SENATE BILL NO. 139–SENATOR HARDY

PREFILED FEBRUARY 13, 2017

Referred to Committee on Health and Human Services

SUMMARY—Makes various changes to provisions relating to patient-centered medical homes. (BDR 40-679)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Yes.

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [~~omitted material~~] is material to be omitted.

AN ACT relating to patient-centered medical homes; requiring the Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease to establish an advisory group to study the delivery of health care through patient-centered medical homes; authorizing the Director of the Department of Health and Human Services to adopt regulations prescribing standards concerning payments to and incentives for patient-centered medical homes; authorizing the inclusion of such payments and incentives in the State Plan for Medicaid; authorizing plans of health insurance to provide such payments and incentives when applicable; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

A patient-centered medical home provides health care through a provider of primary care and a team of health care providers. (NRS 439A.190) Existing law authorizes, but does not require, the Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease to establish an advisory group of interested persons and governmental entities to study the delivery of health care through patient-centered medical homes. (NRS 439.519) **Section 1** of this bill requires the Advisory Council to establish such an advisory group.

Existing law provides that any coordination between an insurer and a patient-centered medical home or acceptance of an incentive from an insurer by a patient-centered medical home that is authorized under federal law does not constitute an unfair method of competition or an unfair or deceptive trade practice. (NRS 439A.190) **Section 6** of this bill authorizes the Director of the Department of Health and Human Services, in consultation with the advisory group established by the Advisory Council and other interested persons and governmental entities, to

adopt regulations prescribing standards concerning certain payments to and incentives for patient-centered medical homes. **Section 7** of this bill provides that incentives that are authorized by those regulations and by federal law are not considered unfair methods of competition or unfair or deceptive trade practices.

Section 11 of this bill authorizes the Director of the Department of Health and Human Services to: (1) include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of any such payment or incentive for which standards are adopted; and (2) take any action necessary to obtain federal financial participation in any such payments or incentives provided by Medicaid. **Sections 9, 13, 15, 16, 18-22 and 25-27** of this bill authorize all other plans of health insurance that provide coverage for a service rendered by a patient-centered medical home, including plans of health insurance provided by state and local governmental entities to their employees and Medicaid managed care plans, to provide any such payments or incentives as applicable. **Sections 12, 14 and 17** of this bill make conforming changes.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 439.519 is hereby amended to read as follows:

439.519 1. The members of the Advisory Council serve terms of 2 years. A member may be reappointed to serve not more than two additional, consecutive terms.

2. A majority of the voting members of the Advisory Council shall select a Chair and a Vice Chair of the Advisory Council.

3. A majority of the voting members of the Advisory Council may:

(a) Appoint committees or subcommittees to study issues relating to wellness and the prevention of chronic disease.

(b) Remove a nonlegislative member of the Advisory Council for failing to carry out the business of, or serve the best interests of, the Advisory Council.

~~[(c) Establish]~~

4. The Advisory Council shall establish an advisory group of interested persons and governmental entities to study the delivery of health care through patient-centered medical homes. Interested persons and governmental entities that serve on the advisory group may include, without limitation:

~~[(1)]~~ ***(a)*** Public health agencies;

~~[(2)]~~ ***(b)*** Public and private insurers;

~~[(3)]~~ ***(c)*** Providers of primary care, including, without limitation, physicians and advanced practice registered nurses who provide primary care; and

~~[(4)]~~ ***(d)*** Recipients of health care services.

~~[4.]~~ ***5.*** The Division shall, within the limits of available money, provide the necessary professional staff and a secretary for the Advisory Council.

~~[5.]~~ ***6.*** A majority of the voting members of the Advisory Council constitutes a quorum to transact all business, and a majority of those voting members present, physically or via telecommunications, must concur in any decision.

~~[6.]~~ ***7.*** The Advisory Council shall, within the limits of available money, meet at the call of the Administrator, the Chair or a majority of the voting members of the Advisory Council quarterly or as is necessary.

~~[7.]~~ ***8.*** The members of the Advisory Council serve without compensation, except that each member is entitled, while engaged in the business of the Advisory Council and within the limits of available money, to the per diem allowance and travel expenses provided for state officers and employees generally.

