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REFERENCE TITLE: AHCCCS; outpatient hospital; reimbursement

State of Arizona  
Senate  
Forty-sixth Legislature  
Second Regular Session  
2004

## **SB 1165**

Introduced by  
Senators Allen, Cannell R

AN ACT

AMENDING SECTION 36-2903.01, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 36-2903.01, Arizona Revised Statutes, is amended to  
3 read:

4 36-2903.01. Additional powers and duties

5 A. The director of the Arizona health care cost containment system  
6 administration may adopt rules that provide that the system may withhold or  
7 forfeit payments to be made to a noncontracting provider by the system if the  
8 noncontracting provider fails to comply with this article, the provider  
9 agreement or rules that are adopted pursuant to this article and that relate  
10 to the specific services rendered for which a claim for payment is made.

11 B. The director shall:

12 1. Prescribe uniform forms to be used by all contractors. The rules  
13 shall require a written and signed application by the applicant or an  
14 applicant's authorized representative, or, if the person is incompetent or  
15 incapacitated, a family member or a person acting responsibly for the  
16 applicant may obtain a signature or a reasonable facsimile and file the  
17 application as prescribed by the administration.

18 2. Enter into an interagency agreement with the department to  
19 establish a streamlined eligibility process to determine the eligibility of  
20 all persons defined pursuant to section 36-2901, paragraph 6, subdivision  
21 (a). At the administration's option, the interagency agreement may allow the  
22 administration to determine the eligibility of certain persons including  
23 those defined pursuant to section 36-2901, paragraph 6, subdivision (a).

24 3. Enter into an intergovernmental agreement with the department to:

25 (a) Establish an expedited eligibility and enrollment process for all  
26 persons who are hospitalized at the time of application.

27 (b) Establish performance measures and incentives for the department.

28 (c) Establish the process for management evaluation reviews that the  
29 administration shall perform to evaluate the eligibility determination  
30 functions performed by the department.

31 (d) Establish eligibility quality control reviews by the  
32 administration.

33 (e) Require the department to adopt rules, consistent with the rules  
34 adopted by the administration for a hearing process, that applicants or  
35 members may use for appeals of eligibility determinations or  
36 redeterminations.

37 (f) Establish the department's responsibility to place sufficient  
38 eligibility workers at federally qualified health centers to screen for  
39 eligibility and at hospital sites and level one trauma centers to ensure that  
40 persons seeking hospital services are screened on a timely basis for  
41 eligibility for the system, including a process to ensure that applications  
42 for the system can be accepted on a twenty-four hour basis, seven days a  
43 week.

1 (g) Withhold payments based on the allowable sanctions for errors in  
2 eligibility determinations or redeterminations or failure to meet performance  
3 measures required by the intergovernmental agreement.

4 (h) Recoup from the department all federal fiscal sanctions that  
5 result from the department's inaccurate eligibility determinations. The  
6 director may offset all or part of a sanction if the department submits a  
7 corrective action plan and a strategy to remedy the error.

8 4. By rule establish a procedure and time frames for the intake of  
9 grievances and requests for hearings, for the continuation of benefits and  
10 services during the appeal process and for a grievance process at the  
11 contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and  
12 41-1092.05, the administration shall develop rules to establish the procedure  
13 and time frame for the informal resolution of grievances and appeals. A  
14 grievance that is not related to a claim for payment of system covered  
15 services shall be filed in writing with and received by the administration or  
16 the prepaid capitated provider or program contractor not later than sixty  
17 days after the date of the adverse action, decision or policy implementation  
18 being grieved. A grievance that is related to a claim for payment of system  
19 covered services must be filed in writing and received by the administration  
20 or the prepaid capitated provider or program contractor within twelve months  
21 after the date of service, within twelve months after the date that  
22 eligibility is posted or within sixty days after the date of the denial of a  
23 timely claim submission, whichever is later. A grievance for the denial of a  
24 claim for reimbursement of services may contest the validity of any adverse  
25 action, decision, policy implementation or rule that related to or resulted  
26 in the full or partial denial of the claim. A policy implementation may be  
27 subject to a grievance procedure, but it may not be appealed for a hearing.  
28 The administration is not required to participate in a mandatory settlement  
29 conference if it is not a real party in interest. In any proceeding before  
30 the administration, including a grievance or hearing, persons may represent  
31 themselves or be represented by a duly authorized agent who is not charging a  
32 fee. A legal entity may be represented by an officer, partner or employee  
33 who is specifically authorized by the legal entity to represent it in the  
34 particular proceeding.

