LEGISLATURE OF THE STATE OF IDAHO

Sixty-eighth Legislature First Regular Session - 2025

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 345

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO LEGISLATIVE APPROVAL FOR MEDICAID STATE PLAN AMENDMENTS AND WAIVERS; REPEALING SECTION 56-270, IDAHO CODE, AS ENACTED BY SECTION 1, CHAPTER 288, LAWS OF 2024, RELATING TO LEGISLATIVE APPROVAL OF WAIVERS AND STATE PLAN AMENDMENTS; AMENDING TITLE 56, IDAHO CODE, BY THE ADDITION OF A NEW CHAPTER 22, TITLE 56, IDAHO CODE, TO PROVIDE THAT LEGISLATIVE APPROVAL IS REQUIRED FOR CERTAIN STATE PLAN AMENDMENTS AND WAIVERS, TO PROVIDE LEGISLATIVE APPROVAL FOR A STATE PLAN AMENDMENT REGARDING RURAL EMERGENCY HOSPITAL DESIGNATION, TO PROVIDE LEGISLATIVE APPROVAL FOR A STATE PLAN AMENDMENT REGARDING MEDICAID COST-SHARING, TO PROVIDE LEGISLATIVE APPROVAL FOR STATE PLAN AMENDMENTS AND WAIVERS REGARDING COMPREHENSIVE MEDICAID MANAGED CARE, TO PROVIDE LEGISLATIVE APPROVAL FOR STATE PLAN AMENDMENTS AND WAIVERS REGARDING MEDICAID EXPANSION LIMITS, TO PROVIDE LEGISLATIVE APPROVAL FOR A STATE PLAN AMENDMENT REGARDING PRACTICE AUTHORITY PROTECTION, AND TO PROVIDE LEGISLATIVE APPROVAL FOR A STATE PLAN AMENDMENT REGARDING SITE NEUTRAL PAYMENTS; REPEALING SECTION 56-253, IDAHO CODE, RELATING TO POWERS AND DUTIES OF THE DIRECTOR; AMENDING SECTION 56-263, IDAHO CODE, TO REMOVE OBSOLETE LANGUAGE AND TO PROVIDE THAT THE DEPARTMENT OF HEALTH AND WELFARE SHALL DISCONTINUE CERTAIN CONTRACTING AND REIMBURSEMENT; AMENDING SECTION 56-265, IDAHO CODE, TO PROVIDE THAT FEDERALLY QUALIFIED HEALTH CENTERS SHALL BE EXEMPT FROM FINANCIAL RISK IN CERTAIN PAYMENT ARRANGEMENTS; AMENDING SECTION 56-267, IDAHO CODE, TO REVISE PROVISIONS REGARDING ELIGIBILITY EXPANSION; AMENDING SECTION 56-1403, IDAHO CODE, TO REVISE PROVISIONS REGARDING THE HOSPITAL ASSESSMENT FUND; AMENDING SECTION 56-1404, IDAHO CODE, TO REVISE PROVISIONS REGARDING THE UPPER PAYMENT LIMIT ASSESSMENT RATE; PROVIDING THAT CERTAIN ADMINISTRATIVE RULES CONTAINED IN IDAPA 16.03.17 SHALL BE NULL, VOID, AND OF NO FORCE AND EFFECT; PROVIDING THAT CERTAIN ADMINISTRATIVE RULES CONTAINED IN IDAPA 16.03.18 SHALL BE NULL, VOID, AND OF NO FORCE AND EFFECT; PROVIDING THAT CERTAIN ADMINISTRATIVE RULES CONTAINED IN IDAPA 16.03.09 SHALL BE NULL, VOID, AND OF NO FORCE AND EFFECT; PROVIDING THAT CERTAIN ADMINISTRATIVE RULES CONTAINED IN IDAPA 16.03.10 SHALL BE NULL, VOID, AND OF NO FORCE AND EFFECT; AND DECLARING AN EMERGENCY.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 56-270, Idaho Code, as enacted by Section 1, Chapter 288, Laws of 2024, be, and the same is hereby repealed.

