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LEGISLATURE OF NEBRASKA

ONE HUNDRED FOURTH LEGISLATURE

FIRST SESSION

LEGISLATIVE BILL 472

Introduced by Campbell, 25; Crawford, 45; Howard, 9; Mello, 5; Nordquist, 7.

Read first time January 20, 2015

Committee: Health and Human Services

A BILL FOR AN ACT relating to medical assistance; to amend sections 44-4225, 68-901, 68-906, 68-908, and 68-909, Revised Statutes Cumulative Supplement, 2014; to adopt the Medicaid Redesign Act; to change provisions relating to the Comprehensive Health Insurance Pool Distributive Fund; to create a fund; to adopt by reference changes to federal law; to eliminate the Medicaid Reform Council and obsolete provisions; to harmonize provisions; to provide severability; to repeal the original sections; to outright repeal sections 68-948 and 68-949, Reissue Revised Statutes of Nebraska; and to declare an emergency.

Be it enacted by the people of the State of Nebraska,

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Section 1. Sections 1 to 15 of this act shall be known and may be cited as the Medicaid Redesign Act.

Sec. 2. The Legislature finds that:

(1) The medical assistance program, as a major expenditure of state health care funds, can be a driver of high-quality, cost-efficient health care transformation for Nebraska;

(2) It is imperative that public funds purchase high-quality health care in a cost-effective manner;

(3) The strategic investment of public funds in innovative, evidence-based, and promising practices can drive change for the entire Nebraska health care system;

(4) A Medicaid Redesign Task Force could facilitate the coordination of the various agencies and silos that currently provide uncoordinated services to persons receiving medical assistance, including superutilizers and special populations;

(5) Better management of health care for persons receiving medical assistance, including superutilizers and special populations with chronic conditions, can improve the quality of life and reduce costs by keeping people healthier;

(6) The development of a medicaid demonstration waiver for newly eligible individuals can provide a structure to redesign the current medicaid state plan and provide access to health care for Nebraskans, leveraging enhanced federal funding available for that purpose; and

(7) A medicaid demonstration waiver should test models of health care delivery systems to ascertain the best system and best payment methodology to be utilized for all recipients under the medical assistance program to improve care and quality and reduce cost.

Sec. 3. It is the intent of the Legislature that a review of the medical assistance program be conducted to:

(1) Analyze needs, resources, and activities of the medical assistance program;

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(2) Develop models to demonstrate innovative and efficient health care delivery systems, utilizing federal funding for persons receiving benefits under the medical assistance program and for newly eligible individuals, including superutilizers and individuals with exceptional medical conditions; and

(3) Assist public policy makers, providers, payers, and patients to develop initiatives and encourage partnerships and coordination and develop targeting strategies for action in the medical assistance program.

Sec. 4. For purposes of the Medicaid Redesign Act:

(1) Department means the Department of Health and Human Services;

(2) Exceptional medical condition means medically frail or a disabling mental disorder, a serious and complex medical condition, and physical or mental disabilities that significantly impair an individual's ability to perform one or more activities of daily living. Exceptional medical condition includes (a) at least two chronic conditions, (b) one chronic condition and the risk of a second chronic condition, or (c) a serious and persistent mental health condition. For purposes of this subdivision, chronic condition includes, but is not limited to, a mental health condition, substance use disorder, asthma, diabetes, heart disease, or being obese;

(3) Medical assistance program means the program established pursuant to section 68-903;

(4) Newly eligible individual means an individual who becomes eligible for medical assistance program benefits for the first time as a result of enactment of the federal Patient Protection and Affordable Care Act, Public Law 111-148, in accordance with section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act, as amended, 42 U.S.C. 1396a(a)(10)(A)(i)(VIII), as such section existed on January 1, 2015, which individual: (a) Is nineteen years of age or older and sixty-four years of age or younger; (b) is not pregnant; (c) is not entitled to or enrolled

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in medicare benefits under Part A or enrolled in medicare benefits under Part B of Title XVIII of the federal Social Security Act, 42 U.S.C. 1395c et seq., as such title existed on January 1, 2015; (d) is not otherwise described in section 1902(a)(10)(A)(i) of the federal Social Security Act, 42 U.S.C. 1396a(a)(10)(A)(i), as such section existed on January 1, 2015; (e) is not exempt pursuant to section 1902(k)(3) of the federal Social Security Act, 42 U.S.C. 1396a(k)(3), as such section existed on January 1, 2015; and (f) has a household income as determined under 1902(e)(14) of the federal Social Security Act, 42 U.S.C. 1396a(e)(14), as such section existed on January 1, 2015, that is between zero and one hundred thirty-three percent of the federal poverty level, as defined in section 2110(c)(5) of the federal Social Security Act, 42 U.S.C. 1397jj(c)(5), as such section existed on January 1, 2015, for the applicable family size;

(5) Patient-centered medical home means a health care delivery system pursuant to which the patient establishes an ongoing relationship with a primary care provider team to provide comprehensive, accessible, and continuous evidence-based primary and preventive care and to coordinate the patient's health care needs across the health care system to improve quality, safety, access, and health outcomes in a cost-effective manner; and

(6) Superutilizer means an individual with (a) complex health issues that, left unattended, can exacerbate a disease process, including susceptibility to co-occurring conditions or (b) special health issues, including age, socioeconomic issues, mental illness, or substance abuse disorders.