35 5. Apply for and accept federal funds available under title XIX of the  
36 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section  
37 1396 (1980)) in support of the system. The application made by the director  
38 pursuant to this paragraph shall be designed to qualify for federal funding  
39 primarily on a prepaid capitated basis. Such funds may be used only for the  
40 support of persons defined as eligible pursuant to title XIX of the social  
41 security act or the approved section 1115 waiver.

42 6. At least thirty days before the implementation of a policy or a  
43 change to an existing policy relating to reimbursement, provide notice to  
44 interested parties. Parties interested in receiving notification of policy

1 changes shall submit a written request for notification to the  
2 administration.

3 C. The director is authorized to apply for any federal funds available  
4 for the support of programs to investigate and prosecute violations arising  
5 from the administration and operation of the system. Available state funds  
6 appropriated for the administration and operation of the system may be used  
7 as matching funds to secure federal funds pursuant to this subsection.

8 D. The director may adopt rules or procedures to do the following:

9 1. Authorize advance payments based on estimated liability to a  
10 contractor or a noncontracting provider after the contractor or  
11 noncontracting provider has submitted a claim for services and before the  
12 claim is ultimately resolved. The rules shall specify that any advance  
13 payment shall be conditioned on the execution before payment of a contract  
14 with the contractor or noncontracting provider that requires the  
15 administration to retain a specified percentage, which shall be at least  
16 twenty per cent, of the claimed amount as security and that requires  
17 repayment to the administration if the administration makes any overpayment.

18 2. Defer liability, in whole or in part, of contractors for care  
19 provided to members who are hospitalized on the date of enrollment or under  
20 other circumstances. Payment shall be on a capped fee-for-service basis for  
21 services other than hospital services and at the rate established pursuant to  
22 subsection G or H of this section for hospital services or at the rate paid  
23 by the health plan, whichever is less.

24 3. Deputize, in writing, any qualified officer or employee in the  
25 administration to perform any act that the director by law is empowered to do  
26 or charged with the responsibility of doing, including the authority to issue  
27 final administrative decisions pursuant to section 41-1092.08.

28 4. Notwithstanding any other law, require persons eligible pursuant to  
29 section 36-2901, paragraph 6, subdivision (a), section 36-2931, paragraph 5  
30 and section 36-2981, paragraph 6, and before July 1, 2004, pursuant to  
31 section 36-2981.01 to be financially responsible for any cost sharing  
32 requirements established in a state plan or a section 1115 waiver and  
33 approved by the centers for medicare and medicaid services. Cost sharing  
34 requirements may include copayments, coinsurance, deductibles, enrollment  
35 fees and monthly premiums for enrolled members, including households with  
36 children enrolled in the Arizona long-term care system.

37 E. The director shall adopt rules ~~which~~ THAT further specify the  
38 medical care and hospital services ~~which~~ THAT are covered by the system  
39 pursuant to section 36-2907.

40 F. In addition to the rules otherwise specified in this article, the  
41 director may adopt necessary rules pursuant to title 41, chapter 6 to carry  
42 out this article. Rules adopted by the director pursuant to this subsection  
43 shall consider the differences between rural and urban conditions on the  
44 delivery of hospitalization and medical care.

1 G. For inpatient hospital admissions and all outpatient hospital  
2 services before March 1, 1993, the administration shall reimburse a  
3 hospital's adjusted billed charges according to the following procedures:

4 1. The director shall adopt rules that, for services rendered from and  
5 after September 30, 1985 until October 1, 1986, define "adjusted billed  
6 charges" as that reimbursement level that has the effect of holding constant  
7 whichever of the following is applicable:

8 (a) The schedule of rates and charges for a hospital in effect on  
9 April 1, 1984 as filed pursuant to chapter 4, article 3 of this title.

10 (b) The schedule of rates and charges for a hospital that became  
11 effective after May 31, 1984 but before July 2, 1984, if the hospital's  
12 previous rate schedule became effective before April 30, 1983.