~~[8.]~~ ***9.*** As used in this section, "patient-centered medical home" has the meaning ascribed to it in ~~[NRS 439A.190.]~~ ***section 4 of this act.***

Sec. 2. Chapter 439A of NRS is hereby amended by adding thereto the provisions set forth as sections 3 to 6, inclusive, of this act.

Sec. 3. ***As used in NRS 439A.190 and sections 3 to 6, inclusive, of this act, the words and terms defined in sections 4 and 5 of this act have the meanings ascribed to them in those sections.***

Sec. 4. ***"Patient-centered medical home" means a primary care practice that:***

1. Offers patient-centered, continuous, culturally competent, evidence-based, comprehensive health care that is led by a provider of primary care and a team of health care providers, coordinates the health care needs of the patient and uses enhanced communication strategies and health information technology; and

2. Emphasizes enhanced access to practitioners and preventive care to improve the outcomes for and experiences of patients and lower the costs of health services.

Sec. 5. ***"Primary care practice" means a federally qualified health center, as defined in 42 U.S.C. § 1396d(l)(2)(B), or a business where health services are provided by one or more advanced practice registered nurses who are licensed pursuant to chapter 632 of NRS or one or more physicians who are licensed pursuant to chapter 630 or 633 of NRS and who practice in the area of family practice, internal medicine or pediatrics.***

Sec. 6. ***The Director, in consultation with the advisory group established pursuant to NRS 439.519 and other interested persons and governmental entities, may adopt regulations establishing one or more of the following standards:***

1. Payment methods that a plan of health insurance must use to coordinate the provision of health care services covered by the plan.

2. Incentives that a plan of health insurance must use to compensate a patient-centered medical home based on improved health care outcomes and coordination of care resulting from operation as a patient-centered medical home.

3. Incentives that a plan of health insurance must use to compensate a patient-centered medical home based on a reduction in the cost of care resulting from operation as a patient-centered medical home.

Sec. 7. NRS 439A.190 is hereby amended to read as follows:

439A.190 1. A primary care practice shall not represent itself as a patient-centered medical home unless the primary care practice is certified, accredited or otherwise officially recognized as a patient-centered medical home by a nationally recognized organization for the accrediting of patient-centered medical homes.

2. The Department shall post on an Internet website maintained by the Department links to nationally recognized organizations for the accrediting of patient-centered medical homes and any other information specified by the Department to allow patients to find a patient-centered medical home that meets the requirements of this section and any regulations adopted pursuant thereto.

3. Any coordination between an insurer and a patient-centered medical home ~~[or acceptance]~~ ***, the payment*** of an incentive from an insurer ~~[by]~~ ***to*** a patient-centered medical home ***or the acceptance of such an incentive by a patient-centered medical home*** that is authorized by federal law ***and any regulations adopted pursuant to section 6 of this act*** shall not be deemed to be an unfair method of competition or an unfair or deceptive trade practice or other act or practice prohibited by the provisions of chapter 598 or 686A of NRS.

~~[4. As used in this section:~~

~~(a) "Patient-centered medical home" means a primary care practice that:~~

~~(1) Offers patient-centered, continuous, culturally competent, evidence-based, comprehensive health care that is led by a provider of primary care and a team of health care providers, coordinates the health care needs of the patient and uses enhanced communication strategies and health information technology; and~~

~~(2) Emphasizes enhanced access to practitioners and preventive care to improve the outcomes for and experiences of patients and lower the costs of health services.~~

~~(b) "Primary care practice" means a federally qualified health center, as defined in 42 U.S.C. § 1396d(l)(2)(B), or a business~~

~~where health services are provided by one or more advanced practice registered nurses or one or more physicians who are licensed pursuant to chapter 630 or 633 of NRS and who practice in the area of family practice, internal medicine or pediatrics.~~]

Sec. 8. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, ***and section 11 of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.621 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department, other than the State Public Defender of the Office of State Public Defender who is appointed pursuant to NRS 180.010.