SECTION 2. That Title 56, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW CHAPTER, to be known and designated as Chapter 22, Title 56, Idaho Code, and to read as follows:

CHAPTER 22

LEGISLATIVE APPROVAL FOR MEDICAID STATE PLAN AMENDMENTS AND WAIVERS

56-2201. LEGISLATIVE APPROVAL REQUIRED. Notwithstanding any provision of law to the contrary, the state department of health and welfare shall not seek or implement a medicaid state plan amendment or a waiver pursuant to section 1115 or 1915 of the social security act that would expand coverage to any additional individuals or class of individuals or would increase any net cost to the state without first obtaining approval from the legislature. Such approval must be provided in statute and, to be effective, must be listed in this chapter. The provisions of this section shall not affect any state plan amendment or waiver program previously authorized by statute or already implemented as of July 1, 2025. The provisions of this section shall not apply to any medicaid state plan amendment or waiver program that does not expand coverage to any individuals or class of individuals and does not increase any net cost to the state. The department of health and welfare shall provide regular updates to the medicaid legislative review panel on a schedule determined by the cochairs and shall seek input from the medicaid legislative review panel to design any waivers submitted to the centers for medicare and medicaid services on behalf of the state.

56-2202. LEGISLATIVE APPROVAL -- RURAL EMERGENCY HOSPITAL DESIGNATION AND REIMBURSEMENT. The department of health and welfare is authorized to and shall submit a state plan amendment to the centers for medicare and medicaid services allowing the recognition and reimbursement of medicaid services provided by a rural emergency hospital. For the purposes of this section, "rural emergency hospital" has the same meaning as provided in 42 U.S.C. 1395x(kkk)(2).

56-2203. LEGISLATIVE APPROVAL -- MEDICAID COST-SHARING. (1) The department of health and welfare is authorized to and shall submit a state plan amendment to the centers for medicare and medicaid services to include participant cost-sharing as a condition of participation in a medical assistance program, to the extent allowed under federal law, that is at least to the levels developed by other states and up to the maximum charged by other states.

(2) The department of health and welfare shall:

(a) Take such actions as are necessary to implement the provisions of this section;

(b) Begin the application process for federal approval of the state plan amendment required by this section no later than July 1, 2026; and

(c) Continue any existing cost-sharing under the medicaid state plan in effect at the time of the passage of this act until supplanted by the new state plan amendment required by this section.

56-2204. LEGISLATIVE APPROVAL -- COMPREHENSIVE MEDICAID MANAGED CARE. (1) The department of health and welfare is authorized to and shall submit to the centers for medicare and medicaid services all state plan and waiver authorities required to implement a plan for comprehensive medicaid managed care.

(2) The department of health and welfare shall:

(a) Take such actions as are necessary to implement the provisions of this section;
(b) Submit the application for federal approval of the state plan amendments and waivers required by this section no later than July 1, 2026;
(c) Continue any existing managed care under the medicaid state plan and its waivers in effect at the time of the passage of this act until supplanted by the new comprehensive managed care plan required under this section;
(d) Undertake cost containment strategies, such as bidding multi-year contracts with predetermined inflationary adjustments or withholding a percentage of capitation if managed care organizations do not meet these cost containment targets; and
(e) Engage medicaid providers and participants in the substance and design of a comprehensive managed care plan.

56-2205. LEGISLATIVE APPROVAL -- MEDICAID EXPANSION LIMITS. (1) The department of health and welfare is authorized to and shall submit to the centers for medicare and medicaid services the following state plan amendments and waivers no later than July 1, 2026:
(a) Work-requirements for able-bodied adults enrolled in medicaid in which no individual shall be eligible to participate in the medicaid program pursuant to section 56-267, Idaho Code, unless the individual is:
(i) Working twenty (20) hours or more per week, averaged monthly;
(ii) Participating in and complying with the requirements of a work program twenty (20) hours or more per week, as determined by the department;
(iii) Volunteering twenty (20) hours or more per week, as determined by the department;
(iv) Meeting any combination of working and participating in a work program for a total of twenty (20) hours or more per week, as determined by the department; or
(v) Participating and complying with the requirements of a workfare program, unless the individual is:
1. Younger than nineteen (19) years of age;
2. Older than sixty-four (64) years of age;
3. Medically classified as physically or mentally unfit for employment;
4. Pregnant;
5. A parent or caretaker responsible for the care of a dependent child younger than six (6) years of age;
6. A parent or caretaker personally providing the care for a dependent with a serious medical condition or with a disability, as determined by the department;
7. Receiving unemployment compensation and complying with the work requirements as part of the federal-state unemployment compensation system;
8. Participating in a drug addiction or alcohol treatment and rehabilitation program; or

9. Enrolled at least part-time in a college, university, or vocational education program.

(b) Allow persons eligible for medicaid under section 56-267, Idaho Code, who have a modified adjusted gross income at least at or above one hundred percent (100%) of the federal poverty level to receive the advance premium tax credit to purchase a qualified health plan through the Idaho health insurance exchange established by chapter 61, title 41, Idaho Code, instead of enrolling in medicaid, except that the person may choose to enroll in medicaid instead of receiving the advance premium tax credit to purchase a qualified health plan.