13 (c) The schedule of rates and charges for a hospital that became  
14 effective after May 31, 1984 but before July 2, 1984, limited to five per  
15 cent over the hospital's previous rate schedule, and if the hospital's  
16 previous rate schedule became effective on or after April 30, 1983 but before  
17 October 1, 1983. For the purposes of this paragraph, "constant" means equal  
18 to or lower than.

19 2. The director shall adopt rules that, for services rendered from and  
20 after September 30, 1986, define "adjusted billed charges" as that  
21 reimbursement level that has the effect of increasing by four per cent a  
22 hospital's reimbursement level in effect on October 1, 1985 as prescribed in  
23 paragraph 1 of this subsection. Beginning January 1, 1991, the Arizona  
24 health care cost containment system administration shall define "adjusted  
25 billed charges" as the reimbursement level determined pursuant to this  
26 section, increased by two and one-half per cent.

27 3. In no event shall a hospital's adjusted billed charges exceed the  
28 hospital's schedule of rates and charges filed with the department of health  
29 services and in effect pursuant to chapter 4, article 3 of this title.

30 4. For services rendered the administration shall not pay a hospital's  
31 adjusted billed charges in excess of the following:

32 (a) If the hospital's bill is paid within thirty days of the date the  
33 bill was received, eighty-five per cent of the adjusted billed charges.

34 (b) If the hospital's bill is paid any time after thirty days but  
35 within sixty days of the date the bill was received, ninety-five per cent of  
36 the adjusted billed charges.

37 (c) If the hospital's bill is paid any time after sixty days of the  
38 date the bill was received, one hundred per cent of the adjusted billed  
39 charges.

40 5. The director shall define by rule the method of determining when a  
41 hospital bill will be considered received and when a hospital's billed  
42 charges will be considered paid. Payment received by a hospital from the  
43 administration pursuant to this subsection or from a contractor either by  
44 contract or pursuant to section 36-2904, subsection I shall be considered  
45 payment of the hospital bill in full, except that a hospital may collect any

1 unpaid portion of its bill from other third party payors or in situations  
2 covered by title 33, chapter 7, article 3.

3 H. For inpatient hospital admissions and outpatient hospital services  
4 on and after March 1, 1993 the administration shall adopt rules for the  
5 reimbursement of hospitals according to the following procedures:

6 1. For inpatient hospital stays, the administration shall use a  
7 prospective tiered per diem methodology, using hospital peer groups if  
8 analysis shows that cost differences can be attributed to independently  
9 definable features that hospitals within a peer group share. In peer  
10 grouping the administration may consider such factors as length of stay  
11 differences and labor market variations. If there are no cost differences,  
12 the administration shall implement a stop loss-stop gain or similar  
13 mechanism. Any stop loss-stop gain or similar mechanism shall ensure that  
14 the tiered per diem rates assigned to a hospital do not represent less than  
15 ninety per cent of its 1990 base year costs or more than one hundred ten per  
16 cent of its 1990 base year costs, adjusted by an audit factor, during the  
17 period of March 1, 1993 through September 30, 1994. The tiered per diem  
18 rates set for hospitals shall represent no less than eighty-seven and  
19 one-half per cent or more than one hundred twelve and one-half per cent of  
20 its 1990 base year costs, adjusted by an audit factor, from October 1, 1994  
21 through September 30, 1995 and no less than eighty-five per cent or more than  
22 one hundred fifteen per cent of its 1990 base year costs, adjusted by an  
23 audit factor, from October 1, 1995 through September 30, 1996. For the  
24 periods after September 30, 1996 no stop loss-stop gain or similar mechanisms  
25 shall be in effect. An adjustment in the stop loss-stop gain percentage may  
26 be made to ensure that total payments do not increase as a result of this  
27 provision. If peer groups are used the administration shall establish  
28 initial peer group designations for each hospital before implementation of  
29 the per diem system. The administration may also use a negotiated rate  
30 methodology. The tiered per diem methodology may include separate  
31 consideration for specialty hospitals that limit their provision of services  
32 to specific patient populations, such as rehabilitative patients or children.  
33 The initial per diem rates shall be based on hospital claims and encounter  
34 data for dates of service November 1, 1990 through October 31, 1991 and  
35 processed through May of 1992.

36 2. For rates effective on October 1, 1994, and annually thereafter,  
37 the administration shall adjust THE tiered per diem payments for inpatient  
38 hospital care by the data resources incorporated market basket index for  
39 prospective payment system hospitals. For rates effective beginning on  
40 October 1, 1999, the administration shall adjust payments to reflect changes  
41 in length of stay for the maternity and nursery tiers.

