

HFS

Illinois Department of
Healthcare and Family Services

2025 UM Service Authorization Data Analysis Summary Report

April 2026



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Executive Summary

Overview

Utilization management (UM) is a strategy used by health plans and states to control healthcare costs while ensuring patients receive necessary, appropriate, and high-quality care. A component of UM is a service authorization program, which is a process where a request is submitted for approval to provide a service or group of services to an individual. A “service authorization request” (e.g., a prior authorization [PA] request) is made by a provider to a service authorization program to determine whether a healthcare service meets the reimbursement eligibility requirements for medically necessary, clinically appropriate care, resulting in the issuance of a service authorization determination.¹ The processes that a service authorization program uses to review service authorization requests and make determinations are regulated in accordance with the Centers for Medicare & Medicaid Services (CMS) Code of Federal Regulations (CFR) Title 42 Part 438 and Illinois statute 305 ILCS 5/5-30.1.²

To meet the federal and State statutory and regulatory service authorization requirements, the Illinois Department of Healthcare and Family Services (HFS) completes oversight activities related to compliance with the State and federal coverage and authorization regulations. Pursuant to 305 ILCS 5/5-30.1(g-13)(3), HFS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct a review of hospital service authorization data and information for all HealthChoice Illinois health plans and the YouthCare Specialty Plan (collectively termed “health plans”). The purpose of the review is to provide meaningful information to HFS regarding the evaluation of each health plan’s hospital service authorization data.

This report provides a summary of the findings from an analysis of July through September 2025 hospital service authorization requests and determinations across all health plans.

Table 1 lists the health plans included in the analysis and the associated health plan abbreviated names.

Table 1—List of Health Plan Names and Abbreviated Names

Health Plan Name	Health Plan Abbreviated Name
HealthChoice Health Plans	
Aetna Better Health of Illinois	Aetna
Blue Cross Community Health Plans	BCBSIL
CountyCare	CountyCare

¹ Illinois General Assembly. Illinois Compiled Statutes, 305 ILCS 5/5-30.1. Available at: <https://www.ilga.gov/documents/legislation/publicacts/103/PDF/103-0593.pdf>. Accessed on: Jan 23, 2026.

² Ibid.

Health Plan Name	Health Plan Abbreviated Name
Meridian	Meridian
Molina Healthcare of Illinois	Molina
Specialty Foster Care Plan	
YouthCare Specialty Plan	YouthCare

Methodology

HSAG collaborated with HFS to define the scope of the review to include applicable federal and State regulations and laws.

The analysis consisted of:

- Analysis of hospital service authorization request data, which were self-reported by the health plans.
- Analysis of fee-for-service (FFS) hospital service authorization requests, denials, and appeals data.
- Comparisons of hospital service authorization determination outcomes.
- Supportive information, including review of the health plans’ UM policies, procedures, and information and results of other service authorization request activities and/or reporting.

Detailed information regarding the methodology is included in Section 2 of this report.

Limitations

The findings presented in this report are subject to some limitations, which should be considered when interpreting or generalizing the findings.

- Data analysis was limited due to the review time period (July through September 2025).
- Health plan and HFS data were self-reported. Self-reported data were not validated; therefore, accuracy and completeness were not evaluated.
- System limitations may not have allowed for the specificity of categorization assessed.
- Although the primary goal of the analysis was to review hospital service authorizations, supplemental analyses that included other types of authorizations were included.

Results

HSAG assessed the health plans’ and FFS data and information and noted the following results.

- All health plans were compliant with the adoption and use of nationally recognized clinical decision support criteria.
- All health plans had procedures to ensure equitable standards of care for enrollees, and data analysis did not identify any concerns with parity.
- General acute hospitals contributed the most service authorization requests for both the health plans and FFS.
- Health plan and FFS hospital service authorization approval rates were higher than denial rates.
- Of the health plans' total hospital service authorization requests, less than 5 percent underwent, at a minimum, one second level of review.
- Most health plan denials were overturned via the peer-to-peer and reconsideration processes. The health plans' submissions confirmed that the health plans conduct the peer-to-peer and reconsideration processes after the Notice of Adverse Benefit Decision (NOABD, or denial) has been delivered to the enrollee and provider, which is inconsistent with CMS guidance and the Medicaid managed care rule. Service authorization requests result in denials when provider information to support medical necessity is not initially submitted. Providers should continue to be encouraged to submit complete information when requesting service authorizations, and health plans should utilize peer-to-peer processes and allowable extensions to obtain needed information prior to delivering denial decisions.

Detailed overall results are included in the “Results” section of this report, and in Appendix A for each health plan.

Recommendations

Based on the results of the review, HSAG offered the following recommendations.

- Due to the limited data set, HSAG recommends that future reviews include a full fiscal year of data. Reporting of a fiscal year would allow for a more comprehensive review of the health plans' data, a baseline for comparisons, and analysis of data variances that may be impacted by seasonality or other special causes.
- For future reviews, HFS should consider requiring health plans to attest to the accuracy of their self-reported data.

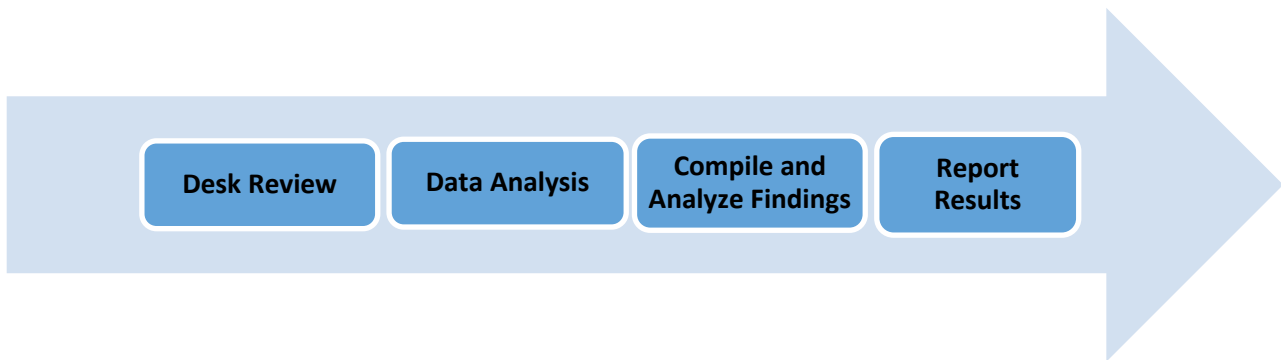
Methodology

The UM service authorization data analysis review identified and addressed differences between health plan application of service authorization requirements and service authorization request outcomes.

Process

The UM service authorization data analysis activities are illustrated in Figure 1 and described below.

Figure 1—UM Service Authorization Data Analysis Activities



Activity 1: Desk Review

HSAG requested UM documents and service authorization data from each health plan to inform HSAG’s review team of each health plan’s internal processes for managing service authorization requests.

Definitions referenced by HSAG during the desk review process are included in Appendix C.

A description of the process HSAG used to perform a desk review is detailed in Table 2.

Table 2—Activity 1: Perform Desk Review

For this step,	HSAG will...
Step 1:	Notify health plans of review.
	Health plans were provided an activity timeline and data file layout. HSAG provided assistance to all health plans prior to the review. This assistance included clear instructions regarding the scope of the review and any other expectations or responsibilities.

For this step,	HSAG will...
Step 2:	Receive policy and procedure documentation and data.
	HSAG confirmed that the health plans submitted all documentation requested. HSAG reviewed all documentation submitted. HSAG leveraged the results of each health plan’s administrative compliance file review of denials and appeals to evaluate components of PA decisions. HSAG also leveraged the results of mental health parity (MHP) reviews ³ to evaluate components of equitable standards of care.
Step 3:	Review health plan policies and procedures.
	This included review of all documents provided by the health plans and HFS. HSAG evaluated the health plans’ compliance with nationally recognized clinical decision support criteria. HSAG evaluated the results of the compliance review file reviews, ⁴ which were assessed for compliance against the following elements: <ul style="list-style-type: none"> • The ABD notice was sent within the required time frame. • The ABD notice met the readability protocol. HSAG identified health plan successes and/or opportunities for improvement.

Quarterly Business Review (QBR) Data Assessment

Monthly, the health plans self-reported data related to PA approvals and denials to HFS.⁵ HSAG analyzed the health plans’ calendar year (CY) 2024 data to determine parity between medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) denials. Analyses included Chi-square test to determine if there was any association between denial rates, and to evaluate the extent to which UM metrics differed between M/S and MH/SUD services. HSAG assigned a deviation rating of *None*, *Moderate*, or *Substantial*, as defined in Table 3, to indicate the degree to which each health plan’s reported metrics differed across MH/SUD and M/S services.

Table 3—Deviation Rating Definitions

Rating	Definition
<i>None</i>	Difference between metrics is less than (<) 5 percentage points.
<i>Moderate</i>	Difference between metrics is greater than or equal to (≥) 5 percentage points and less than (<) 10 percentage points.
<i>Substantial</i>	Difference between metrics is greater than or equal to (≥) 10 percentage points.

³ Mental health parity reviews were not limited to hospital service authorizations only.

⁴ Compliance file reviews were not limited to hospital service authorizations only.

⁵ Self-reported data were not limited to hospital service authorizations only and were not validated or assessed for accuracy.

Activity 2: Data Analysis

HSAG received and analyzed HFS’ FFS data and health plan self-reported data from July through September 2025 to evaluate hospital service authorization data and outcomes. The data analysis process that HSAG followed is described in Table 4.

Table 4—Activity 2: Data Analysis

For this step,	HSAG will...
Step 1:	Receive hospital service authorization data from the health plans and HFS.
	HSAG confirmed that the health plans and HFS submitted all data requested. HSAG reviewed all data submitted.
Step 2:	Analyze data to provide results and comparisons.
	HSAG analyzed FFS and health plan self-reported data to provide the total number of service authorization requests and service authorization outcomes.

Activity 3: Compile and Analyze Findings

HSAG documented components of the review and its final conclusions. HSAG summarized service authorization volumes and service authorization determination outcomes. HSAG analyzed data findings to determine deviations between health plans, utilizing the deviation rating definitions described in Table 3.

Activity 4: Report Results

HSAG prepared a draft report that describes its findings, deviation ratings, conclusions, and recommendations. Following HFS’ approval of the draft report, HSAG will issue the final report to HFS.

Results

HSAG derived results from its assessment of information received from the health plans and HFS, including:

- Analysis of hospital service authorization request data, which were self-reported by the health plans.
- Analysis of FFS hospital service authorization requests, denials, and appeals data.
- Comparisons of hospital service authorization determination outcomes.
- Supportive information, including review of the health plans’ UM policies, procedures, and information and results of other service authorization request activities and/or reporting.

Results Summary

Hospital Service Authorization Data Assessment

To evaluate health plan hospital service authorizations in accordance with 305 ILCS 5/5-30.1(g-13)(3)(D), HSAG received data from each health plan representing hospital service authorization requests received from July 2025 through September 2025. Table 5 displays the number of service authorization requests by health plan, hospital type, and service request category.

Table 5—Hospital Service Authorizations by Health Plan, Hospital Type, and Service Request Category

Health Plan and Hospital Type	PA	Concurrent	Post-service	Total
Aetna	4,872	10,219	433	15,524
<i>General Acute</i>	4,783	9,038	430	14,251
<i>Psychiatric</i>	78	1,089	1	1,168
<i>Rehabilitation</i>	11	81	2	94
<i>Long Term Acute Care</i>	0	11	0	11
<i>Children’s</i>	0	0	0	0
<i>Other</i>	0	0	0	0
BCBSIL	62,457	26,936	7,138	96,531
<i>General Acute</i>	51,907	20,908	6,385	79,200
<i>Psychiatric</i>	4,766	2,939	5	7,710
<i>Rehabilitation</i>	245	45	0	290
<i>Long Term Acute Care</i>	270	51	0	321

Health Plan and Hospital Type	PA	Concurrent	Post-service	Total
<i>Children's</i>	5,199	2,993	731	8,923
<i>Other</i>	70	0	17	87
CountyCare	5,007	16,271	53	21,334*
<i>General Acute</i>	3,835	10,923	35	14,793
<i>Psychiatric</i>	291	3,668	13	3,972
<i>Rehabilitation</i>	94	131	1	226
<i>Long Term Acute Care</i>	101	86	1	188
<i>Children's</i>	627	1,396	3	2,026
<i>Other</i>	59	67	0	126
Meridian	42,985	17,822	1,282	62,089
<i>General Acute</i>	42,806	12,709	1,132	56,647
<i>Psychiatric</i>	1	4,612	89	4,702
<i>Rehabilitation</i>	107	136	0	243
<i>Long Term Acute Care</i>	37	54	0	91
<i>Children's</i>	2	295	59	356
<i>Other</i>	32	16	2	50
Molina	10,389	8,209	498	19,096
<i>General Acute</i>	9,915	5,559	434	15,908
<i>Psychiatric</i>	63	1,638	22	1,723
<i>Rehabilitation</i>	3	83	0	86
<i>Long Term Acute Care</i>	0	35	3	38
<i>Children's</i>	408	894	39	1,341
<i>Other</i>	0	0	0	0
YouthCare	1,187	1,071	70	2,328
<i>General Acute</i>	1,187	277	57	1,521
<i>Psychiatric</i>	0	777	8	785
<i>Rehabilitation</i>	0	3	0	3
<i>Long Term Acute Care</i>	0	2	0	2
<i>Children's</i>	0	6	5	11

Health Plan and Hospital Type	PA	Concurrent	Post-service	Total
<i>Other</i>	0	6	0	6

*The sum of the categories may not equal the total (e.g., the health plan did not provide categorization).

Review of the hospital service authorizations identified the following:

- BCBSIL and Meridian reported the highest number of hospital service authorization requests. HSAG noted that these data may be expected as BCBSIL and Meridian represent the largest HealthChoice enrollment⁶ among the health plans.
- Three of the six health plans reported that most of the hospital service authorization requests were received as PAs. Aetna and CountyCare reported that most of their service authorizations were received as concurrent requests. YouthCare’s service authorizations were distributed almost equally between PAs and concurrent requests.
- When the three service request categories were compared, all six health plans reported their lowest service requests as post-service.
- When the hospital types were compared, five of the six health plans reported that most requests, across all categories, were received from general acute hospitals. Although YouthCare reported that most PAs were requested from general acute hospitals, most concurrent requests were received from psychiatric hospitals.
- HSAG noted that Aetna was the only health plan that reported no authorizations from children’s hospitals; Aetna reported that its authorization system does not include this specificity but that it can pull data from its claims system to report on children-specific facilities.

Determination Outcomes

HSAG assessed the outcomes of the hospital service authorization determinations to quantify the types of approvals and denials.

Approvals

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially approved (not denied).
- Initially denied but overturned, resulting in an approval of the service authorization request.

⁶ HFS Detailed Enrollment Totals. Enrollment as of November 1, 2025. Available at: <https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/mcoaggregatedreport112025.pdf>. Accessed on: Jan 23, 2026.

- Initially partially approved with the partial denial overturned, resulting in an approval of the service authorization request.

Table 6 displays the approval totals by health plan, with stratification by category of approval type for those service authorization requests that were initially denied but subsequently approved, in accordance with 305 ILCS 5/5-30.1(g-13)(3)(E)(i).

Table 6—Hospital Service Authorization Approvals by Health Plan and Approval Type

Health Plan and Approval Type*	Total ⁷
Aetna	12,418
<i>Initially approved; no further action required</i>	11,491
<i>Initially denied but overturned through appeal</i>	9
<i>Initially denied but overturned through peer-to-peer</i>	809
<i>Initially denied but overturned through reconsideration</i>	18
<i>Initially denied but overturned through fair hearings</i>	0
<i>Initially denied but overturned by provider dispute</i>	88
<i>Initially denied but overturned through external quality review organization (EQRO) process</i>	0
<i>Other</i>	3
BCBSIL	88,976
<i>Initially approved; no further action required</i>	88,489
<i>Initially denied but overturned through appeal</i>	65
<i>Initially denied but overturned through peer-to-peer</i>	193
<i>Initially denied but overturned through reconsideration</i>	39
<i>Initially denied but overturned through fair hearings</i>	0
<i>Initially denied but overturned by provider dispute</i>	27
<i>Initially denied but overturned through EQRO process</i>	0
<i>Other</i>	163
CountyCare	20,589
<i>Initially approved; no further action required</i>	20,256
<i>Initially denied but overturned through appeal</i>	1

⁷ Health plan totals include all approvals, including those that were initially approved and did not require additional review, as well as those that were partially approved/partially denied but ultimately approved. Initially denied categories are provided as a subset of the total number of authorizations that were ultimately approved.