(c) Implement the following changes to eligibility determination:

(i) Suspend requirements to renew eligibility automatically based on available information and pre-populated forms; and

(ii) Implement biannual redetermination for persons eligible for medicaid under section 56-267, Idaho Code.

(d) Implement the following changes to benefits:

(i) No funds shall be used to fulfill any contract or commercial transaction with any health care provider or health care facility under the terms of which such health care provider or health care facility agrees to provide services prohibited under section 18-1506C, Idaho Code; and

(ii) No funds shall be used to fulfill any gender reassignment procedures, including treatment and surgery for any resident eighteen (18) years of age or older.

(2) An individual is exempt from the provisions of any state plan amendment or waiver pursuant to this section if the individual is an American Indian or Alaska native who is eligible for services through the Indian health service or through a tribal program pursuant to the Indian self-determination and education assistance act or the Indian health care improvement act.

56-2206. LEGISLATIVE APPROVAL -- PRACTICE AUTHORITY PROTECTION. The department of health and welfare is authorized to and shall submit a state plan amendment to the centers for medicare and medicaid services by July 1, 2025, allowing for practice authority protection to the extent permitted by state law.

56-2207. LEGISLATIVE APPROVAL -- SITE-NEUTRAL PAYMENTS. The department of health and welfare is authorized to seek and shall submit a state plan amendment by July 1, 2026, that sets reimbursement rates for hospital-acquired physician practices at the same rate as physician-owned medical practices for all equivalent outpatient health services where the service is not dependent on the hospital facility's associated technologies and in the absence of any evidence-based rationale. The department shall except critical access hospitals and rural emergency hospitals to the extent allowable.

SECTION 3. That Section 56-253, Idaho Code, be, and the same is hereby repealed.

SECTION 4. That Section 56-263, Idaho Code, be, and the same is hereby amended to read as follows:

56-263. MEDICAID MANAGED CARE PLAN. ~~(1) The department shall present to the legislature on the first day of the second session of the sixty-first Idaho legislature a plan for medicaid managed care with focus on high-cost populations, including but not limited to:~~

~~(a) Dual eligibles; and~~

~~(b) High-risk pregnancies.~~

~~(2) The medicaid managed care plan shall include but not be limited to the following elements:~~

~~(a) Improved coordination of care through primary care medical homes.~~

~~(b) Approaches that improve coordination and provide case management for high-risk, high-cost disabled adults and children that reduce costs and improve health outcomes, including mandatory enrollment in special needs plans, and that consider other managed care approaches.~~

~~(c) Managed care contracts to pay for behavioral health benefits as described in executive order no. 2011-01 and in any implementing legislation. At a minimum, the system should include independent, standardized, statewide assessment and evidence-based benefits provided by businesses that meet national accreditation standards.~~

~~(d) The elimination of duplicative practices that result in unnecessary utilization and costs.~~

~~(e) Contracts based on gain-sharing, risk-sharing or a capitated basis.~~

~~(f) Medical home development with focus on populations with chronic disease using a tiered case management fee.~~

~~(3) The department shall seek federal approval or a waiver to require that a medicaid participant who has a medical home as required in section 56-255(5)(b), Idaho Code, and who seeks family planning services or supplies from a provider outside the participant's medical home, must have a referral to such outside provider. The provisions of this subsection shall apply to medicaid participants upon such approval or the granting of such a waiver.~~

~~(4)~~ (1) The department shall seek approval as soon as practicable but no later than July 1, 2027, from the centers for medicare and medicaid services for directed payments to qualifying ~~hospitals~~ entities participating in the Idaho behavioral health plan or any comprehensive managed care plan in accordance with 42 CFR 438~~.~~, with thirty percent (30%) of the directed payments being utilized for general fund medicaid needs. Such funds shall be continuously appropriated.

~~(5)~~ (2) Subject to written approval by the centers for medicare and medicaid services, the department shall make directed payments to qualifying hospitals participating in medicaid managed care programs in an amount not to exceed the maximum allowable payment authorized by federal regulations.