42 3. THROUGH JUNE 30, 2004, for outpatient hospital services, the  
43 administration shall reimburse a hospital by applying a hospital specific  
44 outpatient cost-to-charge ratio to the covered charges. BEGINNING ON JULY 1,  
45 2004 THROUGH DECEMBER 31, 2004, THE ADMINISTRATION SHALL REDUCE EACH

1 HOSPITAL'S SPECIFIC OUTPATIENT COST-TO-CHARGE RATIO BY TEN PER CENT AND  
2 REIMBURSE CLEAN CLAIMS WITH DATES OF SERVICE ON OR AFTER JULY 1, 2004 BASED  
3 ON THIS ADJUSTMENT. THE ADMINISTRATION SHALL DEVELOP A METHODOLOGY FOR A  
4 CAPPED FEE-FOR-SERVICE SCHEDULE. ANY COVERED OUTPATIENT HOSPITAL SERVICE NOT  
5 INCLUDED IN THE CAPPED FEE-FOR-SERVICE SCHEDULE SHALL BE REIMBURSED BY  
6 APPLYING THE COST-TO-CHARGE RATIO THAT IS BASED ON THE SERVICES NOT INCLUDED  
7 IN THE STATEWIDE FEE SCHEDULE AND THEN REDUCING THE CALCULATION BY TEN PER  
8 CENT. BEGINNING ON JANUARY 1, 2005, THE ADMINISTRATION SHALL REIMBURSE CLEAN  
9 CLAIMS WITH DATES OF SERVICE ON OR AFTER JANUARY 1, 2005 BASED ON THE CAPPED  
10 FEE-FOR-SERVICE SCHEDULE OR THE STATEWIDE COST-TO-CHARGE RATIO DEVELOPED  
11 PURSUANT TO THIS PARAGRAPH.

12 4. Except if submitted under an electronic claims submission system, a  
13 hospital bill is considered received for purposes of this paragraph on  
14 initial receipt of the legible, error-free claim form by the administration  
15 if the claim includes the following error-free documentation in legible form:

- 16 (a) An admission face sheet.
- 17 (b) An itemized statement.
- 18 (c) An admission history and physical.
- 19 (d) A discharge summary or an interim summary if the claim is split.
- 20 (e) An emergency record, if admission was through the emergency room.
- 21 (f) Operative reports, if applicable.
- 22 (g) A labor and delivery room report, if applicable.

23 Payment received by a hospital from the administration pursuant to this  
24 subsection or from a contractor either by contract or pursuant to section  
25 36-2904, subsection ~~J~~ I is considered payment by the administration or the  
26 contractor of the administration's or contractor's liability for the hospital  
27 bill. A hospital may collect any unpaid portion of its bill from other third  
28 party payors or in situations covered by title 33, chapter 7, article 3.

29 5. For services rendered on and after October 1, 1997, the  
30 administration shall pay a hospital's rate established according to this  
31 section subject to the following:

32 (a) If the hospital's bill is paid within thirty days of the date the  
33 bill was received, the administration shall pay ninety-nine per cent of the  
34 rate.

35 (b) If the hospital's bill is paid after thirty days but within sixty  
36 days of the date the bill was received, the administration shall pay one  
37 hundred per cent of the rate.

38 (c) If the hospital's bill is paid any time after sixty days of the  
39 date the bill was received, the administration shall pay one hundred per cent  
40 of the rate plus a fee of one per cent per month for each month or portion of  
41 a month following the sixtieth day of receipt of the bill until the date of  
42 payment.

43 6. In developing the reimbursement methodology, if a review of the  
44 reports filed by a hospital pursuant to section 36-125.04 indicates that  
45 further investigation is considered necessary to verify the accuracy of the

1 information in the reports, the administration may examine the hospital's  
2 records and accounts related to the reporting requirements of section  
3 36-125.04. The administration shall bear the cost incurred in connection  
4 with this examination unless the administration finds that the records  
5 examined are significantly deficient or incorrect, in which case the  
6 administration may charge the cost of the investigation to the hospital  
7 examined.

