Health Plan Name	Aetna Better Health of Illinois - ABHIL	2024
Link to list of Prior Authorization requirements for Healthcare Services		https://www.aetnabetterhealth.com/illinois-medicaid/providers/prior-authorization.html
Link to formulary with prior authorization requirements for Pharmaceuticals		https://www.aetnabetterhealth.com/illinois-medicaid/providers/pha
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.**	**149,388**
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.**	**14,984**
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.**	**5.1%**

Percentage of claims payments for physical health services with PA compared to all claim payments (%)	**column is to point out a lot of drugs are covered without PA.** ***Include a %.** ***Count claims rather than service lines.**	**25.7%**
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.**	**15,508**
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**	**658**
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).**	**3.1%**
Percentage of claims payments for behavioral health services with PA compared to all claim payments (%)	**column is to point out a lot of drugs are covered without PA.** ***Include a %.**	**23.9%**

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.**	**38,674**
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.**	**15,907**
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.**	**0.38%**

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.**	**3.32%**
Total # of appeals decided for physical health	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**7,948**
Total # of appeals upheld for physical health	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**5,211**
Total # of appeals with decision overturned for physical health	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**2,737**
Total # of appeals for behavorial health	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**1,235**
Total # of appeals upheld for behavioral health	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**1,109**
Total # of appeals with decision overturned for behavioral health	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**123**
Total # of appeals for Rx	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**2,031**
Total # of appeals upheld for Rx	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**1,733**
Total # of appeals with decision overturned for Rx	***This should include provider and member appeals.** ***This should be 2022 decisions.**	**298**
# 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.**	**Claims Review**
#4 denial reason for physical health PA	***This should be authorization denial reason.**	**Admin Denial**
#5 denial reason for physical health PA	***This should be authorization denial reason.**	**Upheld**
# 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.**	
#4 denial reason for BH PA	***This should be authorization denial reason.**	
#5 denial reason for BH PA	***This should be authorization denial reason.**	
# 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.**	**Medical Necessity –Diagnosis Off Label**
#4 denial reason for Rx	***This should be authorization denial reason.**	**Administrative Denials**

#5 denial reason for Rx	***This should be authorization denial reason.**	**Additional Information Required**
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: 55 hrs** **Urgent: 49 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: 54 hrs** **Urgent: 38 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: 9hrs 9min** **Urgent: 8hrs 32 min**