~~(6)~~ (3) Qualifying behavioral health hospitals assessed pursuant to this section for the Idaho behavioral health plan are exempt from assessment pursuant to section 56-1404, Idaho Code.

(4) The department shall discontinue contracting and reimbursing as part of the healthy connections value care program through value care organizations and the healthy connections primary care case management program by January 1, 2026.

SECTION 5. That Section 56-265, Idaho Code, be, and the same is hereby amended to read as follows:

56-265. PROVIDER PAYMENT. (1) Where there is an equivalent, the payment to medicaid providers:

(a) May be up to but shall not exceed one hundred percent (100%) of the current medicare rate for primary care procedure codes as defined by the centers for medicare and medicaid services; and

(b) Shall be ninety percent (90%) of the current medicare rate for all other procedure codes.

(2) Where there is no medicare equivalent, the payment rate to medicaid providers shall be prescribed by rule.

(3) Notwithstanding any other provision of this chapter, if the services are provided by a private, freestanding mental health hospital facility that is an institution for mental disease as defined in 42 U.S.C. 1396d(i), the department shall reimburse for inpatient services at a rate not to exceed ninety-one percent (91%) of the current medicare rate within federally allowed reimbursement under the medicaid program. The reimbursement provided for in this subsection shall be effective until July 1, 2021.

(4) The department shall, through the annual budget process, include a line-item request for adjustments to provider rates. All changes to provider payment rates shall be subject to approval of the legislature by appropriation.

(5) Notwithstanding any other provision of this chapter, the department may enter into agreements with providers to pay for services based on their value in terms of measurable health care quality and positive impacts to participant health.

(a) Any such agreement shall be designed to be cost-neutral or cost-saving compared to other payment methodologies.

(b) The department is authorized to pursue waiver agreements with the federal government as needed to support value-based payment arrangements, up to and including fully capitated provider-based managed care.

(c) Beginning with the 2024 performance period and for all future performance periods thereafter, federally qualified health centers and any organization owned and controlled by a federally qualified health center shall be exempt from any financial risk in value-based payment agreements created pursuant to this section.

(6) Medicaid reimbursement for critical access, out-of-state, and state-owned hospitals shall be as follows:

(a) In-state, critical access hospitals as designated according to 42 U.S.C. 1395i-4(c)(2)(B) shall be reimbursed at one hundred one percent (101%) of cost;

(b) Out-of-state hospitals shall be reimbursed at eighty-seven percent (87%) of cost;

(c) State-owned hospitals shall be reimbursed at one hundred percent (100%) of cost; and

(d) Out-of-state hospital institutions for mental disease as defined in 42 U.S.C. 1396d(i) shall be reimbursed at a per diem equivalent to ninety-five percent (95%) of cost.

(7) The department shall equitably reduce net reimbursements for all hospital services, including in-state institutions for mental disease but excluding all hospitals and institutions described in subsection (6) of this section, by amounts targeted to reduce general fund needs for hospital

payments by three million one hundred thousand dollars ($3,100,000) in state fiscal year 2020 and eight million seven hundred twenty thousand dollars ($8,720,000) in state fiscal year 2021.

(8) The department shall work with all Idaho hospitals, including institutions for mental disease as defined in 42 U.S.C. 1396d(i), to establish value-based payment methods for inpatient and outpatient hospital services to replace existing cost-based reimbursement methods for in-state hospitals, other than those hospitals and institutions described in subsection (6) of this section, effective July 1, 2021. Budgets for hospital payments shall be subject to prospective legislative approval.

(9) The department shall work with Idaho hospitals to establish a quality payment program for inpatient and outpatient adjustment payments described in section 56-1406, Idaho Code. Inpatient and outpatient adjustment payments shall be subject to increase or reduction based on hospital service quality measures established by the department in consultation with Idaho hospitals.

SECTION 6. That Section 56-267, Idaho Code, be, and the same is hereby amended to read as follows:

56-267. MEDICAID ELIGIBILITY EXPANSION. (1) Notwithstanding any provision of law or federal waiver to the contrary, the state shall amend its state plan to expand medicaid eligibility to include those persons under sixty-five (65) years of age whose modified adjusted gross income is one hundred thirty-three percent (133%) of the federal poverty level or below and who are not otherwise eligible for any other coverage under the state plan, in accordance with sections 1902(a)(10)(A)(i)(VIII) and 1902(e)(14) of the social security act.

