned appeals count as a denial.** ***Plans should use the same specifications for partial approvals as the QBRs.**	**627**
Total # of prior authorization denials for behavioral health compared to total # of services provided (ratio)	**This should be total volume of denials/total covered services via claim counts.** ***Compare authorization denial volume counts to covered services via claim counts.** ***Report the total number of covered services in the reporting period by reporting total claim counts (paid and partially paid claims).** ***To break out BH vs PH vs Pharmacy, use the logic you currently use for HFS claim reporting.** ***Use HFS MPR Handbook for reference on HFS claim reporting.**	**1.4%**
Percentage of claims payments for behavioral health services with PA compared to all claim payments (%)	**This should be a comparison to all services covered even if there wasn't a PA required. This column is to point out a lot of drugs are covered without PA.** ***Include a %.** ***Count claims rather than service lines.**	**23.5%**

Total # of prior authorization requests for pharmaceuticals	**This should be the # of PA requests for the pharmaceutical benefit.** ***Include initial requests and not extensions** ***Do not include voids and withdrawals** ***This should be unique prior authorization requests. If there are multiple requests for the same service and same member, that counts as 1 request.** ***This should be reported at the case level associated with GPI 14 rather than the review level.** ***Defining PH vs BH for Pharmacy: Only medications covered under the medical benefit need to be distinguished by PH vs. BH. Pharmaceuticals do not need to be broken down further.** ***Use the decision dates for reporting timeframe.**	**39,514**
Total # of prior authorization requests denied for pharmaceuticals	**This should be the # of PA request denials for the pharmaceutical benefit.** ***No exclusions - report member denied based on GPI 14 - last decision made.** ***Do not include voids and withdrawals.** ***This should be reported at the case level associated with GPI 14 rather than the review level.** ***Denials for behavioral health should be inclusive of medical necessity denials and administrative denials.** ***Overturned appeal counts as a denial.** ***Plans should use the same specifications for partial approvals as the QBRs.**	**18,108**

Total # of prior authorization denials for pharmaceuticals compared to total # of Rxs received (ratio)	**This should be total volume of denials/total covered Rxs via claim counts.** ***No exclusions - report member denied based on GPI 14 - last decision made.** ***Compare authorization denial volume counts to covered services via claim counts** ***Report the total number of covered services in the reporting period by reporting total claim counts (paid and partially paid claims)** ***Information on pharmacy should only include the pharmacy benefit.**	**0.41%**
Percentage of claims payments for pharmaceuticals with PA compared to all claim payments (%)	**This should be a comparison to all drugs covered even if there wasn't a PA required. This column is to point out a lot of drugs are covered without PA.** ***Include a %.** ***No exclusions - report member denied based on GPI 14 - last decision made.**	**3.24%**
Total # of appeals decided for physical health	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**5,788**
Total # of appeals upheld for physical health	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**3,837**
Total # of appeals with decision overturned for physical health	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**1,951**
Total # of appeals for behavorial health	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**1,044**
Total # of appeals upheld for behavioral health	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**879**

Total # of appeals with decision overturned for behavioral health	*This should include provider and member appeals. *This should be 2022 decisions.	165
Total # of appeals for Rx	*This should include provider and member appeals. *This should be 2022 decisions.	1,755
Total # of appeals upheld for Rx	*This should include provider and member appeals. *This should be 2022 decisions.	1,440
Total # of appeals with decision overturned for Rx	*This should include provider and member appeals. *This should be 2022 decisions.	315
# 1 denial reason for physical health PA	*This should be authorization denial reason.	Medical Necessity
# 2 denial reason for physical health PA	*This should be authorization denial reason.	Delegated Entity Denial
#3 denial reason for physical health PA	*This should be authorization denial reason.	Admin Denial
#4 denial reason for physical health PA	*This should be authorization denial reason.	Claims Review
#5 denial reason for physical health PA	*This should be authorization denial reason.	Ext. Review Denial
# 1 denial reason for BH PA	*This should be authorization denial reason.	Medical Necessity
# 2 denial reason for BH PA	*This should be authorization denial reason.	Admin Denial
#3 denial reason for BH PA	*This should be authorization denial reason.	Claims Review

#4 denial reason for BH PA	*This should be authorization denial reason.	**Ext. Review Denial**
#5 denial reason for BH PA	*This should be authorization denial reason.	**Upheld**
# 1 denial reason for Rx	*This should be authorization denial reason.	**Trial of preferred drug required**
# 2 denial reason for Rx	*This should be authorization denial reason.	**Clinical guideline Not Met**
#3 denial reason for Rx	*This should be authorization denial reason.	**Additional Information Required**
#4 denial reason for Rx	*This should be authorization denial reason.	**Administrative Denials**
#5 denial reason for Rx	*This should be authorization denial reason.	**Medical Necessity –Diagnosis Off Label**
Average time between submission of a complete PA request and response for physical health	*Report urgent and non-urgent separately. *Use PA receipt date and response letter date. *Use the State PA report notification time.	**Non-Urgent: 59 hrs Urgent: 52 hrs**
Average time between submission of a complete PA request and response for behavioral health	*Report urgent and non-urgent separately. *Use PA receipt date and response letter date. *Use the State PA report notification time.	**Non-Urgent: 64 hrs Urgent: 54 hrs**

Average time between submission of a complete PA request and response for Rx	***Report urgent and non-urgent separately.** ***Use PA receipt date and response letter date.** ***Use the State PA report notification time.**	**Non-Urgent: 12hrs 2min** **Urgent: 11hrs 14 min**