8 7. Except for privileged medical information, the administration shall  
9 make available for public inspection the cost and charge data and the  
10 calculations used by the administration to determine payments under the  
11 tiered per diem system, provided that individual hospitals are not identified  
12 by name. The administration shall make the data and calculations available  
13 for public inspection during regular business hours and shall provide copies  
14 of the data and calculations to individuals requesting such copies within  
15 thirty days of receipt of a written request. The administration may charge a  
16 reasonable fee for the provision of the data or information.

17 8. The prospective tiered per diem payment methodology for inpatient  
18 hospital services shall include a mechanism for the prospective payment of  
19 inpatient hospital capital related costs. The capital payment shall include  
20 hospital specific and statewide average amounts. For tiered per diem rates  
21 beginning on October 1, 1999, the capital related cost component is frozen at  
22 the blended rate of forty per cent of the hospital specific capital cost and  
23 sixty per cent of the statewide average capital cost in effect as of January  
24 1, 1999 and as further adjusted by the calculation of tier rates for  
25 maternity and nursery as prescribed by law. The administration shall adjust  
26 the capital related cost component by the data resources incorporated market  
27 basket index for prospective payment system hospitals.

28 9. Beginning September 30, 1997, the administration shall establish a  
29 separate graduate medical education program to reimburse hospitals that had  
30 graduate medical education programs that were approved by the administration  
31 as of October 1, 1999. The administration shall separately account for  
32 monies for the graduate medical education program based on the total  
33 reimbursement for graduate medical education reimbursed to hospitals by the  
34 system in federal fiscal year 1995-1996 pursuant to the tiered per diem  
35 methodology specified in this section. The graduate medical education  
36 program reimbursement shall be adjusted annually by the increase or decrease  
37 in the index published by the data resources incorporated hospital market  
38 basket index for prospective hospital reimbursement. Subject to legislative  
39 appropriation, on an annual basis, each qualified hospital shall receive a  
40 single payment from the graduate medical education program that is equal to  
41 the same percentage of graduate medical education reimbursement that was paid  
42 by the system in federal fiscal year 1995-1996. Any reimbursement for  
43 graduate medical education made by the administration shall not be subject to  
44 future settlements or appeals by the hospitals to the administration.

1           10. The prospective tiered per diem payment methodology for inpatient  
2 hospital services may include a mechanism for the payment of claims with  
3 extraordinary operating costs per day. For tiered per diem rates effective  
4 beginning on October 1, 1999, outlier cost thresholds are frozen at the  
5 levels in effect on January 1, 1999 and adjusted annually by the  
6 administration by the data resources incorporated market basket index for  
7 prospective payment system hospitals.

8           11. Notwithstanding section 41-1005, subsection A, paragraph 9, the  
9 administration shall adopt rules pursuant to title 41, chapter 6 establishing  
10 the methodology for determining the prospective tiered per diem payments **AND**  
11 **REIMBURSEMENT FOR OUTPATIENT HOSPITAL SERVICES**.

12           I. The director may adopt rules that specify enrollment procedures  
13 including notice to contractors of enrollment. The rules may provide for  
14 varying time limits for enrollment in different situations. The  
15 administration shall specify in contract when a person who has been  
16 determined eligible will be enrolled with that contractor and the date on  
17 which the contractor will be financially responsible for health and medical  
18 services to the person.

19           J. The administration may make direct payments to hospitals for  
20 hospitalization and medical care provided to a member in accordance with this  
21 article and rules. The director may adopt rules to establish the procedures  
22 by which the administration shall pay hospitals pursuant to this subsection  
23 if a contractor fails to make timely payment to a hospital. Such payment  
24 shall be at a level determined pursuant to section 36-2904, subsection ~~I~~ H  
25 or ~~J~~ I. The director may withhold payment due to a contractor in the amount  
26 of any payment made directly to a hospital by the administration on behalf of  
27 a contractor pursuant to this subsection.

28           K. The director shall establish a special unit within the  
29 administration for the purpose of monitoring the third party payment  
30 collections required by contractors and noncontracting providers pursuant to  
31 section 36-2903, subsection B, paragraph 10 and subsection F and section  
32 36-2915, subsection E. The director shall determine by rule:

33           1. The type of third party payments to be monitored pursuant to this  
34 subsection.

35           2. The percentage of third party payments that is collected by a  
36 contractor or noncontracting provider and that the contractor or  
37 noncontracting provider may keep and the percentage of such payments that the  
38 contractor or noncontracting provider may be required to pay to the  
39 administration. Contractors and noncontracting providers must pay to the  
40 administration one hundred per cent of all third party payments that are  
41 collected and that duplicate administration fee-for-service payments. A  
42 contractor that contracts with the administration pursuant to section  
43 36-2904, subsection A may be entitled to retain a percentage of third party  
44 payments if the payments collected and retained by a contractor are reflected  
45 in reduced capitation rates. A contractor may be required to pay the

1 administration a percentage of third party payments that are collected by a  
2 contractor and that are not reflected in reduced capitation rates.

3 L. On oral or written notice from the patient that the patient  
4 believes the claims to be covered by the system, a contractor or  
5 noncontracting provider of health and medical services prescribed in section  
6 36-2907 shall not do either of the following unless the contractor or  
7 noncontracting provider has verified through the administration that the  
8 person has been determined ineligible, has not yet been determined eligible  
9 or was not, at the time services were rendered, eligible or enrolled:

10 1. Charge, submit a claim to or demand or otherwise collect payment  
11 from a member or person who has been determined eligible unless specifically  
12 authorized by this article or rules adopted pursuant to this article.

13 2. Refer or report a member or person who has been determined eligible  
14 to a collection agency or credit reporting agency for the failure of the  
15 member or person who has been determined eligible to pay charges for system  
16 covered care or services unless specifically authorized by this article or  
17 rules adopted pursuant to this article.

18 M. The administration may conduct postpayment review of all claims  
19 paid by the administration and may recoup any monies erroneously paid. The  
20 director may adopt rules that specify procedures for conducting postpayment  
21 review. A contractor may conduct a postpayment review of all claims paid by  
22 the contractor and may recoup monies that are erroneously paid.

23 N. The director or the director's designee may employ and supervise  
24 personnel necessary to assist the director in performing the functions of the  
25 administration.

26 O. The administration may contract with contractors for obstetrical  
27 care who are eligible to provide services under title XIX of the social  
28 security act.

29 P. Notwithstanding any law to the contrary, on federal approval the  
30 administration may make disproportionate share payments to private hospitals,  
31 county operated hospitals, including hospitals owned or leased by a special  
32 health care district, and state operated institutions for mental disease  
33 beginning October 1, 1991 in accordance with federal law and subject to  
34 legislative appropriation. If at any time the administration receives  
35 written notification from federal authorities of any change or difference in  
36 the actual or estimated amount of federal funds available for  
37 disproportionate share payments from the amount reflected in the legislative  
38 appropriation for such purposes, the administration shall provide written  
39 notification of such change or difference to the president and the minority  
40 leader of the senate, the speaker and the minority leader of the house of  
41 representatives, the director of the joint legislative budget committee, the  
42 legislative committee of reference and any hospital trade association within  
43 this state, within three working days not including weekends after receipt of  
44 the notice of the change or difference. In calculating disproportionate  
45 share payments as prescribed in this section, the administration may use

1 either a methodology based on claims and encounter data that is submitted to  
2 the administration from contractors or a methodology based on data that is  
3 reported to the administration by private hospitals and state operated  
4 institutions for mental disease. The selected methodology applies to all  
5 private hospitals and state operated institutions for mental disease  
6 qualifying for disproportionate share payments.

7 Q. Notwithstanding any law to the contrary, the administration may  
8 receive confidential adoption information to determine whether an adopted  
9 child should be terminated from the system.

10 R. The adoption agency or the adoption attorney shall notify the  
11 administration within thirty days after an eligible person receiving services  
12 has placed that person's child for adoption.

13 S. If the administration implements an electronic claims submission  
14 system it may adopt procedures pursuant to subsection H of this section  
15 requiring documentation different than prescribed under subsection H,  
16 paragraph 4 of this section.

17 Sec. 2. Exemption from rule making

18 A. For the purposes of this act, the Arizona health care cost  
19 containment system administration is exempt from the rule making requirements  
20 of title 41, chapter 6, Arizona Revised Statutes, for one year after the  
21 effective date of this act.

22 B. The administration shall hold at least one public hearing in a  
23 rural county and in an urban county before adopting rules pursuant to this  
24 act.

25 Sec. 3. Emergency

26 This act is an emergency measure that is necessary to preserve the  
27 public peace, health or safety and is operative immediately as provided by  
28 law.