(2) No later than ninety (90) days after approval of this act, the department shall submit any necessary state plan amendments to the United States department of health and human services, centers for medicare and medicaid services to implement the provisions of this section. The department is required and authorized to take all actions necessary to implement the provisions of this section as soon as practicable.

(3) Eligibility for medicaid as described in this section shall not be delayed if the centers for medicare and medicaid services fail to approve any waivers of the state plan for which the department applies, nor shall such eligibility be delayed while the department is considering or negotiating any waivers to the state plan. The department shall not implement any waiver that would result in a reduction in federal financial participation for persons identified in subsection (1) of this section below the ninety percent (90%) commitment described in section 1905(y) of the social security act.

(4) If section 1905(y) of the social security act is held unlawful or unconstitutional by the United States supreme court, then the legislature shall declare this section to be null, void, and of no force and effect.

(5) If federal financial participation for persons identified in subsection (1) of this section is reduced below the ninety percent (90%) commitment described in section 1905(y) of the social security act, then the senate and house of representatives health and welfare committees shall, as soon as practicable, review the effects of such reduction and make a recommendation to the legislature as to whether medicaid eligibility expansion should

remain in effect. The review and recommendation described in this subsection shall be conducted by the date of adjournment of the regular legislative session following the date of reduction in federal financial participation. Notwithstanding any other provision of law to the contrary, if the reduction in federal financial participation occurs outside of a state legislative session, the department shall take any action necessary to offset the increase in state funding, including but not limited to reductions in provider payment rates or elimination of optional benefits. Such actions shall be taken until such time as the state legislature may convene and determine a proper course of action.

~~(6) The department:~~

~~(a) Shall place all persons participating in medicaid pursuant to this section in a care management program authorized under section 56-265(5), Idaho Code, or in another managed care program to improve the quality of their care, to the extent possible; and~~

~~(b) Is authorized to seek any federal approval necessary to implement the provisions of this subsection.~~

~~(7) No later than January 31 in the 2023 legislative session, the senate and house of representatives health and welfare committees shall review all fiscal, health, and other impacts of medicaid eligibility expansion pursuant to this section and shall make a recommendation to the legislature as to whether such expansion should remain in effect.~~

SECTION 7. That Section 56-1403, Idaho Code, be, and the same is hereby amended to read as follows:

56-1403. HOSPITAL ASSESSMENT FUND ESTABLISHED. (1) There is hereby created in the office of the state treasurer a dedicated fund to be known as the hospital assessment fund, hereinafter "fund," to be administered by the department of health and welfare, hereinafter "department." The state treasurer shall invest idle moneys in the fund and any interest received on those investments shall be returned to the fund. All moneys in the fund are continuously appropriated to the department for the purposes specified in this chapter.

(2) Moneys in the fund shall consist of:

(a) All moneys collected or received by the department from private hospital assessments required by this chapter;

(b) All federal matching funds received by the department as a result of expenditures made by the department that are attributable to moneys deposited in the fund;

(c) Any interest or penalties levied in conjunction with the administration of this chapter; and

(d) Any appropriations, federal funds, donations, gifts or moneys from any other sources.

(3) The fund is created for the purpose of receiving moneys in accordance with this section and section 56-1404, Idaho Code. Moneys in the fund shall be distributed by the department ~~subject to appropriation~~ for the following purposes only:

(a) Payments to private hospitals as required under Idaho's medical assistance program as set forth in sections 56-209b through 56-209d, Idaho Code;

(b) Reimbursement of moneys collected by the department from private hospitals through error or mistake in performing the activities authorized under Idaho's medical assistance program;
(c) Payments of administrative expenses incurred by the department or its agent in performing the activities authorized by this chapter;
(d) Payments made to the federal government to repay excess payments made to private hospitals from the fund if the assessment plan is deemed out of compliance and after the state has appealed the findings. Hospitals shall refund the payments in question to the assessment fund. The state in turn shall return funds to both the federal government and hospital providers in the same proportion as the original financing. Individual hospitals shall be reimbursed based on the proportion of the individual hospital's assessment to the total assessment paid by all private hospitals. If a hospital is unable to refund payments, the state shall develop a payment plan and deduct moneys from future medicaid payments;
(e) Transfers to any other fund in the state treasury, provided such transfers shall not exceed the amount transferred previously from that other fund into the hospital assessment fund;
(f) Making refunds to hospitals pursuant to section 56-1410, Idaho Code; and
(g) Offsetting general funding needed to support Idaho medicaid.