Sec. 9. NRS 287.010 is hereby amended to read as follows:

287.010 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada may:

(a) Adopt and carry into effect a system of group life, accident or health insurance, or any combination thereof, for the benefit of its officers and employees, and the dependents of officers and employees who elect to accept the insurance and who, where necessary, have authorized the governing body to make deductions from their compensation for the payment of premiums on the insurance.

(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 687B.408, 689B.030 to 689B.050, inclusive, ***and section 15 of this act*** and 689B.287 apply to coverage provided pursuant to this paragraph.

(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada.

2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.

4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.

5. A contract that is entered into pursuant to subsection 3:

(a) Must be submitted to the Commissioner of Insurance for approval not less than 30 days before the date on which the contract is to become effective.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

6. As used in this section, "legal services organization" means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.

Sec. 10. (Deleted by amendment.)

Sec. 11. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Director may:

(a) To the extent authorized by federal law, include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenses incurred to provide any payment or incentive for patient-centered medical homes for which standards are adopted pursuant to section 6 of this act; and

(b) Take any action necessary to obtain federal financial participation in any such payment or incentive.

2. As used in this section, "patient-centered medical home" has the meaning ascribed to it in section 4 of this act.

Sec. 12. NRS 686B.080 is hereby amended to read as follows:

686B.080 1. Except as otherwise provided in subsections 2 to 5, inclusive, each filing and any supporting information filed under NRS 686B.010 to 686B.1799, inclusive, must, as soon as filed, be open to public inspection at any reasonable time. Copies may be obtained by any person on request and upon payment of a reasonable charge therefor.

2. All rates for health benefit plans available for purchase by individuals and small employers are considered proprietary and constitute trade secrets, and are not subject to disclosure by the Commissioner to persons outside the Division except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

3. The provisions of subsection 2 expire annually on the date 30 days before open enrollment.

4. Except in cases of violations of NRS 689A.010 to 689A.740, inclusive, ***and section 13 of this act*** or 689C.015 to 689C.355, inclusive, ***and section 16 of this act,*** the unified rate review template and rate filing documentation used by carriers servicing the individual and small employer markets are considered proprietary and constitute a trade secret, and are not subject to disclosure by the Commissioner to persons outside the Division except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

5. An insurer providing blanket health insurance in accordance with the provisions of chapter 689B of NRS shall make all information concerning rates available to the Commissioner upon request. Such information is considered proprietary and constitutes a trade secret and is not subject to disclosure by the Commissioner to persons outside the Division except as agreed by the insurer or as ordered by a court of competent jurisdiction.

6. For the purposes of this section:

(a) "Open enrollment" has the meaning ascribed to it in 45 C.F.R. § 147.104(b)(1)(ii).

(b) "Rate filing documentation" and "unified rate review template" have the meanings ascribed to them in 45 C.F.R. § 154.215.

Sec. 13. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. A policy of health insurance that provides coverage for a service rendered by a patient-centered medical home may provide any applicable payment or incentive for which standards are adopted pursuant to section 6 of this act.

2. As used in this section, "patient-centered medical home" has the meaning ascribed to it in section 4 of this act.

Sec. 14. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~,~~ ***, and section 13 of this act.***

Sec. 15. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A policy of group or blanket health insurance that provides coverage for a service rendered by a patient-centered medical home may provide any applicable payment or incentive for which standards are adopted pursuant to section 6 of this act.

2. As used in this section, "patient-centered medical home" has the meaning ascribed to it in section 4 of this act.

Sec. 16. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health benefit plan that provides coverage for a service rendered by a patient-centered medical home may provide any applicable payment or incentive for which standards are adopted pursuant to section 6 of this act.

2. As used in this section, "patient-centered medical home" has the meaning ascribed to it in section 4 of this act.

Sec. 17. NRS 689C.156 is hereby amended to read as follows:

689C.156 1. As a condition of transacting business in this State with small employers, a carrier shall actively market to a small employer each health benefit plan which is actively marketed in this State by the carrier to any small employer in this State. A carrier shall be deemed to be actively marketing a health benefit plan when it makes available any of its plans to a small employer that is not currently receiving coverage under a health benefit plan issued by that carrier.