Health Plan and Approval Type*	Total ⁷
<i>Initially denied but overturned through peer-to-peer</i>	284
<i>Initially denied but overturned through reconsideration</i>	0
<i>Initially denied but overturned through fair hearings</i>	0
<i>Initially denied but overturned by provider dispute</i>	0
<i>Initially denied but overturned through EQRO process</i>	0
<i>Other</i>	48
Meridian	47,123
<i>Initially approved; no further action required</i>	44,904
<i>Initially denied but overturned through appeal</i>	1
<i>Initially denied but overturned through peer-to-peer</i>	545
<i>Initially denied but overturned through reconsideration</i>	1,583
<i>Initially denied but overturned through fair hearings</i>	0
<i>Initially denied but overturned by provider dispute</i>	82
<i>Initially denied but overturned through EQRO process</i>	0
<i>Other</i>	8
Molina	15,998
<i>Initially approved; no further action required</i>	14,894
<i>Initially denied but overturned through appeal</i>	335
<i>Initially denied but overturned through peer-to-peer</i>	613
<i>Initially denied but overturned through reconsideration</i>	74
<i>Initially denied but overturned through fair hearings</i>	0
<i>Initially denied but overturned by provider dispute</i>	82
<i>Initially denied but overturned through EQRO process</i>	0
YouthCare	2,013
<i>Initially approved; no further action required</i>	1,963
<i>Initially denied but overturned through appeal</i>	0
<i>Initially denied but overturned through peer-to-peer</i>	8
<i>Initially denied but overturned through reconsideration</i>	40
<i>Initially denied but overturned through fair hearings</i>	0
<i>Initially denied but overturned by provider dispute</i>	2

Health Plan and Approval Type*	Total ⁷
<i>Initially denied but overturned through EQRO process</i>	0

*HSAG included a category of “other” if the health plan listed an approval in more than one category.

Denials

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially denied and did not have post-denial requests.
- Initially denied with a post-denial request, resulting in a final denial (initial denial upheld regardless of the post-denial request process).
- Initially partially denied with the partial denial upheld, resulting in a final denial of the service authorization request.

Table 7 displays the denial totals by health plan, with stratification by category of denial type for those service authorization requests that were initially denied with the denial ultimately upheld, in accordance with 305 ILCS 5/5-30.1(g-13)(3)(E)(i).

Table 7—Hospital Service Authorization Denials by Health Plan and Denial Type

Health Plan and Denial Type	Total ⁸
Aetna	3,106
<i>Initially denied; no further action requested by enrollee/provider</i>	1,924
<i>Peer-to-peer held; denial upheld</i>	958
<i>Appeal submitted; denial upheld</i>	66
<i>Considered under reconsideration or escalation process; denial upheld</i>	6
<i>Fair hearings process completed; denial upheld</i>	0
<i>Provider dispute submitted; denial upheld</i>	449
<i>Denial upheld through EQRO process</i>	0
BCBSIL	7,555
<i>Initially denied; no further action requested by enrollee/provider</i>	7,280

⁸ Health plan totals include all denials, including those that were initially denied and did not include additional review requests, as well as those that were partially approved/partially denied but ultimately denied. A single denied request may go through multiple post-denial processes, resulting in reporting of a single request in multiple subcategories. Health plans may also have cases reported as “pending,” which are counted in denial totals as they do not yet have an outcome that would allow for classification as “approved.”

Health Plan and Denial Type	Total ⁸
<i>Peer-to-peer held; denial upheld</i>	104
<i>Appeal submitted; denial upheld</i>	58
<i>Considered under reconsideration or escalation process; denial upheld</i>	28
<i>Fair hearings process completed; denial upheld</i>	0
<i>Provider dispute submitted; denial upheld</i>	115
<i>Denial upheld through EQRO process</i>	0
CountyCare	745
<i>Initially denied; no further action requested by enrollee/provider</i>	609
<i>Peer-to-peer held; denial upheld</i>	92
<i>Appeal submitted; denial upheld</i>	45
<i>Considered under reconsideration or escalation process; denial upheld</i>	58
<i>Fair hearings process completed; denial upheld</i>	0
<i>Provider dispute submitted; denial upheld</i>	31
<i>Denial upheld through EQRO process</i>	0
Meridian	14,966
<i>Initially denied; no further action requested by enrollee/provider</i>	12,705
<i>Peer-to-peer held; denial upheld</i>	1,324
<i>Appeal submitted; denial upheld</i>	8
<i>Considered under reconsideration or escalation process; denial upheld</i>	1,032
<i>Fair hearings process completed; denial upheld</i>	0
<i>Provider dispute submitted; denial upheld</i>	293
<i>Denial upheld through EQRO process</i>	0
Molina	3,098
<i>Initially denied; no further action requested by enrollee/provider</i>	1,949
<i>Peer-to-peer held; denial upheld</i>	754
<i>Appeal submitted; denial upheld</i>	608
<i>Considered under reconsideration or escalation process; denial upheld</i>	78

Health Plan and Denial Type	Total ⁸
<i>Fair hearings process completed; denial upheld</i>	0
<i>Provider dispute submitted; denial upheld</i>	32
<i>Denial upheld through EQRO process</i>	0
YouthCare	315
<i>Initially denied; no further action requested by enrollee/provider</i>	281
<i>Peer-to-peer held; denial upheld</i>	22
<i>Appeal submitted; denial upheld</i>	0
<i>Considered under reconsideration or escalation process; denial upheld</i>	17
<i>Fair hearings process completed; denial upheld</i>	0
<i>Provider dispute submitted; denial upheld</i>	3
<i>Denial upheld through EQRO process</i>	0

Conclusions

Review of the hospital service authorization determination outcomes identified the following:

- BCBSIL and Meridian reported the highest number of hospital service authorization requests. HSAG noted that these data may be expected as BCBSIL and Meridian represent the largest HealthChoice enrollment⁹ among the health plans.
- For those requests that were initially denied but subsequently approved, most were overturned as a result of the peer-to-peer or reconsideration processes.
- For those requests that were initially denied but had subsequent requests for review, most were upheld after a peer-to-peer or reconsideration process was conducted.
- Of the health plans’ total hospital service authorization requests (216,902), 4.7 percent (10,157) underwent, at a minimum, one second level of review. HSAG noted that this includes authorization requests which may have received multiple levels of review after an initial denial.
- For those requests that were initially denied but subsequently approved, four of the health plans reported requests that were categorized as more than one denial type and were displayed as “Other.” Many of these requests were categorized as both a peer-to-peer and provider dispute, which may be expected as health plans may outreach a provider upon receipt of a dispute, which then results in a peer-to-peer conversation.

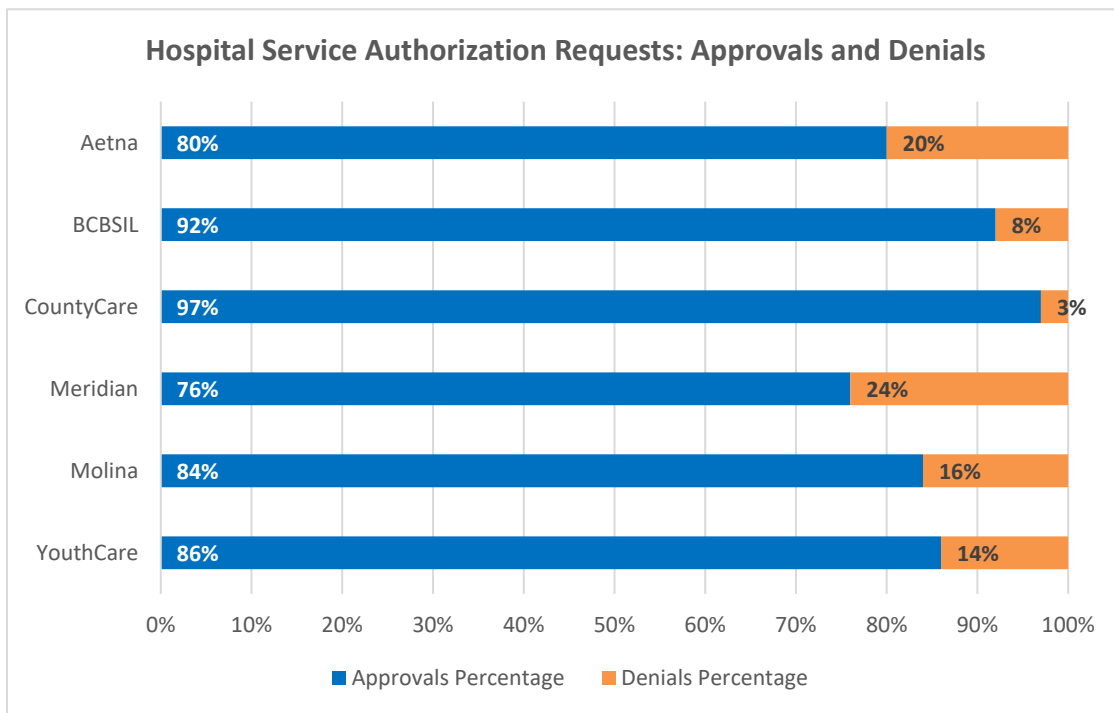
⁹ HFS Detailed Enrollment Totals. Enrollment as of November 1, 2025. Available at: <https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/mcoaggregatedreport112025.pdf>. Accessed on: Jan 23, 2026.

HSAG also assessed approvals and denials by the type of service requested, including outpatient services; inpatient, non-emergent initial admissions; emergent inpatient initial admissions; and continued inpatient stays, in accordance with 305 ILCS 5/5-30.1(g-13)(3)(F). These stratified data are available in Appendix B.

Hospital Service Authorization Request Comparison

HSAG analyzed the percentage of hospital service authorization request outcomes¹⁰ and compared the rates among health plans, in accordance with 305 ILCS 5/5-30.1(g-13)(3)(C). Figure 2 displays the rates for the health plans.

Figure 2—Hospital Service Authorization Request Approval and Denial Rates



HSAG also used a deviation rating to designate whether the difference between health plan hospital service authorization denial rates was *None*, *Moderate*, or *Substantial*, as described in the methodology. Table 8 displays the comparison.

¹⁰ HSAG calculated the hospital denial rates by dividing the total number of hospital authorization requests by the total number of denials.

Table 8—Comparisons of Hospital Service Authorization Request Denial Rates

Health Plan	Aetna 20%	BCBSIL 8%	CountyCare 3%	Meridian 24%	Molina 16%	YouthCare 14%
Aetna 20%		↑ <i>Substantial</i>	↑ <i>Substantial</i>	None	None	↑ <i>Moderate</i>
BCBSIL 8%	↓ <i>Substantial</i>		↑ <i>Moderate</i>	↓ <i>Substantial</i>	↓ <i>Moderate</i>	↓ <i>Moderate</i>
CountyCare 3%	↓ <i>Substantial</i>	↓ <i>Moderate</i>		↓ <i>Substantial</i>	↓ <i>Substantial</i>	↓ <i>Substantial</i>
Meridian 24%	None	↑ <i>Substantial</i>	↑ <i>Substantial</i>		↑ <i>Moderate</i>	↑ <i>Substantial</i>
Molina 16%	None	↑ <i>Moderate</i>	↑ <i>Substantial</i>	↓ <i>Moderate</i>		None
YouthCare 14%	None	↑ <i>Moderate</i>	↑ <i>Substantial</i>	↓ <i>Substantial</i>	None	

↑ Represents that the health plan’s rate (in the health plan column) is higher than the comparison health plan’s rate (in the header row).
 ↓ Represents that the health plan’s rate (in the health plan column) is lower than the comparison health plan’s rate (in the header row).

Overall hospital authorization request denial rates ranged from 3 percent to 24 percent. CountyCare demonstrated the lowest overall denial rate; however, HSAG noted that CountyCare serves Cook County enrollees only and the rate may not be comparable to the other statewide health plans.

While denial rates varied among the health plans, no specific contributing factors were identified from the data analysis conducted for this report.

FFS Data Review

HSAG evaluated FFS hospital service authorizations in accordance with 305 ILCS 5/5-30.1(g-13)(3)(C), representing hospital service authorization requests received from July 2025 through September 2025. Table 9 displays the number of FFS service authorization requests by hospital type and service request category.

Table 9—Service Authorizations by Hospital Type and Service Request Category

Hospital Type	PA	Concurrent	Post-service	Total
General Acute	0	8,544	2,762	11,306
Psychiatric	0	1,215	35	1,250
Rehabilitation	0	0	0	0
Long Term Acute Care	0	367	3	370
Children’s	0	0	0	0

Hospital Type	PA	Concurrent	Post-service	Total
Other	0	0	0	0

Of the service authorization requests, most came from general acute hospitals. Most service authorization requests were concurrent requests.

HSAG noted that there were no reported PA requests during the July through September 2025 period. FFS PAs are required for selected inpatient procedures (coronary artery bypass grafts and back surgeries), admissions to long term acute care hospitals, and family support program residential treatment services only. These services may not have been requested by FFS enrollees during the time period reviewed.

Determination Outcomes

HSAG assessed the outcomes of the hospital service authorization determinations to determine the types of approvals and denials.

Approvals

Of the total number of service authorizations received, HSAG analyzed the number of requests that were:

- Initially approved (not denied).
- Initially denied but overturned, resulting in an approval of the service authorization request.
- Initially partially approved with the partial denial overturned, resulting in an approval of the service authorization request.

FFS data reported a total of 11,653 approved service authorization requests. Of those, 11,628 were approved and did not require additional levels of review. Table 10 displays the approval totals with stratification by category of approval type for those service authorization requests that were initially denied but subsequently approved.

Table 10—FFS Hospital Service Authorization Approvals by Approval Type

Approval Type	Total N=11,653
Initially approved; no further action required	11,628
Initially denied but overturned through appeal	0
Initially denied but overturned through peer-to-peer	0
Initially denied but overturned through reconsideration	25
Initially denied but overturned through fair hearings	0

Approval Type	Total N=11,653
Initially denied but overturned by provider dispute	0
Initially denied but overturned through EQRO process	0

Of the service authorization approvals which were initially denied but overturned through a review process, all were overturned through reconsideration.

Denials

Of the total number of service authorizations received, HSAG analyzed the number of requests that were:

- Initially denied and did not have post-denial requests.
- Initially denied with a post-denial request, resulting in a final denial (initial denial upheld regardless of the post-denial request process).
- Initially partially denied with the partial denial upheld, resulting in a final denial of the service authorization request.

FFS data reported a total of 1,273 denials. Of those, 1,032 were denied and did not include additional review requests. Table 11 displays the denial totals with stratification by category of denial type for those service authorization requests that were initially denied with the denial ultimately upheld.

Table 11—FFS Hospital Service Authorization Denials by Denial Type

Denial Type	Total N=1,273
Initially denied; no further action requested by enrollee/provider	1,032
Peer-to-peer held; denial upheld	22
Appeal submitted; denial upheld	0
Considered under reconsideration or escalation process; denial upheld	225
Fair hearings process completed; denial upheld	0
Denial upheld through EQRO process	0

Of the service authorization denials which were upheld after a review process, most were upheld after a reconsideration process.

Conclusions

HSAG’s assessment of the health plans’ and FFS data and information yielded the following conclusions:

- All health plans were compliant with the adoption and use of nationally recognized clinical decision support criteria.

- All health plans had procedures to ensure equitable standards of care for enrollees, and data analysis did not identify any concerns with parity.
- General acute hospitals contributed the most service authorization requests for both the health plans and FFS.
- Health plan and FFS hospital service authorization approval rates were higher than denial rates.
- Although both FFS and the health plans receive hospital service authorization requests, the data are not comparable as the FFS authorization requirements are limited to a very specific set of services.
- Peer-to-peer and reconsideration processes were widely used to re-review denied service authorization requests, with many resulting in overturned decisions.

Supportive Information

Although the focus of this data analysis was to evaluate hospital service authorizations, additional information and data were reviewed to provide supportive information on the health plans’ overall processes for managing service authorization requests. This information was not limited to hospital service authorizations only but provided additional context to support oversight and monitoring of service authorizations and determination outcomes.

Review of Health Plan UM Procedures

HSAG leveraged documents from each health plan’s 2025 administrative compliance review to inform HSAG’s review team of each health plan’s internal UM processes, including policies, procedures, and information.

Overall, documentation demonstrated that the health plans have established standardized UM processes and have adopted nationally recognized clinical decision guidelines. Table 12 displays the clinical guidelines used by each health plan for UM decision-making, in accordance with 305 ILCS 5/5-30.1(g-13)(3)(A).