SECTION 8. That Section 56-1404, Idaho Code, be, and the same is hereby amended to read as follows:

56-1404. ASSESSMENTS. (1) All private hospitals, except those exempted under section 56-1408, Idaho Code, shall make payments to the fund in accordance with this chapter. Subject to section 56-1410, Idaho Code, an annual assessment on both inpatient and outpatient services is determined for each qualifying hospital for each state fiscal year in an amount calculated by multiplying the rate, as set forth in subsections (2)(c) and (3)(b) of this section, by the assessment base, as set forth in subsection (5) of this section.
(2)(a) The department shall calculate the private hospital upper payment limit gap for both inpatient and outpatient services. The upper payment limit gap is the difference between the maximum allowable payments eligible for federal match, less medicaid payments not financed using hospital assessment funds. The upper payment limit gap shall be calculated separately for hospital inpatient and outpatient services. Medicaid disproportionate share payments shall be excluded from the calculation.
(b) Idaho medicaid will start work toward approval by the centers for medicare and medicaid services (CMS) of an updated upper payment limit calculation methodology no later than July 1, 2022. This change is needed due to the change reflected in section 56-265, Idaho Code, in reimbursement from retrospective cost settlements to prospective payment systems.
(c) The department shall calculate the upper payment limit assessment rate for each state fiscal year to be the percentage that, when multi-

plied by the assessment base as defined in subsection (5) of this section, equals the upper payment limit payment.

(d) Beginning July 1, 2022, or upon approval by CMS, whichever is later, the assessment rate referenced in paragraph (c) of this subsection will increase to the amount needed to attain an increased supplemental upper payment limit payment. This payment amount is subject to CMS approval of the updated upper payment limit methodology described in paragraph (a) of this subsection and ~~legislative appropriation~~ shall be continuously appropriated.

(e) Beginning July 1, 2023, an additional amount will be assessed at thirty percent (30%) of the upper payment limit payment to be utilized for general fund medicaid needs.

(f) If CMS does not approve the updated upper payment limit methodology described in paragraph (b) of this subsection, then the additional assessment described in paragraph (e) of this subsection shall not be implemented.

(g) The assessment described in paragraph (e) of this subsection shall be assessed only if the upper payment limit payment is greater than the total assessment.

(3)(a) The department shall calculate the disproportionate share allotment amount to be paid to private in-state hospitals.

(b) The department shall calculate the disproportionate share assessment rate for private in-state hospitals to be the percentage that, when multiplied by the assessment base as defined in subsection (5) of this section, equals the amount of state funding necessary to pay the private in-state hospital disproportionate share allotment determined in paragraph (a) of this subsection.

(4) For private in-state hospitals, the assessments calculated pursuant to subsections (2) and (3) of this section shall not be greater than the federal limit as referenced in 42 CFR 433.68 of the assessment base as defined in subsection (5) of this section.

(5) The assessment base shall be the hospital's net patient revenue for the applicable period. Net patient revenue, beginning with state fiscal year 2023, shall be determined using each hospital's fiscal year 2021 medicare cost report on file with the department, without regard to any subsequent adjustments or changes to such data. If the 2021 cost report has not been filed, the prior year's cost report will be used. Net patient revenue for each state fiscal year thereafter shall be determined in the same manner using a rolling yearly schedule for each hospital's fiscal year medicare cost report.

SECTION 9. The rules contained in IDAPA 16.03.17, Department of Health and Welfare, relating to Medicare/Medicaid Coordinated Plan Benefits, shall be null, void, and of no force and effect on and after July 1, 2025.

SECTION 10. The rules contained in IDAPA 16.03.18, Department of Health and Welfare, relating to Medicaid Cost-Sharing, shall be null, void, and of no force and effect on and after July 1, 2025.

SECTION 11. The rules contained in IDAPA 16.03.09, Department of Health and Welfare, relating to Medicaid Basic Plan Benefits, shall be null, void, and of no force and effect on and after July 1, 2025.

SECTION 12. The rules contained in IDAPA 16.03.10, Department of Health and Welfare, relating to Medicaid Enhanced Plan Benefits, shall be null, void, and of no force and effect on and after July 1, 2025.

SECTION 13. An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval.