REPORT # 1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
HOSPITAL EMERGENCY ROOM UTILIZATION PER 1000 MM
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
EMERGENCY ROOM VISITS RESULTING IN INPATIENT ADMISSION					
# of ER VISITS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ER VISITS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
MATERNITY VISITS	xxxx	xxxx	xxxx	xxxx	xxxx
EMERGENCY ROOM VISITS: NO INPATIENT ADMISSION					
# of ER VISITS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ER VISITS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
MATERNITY VISITS	xxxx	xxxx	xxxx	xxxx	xxxx
TOTAL ER VISITS					
# of ER VISITS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ER VISITS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
MATERNITY VISITS	xxxx	xxxx	xxxx	xxxx	xxxx

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.
2) These beneficiary groups do not represent 100% of Acute Care members thus numbers will not tie to other UR reports.

REPORT # 7

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
SERVICE UTILIZATION
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
Total Member Months	xxxxx	xxxxx	xxxxx	xxxxx	xxxxx
# Of Unduplicated Members Enrolled in the Health Plan	xxxxx	xxxxx	xxxxx	xxxxx	xxxxx
% of Members Who Received Services	xxx	xxx	xxx	xxx	xxx
# of Services PM/PM	xxxx	xxxx	xxxx	xxxx	xxxx

NOTES: 1) Title XIX, HIFA I and HIFA Parents are included in the Acute Non-KidsCare population.

REPORT # 6

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INPATIENT HOSPITAL / CLINICS MATERNITY SERVICES UTILIZATION
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare) PART A	DUAL ELIGIBLES (With Medicare) OTHER	HIFA I	HIFA PARENT	PROP204
DELIVERY ADMISSION					
# of DELIVERIES	xxxx	xxxx	xxxx	xxxx	xxxx
# of DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DELIVERIES per 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER DEL	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER DEL	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER DEL	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
NON HOSPITAL DEL	xxx	xxx	xxx	xxx	xxx
VAGINAL DELIVERY					
# of DELIVERIES	xxxx	xxxx	xxxx	xxxx	xxxx
# of DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DELIVERIES per 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER DEL	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER DEL	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER DEL	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
CESAREAN SECTION					
# of DELIVERIES	xxxx	xxxx	xxxx	xxxx	xxxx
# of DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DELIVERIES per 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER DEL	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER DEL	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER DEL	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.
2) These beneficiary groups do not represent 100% of Acute Care members thus numbers will not tie to other UR reports.
3) Non-hospital Delivery includes deliveries in free-standing birthing centers (Provider type 83).

REPORT # 5

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
TRANSPORTATION SERVICES UTILIZATION
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
EMERGENCY TRANSPORTATION PROVIDERS					
EMERGENCY: AIR TRANSPORTATION					
# of TRIPS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
EMERGENCY: GROUND TRANSPORTATION					
# of TRIPS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
TOTAL EMERGENCY SERVICES					
# of TRIPS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
TOTAL NON-EMERGENCY SERVICES					
# of TRIPS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
EMERGENCY TRANSPORTATION PROVIDER TOTAL					
# of TRIPS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.
2) These beneficiary groups do not represent 100% of Acute Care members thus numbers will not tie to other UR reports.

REPORT # 5

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
TRANSPORTATION SERVICES UTILIZATION
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare) PART A	DUAL ELIGIBLES (With Medicare) OTHER	HIFA I	HIFA PARENT	PROP204
NON-EMERGENCY TRANSPORTATION PROVIDERS					
TAXI SERVICES					
# of TRIPS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
BUS SERVICES					
# of TRIPS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
VAN SERVICES					
# of TRIPS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AIR TAXI SERVICES					
# of TRIPS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
NON-EMERGENCY TRANSPORTATION PROVIDER TOTAL					
# of TRIPS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00	$$$$$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.
2) These beneficiary groups do not represent 100% of Acute Care members thus numbers will not tie to other UR reports.

REPORT # 4

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DENTAL SERVICES UTILIZATION
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
PREVENTATIVE SERVICES					
# of SERVICES	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TREATMENT					
# of SERVICES	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TOTAL DENTAL SERVICES					
# OF SERVICES	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.
2) These beneficiary groups do not represent 100% of Acute Care members thus numbers will not tie to other UR reports.

REPORT # 3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INPATIENT HOSPITAL STATISTICS by TIER
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
ICU / ROUTINE					
Excluding Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TOTAL ICU/ROUTINE					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.
2) These beneficiary groups do not represent 100% of Acute Care members thus numbers will not tie to other UR reports.

REPORT # 3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INPATIENT HOSPITAL STATISTICS by TIER
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
ICU / PSYCHIATRIC					
Excluding Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TOTAL ICU/PSYCHIATRIC					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.
2) These beneficiary groups do not represent 100% of Acute Care members thus numbers will not tie to other UR reports.

REPORT # 3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INPATIENT HOSPITAL STATISTICS by TIER
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
ICU / SURGERY					
Excluding Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TOTAL ICU/SURGERY					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.
2) These beneficiary groups do not represent 100% of Acute Care members thus numbers will not tie to other UR reports.

REPORT # 3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INPATIENT HOSPITAL STATISTICS by TIER
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
NICU / NURSERY					
Excluding Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TOTAL NICU/NURSERY					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.
2) These beneficiary groups do not represent 100% of Acute Care members thus numbers will not tie to other UR reports.

REPORT # 3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INPATIENT HOSPITAL STATISTICS by TIER
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
ROUTINE					
Excluding Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TOTAL ROUTINE					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.
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REPORT # 3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INPATIENT HOSPITAL STATISTICS by TIER
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
NURSERY					
Excluding Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TOTAL NURSERY					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

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REPORT # 3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INPATIENT HOSPITAL STATISTICS by TIER
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
PSYCHIATRIC					
Excluding Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TOTAL PSYCHIATRIC					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.
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REPORT # 3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INPATIENT HOSPITAL STATISTICS by TIER
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
SURGERY					
Excluding Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TOTAL SURGERY					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

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REPORT # 3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INPATIENT HOSPITAL STATISTICS by TIER
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare) PART A	DUAL ELIGIBLES (With Medicare) OTHER	HIFA I	HIFA PARENT	PROP204
ICU					
Excluding Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TOTAL ICU					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

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REPORT # 3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INPATIENT HOSPITAL STATISTICS by TIER
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare) PART A	DUAL ELIGIBLES (With Medicare) OTHER	HIFA I	HIFA PARENT	PROP204
NICU					
Excluding Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TOTAL NICU					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

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REPORT # 3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INPATIENT HOSPITAL STATISTICS by TIER
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
MATERNITY					
Excluding Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
Qualified Outlier Totals for the Tier					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TOTAL MATERNITY					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF TIER DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

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REPORT # 2

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
OUTPATIENT HOSPITAL VISITS PER 1000 MM
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
I. OUTPATIENT VISITS RESULTING IN INPATIENT ADMISSION					
# of ADMITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# OF DAYS	xxxx	xxxx	xxxx	xxxx	xxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
ALOS	xxx	xxx	xxx	xxx	xxx
# of DAYS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER ADMIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
II. OUTPATIENT VISITS: NO INPATIENT ADMISSION					
EMERGENCY ROOM VISITS					
# of VISITS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of VISITS PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER VISIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER VISIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER VISIT	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
CLINIC SERVICES					
# OF SERVICES	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
SURGERY					
# of SURGERIES	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

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REPORT # 2

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
OUTPATIENT HOSPITAL VISITS PER 1000 MM
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
OBSERVATION SERVICES					
# OF SERVICES	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
RADIOLOGY SERVICES					
# OF SERVICES	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
LABORATORY SERVICES					
# OF LAB TESTS	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
THERAPEUTIC SERVICES					
# OF SERVICES	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
DIAGNOSTIC SERVICES					
# Of SERVICES	xxxx	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

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REPORT # 2

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
OUTPATIENT HOSPITAL VISITS PER 1000 MM
CONTRACT YEAR XX-XX
BENEFICIARY GROUPS

XXXXXX Health Plan Name

	DUAL ELIGIBLES (With Medicare)		HIFA I	HIFA PARENT	PROP204
	PART A	OTHER			
ALL OTHER SERVICES					
# Of SERVICES	xxxx	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
TOTAL OUTPATIENT VISITS: NO INPATIENT ADMISSION					
# OF SERVICES	xxxx	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
III. TOTAL OUTPATIENT VISITS					
# OF SERVICES	xxxx	xxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
MEMBER MONTHS	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx
# of SERVICES PER 1000 MM	xxx	xxx	xxx	xxx	xxx
AVG HEALTH PLAN PMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG AHCCCS ALLOWED AMT PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00
AVG BILLED CHARGES PER SVC	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00	$$$$$$.00

NOTES: 1) Dual Eligibles cross over beneficiary groups and other program (ALTCS), thus not mutually exclusive; all other beneficiary groups are mutually exclusive.
2) These beneficiary groups do not represent 100% of Acute Care members thus numbers will not tie to other UR reports.