Table 12—Service Authorization Criteria by Health Plan

Health Plan	M/S Criteria Used	MH/SUD Criteria Used	Pharmacy Criteria Used
Aetna	MCG [®] and Aetna Clinical Policy Bulletins	MCG [®] , ASAM [®] , and Aetna Clinical Policy Bulletins	State guidelines (including the PDL), Aetna Medicaid Pharmacy Guidelines, CVS Health Pharmacy and Therapeutics (P&T) Committee, and HFS Drug and Therapeutic Committee

Health Plan	M/S Criteria Used	MH/SUD Criteria Used	Pharmacy Criteria Used
BCBSIL	CMS National Coverage Determinations, MCG [®] , ASAM [®] , and BCBSIL's (and its delegates') clinical guidelines	CMS National Coverage Determinations, MCG [®] , ASAM [®] , and BCBSIL's clinical guidelines	State guidelines (including the PDL), FDA, CMS-endorsed compendia, professional organization guidelines, clinical trials
CountyCare	InterQual [®]	ASAM [®] for all SUD services; InterQual [®] for non-SUD MH services	State guidelines (including the PDL), peer-reviewed medical literature
Meridian	InterQual [®] , federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature	ASAM [®] for all SUD services; InterQual [®] for non-SUD MH services, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature	State guidelines (including the PDL), national drug compendia, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature
Molina	MCG [®] and internal clinical policies	ASAM [®] and internal clinical policies	State guidelines (including the PDL), FDA-approved drug labeling, accepted clinical compendia, professional medical society guidelines, available clinical literature and expert reviews, and internal clinical policies
YouthCare	InterQual [®] , federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature	ASAM [®] for all SUD services; InterQual [®] for non-SUD MH services, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature	State guidelines (including the PDL), national drug compendia, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature

ASAM=American Society of Addiction Medicine

FDA=Food and Drug Administration

PDL=Medicaid Preferred Drug List

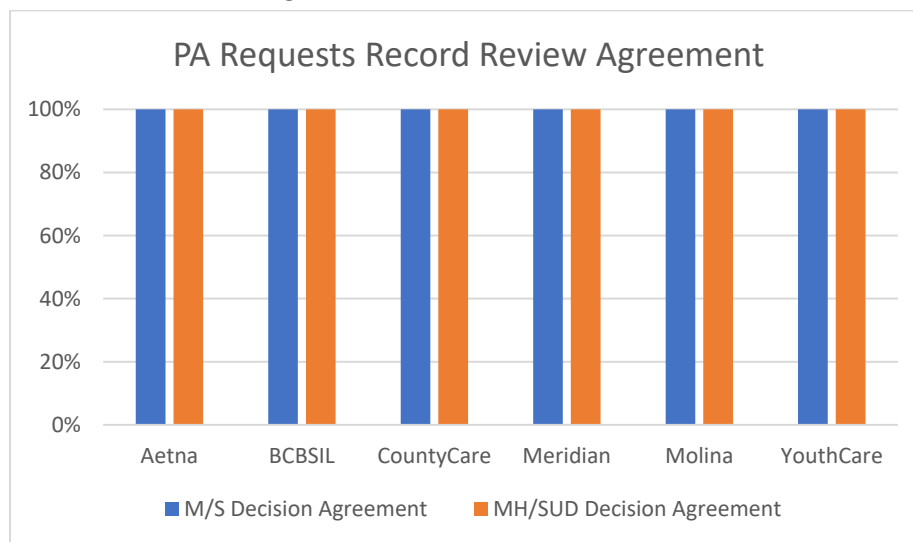
ABD File Review¹¹

To support analysis of each health plan’s compliance with the clinical decision guidelines in accordance with 305 ILCS 5/5-30.1(g-13)(3)(A), HSAG leveraged the results of a 2023 MHP file review of PA requests. HSAG reviewed a random sample of 25 M/S and 25 MH/SUD ABD records for each health plan, which were assessed against the following evaluation elements:

- Agreement with the criteria used for decision making.
- Agreement with the health plan decision (approval or denial).

During the file review, HSAG reviewed the PA request documentation submitted by the health plans, including provider medical records and clinical criteria used to make decisions. The results of the file review are displayed in Figure 3.

Figure 3—ABD File Review Results



HSAG’s review resulted in 100 percent agreement with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plans’ decisions.

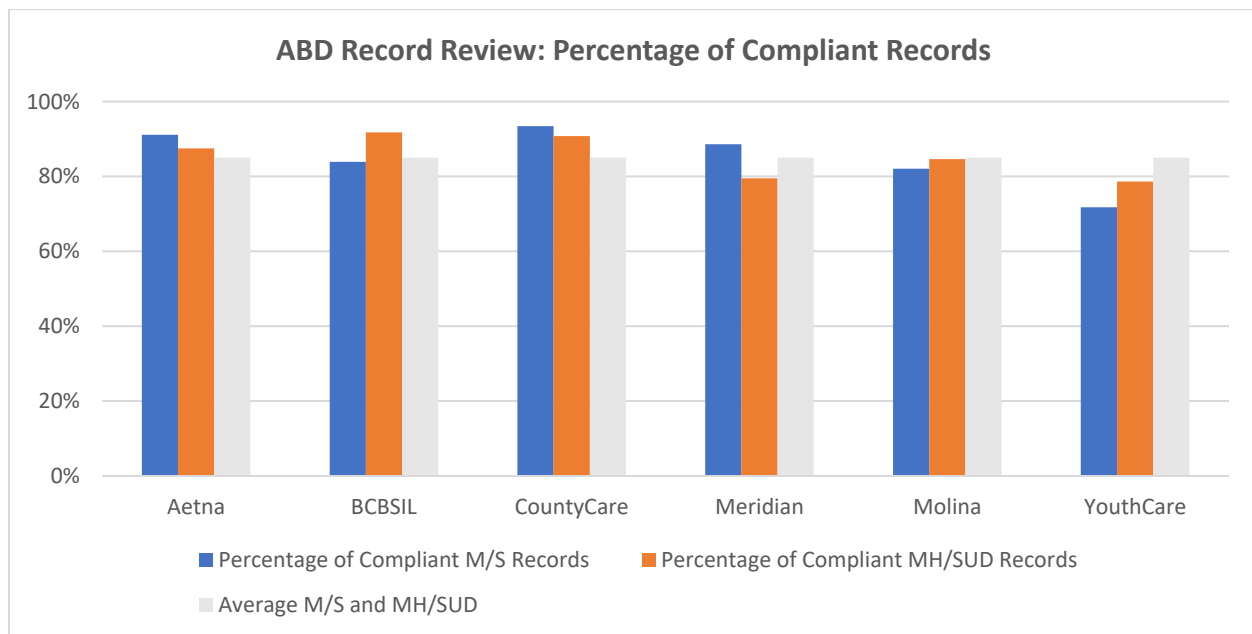
In addition, HSAG leveraged the results of the health plans’ 2025 compliance review to evaluate compliance with 42 CFR §438.210, which provides requirements for coverage and authorization of services. In addition to the evaluation of each health plan’s UM processes, policies, and procedures, HSAG also reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes. The file review included:

¹¹ The ABD file reviews included a review of requests sampled from the health plans’ total authorization request data and were not limited to hospital requests only.

- Assessing compliance with federal and State regulations governing the processing of member NOABDs for service authorization denials, including accessibility.
- Assessing the timeliness of service authorization denials.

The health plans demonstrated a high level of compliance with ABD record elements, as displayed in Figure 4.

Figure 4—ABD File Review Results



The health plans demonstrated compliance with nationally recognized clinical decision guidelines and federal and State regulatory requirements surrounding the processing of NOABDs.

Equitable Standards of Care

HFS and the health plans are committed to ensuring that all individuals are being treated in accordance with equitable standards of care. Annually, HFS directs a MHP review to determine to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits.

As part of this review, HSAG reviewed the results of the 2025 MHP review to inform its evaluation of the health plans’ assurances of equitable standards of care, in accordance with 305 ILCS 5/5-30.1(g-13)(3)(B). HSAG assessed the health plans’ data to determine evidence of parity between M/S and

MH/SUD authorization approvals and denials,¹² as self-reported as part of HFS’ QBR process. Table 13 displays the results of the assessment.

Table 13—QBR Data Assessment: Total Requests Approved and Denied—CY 2024

Health Plan	Medical* PA Requests Rate	Behavioral Health PA Requests Rate	Deviation Rating**
Approvals			
Aetna	87%	96%	<i>Moderate</i>
BCBSIL	86%	99%	<i>Substantial</i>
CountyCare	94%	99%	<i>Moderate</i>
Meridian	92%	92%	<i>None</i>
Molina	92%	93%	<i>None</i>
YouthCare	97%	99%	<i>None</i>
Denials			
Aetna	13%	4%	<i>Moderate</i>
BCBSIL	14%	0.45%	<i>Substantial</i>
CountyCare	6%	1%	<i>Moderate</i>
Meridian	7%	3%	<i>None</i>
Molina	8%	7%	<i>None</i>
YouthCare	3%	1%	<i>None</i>

Total rates (approvals + denials) may not equal 100%.

*Non-Behavioral Health, Nursing Facility, Rehabilitation (Rehab), Durable Medical Equipment, Home Health, Imaging, and Pain Management

** Indicates the degree to which each health plan’s reported metrics differed between MH/SUD and M/S services.

HSAG completed a Chi-square test to determine statistically significant differences between the health plans’ denial rates for M/S and MH/SUD services. Four of the six health plans denied M/S authorization requests at a statistically significantly higher rate than MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials. Although two health plans demonstrated *Moderate* differences and one health plan demonstrated a *Substantial* difference, the differences were driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity.

HSAG’s review supported evidence of the health plans’ processes to make service authorization determinations that ensure individuals are treated in accordance with equitable standards of care.

¹² The data include the health plans’ total authorization requests and were not limited to hospital requests only.

Appendix A. Health Plan-Specific Findings

This appendix provides detailed findings from the UM service authorization data analysis review and general observations for each health plan.

Aetna Better Health of Illinois (Aetna)

Hospital Service Authorization Data Assessment

To evaluate health plan hospital service authorizations, HSAG received data from each health plan representing hospital service authorization requests received from July 2025 through September 2025. Table 14 displays the number of service authorization requests by hospital type and service request category.

Table 14—Hospital Service Authorization Requests by Hospital Type and Service Request Category
N=15,524

Hospital Type	PA	Concurrent	Post-service	Total
General Acute	4,783	9,038	430	14,251
Psychiatric	78	1,089	1	1,168
Rehabilitation	11	81	2	94
Long Term Acute Care	0	11	0	11
Children’s	0	0	0	0
Other	0	0	0	0

Of the service authorization requests received, most came from general acute hospitals. Of the service request categories, most were concurrent requests.

HSAG noted that Aetna reported no authorizations from children’s hospitals. Aetna reported that its authorization system does not include this specificity but that it can pull data from its claims system to report on children-specific facilities.

Determination Outcomes

HSAG assessed the outcomes of the hospital service authorization determinations to determine the types of approvals and denials.

Approvals

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially approved (not denied).
- Initially denied but overturned, resulting in an approval of the service authorization request.
- Initially partially approved with the partial denial overturned, resulting in an approval of the service authorization request.

Aetna reported a total of 12,418 approved service authorization requests. Of those, 11,491 were approved and did not require additional levels of review. Table 15 displays the remaining approval totals, with stratification by category of approval type for those service authorization requests that were initially denied but subsequently approved.

Table 15—Hospital Service Authorization Totals by Approval Type

Approval Type	Total ¹³ N=12,418
Initially approved; no further action required	11,491
Initially denied but overturned through appeal	9
Initially denied but overturned through peer-to-peer	809
Initially denied but overturned through reconsideration	18
Initially denied but overturned through fair hearings	0
Initially denied but overturned by provider dispute	88
Initially denied but overturned through EQRO process	0
Other*	3

*HSAG included a category of “other” if the health plan listed an approval in more than one category.

HSAG noted that, for those denials which included an additional level of review and were subsequently approved (denial overturned), most were conducted via the peer-to-peer process.

Denials

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially denied and did not have post-denial requests.

¹³ Health plan totals include all approvals, including those that were initially approved and did not require additional review, as well as those that were partially approved/partially denied but ultimately approved. Initially denied categories are provided as a subset of the total number of authorizations that were ultimately approved.

- Initially denied with a post-denial request, resulting in a final denial (initial denial upheld regardless of the post-denial request process).
- Initially partially denied with the partial denial upheld, resulting in a final denial of the service authorization request.

Aetna reported a total of 3,106 denials. Of those, 1,924 were denied and did not include additional review requests. Table 16 displays the remaining denial totals, with stratification by category of denial type for those service authorization requests that were initially denied with the denial ultimately upheld.

Table 16—Hospital Service Authorization Totals by Denial Type

Denial Type	Total ¹⁴ N=3,106
Initially denied; no further action requested by enrollee/provider	1,924
Peer-to-peer held; denial upheld	958
Appeal submitted; denial upheld	66
Considered under reconsideration or escalation process; denial upheld	6
Fair hearings process completed; denial upheld	0
Provider dispute submitted; denial upheld	449
Denial upheld through EQRO process	0

HSAG noted that, for those denials which included an additional level of review and remained denied (denial upheld), most were conducted via the peer-to-peer process.

HSAG noted that most denials were overturned via the peer-to-peer process. The health plan’s submission confirmed that the health plan conducts the peer-to-peer process after the NOABD has been delivered to the enrollee and provider. The health plan also confirmed that its reconsideration process allows the provider, after receipt of the NOABD, to submit additional clinical information to support medical necessity. HSAG also confirmed these processes during the health plan’s administrative compliance review. However, these processes constitute an additional level of review that occurs after the initial denial notice is mailed to the enrollee and prior to the appeal process. Based on recent guidance, CMS has clarified that a health plan’s practice of adjusting service authorization denial decisions based on peer-to-peer discussions occurring after the health plan sends the enrollee an ABD notice is inconsistent with the Medicaid managed care rule; the health plan’s review of a PA denial with an enrollee’s provider after the health plan provides the enrollee with the ABD notice is consistent with the definition of “appeal”; and if the health plan does not seek the consent of the enrollee on whose

¹⁴ Health plan totals include all denials, including those that were initially denied and did not include additional review requests, as well as those that were partially approved/partially denied but ultimately denied. A single denied request may go through multiple post-denial processes, resulting in reporting of a single request in multiple subcategories. Health plans may also have cases reported as “pending,” which are counted in denial totals as they do not yet have an outcome that would allow for classification as “approved.”

behalf these decisions are being reconsidered (i.e., an appeal) prior to the peer-to-peer discussions, the enrollee may be unaware that an appeal is occurring on his or her behalf. As a result of the administrative compliance review findings, the health plan was instructed to develop processes to comply with CMS guidance, which will be monitored via the administrative compliance review process.

HSAG also noted that partial approvals/partial denials that were reported as overturned due to peer-to-peer review were also listed as provider disputes. As a provider disputing a denial may be offered a peer-to-peer discussion about the denial with the health plan's medical director, duplication of categories may occur.

HSAG assessed the health plan's approvals and denials to determine the number of authorization requests for which a second level of review was requested. Of the health plan's total hospital service authorization requests (15,524), 13.6 percent (2,109) underwent, at a minimum, a second level of review. HSAG noted that this includes authorization requests which may have received multiple levels of review after an initial denial.

HSAG also assessed approvals and denials by the type of service requested, including outpatient services; inpatient, non-emergent initial admissions; emergent inpatient initial admissions; and continued inpatient stays. These stratified data are available in Appendix B.

Supportive Information

Although the focus of this data analysis was to evaluate hospital service authorizations, additional information and data were reviewed to provide supportive information on the health plan's overall processes for managing service authorization requests. This information was not limited to hospital service authorizations only but provided additional context to support oversight and monitoring of service authorizations and determination outcomes.

Review of Health Plan UM Procedures

HSAG leveraged documents from the health plan's 2025 administrative compliance review to inform HSAG's review team of the health plan's internal UM processes, including policies, procedures, and information.

Aetna reported the use of the following evidence-based clinical criteria to evaluate the necessity of care:

- Physical Health: MCG[®] and Aetna Clinical Policy Bulletins
- Behavioral Health: MCG[®], ASAM[®], and Aetna Clinical Policy Bulletins
- Pharmacy: State guidelines (including the PDL), Aetna Medicaid Pharmacy Guidelines, CVS Health P&T Committee, and HFS Drug and Therapeutic Committee

Aetna used nationally recognized and state-developed utilization review criteria. HSAG did not identify any concerns from review of the health plan's UM procedures.

ABD File Review¹⁵

To support analysis of each health plan’s compliance with the clinical decision guidelines, HSAG leveraged the results of a 2023 file review of PA requests. HSAG reviewed a random sample of 25 M/S and 25 MH/SUD ABD records for each health plan, which were assessed against the following evaluation elements:

- Agreement with the criteria used for decision making.
- Agreement with the health plan decision (approval or denial).

During the file review, HSAG reviewed the PA request documentation submitted by the health plans, including provider medical records and clinical criteria used to make decisions. The results of the file review are displayed in Table 17.

Table 17—PA Decisions Record Review Results

Type of Record	Number of Records With Agreement	Number of Records With Disagreement	Total Reviewed	Percent Agreement
Overall Agreement	50	0	50	100%
M/S	25	0	25	100%
<i>Inpatient</i>	16	0	16	100%
<i>Outpatient</i>	9	0	9	100%
MH/SUD	25	0	25	100%
<i>Inpatient</i>	18	0	18	100%
<i>Outpatient</i>	7	0	7	100%

HSAG’s review resulted in 100 percent agreement with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plan’s decisions.

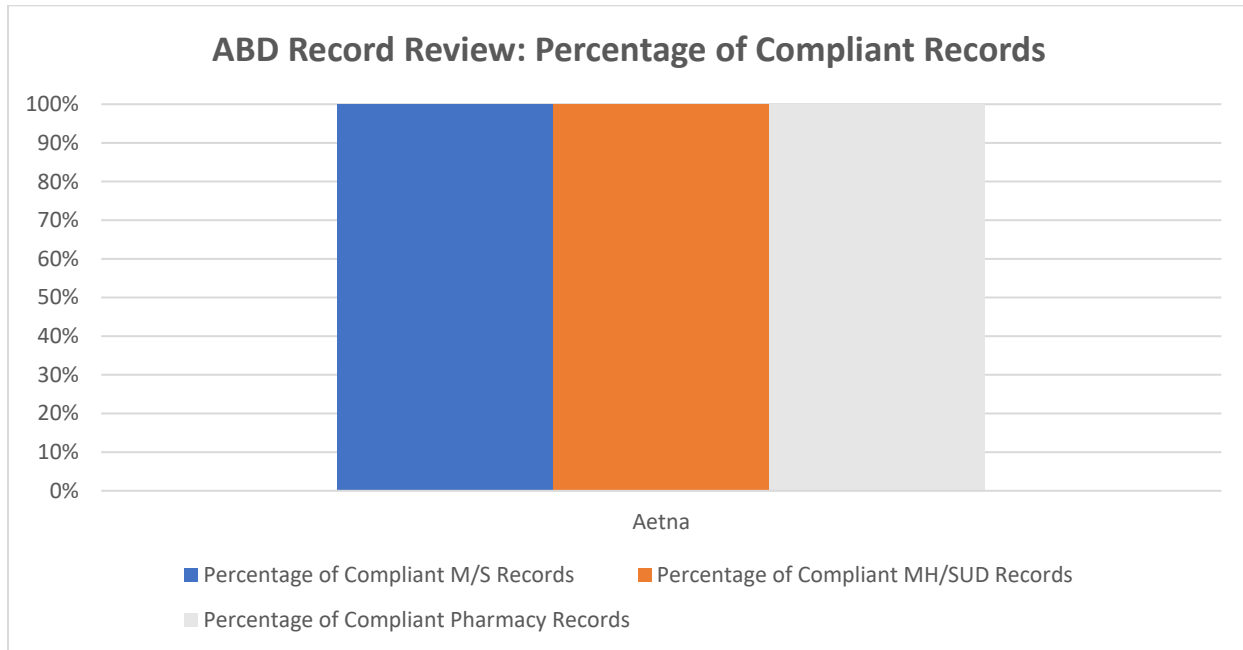
In addition, HSAG leveraged the results of the health plans’ 2025 compliance review to evaluate compliance with 42 CFR §438.210, which provides requirements for coverage and authorization of services. In addition to the evaluation of each health plan’s UM processes, policies, and procedures, HSAG also reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes. The file review included:

- Assessing compliance with federal and State regulations governing the processing of member NOABDs for service authorization denials, including accessibility.
- Assessing the timeliness of service authorization denials.

¹⁵ The ABD file reviews included a review of requests sampled from the health plan’s total authorization request data and were not limited to hospital requests only.

The health plan demonstrated a high level of compliance with ABD record elements, as displayed in Figure 5.

Figure 5—ABD File Review Results



HSAG’s review of the health plan’s procedures, including service authorization guidelines and ABD file review, confirmed that the health plan demonstrated compliance with nationally recognized clinical decision guidelines and federal and State regulatory requirements surrounding the processing of NOABDs.

Equitable Standards of Care

HFS and the health plans are committed to ensuring that all individuals are being treated in accordance with equitable standards of care. Annually, HFS directs an MHP review to determine to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits.

As part of this review, HSAG reviewed the results of the 2025 MHP review to inform its evaluation of the health plan’s assurances of equitable standards of care. HSAG assessed the health plan’s data to determine evidence of parity between M/S and MH/SUD authorization approvals and denials,¹⁶ as self-reported as part of HFS’ QBR process. Table 18 presents the results of the assessment.

¹⁶ The data include the health plan’s total authorization requests and were not limited to hospital requests only.

Table 18—QBR Data Assessment: Total Requests Approved and Denied

QBR Data Assessment	Numerator	Denominator	Percent
Approvals			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	76,967	88,445	87%
PA (Behavioral Health Only)	11,415	11,950	96%
Denials			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	11,478	88,445	13%
PA (Behavioral Health Only)	535	11,950	4%

HSAG completed a Chi-square analysis to determine statistically significant differences between the health plan’s denial rates for M/S and MH/SUD services. The health plan denied M/S authorization requests at a statistically significantly higher rate than MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials. While the difference was *Substantial*, the differences were driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity.

Findings and Recommendations

HSAG noted that observations related to the peer-to-peer and reconsideration processes are being addressed through the administrative compliance review process. Based on the results of the review, HSAG did not identify any findings or recommendations for Aetna.

Blue Cross Community Health Plans (BCBSIL)

Hospital Service Authorization Data Assessment

To evaluate health plan hospital service authorizations, HSAG received data from each health plan representing hospital service authorization requests received from July 2025 through September 2025. Table 19 displays the number of service authorization requests by hospital type and service request category.

Table 19—Hospital Service Authorization Requests by Hospital Type and Service Request Category
N=96,531

Hospital Type	PA	Concurrent	Post-service	Total
General Acute	51,907	20,908	6,385	79,200
Psychiatric	4,766	2,939	5	7,710
Rehabilitation	245	45	0	290
Long Term Acute Care	270	51	0	321
Children’s	5,199	2,993	731	8,923
Other	70	0	17	87

Of the service authorization requests received, most came from general acute hospitals. Of the service request categories, most were PA requests.

Determination Outcomes

HSAG assessed the outcomes of the hospital service authorization determinations to determine the types of approvals and denials.

Approvals

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially approved (not denied).
- Initially denied but overturned, resulting in an approval of the service authorization request.
- Initially partially approved with the partial denial overturned, resulting in an approval of the service authorization request.

BCBSIL reported a total of 88,976 approved service authorization requests. Of those, 88,489 were approved and did not require additional levels of review. Table 20 displays the remaining approval totals, with stratification by category of approval type for those service authorization requests that were initially denied but subsequently approved.

Table 20—Hospital Service Authorization Totals by Approval Type

Approval Type	Total ¹⁷ N=88,976
Initially approved; no further action required	88,489
Initially denied but overturned through appeal	65
Initially denied but overturned through peer-to-peer	193
Initially denied but overturned through reconsideration	39
Initially denied but overturned through fair hearings	0
Initially denied but overturned by provider dispute	27
Initially denied but overturned through EQRO process	0
Other	163

*HSAG included a category of “other” if the health plan listed an approval in more than one category.

HSAG noted that, for those denials which included an additional level of review and were subsequently approved (denial overturned), most were conducted via the peer-to-peer and reconsideration processes.

Denials

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially denied and did not have post-denial requests.
- Initially denied with a post-denial request, resulting in a final denial (initial denial upheld regardless of the post-denial request process).
- Initially partially denied with the partial denial upheld, resulting in a final denial of the service authorization request.

BCBSIL reported a total of 7,555 denials. Of those, 7,280 were denied and did not include additional review requests. Table 21 displays the remaining denial totals, with stratification by category of denial type for those service authorization requests that were initially denied with the denial ultimately upheld.

¹⁷ Health plan totals include all approvals, including those that were initially approved and did not require additional review, as well as those that were partially approved/partially denied but ultimately approved. Initially denied categories are provided as a subset of the total number of authorizations that were ultimately approved.

Table 21—Hospital Service Authorization Totals by Denial Type

Denial Type	Total ¹⁸ N=7,555
Initially denied; no further action requested by enrollee/provider	7,280
Peer-to-peer held; denial upheld	104
Appeal submitted; denial upheld	58
Considered under reconsideration or escalation process; denial upheld	28
Fair hearings process completed; denial upheld	0
Provider dispute submitted; denial upheld	115
Denial upheld through EQRO process	0

HSAG noted that, for those denials which included an additional level of review and remained denied (denial upheld), most were conducted via the peer-to-peer process.

HSAG noted that most denials were overturned via the peer-to-peer and reconsideration processes. The health plan’s submission confirmed that the health plan conducts the peer-to-peer and reconsideration processes after the NOABD has been delivered to the enrollee and provider. HSAG also confirmed these processes during the health plan’s administrative compliance review. However, these processes constitute an additional level of review that occurs after the initial denial notice is mailed to the enrollee and prior to the appeal process. Based on recent guidance, CMS has clarified that a health plan’s practice of adjusting service authorization denial decisions based on peer-to-peer discussions occurring after the health plan sends the enrollee an ABD notice is inconsistent with the Medicaid managed care rule; the health plan’s review of a PA denial with an enrollee’s provider after the health plan provides the enrollee with the ABD notice is consistent with the definition of “appeal”; and if the health plan does not seek the consent of the enrollee on whose behalf these decisions are being reconsidered (i.e., an appeal) prior to the peer-to-peer discussions, the enrollee may be unaware that an appeal is occurring on his or her behalf. As a result of the administrative compliance review findings, the health plan was instructed to develop processes to comply with CMS guidance, which will be monitored via the administrative compliance review process.

HSAG assessed the health plan's approvals and denials to determine the number of authorization requests for which a second level of review was requested. Of the health plan's total hospital service authorization requests (96,531), 0.8 percent (762) underwent, at a minimum, one second level of review.

¹⁸ Health plan totals include all denials, including those that were initially denied and did not include additional review requests, as well as those that were partially approved/partially denied but ultimately denied. A single denied request may go through multiple post-denial processes, resulting in reporting of a single request in multiple subcategories. Health plans may also have cases reported as “pending,” which are counted in denial totals as they do not yet have an outcome that would allow for classification as “approved.”

HSAG noted that this includes authorization requests which may have received multiple levels of review after an initial denial.

HSAG also assessed approvals and denials by the type of service requested, including outpatient services; inpatient, non-emergent initial admissions; emergent inpatient initial admissions; and continued inpatient stays. These stratified data are available in Appendix B.

Supportive Information

Although the focus of this data analysis was to evaluate hospital service authorizations, additional information and data were reviewed to provide supportive information on the health plan's overall processes for managing service authorization requests. This information was not limited to hospital service authorizations only but provided additional context to support oversight and monitoring of service authorizations and determination outcomes.

Review of Health Plan UM Procedures

HSAG leveraged documents from the health plan's 2025 administrative compliance review to inform HSAG's review team of the health plan's internal UM processes, including policies, procedures, and information.

BCBSIL reported the use of the following evidence-based clinical criteria to evaluate the necessity of care:

- Physical Health: CMS National Coverage Determinations, MCG[®], ASAM[®], and BCBSIL's (and its delegates') clinical guidelines
- Behavioral Health: CMS National Coverage Determinations, MCG[®], ASAM[®], and BCBSIL's clinical guidelines
- Pharmacy: State guidelines (including the PDL), FDA, CMS-endorsed compendia, professional organization guidelines, clinical trials

BCBSIL used nationally recognized and state-developed utilization review criteria. HSAG did not identify any concerns from review of the health plan's UM procedures.

ABD File Review¹⁹

To support analysis of each health plan's compliance with the clinical decision guidelines, HSAG leveraged the results of a 2023 file review of PA requests. HSAG reviewed a random sample of 25 M/S

¹⁹ The ABD file reviews included a review of requests sampled from the health plan's total authorization request data and were not limited to hospital requests only.

and 25 MH/SUD ABD records for each health plan, which were assessed against the following evaluation elements:

- Agreement with the criteria used for decision making.
- Agreement with the health plan decision (approval or denial).

During the file review, HSAG reviewed the PA request documentation submitted by the health plans, including provider medical records and clinical criteria used to make decisions. The results of the file review are displayed in Table 22.

Table 22—PA Decisions Record Review Results

Type of Record	Number of Records With Agreement	Number of Records With Disagreement	Total Reviewed	Percent Agreement
Overall Agreement	50	0	50	100%
M/S	25	0	25	100%
<i>Inpatient</i>	2	0	2	100%
<i>Outpatient</i>	23	0	23	100%
MH/SUD	25	0	25	100%
<i>Inpatient</i>	18	0	18	100%
<i>Outpatient</i>	7	0	7	100%

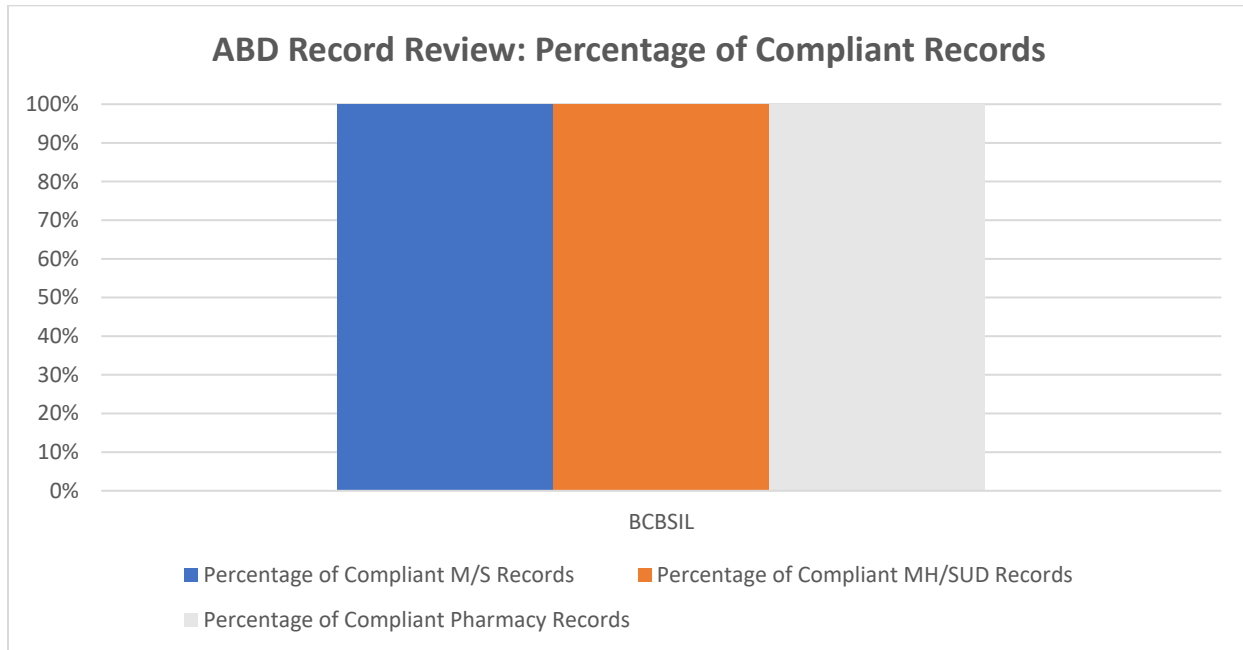
HSAG’s review resulted in 100 percent agreement with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plan’s decisions.

In addition, HSAG leveraged the results of the health plans’ 2025 compliance review to evaluate compliance with 42 CFR §438.210, which provides requirements for coverage and authorization of services. In addition to the evaluation of each health plan’s UM processes, policies, and procedures, HSAG also reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes. The file review included:

- Assessing compliance with federal and State regulations governing the processing of member NOABDs for service authorization denials, including accessibility.
- Assessing the timeliness of service authorization denials.

The health plan demonstrated a high level of compliance with ABD record elements, as displayed in Figure 6.

Figure 6—ABD File Review Results



HSAG’s review of the health plan’s procedures, including service authorization guidelines and ABD file review, confirmed that the health plan demonstrated compliance with nationally recognized clinical decision guidelines and federal and State regulatory requirements surrounding the processing of NOABDs.

Equitable Standards of Care

HFS and the health plans are committed to ensuring that all individuals are being treated in accordance with equitable standards of care. Annually, HFS directs an MHP review to determine to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits.

As part of this review, HSAG reviewed the results of the 2025 MHP review to inform its evaluation of the health plan’s assurances of equitable standards of care. HSAG assessed the health plan’s data to determine evidence of parity between M/S and MH/SUD authorization approvals and denials,²⁰ as self-reported as part of HFS’ QBR process. Table 23 presents the results of the assessment.

²⁰ The data include the health plan’s total authorization requests and were not limited to hospital requests only.

Table 23—QBR Data Assessment: Total Requests Approved and Denied

QBR Data Assessment	Numerator	Denominator	Percent
Approvals			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	94,414	109,818	86%
PA (Behavioral Health Only)	25,214	25,328	99.5%
Denials			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	15,036	109,818	14%
PA (Behavioral Health Only)	114	25,328	0.5%

HSAG completed a Chi-square analysis to determine statistically significant differences between the health plan’s denial rates for M/S and MH/SUD services. The health plan denied M/S authorization requests at a statistically significantly higher rate than MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials. While the difference was *Substantial*, the differences were driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity.

Findings and Recommendations

HSAG noted that observations related to the peer-to-peer and reconsideration processes are being addressed through the administrative compliance review process. Based on the results of the review, HSAG did not identify any findings or recommendations for BCBSIL.

CountyCare

Hospital Service Authorization Data Assessment

To evaluate health plan hospital service authorizations, HSAG received data from each health plan representing hospital service authorization requests received from July 2025 through September 2025. Table 24 displays the number of service authorization requests by hospital type and service request category.

Table 24—Hospital Service Authorization Requests by Hospital Type and Service Request Category
N=21,334*

Hospital Type	PA	Concurrent	Post-service	Total
General Acute	3,835	10,923	35	14,793
Psychiatric	291	3,668	13	3,972
Rehabilitation	94	131	1	226
Long Term Acute Care	101	86	1	188
Children’s	627	1,396	3	2,026
Other	59	67	0	126

*The sum of the categories may not equal the total (e.g., the health plan did not provide categorization).

Of the service authorization requests received, most came from general acute hospitals. Of the service request categories, most were concurrent requests.

Determination Outcomes

HSAG assessed the outcomes of the hospital service authorization determinations to determine the types of approvals and denials.

Approvals

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially approved (not denied).
- Initially denied but overturned, resulting in an approval of the service authorization request.
- Initially partially approved with the partial denial overturned, resulting in an approval of the service authorization request.

CountyCare reported a total of 20,589 approved service authorization requests. Of those, 20,256 were approved and did not require additional levels of review. Table 25 displays the remaining approval

totals, with stratification by category of approval type for those service authorization requests that were initially denied but subsequently approved.

Table 25—Hospital Service Authorization Totals by Approval Type

Approval Type	Total ²¹ N=20,589
Initially approved; no further action required	20,256
Initially denied but overturned through appeal	1
Initially denied but overturned through peer-to-peer	284
Initially denied but overturned through reconsideration	0
Initially denied but overturned through fair hearings	0
Initially denied but overturned by provider dispute	0
Initially denied but overturned through EQRO process	0
Other	48

*HSAG included a category of “other” if the health plan listed an approval in more than one category.

HSAG noted that, for those denials which included an additional level of review and were subsequently approved (denial overturned), most were conducted via the peer-to-peer process.

Denials

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially denied and did not have post-denial requests.
- Initially denied with a post-denial request, resulting in a final denial (initial denial upheld regardless of the post-denial request process).
- Initially partially denied with the partial denial upheld, resulting in a final denial of the service authorization request.

CountyCare reported a total of 745 denials. Of those, 609 were denied and did not include additional review requests. Table 26 displays the remaining denial totals, with stratification by category of denial type for those service authorization requests that were initially denied with the denial ultimately upheld.

²¹ Health plan totals include all approvals, including those that were initially approved and did not require additional review, as well as those that were partially approved/partially denied but ultimately approved. Initially denied categories are provided as a subset of the total number of authorizations that were ultimately approved.

Table 26—Hospital Service Authorization Totals by Denial Type

Denial Type	Total ²² N=745
Initially denied; no further action requested by enrollee/provider	609
Peer-to-peer held; denial upheld	92
Appeal submitted; denial upheld	45
Considered under reconsideration or escalation process; denial upheld	58
Fair hearings process completed; denial upheld	0
Provider dispute submitted; denial upheld	31
Denial upheld through EQRO process	0

HSAG noted that, for those denials which included an additional level of review and remained denied (denial upheld), most were conducted via the peer-to-peer process.

HSAG noted that most denials were overturned via the peer-to-peer process. The health plan’s submission confirmed that the health plan conducts the peer-to-peer process after the NOABD has been delivered to the enrollee and provider. The health plan also confirmed that its reconsideration process is conducted after the NOABD has been delivered. HSAG confirmed these processes during the health plan’s administrative compliance review. However, these processes constitute an additional level of review that occurs after the initial denial notice is mailed to the enrollee and prior to the appeal process. Based on recent guidance, CMS has clarified that a health plan’s practice of adjusting service authorization denial decisions based on peer-to-peer discussions occurring after the health plan sends the enrollee an ABD notice is inconsistent with the Medicaid managed care rule; the health plan’s review of a PA denial with an enrollee’s provider after the health plan provides the enrollee with the ABD notice is consistent with the definition of “appeal”; and if the health plan does not seek the consent of the enrollee on whose behalf these decisions are being reconsidered (i.e., an appeal) prior to the peer-to-peer discussions, the enrollee may be unaware that an appeal is occurring on his or her behalf. As a result of the administrative compliance review findings, the health plan was instructed to develop processes to comply with CMS guidance, which will be monitored via the administrative compliance review process.

HSAG assessed the health plan's approvals and denials to determine the number of authorization requests for which a second level of review was requested. Of the health plan's total hospital service authorization requests (21,334), 2.2 percent (469) underwent, at a minimum, one second level of review.

²² Health plan totals include all denials, including those that were initially denied and did not include additional review requests, as well as those that were partially approved/partially denied but ultimately denied. A single denied request may go through multiple post-denial processes, resulting in reporting of a single request in multiple subcategories. Health plans may also have cases reported as “pending,” which are counted in denial totals as they do not yet have an outcome that would allow for classification as “approved.”

HSAG noted that this includes authorization requests which may have received multiple levels of review after an initial denial.

HSAG also assessed approvals and denials by the type of service requested, including outpatient services; inpatient, non-emergent initial admissions; emergent inpatient initial admissions; and continued inpatient stays. These stratified data are available in Appendix B.

Supportive Information

Although the focus of this data analysis was to evaluate hospital service authorizations, additional information and data were reviewed to provide supportive information on the health plan's overall processes for managing service authorization requests. This information was not limited to hospital service authorizations only but provided additional context to support oversight and monitoring of service authorizations and determination outcomes.

Review of Health Plan UM Procedures

HSAG leveraged documents from the health plan's 2025 administrative compliance review to inform HSAG's review team of the health plan's internal UM processes, including policies, procedures, and information.

CountyCare reported the use of the following evidence-based clinical criteria to evaluate the necessity of care:

- Physical Health: InterQual[®]
- Behavioral Health: ASAM[®] for all SUD services; InterQual[®] for non-SUD MH services
- Pharmacy: State guidelines (including the PDL), peer-reviewed medical literature.

CountyCare used nationally recognized and state-developed utilization review criteria. HSAG did not identify any concerns from review of the health plan's UM procedures.

ABD File Review²³

To support analysis of each health plan's compliance with the clinical decision guidelines, HSAG leveraged the results of a 2023 file review of PA requests. HSAG reviewed a random sample of 25 M/S and 25 MH/SUD ABD records for each health plan, which were assessed against the following evaluation elements:

- Agreement with the criteria used for decision making.
- Agreement with the health plan decision (approval or denial).

²³ The ABD file reviews included a review of requests sampled from the health plan's total authorization request data and were not limited to hospital requests only.

During the file review, HSAG reviewed the PA request documentation submitted by the health plans, including provider medical records and clinical criteria used to make decisions. The results of the file review are displayed in Table 27.

Table 27—PA Decisions Record Review Results

Type of Record	Number of Records With Agreement	Number of Records With Disagreement	Total Reviewed	Percent Agreement
Overall Agreement	50	0	50	100%
M/S	25	0	25	100%
<i>Inpatient</i>	13	0	13	100%
<i>Outpatient</i>	12	0	12	100%
MH/SUD	25	0	25	100%
<i>Inpatient</i>	18	0	18	100%
<i>Outpatient</i>	7	0	7	100%

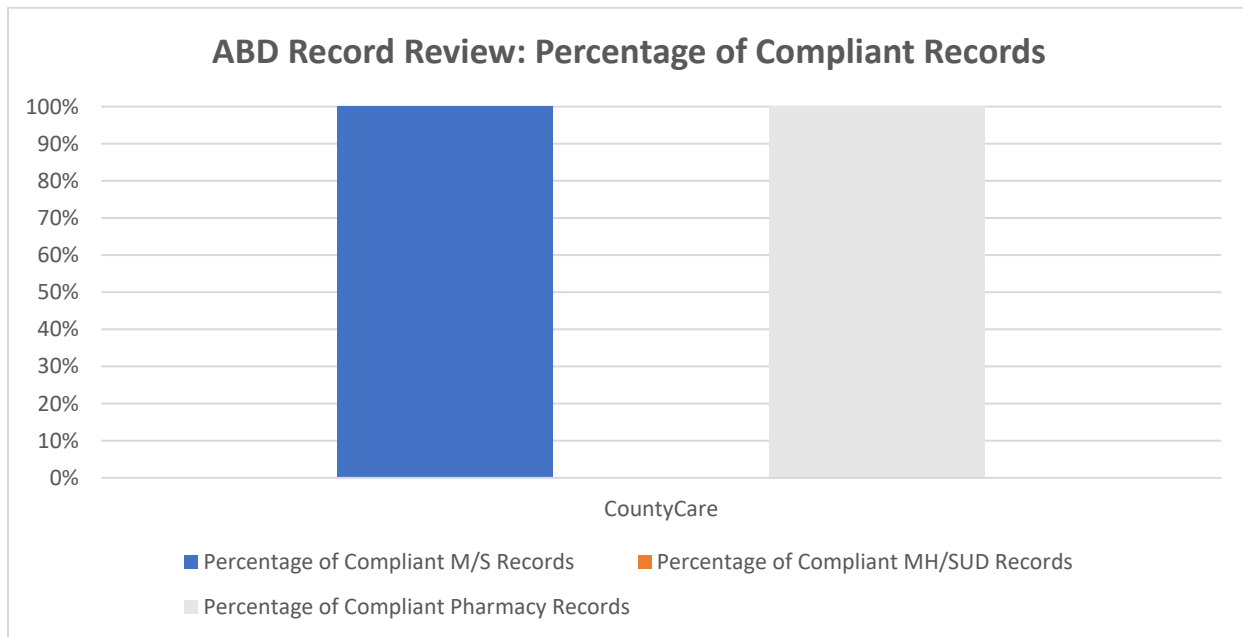
HSAG’s review resulted in 100 percent agreement with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plan’s decisions.

In addition, HSAG leveraged the results of the health plans’ 2025 compliance review to evaluate compliance with 42 CFR §438.210, which provides requirements for coverage and authorization of services. In addition to the evaluation of each health plan’s UM processes, policies, and procedures, HSAG also reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes. The file review included:

- Assessing compliance with federal and State regulations governing the processing of member NOABDs for service authorization denials, including accessibility.
- Assessing the timeliness of service authorization denials.

The health plan demonstrated a high level of compliance with ABD record elements, as displayed in Figure 7.

Figure 7—ABD File Review Results



Although no MH/SUD records were assessed in the final random sample, HSAG noted that the health plan reported and demonstrated consistent ABD processes regardless of the request type.

HSAG’s review of the health plan’s procedures, including service authorization guidelines and ABD file review, confirmed that the health plan demonstrated compliance with nationally recognized clinical decision guidelines and federal and State regulatory requirements surrounding the processing of NOABDs.

Equitable Standards of Care

HFS and the health plans are committed to ensuring that all individuals are being treated in accordance with equitable standards of care. Annually, HFS directs an MHP review to determine to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits.

As part of this review, HSAG reviewed the results of the 2025 MHP review to inform its evaluation of the health plan’s assurances of equitable standards of care. HSAG assessed the health plan’s data to determine evidence of parity between M/S and MH/SUD authorization approvals and denials,²⁴ as self-reported as part of HFS’ QBR process. Table 28 presents the results of the assessment.

²⁴ The data include the health plan’s total authorization requests and were not limited to hospital requests only.

Table 28—QBR Data Assessment: Total Requests Approved and Denied

QBR Data Assessment	Numerator	Denominator	Percent
Approvals			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	29,690	31,549	94%
PA (Behavioral Health Only)	3,275	3,313	99%
Denials			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	1,805	31,549	6%
PA (Behavioral Health Only)	33	3,313	1%

HSAG completed a Chi-square analysis to determine statistically significant differences between the health plan’s denial rates for M/S and MH/SUD services. There was no statistically significant difference in the rates of the health plan’s denied M/S authorization requests when compared to MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials. While the difference was *Moderate*, the differences were driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity.

Findings and Recommendations

HSAG noted that observations related to the peer-to-peer and reconsideration processes are being addressed through the administrative compliance review process. Based on the results of the review, HSAG did not identify any findings or recommendations for CountyCare.

Meridian

Hospital Service Authorization Data Assessment

To evaluate health plan hospital service authorizations, HSAG received data from each health plan representing hospital service authorization requests received from July 2025 through September 2025. Table 29 displays the number of service authorization requests by hospital type and service request category.

Table 29—Hospital Service Authorization Requests by Hospital Type and Service Request Category
N=62,089

Hospital Type	PA	Concurrent	Post-Service	Total
General Acute	42,806	12,709	1,132	56,647
Psychiatric	1	4,612	89	4,702
Rehabilitation	107	136	0	243
Long Term Acute Care	37	54	0	91
Children’s	2	295	59	356
Other	32	16	2	50

Of the service authorization requests received, most came from general acute hospitals. Of the service request categories, most were concurrent requests.

Determination Outcomes

HSAG assessed the outcomes of the hospital service authorization determinations to determine the types of approvals and denials.

Approvals

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially approved (not denied).
- Initially denied but overturned, resulting in an approval of the service authorization request.
- Initially partially approved with the partial denial overturned, resulting in an approval of the service authorization request.

Meridian reported a total of 47,123 approved service authorization requests. Of those, 44,925 were approved and did not require additional levels of review. Table 30 displays the remaining approval

totals, with stratification by category of approval type for those service authorization requests that were initially denied but subsequently approved.

Table 30—Hospital Service Authorization Totals by Approval Type

Approval Type	Total ²⁵ N=47,123
Initially approved; no further action required	44,925
Initially denied but overturned through appeal	1
Initially denied but overturned through peer-to-peer	545
Initially denied but overturned through reconsideration	1,583
Initially denied but overturned through fair hearings	0
Initially denied but overturned by provider dispute	82
Initially denied but overturned through EQRO process	0
Other (categorized as more than one approval type)	8

*HSAG included a category of “other” if the health plan listed an approval in more than one category.

HSAG noted that, for those denials which included an additional level of review and were subsequently approved (denial overturned), most were conducted via the reconsideration process.

Denials

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially denied and did not have post-denial requests.
- Initially denied with a post-denial request, resulting in a final denial (initial denial upheld regardless of the post-denial request process).
- Initially partially denied with the partial denial upheld, resulting in a final denial of the service authorization request.

Meridian reported a total of 14,966 denials. Of those, 12,705 were denied and did not include additional review requests. Table 31 displays the remaining denial totals, with stratification by category of denial type for those service authorization requests that were initially denied with the denial ultimately upheld.

²⁵ Health plan totals include all approvals, including those that were initially approved and did not require additional review, as well as those that were partially approved/partially denied but ultimately approved. Initially denied categories are provided as a subset of the total number of authorizations that were ultimately approved.

Table 31—Hospital Service Authorization Totals by Denial Type

Denial Type	Total ²⁶ N=14,966
Initially denied; no further action requested by enrollee/provider	12,705
Peer-to-peer held; denial upheld	1,324
Appeal submitted; denial upheld	8
Considered under reconsideration or escalation process; denial upheld	1,032
Fair hearings process completed; denial upheld	0
Provider dispute submitted; denial upheld	293
Denial upheld through EQRO process	0

HSAG noted that, for those denials which included an additional level of review and remained denied (denial upheld), most were conducted via the peer-to-peer or reconsideration process.

HSAG noted that most denials were overturned via the peer-to-peer and reconsideration processes. The health plan’s submission confirmed that the health plan conducts the peer-to-peer and reconsideration processes after the NOABD has been delivered to the enrollee and provider. HSAG also confirmed these processes during the health plan’s administrative compliance review. However, these processes constitute an additional level of review that occurs after the initial denial notice is mailed to the enrollee and prior to the appeal process. Based on recent guidance, CMS has clarified that a health plan’s practice of adjusting service authorization denial decisions based on peer-to-peer discussions occurring after the health plan sends the enrollee an ABD notice is inconsistent with the Medicaid managed care rule; the health plan’s review of a PA denial with an enrollee’s provider after the health plan provides the enrollee with the ABD notice is consistent with the definition of “appeal”; and if the health plan does not seek the consent of the enrollee on whose behalf these decisions are being reconsidered (i.e., an appeal) prior to the peer-to-peer discussions, the enrollee may be unaware that an appeal is occurring on his or her behalf. As a result of the administrative compliance review findings, the health plan was instructed to develop processes to comply with CMS guidance, which will be monitored via the administrative compliance review process.

HSAG assessed the health plan's approvals and denials to determine the number of authorization requests for which a second level of review was requested. Of the health plan's total hospital service authorization requests (62,089), 7.2 percent (4,480) underwent, at a minimum, one second level of

²⁶ Health plan totals include all denials, including those that were initially denied and did not include additional review requests, as well as those that were partially approved/partially denied but ultimately denied. A single denied request may go through multiple post-denial processes, resulting in reporting of a single request in multiple subcategories. Health plans may also have cases reported as “pending,” which are counted in denial totals as they do not yet have an outcome that would allow for classification as “approved.”

review. HSAG noted that this includes authorization requests which may have received multiple levels of review after an initial denial.

HSAG also assessed approvals and denials by the type of service requested, including outpatient services; inpatient, non-emergent initial admissions; emergent inpatient initial admissions; and continued inpatient stays. These stratified data are available in Appendix B.

Supportive Information

Although the focus of this data analysis was to evaluate hospital service authorizations, additional information and data were reviewed to provide supportive information on the health plan's overall processes for managing service authorization requests. This information was not limited to hospital service authorizations only but provided additional context to support oversight and monitoring of service authorizations and determination outcomes.

Review of Health Plan UM Procedures

HSAG leveraged documents from the health plan's 2025 administrative compliance review to inform HSAG's review team of the health plan's internal UM processes, including policies, procedures, and information.

Meridian reported the use of the following evidence-based clinical criteria to evaluate the necessity of care:

- Physical Health: InterQual[®], federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature
- Behavioral Health: ASAM[®] for all SUD services; InterQual[®] for non-SUD MH services, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature
- Pharmacy: State guidelines (including the PDL), national drug compendia, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature

Meridian used nationally recognized and state-developed utilization review criteria. HSAG did not identify any concerns from review of the health plan's UM procedures.

ABD File Review²⁷

To support analysis of each health plan's compliance with the clinical decision guidelines, HSAG leveraged the results of a 2023 file review of PA requests. HSAG reviewed a random sample of 25 M/S

²⁷ The ABD file reviews included a review of requests sampled from the health plan's total authorization request data and were not limited to hospital requests only.

and 25 MH/SUD ABD records for each health plan, which were assessed against the following evaluation elements:

- Agreement with the criteria used for decision making.
- Agreement with the health plan decision (approval or denial).

During the file review, HSAG reviewed the PA request documentation submitted by the health plans, including provider medical records and clinical criteria used to make decisions. The results of the file review are displayed in Table 32.

Table 32—PA Decisions Record Review Results

Type of Record	Number of Records With Agreement	Number of Records With Disagreement	Total Reviewed	Percent Agreement
Overall Agreement	50	0	50	100%
M/S	25	0	25	100%
<i>Inpatient</i>	7	0	7	100%
<i>Outpatient</i>	18	0	18	100%
MH/SUD	25	0	25	100%
<i>Inpatient</i>	25	0	25	100%
<i>Outpatient</i>	0	0	0	<i>Not Applicable</i>

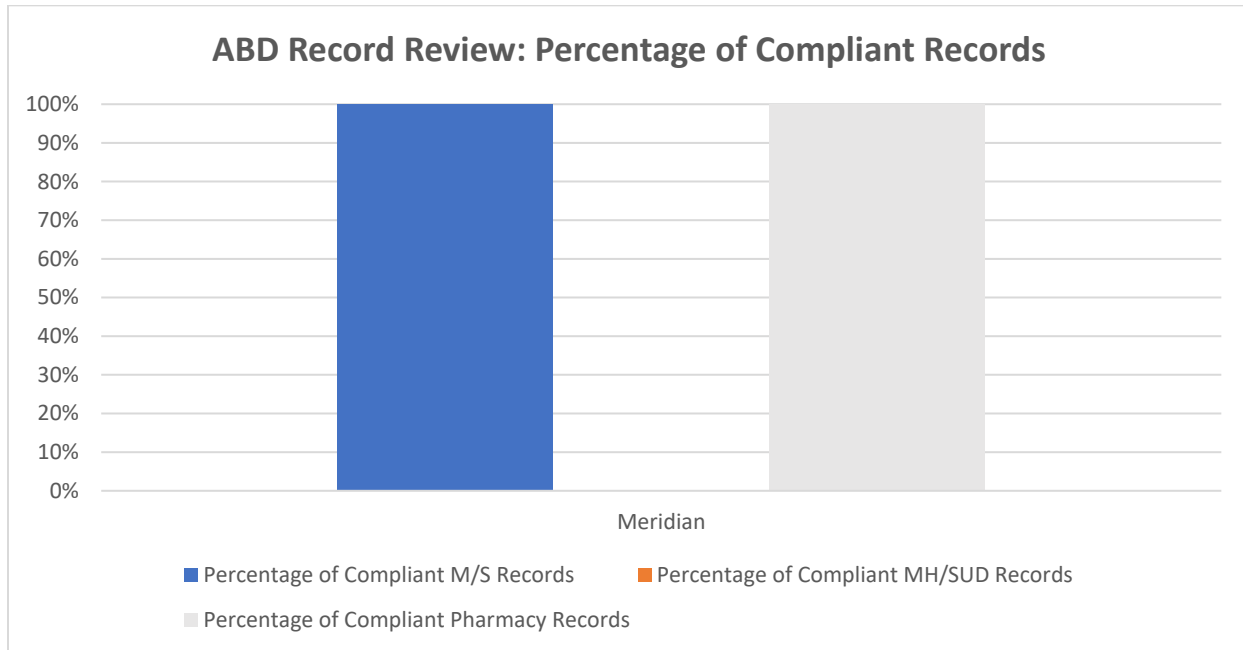
HSAG’s review resulted in 100 percent agreement with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plan’s decisions.

In addition, HSAG leveraged the results of the health plans’ 2025 compliance review to evaluate compliance with 42 CFR §438.210, which provides requirements for coverage and authorization of services. In addition to the evaluation of each health plan’s UM processes, policies, and procedures, HSAG also reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes. The file review included:

- Assessing compliance with federal and State regulations governing the processing of member NOABDs for service authorization denials, including accessibility.
- Assessing the timeliness of service authorization denials.

The health plan demonstrated a high level of compliance with ABD record elements, as displayed in Figure 8.

Figure 8—ABD File Review Results



Although no MH/SUD records were assessed in the final random sample, HSAG noted that the health plan reported and demonstrated consistent ABD processes regardless of the request type.

HSAG’s review of the health plan’s procedures, including service authorization guidelines and ABD file review, confirmed that the health plan demonstrated compliance with nationally recognized clinical decision guidelines and federal and State regulatory requirements surrounding the processing of NOABDs.

Equitable Standards of Care

HFS and the health plans are committed to ensuring that all individuals are being treated in accordance with equitable standards of care. Annually, HFS directs an MHP review to determine to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits.

As part of this review, HSAG reviewed the results of the 2025 MHP review to inform its evaluation of the health plan’s assurances of equitable standards of care. HSAG assessed the health plan’s data to

determine evidence of parity between M/S and MH/SUD authorization approvals and denials,²⁸ as self-reported as part of HFS’ QBR process. Table 33 presents the results of the assessment.

Table 33—QBR Data Assessment: Total Requests Approved and Denied

QBR Data Assessment	Numerator	Denominator	Percent
Approvals			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	32,738	35,463	92%
PA (Behavioral Health Only)	133	145	92%
Denials			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	2,458	35,463	7%
PA (Behavioral Health Only)	5	145	3%

Total request rates (approvals + denials) may not equal 100%.

HSAG completed a Chi-square analysis to determine statistically significant differences between the health plan’s denial rates for M/S and MH/SUD services. The health plan denied M/S authorization requests at a statistically significantly higher rate than MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials. Additionally, HSAG analyzed the difference in the percentage of denials and found there was no difference, suggesting no concerns with parity.

Findings and Recommendations

HSAG noted that observations related to the peer-to-peer and reconsideration processes are being addressed through the administrative compliance review process. Based on the results of the review, HSAG did not identify any findings or recommendations for Meridian.

²⁸ The data include the health plan’s total authorization requests and were not limited to hospital requests only.

Molina Healthcare of Illinois, Inc. (Molina)

Hospital Service Authorization Data Assessment

To evaluate health plan hospital service authorizations, HSAG received data from each health plan representing hospital service authorization requests received from July 2025 through September 2025. Table 34 displays the number of service authorization requests by hospital type and service request category.

Table 34—Hospital Service Authorization Requests by Hospital Type and Service Request Category
N=19,096

Hospital Type	PA	Concurrent	Post-service	Total
General Acute	9,915	5,559	434	15,908
Psychiatric	63	1,638	22	1,723
Rehabilitation	3	83	0	86
Long Term Acute Care	0	35	3	38
Children’s	408	894	39	1,341
Other	0	0	0	0

Of the service authorization requests received, most came from general acute hospitals. Of the service request categories, most were PA or concurrent requests.

Determination Outcomes

HSAG assessed the outcomes of the hospital service authorization determinations to determine the types of approvals and denials.

Approvals

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially approved (not denied).
- Initially denied but overturned, resulting in an approval of the service authorization request.
- Initially partially approved with the partial denial overturned, resulting in an approval of the service authorization request.

Molina reported a total of 15,998 approved service authorization requests. Of those, 14,894 were approved and did not require additional levels of review. Table 35 displays the remaining approval

totals, with stratification by category of approval type for those service authorization requests that were initially denied but subsequently approved.

Table 35—Hospital Service Authorization Totals by Approval Type

Approval Type	Total ²⁹ N=15,998
Initially approved; no further action required	14,894
Initially denied but overturned through appeal	335
Initially denied but overturned through peer-to-peer	613
Initially denied but overturned through reconsideration	74
Initially denied but overturned through fair hearings	0
Initially denied but overturned by provider dispute	82
Initially denied but overturned through EQRO process	0

HSAG noted that, for those denials which included an additional level of review and were subsequently approved (denial overturned), most were conducted via the peer-to-peer process.

Denials

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially denied and did not have post-denial requests.
- Initially denied with a post-denial request, resulting in a final denial (initial denial upheld regardless of the post-denial request process).
- Initially partially denied with the partial denial upheld, resulting in a final denial of the service authorization request.

Molina reported a total of 3,098 denials. Of those, 1,949 were denied and did not include additional review requests. Table 36 displays the remaining denial totals, with stratification by category of denial type for those service authorization requests that were initially denied with the denial ultimately upheld.

²⁹ Health plan totals include all approvals, including those that were initially approved and did not require additional review, as well as those that were partially approved/partially denied but ultimately approved. Initially denied categories are provided as a subset of the total number of authorizations that were ultimately approved.

Table 36—Hospital Service Authorization Totals by Denial Type

Denial Type	Total ³⁰ N=3,098
Initially denied; no further action requested by enrollee/provider	1,949
Peer-to-peer held; denial upheld	754
Appeal submitted; denial upheld	608
Considered under reconsideration or escalation process; denial upheld	78
Fair hearings process completed; denial upheld	0
Provider dispute submitted; denial upheld	32
Denial upheld through EQRO process	0

HSAG noted that, for those denials which included an additional level of review and remained denied (denial upheld), most were conducted via the peer-to-peer or appeal processes.

HSAG noted that most denials were overturned via the peer-to-peer process. The health plan’s submission confirmed that the health plan conducts the peer-to-peer and reconsideration processes after the NOABD has been delivered to the enrollee and provider. HSAG also confirmed these processes during the health plan’s administrative compliance review. However, these processes constitute an additional level of review that occurs after the initial denial notice is mailed to the enrollee and prior to the appeal process. Based on recent guidance, CMS has clarified that a health plan’s practice of adjusting service authorization denial decisions based on peer-to-peer discussions occurring after the health plan sends the enrollee an ABD notice is inconsistent with the Medicaid managed care rule; the health plan’s review of a PA denial with an enrollee’s provider after the health plan provides the enrollee with the ABD notice is consistent with the definition of “appeal”; and if the health plan does not seek the consent of the enrollee on whose behalf these decisions are being reconsidered (i.e., an appeal) prior to the peer-to-peer discussions, the enrollee may be unaware that an appeal is occurring on his or her behalf. As a result of the administrative compliance review findings, the health plan was instructed to develop processes to comply with CMS guidance, which will be monitored via the administrative compliance review process.

HSAG assessed the health plan's approvals and denials to determine the number of authorization requests for which a second level of review was requested. Of the health plan's total hospital service authorization requests (19,096), 11.8 percent (2,253) underwent, at a minimum, one second level of

³⁰ Health plan totals include all denials, including those that were initially denied and did not include additional review requests, as well as those that were partially approved/partially denied but ultimately denied. A single denied request may go through multiple post-denial processes, resulting in reporting of a single request in multiple subcategories. Health plans may also have cases reported as “pending,” which are counted in denial totals as they do not yet have an outcome that would allow for classification as “approved.”

review. HSAG noted that this includes authorization requests which may have received multiple levels of review after an initial denial.

HSAG also assessed approvals and denials by the type of service requested, including outpatient services; inpatient, non-emergent initial admissions; emergent inpatient initial admissions; and continued inpatient stays. These stratified data are available in Appendix B.

Supportive Information

Although the focus of this data analysis was to evaluate hospital service authorizations, additional information and data were reviewed to provide supportive information on the health plan's overall processes for managing service authorization requests. This information was not limited to hospital service authorizations only but provided additional context to support oversight and monitoring of service authorizations and determination outcomes.

Review of Health Plan UM Procedures

HSAG leveraged documents from the health plan's 2025 administrative compliance review to inform HSAG's review team of the health plan's internal UM processes, including policies, procedures, and information.

Molina reported the use of the following evidence-based clinical criteria to evaluate the necessity of care:

- Physical Health: MCG[®] and internal clinical policies
- Behavioral Health: ASAM[®] and internal clinical policies
- Pharmacy: State guidelines (including the PDL), FDA-approved drug labeling, accepted clinical compendia, professional medical society guidelines, available clinical literature and expert reviews, and internal clinical policies

Molina used nationally recognized and state-developed utilization review criteria. HSAG did not identify any concerns from review of the health plan's UM procedures.

ABD File Review³¹

To support analysis of each health plan's compliance with the clinical decision guidelines, HSAG leveraged the results of a 2023 file review of PA requests. HSAG reviewed a random sample of 25 M/S and 25 MH/SUD ABD records for each health plan, which were assessed against the following evaluation elements:

³¹ The ABD file reviews included a review of requests sampled from the health plan's total authorization request data and were not limited to hospital requests only.

- Agreement with the criteria used for decision making.
- Agreement with the health plan decision (approval or denial).

During the file review, HSAG reviewed the PA request documentation submitted by the health plans, including provider medical records and clinical criteria used to make decisions. The results of the file review are displayed in Table 37.

Table 37—PA Decisions Record Review Results

Type of Record	Number of Records With Agreement	Number of Records With Disagreement	Total Reviewed	Percent Agreement
Overall Agreement	50	0	50	100%
M/S	25	0	25	100%
<i>Inpatient</i>	6	0	6	100%
<i>Outpatient</i>	19	0	19	100%
MH/SUD	25	0	25	100%
<i>Inpatient</i>	1	0	1	100%
<i>Outpatient</i>	24	0	24	100%

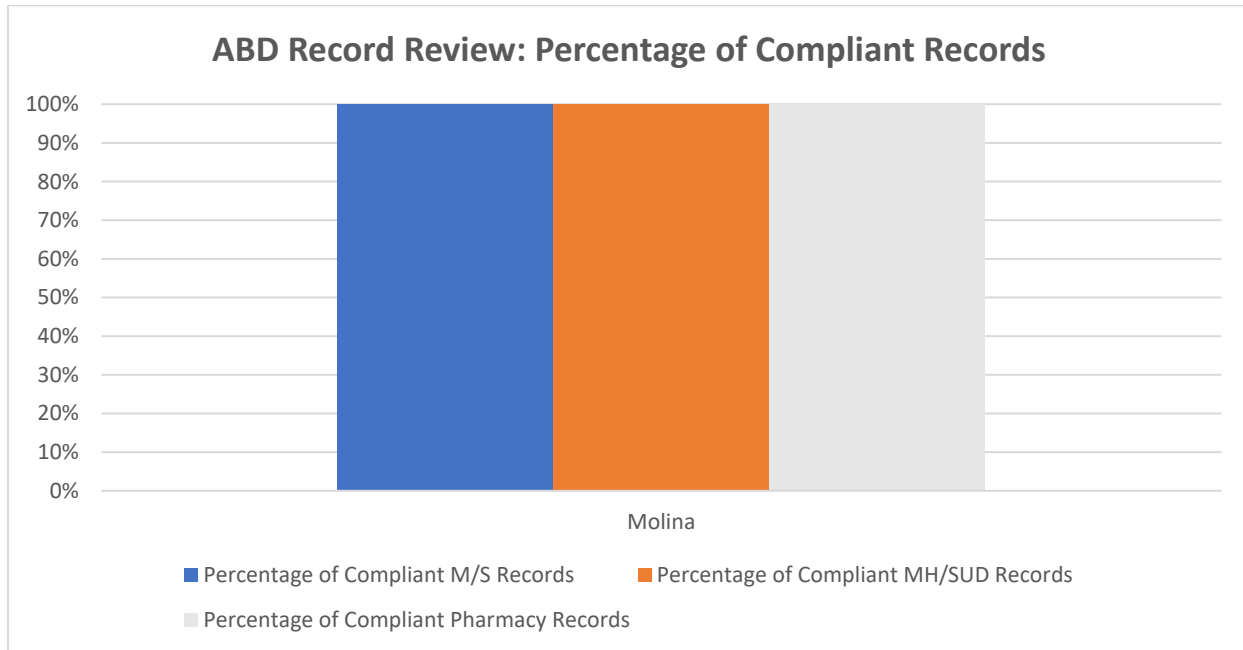
HSAG’s review resulted in 100 percent agreement with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plan’s decisions.