2. A carrier shall issue to a small employer any health benefit plan marketed in accordance with this section if the eligible small employer applies for the plan and agrees to make the required premium payments and satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with NRS 689C.015 to 689C.355, inclusive, ***and section 16 of this act,*** and 689C.610 to 689C.940, inclusive, except that a carrier is not required to issue a health benefit plan to a self-employed person who is covered by, or is eligible for coverage under, a health benefit plan offered by another employer.

3. If a health benefit plan marketed pursuant to this section provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care, the carrier shall provide a system for resolving any complaints of an employee concerning those health care services that complies with the provisions of NRS 695G.200 to 695G.310, inclusive.

Sec. 18. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, ***and section 16 of this act*** to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 19. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. A benefit contract that provides coverage for a service rendered by a patient-centered medical home may provide any applicable payment or incentive for which standards are adopted pursuant to section 6 of this act.

2. As used in this section, "patient-centered medical home" has the meaning ascribed to it in section 4 of this act.

Sec. 20. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A contract for hospital, medical or dental services subject to the provisions of this chapter that provides coverage for a service rendered by a patient-centered medical home may provide any applicable payment or incentive for which standards are adopted pursuant to section 6 of this act.

2. As used in this section, "patient-centered medical home" has the meaning ascribed to it in section 4 of this act.

Sec. 21. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health care plan of a health maintenance organization that provides coverage for a service rendered by a patient-centered medical home may provide any applicable payment or incentive for which standards are adopted pursuant to section 6 of this act.

2. As used in this section, "patient-centered medical home" has the meaning ascribed to it in section 4 of this act.

Sec. 22. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, 695C.1735 to 695C.1755, inclusive, 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance

organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694, 695C.1695, 695C.1708, 695C.1731, 695C.17345 and 695C.1757 ***and section 21 of this act*** apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 23. (Deleted by amendment.)

Sec. 24. (Deleted by amendment.)

Sec. 25. Chapter 695D of NRS is hereby amended by adding thereto a new section to read as follows:

1. A plan for dental care that provides coverage for a service rendered by a patient-centered medical home may provide any applicable payment or incentive for which standards are adopted pursuant to section 6 of this act.

2. As used in this section, "patient-centered medical home" has the meaning ascribed to it in section 4 of this act.

Sec. 26. NRS 695F.090 is hereby amended to read as follows:

695F.090 Prepaid limited health service organizations are subject to the provisions of this chapter and to the following provisions, to the extent reasonably applicable:

1. NRS 687B.310 to 687B.420, inclusive, concerning cancellation and nonrenewal of policies.

2. NRS 687B.122 to 687B.128, inclusive, concerning readability of policies.

3. The requirements of NRS 679B.152.

4. The fees imposed pursuant to NRS 449.465.

5. NRS 686A.010 to 686A.310, inclusive, concerning trade practices and frauds.

6. The assessment imposed pursuant to NRS 679B.700.

7. Chapter 683A of NRS.

8. To the extent applicable, the provisions of NRS 689B.340 to 689B.580, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance.

9. NRS 689A.035, 689A.0463, 689A.410, 689A.413 and 689A.415 ~~.~~ ***and section 13 of this act.***

10. NRS 680B.025 to 680B.039, inclusive, concerning premium tax, premium tax rate, annual report and estimated quarterly tax payments. For the purposes of this subsection, unless

the context otherwise requires that a section apply only to insurers, any reference in those sections to "insurer" must be replaced by a reference to "prepaid limited health service organization."

11. Chapter 692C of NRS, concerning holding companies.

12. NRS 689A.637, concerning health centers.

Sec. 27. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health care plan issued by a managed care organization for group coverage that provides coverage for a service rendered by a patient-centered medical home may provide any applicable payment or incentive for which standards are adopted pursuant to section 6 of this act.

2. As used in this section, "patient-centered medical home" has the meaning ascribed to it in section 4 of this act.

Sec. 28. (Deleted by amendment.)

Sec. 29. This act becomes effective upon passage and approval for the purposes of adopting regulations and performing any other administrative tasks that are necessary to carry out the provisions of this act and on January 1, 2018, for all other purposes.

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