In addition, HSAG leveraged the results of the health plans’ 2025 compliance review to evaluate compliance with 42 CFR §438.210, which provides requirements for coverage and authorization of services. In addition to the evaluation of each health plan’s UM processes, policies, and procedures, HSAG also reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes. The file review included:

- Assessing compliance with federal and State regulations governing the processing of member NOABDs for service authorization denials, including accessibility.
- Assessing the timeliness of service authorization denials.

The health plan demonstrated a high level of compliance with ABD record elements, as displayed in Figure 9.

Figure 9—ABD File Review Results



HSAG’s review of the health plan’s procedures, including service authorization guidelines and ABD file review, confirmed that the health plan demonstrated compliance with nationally recognized clinical decision guidelines and federal and State regulatory requirements surrounding the processing of NOABDs.

Equitable Standards of Care

HFS and the health plans are committed to ensuring that all individuals are being treated in accordance with equitable standards of care. Annually, HFS directs an MHP review to determine to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits.

As part of this review, HSAG reviewed the results of the 2025 MHP review to inform its evaluation of the health plan’s assurances of equitable standards of care. HSAG assessed the health plan’s data to determine evidence of parity between M/S and MH/SUD authorization approvals and denials,³² as self-reported as part of HFS’ QBR process. Table 38 presents the results of the assessment.

³² The data include the health plan’s total authorization requests and were not limited to hospital requests only.

Table 38—QBR Data Assessment: Total Requests Approved and Denied

QBR Data Assessment	Numerator	Denominator	Percent
Approvals			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	27,129	29,552	92%
PA (Behavioral Health Only)	860	921	93%
Denials			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	2,352	29,552	8%
PA (Behavioral Health Only)	61	921	7%

HSAG completed a Chi-square analysis to determine statistically significant differences between the health plan’s denial rates for M/S and MH/SUD services. There was no statistically significant difference in the rates of the health plan’s denied M/S authorization requests when compared to MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials. While the difference was *Moderate*, the differences were driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity.

Findings and Recommendations

HSAG noted that observations related to the peer-to-peer and reconsideration processes are being addressed through the administrative compliance review process. Based on the results of the review, HSAG did not identify any findings or recommendations for Molina.

YouthCare Specialty Plan (YouthCare)

Hospital Service Authorization Data Assessment

To evaluate health plan hospital service authorizations, HSAG received data from each health plan representing hospital service authorization requests received from July 2025 through September 2025. Table 39 displays the number of service authorization requests by hospital type and service request category.

Table 39—Hospital Service Authorization Requests by Hospital Type and Service Request Category
N=2,328

Hospital Type	PA	Concurrent	Post-service	Total
General Acute	1,187	2,77	57	1,521
Psychiatric	0	777	8	785
Rehabilitation	0	3	0	3
Long Term Acute Care	0	2	0	2
Children’s	0	6	5	11
Other	0	6	0	6

Of the service authorization requests received, most came from general acute hospitals. Of the service request categories, most were PA or concurrent requests.

Determination Outcomes

HSAG assessed the outcomes of the hospital service authorization determinations to determine the types of approvals and denials.

Approvals

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially approved (not denied).
- Initially denied but overturned, resulting in an approval of the service authorization request.
- Initially partially approved with the partial denial overturned, resulting in an approval of the service authorization request.

YouthCare reported a total of 2,013 approved service authorization requests. Of those, 1,963 were approved and did not require additional levels of review. Table 40 displays the remaining approval

totals, with stratification by category of approval type for those service authorization requests that were initially denied but subsequently approved.

Table 40—Hospital Service Authorization Totals by Approval Type

Approval Type	Total ³³ N=2,013
Initially approved; no further action required	1,963
Initially denied but overturned through appeal	0
Initially denied but overturned through peer-to-peer	8
Initially denied but overturned through reconsideration	40
Initially denied but overturned through fair hearings	0
Initially denied but overturned by provider dispute	2
Initially denied but overturned through EQRO process	0

HSAG noted that, for those denials which included an additional level of review and were subsequently approved (denial overturned), most were conducted via the reconsideration process.

Denials

Of the total number of hospital service authorizations received, HSAG analyzed the number of requests that were:

- Initially denied and did not have post-denial requests.
- Initially denied with a post-denial request, resulting in a final denial (initial denial upheld regardless of the post-denial request process).
- Initially partially denied with the partial denial upheld, resulting in a final denial of the service authorization request.

YouthCare reported a total of 315 denials. Of those, 281 were denied and did not include additional review requests. Table 41 displays the remaining denial totals, with stratification by category of denial type for those service authorization requests that were initially denied with the denial ultimately upheld.

³³ Health plan totals include all approvals, including those that were initially approved and did not require additional review, as well as those that were partially approved/partially denied but ultimately approved. Initially denied categories are provided as a subset of the total number of authorizations that were ultimately approved.

Table 41—Hospital Service Authorization Totals by Denial Type

Denial Type	Total ³⁴ N=315
Initially denied; no further action requested by enrollee/provider	281
Peer-to-peer held; denial upheld	22
Appeal submitted; denial upheld	0
Considered under reconsideration or escalation process; denial upheld	17
Fair hearings process completed; denial upheld	0
Provider dispute submitted; denial upheld	3
Denial upheld through EQRO process	0

HSAG noted that, for those denials which included an additional level of review and remained denied (denial upheld), all were conducted via the peer-to-peer or reconsideration process.

HSAG noted that all denials were overturned via the peer-to-peer or reconsideration process. The health plan’s submission confirmed that the health plan conducts the peer-to-peer or reconsideration process after the NOABD has been delivered to the enrollee and provider. YouthCare also noted that a reconsideration may be completed prior to the NOABD if a different level of care could be approved. HSAG also confirmed these processes during the health plan’s administrative compliance review. However, these processes constitute an additional level of review that occurs after the initial denial notice is mailed to the enrollee and prior to the appeal process. Based on recent guidance, CMS has clarified that a health plan’s practice of adjusting service authorization denial decisions based on peer-to-peer discussions occurring after the health plan sends the enrollee an ABD notice is inconsistent with the Medicaid managed care rule; the health plan’s review of a PA denial with an enrollee’s provider after the health plan provides the enrollee with the ABD notice is consistent with the definition of “appeal”; and if the health plan does not seek the consent of the enrollee on whose behalf these decisions are being reconsidered (i.e., an appeal) prior to the peer-to-peer discussions, the enrollee may be unaware that an appeal is occurring on his or her behalf. As a result of the administrative compliance review findings, the health plan was instructed to develop processes to comply with CMS guidance, which will be monitored via the administrative compliance review process.

HSAG assessed the health plan's approvals and denials to determine the number of authorization requests for which a second level of review was requested. Of the health plan's total hospital service authorization requests (2,328), 3.6 percent (84) underwent, at a minimum, one second level of review.

³⁴ Health plan totals include all denials, including those that were initially denied and did not include additional review requests, as well as those that were partially approved/partially denied but ultimately denied. A single denied request may go through multiple post-denial processes, resulting in reporting of a single request in multiple subcategories. Health plans may also have cases reported as “pending,” which are counted in denial totals as they do not yet have an outcome that would allow for classification as “approved.”

HSAG noted that this includes authorization requests which may have received multiple levels of review after an initial denial.

HSAG also assessed approvals and denials by the type of service requested, including outpatient services; inpatient, non-emergent initial admissions; emergent inpatient initial admissions; and continued inpatient stays. These stratified data are available in Appendix B.

Supportive Information

Although the focus of this data analysis was to evaluate hospital service authorizations, additional information and data were reviewed to provide supportive information on the health plan's overall processes for managing service authorization requests. This information was not limited to hospital service authorizations only but provided additional context to support oversight and monitoring of service authorizations and determination outcomes.

Review of Health Plan UM Procedures

HSAG leveraged documents from the health plan's 2025 administrative compliance review to inform HSAG's review team of the health plan's internal UM processes, including policies, procedures, and information.

YouthCare reported the use of the following evidence-based clinical criteria to evaluate the necessity of care:

- Physical Health: InterQual[®], federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature
- Behavioral Health: ASAM[®] for all SUD services; InterQual[®] for non-SUD MH services, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature
- Pharmacy: State guidelines (including the PDL), national drug compendia, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature

YouthCare used nationally recognized and state-developed utilization review criteria. HSAG did not identify any concerns from review of the health plan's UM procedures.

ABD File Review³⁵

To support analysis of each health plan's compliance with the clinical decision guidelines, HSAG leveraged the results of a 2023 file review of PA requests. HSAG reviewed a random sample of 25 M/S

³⁵ The ABD file reviews included a review of requests sampled from the health plan's total authorization request data and were not limited to hospital requests only.

and 25 MH/SUD ABD records for each health plan, which were assessed against the following evaluation elements:

- Agreement with the criteria used for decision making.
- Agreement with the health plan decision (approval or denial).

During the file review, HSAG reviewed the PA request documentation submitted by the health plans, including provider medical records and clinical criteria used to make decisions. The results of the file review are displayed in Table 42.

Table 42—PA Decisions Record Review Results

Type of Record	Number of Records With Agreement	Number of Records With Disagreement	Total Reviewed	Percent Agreement
Overall Agreement	50	0	50	100%
M/S	25	0	25	100%
<i>Inpatient</i>	4	0	4	100%
<i>Outpatient</i>	21	0	21	100%
MH/SUD	25	0	25	100%
<i>Inpatient</i>	25	0	25	100%
<i>Outpatient</i>	0	0	0	<i>Not Applicable</i>

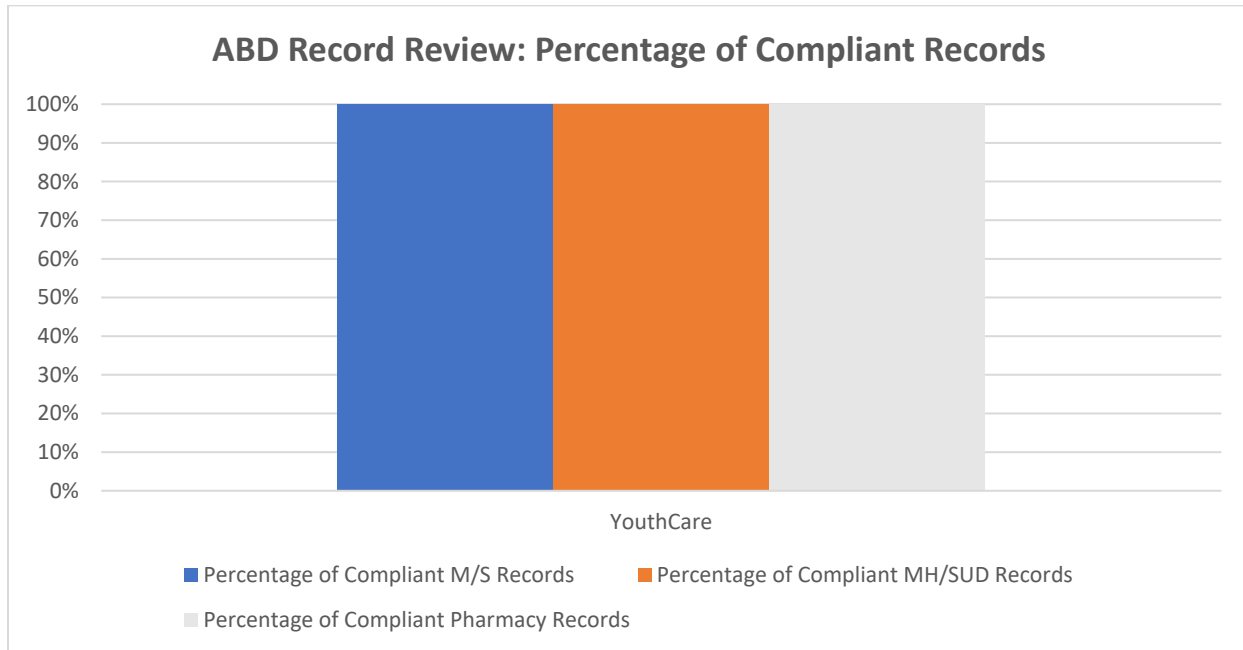
HSAG’s review resulted in 100 percent agreement with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plan’s decisions.

In addition, HSAG leveraged the results of the health plans’ 2025 compliance review to evaluate compliance with 42 CFR §438.210, which provides requirements for coverage and authorization of services. In addition to the evaluation of each health plan’s UM processes, policies, and procedures, HSAG also reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes. The file review included:

- Assessing compliance with federal and State regulations governing the processing of member NOABDs for service authorization denials, including accessibility.
- Assessing the timeliness of service authorization denials.

The health plan demonstrated a high level of compliance with ABD record elements, as displayed in Figure 10.

Figure 10—ABD File Review Results



HSAG’s review of the health plan’s procedures, including service authorization guidelines and ABD file review, confirmed that the health plan demonstrated compliance with nationally recognized clinical decision guidelines and federal and State regulatory requirements surrounding the processing of NOABDs.

Equitable Standards of Care

HFS and the health plans are committed to ensuring that all individuals are being treated in accordance with equitable standards of care. Annually, HFS directs an MHP review to determine to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits.

As part of this review, HSAG reviewed the results of the 2025 MHP review to inform its evaluation of the health plan’s assurances of equitable standards of care. HSAG assessed the health plan’s data to determine evidence of parity between M/S and MH/SUD authorization approvals and denials,³⁶ as self-reported as part of HFS’ QBR process. Table 43 presents the results of the assessment.

³⁶ The data include the health plan’s total authorization requests and were not limited to hospital requests only.

Table 43—QBR Data Assessment: Total Requests Approved and Denied

QBR Data Assessment: Total Denied	Numerator	Denominator	Percent
Approvals			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	1,161	1,196	97%
PA (Behavioral Health Only)	104	105	99%
Denials			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	34	1,196	3%
PA (Behavioral Health Only)	1	105	1%

HSAG completed a Chi-square analysis to determine statistically significant differences between the health plan’s denial rates for M/S and MH/SUD services. There was no statistically significant difference in the rates of the health plan’s denied M/S authorization requests when compared to MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials and found there was no difference, suggesting no concerns with parity.

Findings and Recommendations

HSAG noted that observations related to the peer-to-peer and reconsideration processes are being addressed through the administrative compliance review process. Based on the results of the review, HSAG did not identify any findings or recommendations for YouthCare.

Appendix B. Stratification Analysis

The following tables present stratification of service authorization approvals and denials by service type, in accordance with 305 ILCS 5/5-30.1(g-13)(3)(F).

Approvals³⁷

Health Plan and Approval Type	Outpatient Services	Inpatient, Non-Emergent Initial Admissions	Emergent Inpatient Initial Admissions	Continued Inpatient Stay
Aetna	4,099	881	7,294	144
<i>Initially denied but overturned through appeal</i>	6	1	2	0
<i>Initially denied but overturned through peer-to-peer</i>	24	91	681	14
<i>Initially denied but overturned through reconsideration</i>	0	2	17	0
<i>Initially denied but overturned through fair hearings</i>	0	0	0	0
<i>Initially denied but overturned by provider dispute</i>	7	9	72	0
<i>Initially denied but overturned through EQRO process</i>	0	0	0	0

³⁷ Health plan totals include all approvals, including those that were initially approved and did not require additional review, as well as those that were partially approved/partially denied but ultimately approved. Initially denied categories are provided as a subset of the total number of authorizations that were ultimately approved.

Health Plan and Approval Type	Outpatient Services	Inpatient, Non-Emergent Initial Admissions	Emergent Inpatient Initial Admissions	Continued Inpatient Stay
<i>Other (categorized as more than one approval type or unable to determine)</i>	0	2	1	0
BCBSIL	64,414	2,059	11,875	10,628
<i>Initially denied but overturned through appeal</i>	61	2	0	2
<i>Initially denied but overturned through peer-to-peer</i>	193	0	0	0
<i>Initially denied but overturned through reconsideration</i>	39	0	0	0
<i>Initially denied but overturned through fair hearings</i>	0	0	0	0
<i>Initially denied but overturned by provider dispute</i>	3	0	8	15
<i>Initially denied but overturned through EQRO process</i>	0	0	0	0
<i>Other (categorized as more than one approval type or unable to determine)</i>	162	0	0	1
CountyCare	2,478	1,088	11,174	5,849
<i>Initially denied but overturned through appeal</i>	0	0	0	1
<i>Initially denied but overturned through peer-to-peer</i>	19	33	174	58
<i>Initially denied but overturned through reconsideration</i>	0	0	0	0
<i>Initially denied but overturned through fair hearings</i>	0	0	0	0

Health Plan and Approval Type	Outpatient Services	Inpatient, Non-Emergent Initial Admissions	Emergent Inpatient Initial Admissions	Continued Inpatient Stay
<i>Initially denied but overturned by provider dispute</i>	0	0	0	0
<i>Initially denied but overturned through EQRO process</i>	0	0	0	0
<i>Other (categorized as more than one approval type or unable to determine)</i>	18	2	20	8
Meridian	32,805	60	14,166	92
<i>Initially denied but overturned through appeal</i>	0	0	1	0
<i>Initially denied but overturned through peer-to-peer</i>	1	0	544	0
<i>Initially denied but overturned through reconsideration</i>	1,544	7	32	0
<i>Initially denied but overturned through fair hearings</i>	0	0	0	0
<i>Initially denied but overturned by provider dispute</i>	0	0	81	1
<i>Initially denied but overturned through EQRO process</i>	0	0	0	0
<i>Other (categorized as more than one approval type or unable to determine)</i>	0	0	8	0
Molina	10,014	190	5,794	0*
<i>Initially denied but overturned through appeal</i>	149	22	164	0
<i>Initially denied but overturned through peer-to-peer</i>	33	5	575	0

Health Plan and Approval Type	Outpatient Services	Inpatient, Non-Emergent Initial Admissions	Emergent Inpatient Initial Admissions	Continued Inpatient Stay
<i>Initially denied but overturned through reconsideration</i>	25	2	47	0
<i>Initially denied but overturned through fair hearings</i>	0	0	0	0
<i>Initially denied but overturned by provider dispute</i>	45	1	36	0
<i>Initially denied but overturned through EQRO process</i>	0	0	0	0
YouthCare	953	0	1,059	1
<i>Initially denied but overturned through appeal</i>	0	0	0	0
<i>Initially denied but overturned through peer-to-peer</i>	0	0	8	0
<i>Initially denied but overturned through reconsideration</i>	40	0	0	0
<i>Initially denied but overturned through fair hearings</i>	0	0	0	0
<i>Initially denied but overturned by provider dispute</i>	0	0	2	0
<i>Initially denied but overturned through EQRO process</i>	0	0	0	0

*Molina does not capture service authorization requests in this category.

Denials³⁸

Health Plan and Denial Type	Outpatient Services	Inpatient, Non-Emergent Initial Admissions	Emergent Inpatient Initial Admissions	Continued Inpatient Stay
Aetna	621	274	2,179	32
<i>Peer-to-peer held; denial upheld</i>	38	84	821	15
<i>Appeal submitted; denial upheld</i>	48	9	9	0
<i>Considered under reconsideration or escalation process; denial upheld</i>	0	1	5	0
<i>Fair hearings process completed; denial upheld</i>	0	0	0	0
<i>Provider dispute submitted; denial upheld</i>	13	32	399	5
<i>Denial upheld through EQRO process</i>	0	0	0	0
BCBSIL	6,248	34	677	596
<i>Peer-to-peer held; denial upheld</i>	104	0	0	0
<i>Appeal submitted; denial upheld</i>	48	3	0	7
<i>Considered under reconsideration or escalation process; denial upheld</i>	28	0	0	0
<i>Fair hearings process completed; denial upheld</i>	0	0	0	0
<i>Provider dispute submitted; denial upheld</i>	4	0	41	70

³⁸ Health plan totals include all denials, including those that were initially denied and did not include additional review requests, as well as those that were partially approved/partially denied but ultimately denied. A single denied request may go through multiple post-denial processes, resulting in reporting of a single request in multiple subcategories. Health plans may also have cases reported as “pending,” which are counted in denial totals as they do not yet have an outcome that would allow for classification as “approved.”

Health Plan and Denial Type	Outpatient Services	Inpatient, Non-Emergent Initial Admissions	Emergent Inpatient Initial Admissions	Continued Inpatient Stay
<i>Denial upheld through EQRO process</i>	0	0	0	0
CountyCare	79	86	470	110
<i>Peer-to-peer held; denial upheld</i>	8	28	43	13
<i>Appeal submitted; denial upheld</i>	5	9	24	7
<i>Considered under reconsideration or escalation process; denial upheld</i>	5	11	36	7
<i>Fair hearings process completed; denial upheld</i>	0	0	0	0
<i>Provider dispute submitted; denial upheld</i>	0	2	24	5
<i>Denial upheld through EQRO process</i>	0	0	0	0
Meridian	11,460	38	3,464	4
<i>Peer-to-peer held; denial upheld</i>	674	2	648	0
<i>Appeal submitted; denial upheld</i>	0	0	8	0
<i>Considered under reconsideration or escalation process; denial upheld</i>	1,030	1	1	0
<i>Fair hearings process completed; denial upheld</i>	0	0	0	0
<i>Provider dispute submitted; denial upheld</i>	0	0	293	0
<i>Denial upheld through EQRO process</i>	0	0	0	0
Molina	626	61	2,411	0*
<i>Peer-to-peer held; denial upheld</i>	7	15	732	0
<i>Appeal submitted; denial upheld</i>	29	29	550	0

Health Plan and Denial Type	Outpatient Services	Inpatient, Non-Emergent Initial Admissions	Emergent Inpatient Initial Admissions	Continued Inpatient Stay
<i>Considered under reconsideration or escalation process; denial upheld</i>	11	4	63	0
<i>Fair hearings process completed; denial upheld</i>	0	0	0	0
<i>Provider dispute submitted; denial upheld</i>	2	0	30	0
<i>Denial upheld through EQRO process</i>	0	0	0	0
YouthCare	252	0	63	0
<i>Peer-to-peer held; denial upheld</i>	14	0	8	0
<i>Appeal submitted; denial upheld</i>	0	0	0	0
<i>Considered under reconsideration or escalation process; denial upheld</i>	17	0	0	0
<i>Fair hearings process completed; denial upheld</i>	0	0	0	0
<i>Provider dispute submitted; denial upheld</i>	0	0	3	0
<i>Denial upheld through EQRO process</i>	0	0	0	0

*Molina does not capture service authorization requests in this category.

Appendix C. Definitions

Illinois Statute 305 ILCS 5/5-30.1 Definitions³⁹

“Service authorization determination” is defined as a decision made by a service authorization program in advance of, concurrent to, or after the provision of a health care service to approve, change the level of care, partially deny, deny, or otherwise limit coverage and reimbursement for a health care service upon review of a service authorization request.

“Service authorization program” is defined as any utilization review, UM, peer review, quality review, or other medical management activity conducted by a managed care organization (MCO), or its contracted utilization review organization, including, but not limited to, PA, prior approval, pre-certification, concurrent review, retrospective review, or certification of admission, of health care services provided in the inpatient or outpatient hospital setting.

HSAG Data Submission Definitions

Facility Types

- **General Acute:** A type of hospital that provides short-term, inpatient medical and surgical care for acute illnesses and injuries. This category may include Place of Service (POS) Codes such as 21, 22, and 23.
- **Psychiatric:** A healthcare facility that provides inpatient treatment for individuals with mental health conditions. This category may include POS Codes such as 51 and 52, and may also include codes such as 21, 22, and 23.
- **Rehabilitation:** A specialized healthcare facility that provides intensive, comprehensive care to patients recovering from injuries, illnesses, or surgeries. This category may include POS Codes such as 61 and 62, and may also include codes such as 31 and 32.
- **Long term acute care:** A specialized healthcare facility that provides ongoing medical care for patients who require extended hospitalization, intensive nursing care, and/or rehabilitation services. This category may include POS Codes such as 31 and 32, and may also include codes such as 61 and 62.
- **Children’s:** A specialized healthcare facility dedicated to providing care to infants, children, and young adults. This category may include POS Codes such as 21, 22, and 23, and may also include codes such as 51, 52, 61, and 62.
- **Other:** Use this category only for hospitals/facilities that would not be classified into one of the POS codes previously mentioned.

³⁹ Illinois General Assembly. Illinois Compiled Statutes, 305 ILCS 5/5-30.1. Available at: <https://www.ilga.gov/documents/legislation/publicacts/103/PDF/103-0593.pdf>. Accessed on: Jan 23, 2026.

Table 44—Facility Types

Place of Service Code ⁴⁰	Place of Service Name	Place of Service Description
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus— Outpatient Hospital	A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016.)
23	Emergency Room— Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility— Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

⁴⁰ Centers for Medicare & Medicaid Services. Place of Service Code Set. Available at: <https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets>. Accessed on: Jan 23, 2026.

Place of Service Code ⁴⁰	Place of Service Name	Place of Service Description
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

Service Time Frames

- **Prior:** A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.
- **Concurrent:** A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.
- **Post:** A request for coverage of medical care or services that have been received (e.g., retrospective review).

Request Type

- **Outpatient:** Covered services not provided in an inpatient setting.
- **Inpatient, non-emergent initial admissions:** Planned hospital stays for care that is not an emergency, but requires being admitted (e.g., admission to a rehabilitation facility for physical therapy or stroke recovery).
- **Emergent inpatient initial admissions:** Immediate inpatient admission for urgent/emergent/life-threatening care.
- **Continued inpatient stay:** An uninterrupted period of time to receive inpatient care.

HFS Monthly Progress Report (MPR) Playbook Definitions⁴¹

Prior Authorization Request Report

The MCO [managed care organization] shall have in place and follow written policies and procedures when processing requests for PAs of Covered Services. To ensure appropriate utilization, the MCO may determine which Covered Services shall require PAs unless otherwise prohibited under the MCO Contract, the Department's PDL [Medicaid Preferred Drug List], or state law (e.g., the MCO cannot require PA for Emergency Services). The MCO shall authorize or deny Covered Services that require PA, including pharmacy services, as expeditiously as the Enrollee's health condition requires but no later than certain turnaround times specified in this MCO Handbook, MCO Contract, policy, or law. PA procedures and processes must be compliant with this MCO Handbook, MCO Contract, policy, law, and the MCO's Provider Handbook (for Covered Services requiring PA, not turnaround times). MCOs are required to submit reports on turnaround times for Ordinary/Routine and Expedited PA Requests for Enrollees. (According to Contract eff. 1/1/2018)

Note: Non-Rx (pharmacy) Requests are counted by the type of request, for a specific member, for a date of service, or a consecutive series of dates of service.

Note: Pharmacy requests are counted on a per-prescription basis.

Approved: The MCO agrees to authorize Covered Services in the amount, scope, or duration requested.

Partially Approved: The MCO agrees to authorize a portion of the Covered Services in the amount, scope, or duration requested.

Ordinary/Routine PA Request: The PA Request is reviewed and approved or denied within a Turnaround Time (TAT) of 4 days after receiving the request for authorization from a Provider, with a possible extension of up to 4 additional days if the Enrollee requests the extension or the MCO informs the Provider that there is a need for additional written justification demonstrating that the Covered Service is Medically Necessary and the Enrollee will not be harmed by the extension. Exception: Pharmacy.

Decision: The MCO's oral or written notification of an Approved, Partially Approved, or Denied PA Request. The Contractor shall notify the Provider orally or in writing and shall furnish the Enrollee with written notice of such decision. Such notice shall meet the requirements set forth in 42 CFR §438.404.

Denied: The MCO declines to authorize the Covered Service(s) requested.

⁴¹ Excerpts from the HFS MPR Playbook and MPR Quick Guide, December 2021. Definitions in this document do not reflect MCO contract amendments that occurred after its publication in December 2021.

Electronic vs Non-Electronic (form of PA request): A PA request is categorized as “electronic” if the request was received in a manner that enables the request being automatically entered into the MCO’s PA database/system.

Expedited PA Request: The PA Request approved or denied within a TAT of 48 hours after receiving the request. Expedited PAs shall occur if the Provider indicates, or MCO determines, that following the Ordinary/Routine PA TAT could seriously jeopardize the Enrollee’s life or health. Exception: This Expedited section does not apply to Pharmacy; the established TAT for Pharmacy is within 24 hours.

Pending: PA Request for which the MCO has not issued a Decision.

Pharmacy PA Request: PA Request for Pharmacy services. The established TAT for Pharmacy is within 24 hours after receipt of the request.

PA Request: A request by a Provider on behalf of an Enrollee for the provision of a Covered Service prior to receipt of the Covered Service.

Concurrent Review/Authorization is not included in the PA report.

Turnaround Time (TAT): The number of hours or days between the MCO’s receipt of a PA Request and the date of the Decision. TAT varies per Ordinary/Routine PA Request, Expedited PA Request, and Pharmacy PA Request.

Service Category Definitions

Behavioral Health Service: Covered Service for conditions related to emotional wellness, trauma, mental disorders, and substance use disorders and the services and supports found within the network of providers, or otherwise developed by the MCO, specifically encompassing the prevention, identification, treatment, and provision of recovery support for such conditions for the expressed purpose of increasing the stability of the Enrollee’s functioning levels across various life domains.

Covered Service: Benefits and services agreed to by HFS and the MCO as described in Contract eff. 1/1/2018.

Dental Service: Covered Services related to dentistry; dentistry meaning the healing art which is concerned with the examination, diagnosis, treatment planning, and care of conditions within the human oral cavity and its adjacent tissues and structure, including orthodontia and dentures.

Durable Medical Equipment: Covered Service by a Provider for medical equipment, supplies, prosthetic devices, and orthotic devices.

Home Health Service: Covered Services rendered by a Provider (e.g., home health agency) at the Enrollee’s residence according to a plan of treatment for illness or infirmity prescribed by a Provider (e.g., physician). Covered Services include part-time and intermittent nursing services and other therapeutic services such as physical therapy, occupational therapy, speech therapy, medical social services, or services provided by a home health aide.

Imaging (Advanced and Specialty): Covered Services of technologies used to view the human body in order to diagnose, monitor, or treat medical conditions such as MRI [magnetic resonance imaging] and CT [computed tomography].

Inpatient: Covered Services provided in a hospital or an institutional setting.

Medical (not Behavioral Health): Covered Services not otherwise listed herein for which the MCO requires PA.

Mental Health: Covered Services for mental health services such as mental health services provided under the Medicaid Clinic Option, Medicaid Rehabilitation Option, and Targeted Case Management Option. Utilize prior HFS guidance for BH [behavioral health] services: CMHC [Community Mental Health Center] Fee Schedule Verification, MCO Billing Guidelines CMHC Services, DASA [Division of Alcoholism and Substance Abuse] IL MCO Billing Guide for Encounter Data Reporting, Behavioral Health Combined (Mental Health and Substance Use) Drugs, Behavioral Health Mental Health Drugs, and Behavioral Health Substance Abuse Drugs.

Occupational Therapy: A medically prescribed Covered Service identified in the Individualized Plan of Care that is designed to increase independent functioning through adaptation of a patient’s tasks and environment, and that is provided by a licensed occupational therapist who meets Illinois licensure standards.

Outpatient: Covered Services not provided in an inpatient setting.

Pain Management: Covered Services for the diagnosing, monitoring, or treatment of pain. If pain management is delivered via Pharmacy or Therapy services, please utilize the Pharmacy and Therapy services area of the report to report the activity.

Pharmacy/Prescriptions: Covered Services for outpatient drugs.

Pharmacy—billed under the medical benefit via a “J code”: include these requests in the reported metrics in the applicable delivery of care setting: Inpatient Medical—Expedited, or the Outpatient Medical—Expedited PA section of the report (report in the Behavioral Health section of the report if the prescription is for a BH condition—refer to BH Rx guidance).

Note: PA requests (including pharmacy) are not double counted and therefore a request should not appear in more than one category.

Physical Therapy: A medically prescribed Covered Service that is provided by a licensed physical therapist and identified in the Individualized Plan of Care that utilizes a variety of methods to enhance an Enrollee’s physical strength, agility, and physical capacity for ADL [activities of daily living].

Provider: Medicaid enrolled provider authorized to render the Covered Service.

Rehabilitation: Covered Service for the process of restoration of skills to an individual who has had an illness or injury to regain maximum self-sufficiency and function in a normal or near-normal manner in therapeutic, social, physical, behavioral, and vocational areas.

Skilled Nursing Facility (SNF): Covered Services rendered by a group care facility Provider as follows: Skilled Nursing care, continuous Skilled Nursing observations, restorative nursing, and other Covered Services under professional direction with frequent medical supervision, during the post-acute phase of illness or during recurrences of symptoms in long-term illness.

Speech Therapy: A medically prescribed speech or language-based Covered Service that is provided by a licensed speech therapist and identified in the Individualized Plan of Care, and that is used to evaluate or improve an Enrollee's ability to communicate.

Substance Use Prevention and Recovery (SUPR): Covered Services for subacute alcoholism and substance abuse services. Utilize prior HFS guidance for BH services: CMHC Fee Schedule Verification, MCO Billing Guidelines CMHC Services, Division of SUPR [Substance Use Prevention and Recovery] IL MCO Billing Guide for Encounter Data Reporting, Behavioral Health Combined (Mental Health and Substance Use) Drugs, Behavioral Health Mental Health Drugs, and Behavioral Health Substance Abuse Drugs.

Therapy: Covered Services including Occupational Therapy, Physical Therapy, or Speech Therapy.

Transportation: Ambulance (emergency and nonemergency), Medicar, Taxi, Service Car, Private Auto, and Other (Commercial Train, Air, and Helicopter) Covered Services. When a member/enrollee is given a “pass” that is worth a single or multiple rides (and/or days) for the bus, subway, or other vehicle, when counting the number of requests and identifying the mode of transportation, please identify the number of “passes” as opposed to the number of “rides.”