Sec. 5. The Medicaid Redesign Task Force is created. The task force shall consist of sixteen members, including:

(1) The Governor or his or her designee;

(2) The chairperson of the Appropriations Committee of the Legislature;

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(3) The chairperson of the Banking, Commerce and Insurance Committee of the Legislature;

(4) The chairperson of the Health and Human Services Committee of the Legislature;

(5) The chairperson of the Executive Board of the Legislative Council;

(6) A member of the Health and Human Services Committee of the Legislature, appointed by the chairperson of the committee;

(7) The chief executive officer of the Department of Health and Human Services;

(8) The Director of Medicaid and Long-Term Care of the Division of Medicaid and Long-Term Care of the Department of Health and Human Services;

(9) The Director of Public Health of the Division of Public Health of the department;

(10) The Director of Behavioral Health of the Division of Behavioral Health of the department; and

(11) The Director of Insurance.

In addition, the Governor shall appoint five persons to the task force with expertise in health care delivery, health insurance, health care workforce, health education, and health care consumer advocacy who shall each serve a term of three years and may be reappointed.

Sec. 6. (1) The Medicaid Redesign Task Force shall conduct a comprehensive review of and make recommendations regarding the medical assistance program. The review shall address matters including, but not limited to:

(a) Existing programs in Nebraska and across the country that have resulted in cost savings and improved quality;

(b) Federal programs and opportunities that can help strengthen both expenditure levels and health care delivery systems;

(c) Real-time, evidence-based approaches that promote targets for

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intervention, identify best practices, and maximize efficiencies;

(d) Improved quality measurement, including the alignment and integration of quality measurement across health care programs and initiatives that provide a more accurate and valid picture of health care quality to support and drive innovation within the medical assistance program and across payers;

(e) A process for effective, efficient, and timely dissemination of best practices that drive innovation in health care delivery systems;

(f) Characteristics, costs, and targeted interventions with respect to superutilizers and individuals with exceptional medical conditions; and

(g) The effectiveness of managed care in the medical assistance program.

(2) The recommendations of the task force as a result of the review shall include specific cost savings, quality improvement measures, and innovative models for a medicaid demonstration waiver. Such recommendations shall be the subject of a public hearing.

(3) The task force shall engage medical assistance program stakeholders in the process of conducting the comprehensive review through the planning and implementation of the redesign of the medicaid state plan and the development of the medicaid demonstration waiver. Such engagement may include, but need not be limited to, specific working groups and regional hearings. Participating stakeholders may be assigned to specific working groups consistent with their areas of expertise and interest.

(4) State agencies, including, but not limited to, the department, shall make any data requested by the task force available in a timely manner and in a usable format. For purposes of conducting the review required by this section, the department, in consultation with the task force and subject to appropriations, shall contract by October 1, 2015, with an independent organization with expertise in fiscal analysis,

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claims, and clinical data analysis of medicaid programs, expertise in options for health care delivery through the medical assistance program, and experience with evaluation of managed care programs.

Sec. 7. For purposes of utilizing enhanced federal funding for newly eligible individuals, the department shall develop a medicaid demonstration waiver. The waiver shall promote the following:

(1) Access to affordable and quality health care coverage for uninsured and underinsured individuals in Nebraska by developing innovative models of private health care with the goal of creating a patient-centered, integrated health care system;

(2) Continuity of coverage for vulnerable individuals by phasing in a premium assistance program that will substantially reduce the number of newly eligible individuals who would lose health care coverage as a result of income fluctuations that cause their eligibility for the medical assistance program to change from year to year or multiple times throughout a year;

(3) Coordination of health care delivery for newly eligible individuals to address the entire spectrum of physical and behavioral health by focusing on prevention, wellness, health promotion, and chronic-disease management;

(4) Incentives to encourage personal responsibility, cost-conscious utilization of health care services, and adoption of preventive practices and healthy behaviors. Such incentives shall be limited to financial savings related to health care and may not affect eligibility for public assistance programs or rights and privileges conferred by the state unrelated to the medical assistance program;

(5) Competition, consumer choice, and cost reduction within the private marketplace by implementing a premium assistance program that will enable newly eligible individuals with incomes between one hundred percent and one hundred thirty-three percent of the federal poverty level to obtain coverage in the private marketplace;

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(6) Maximizing access to federal funding during the time in which the federal government will pay ninety percent or more of the cost of medical assistance program benefits provided to newly eligible individuals;

(7) Improving health care coverage with the goals of eliminating cost shifting and substantially reducing the burden of uncompensated care for medical providers and the state; and

(8) Health care cost containment and minimization of administrative costs for services provided to newly eligible individuals who are superutilizers or have exceptional medical conditions and have incomes below one hundred thirty-three percent of the federal poverty level.

Sec. 8. The medicaid demonstration waiver required by section 7 of this act shall serve as a demonstration pilot project for redesign of the medical assistance program, including, but not limited to, four key components: (1) Patient-centered medical homes for newly eligible individuals, either pursuant to the medical assistance program or through the private marketplace; (2) health homes for newly eligible individuals who are superutilizers or individuals with exceptional medical conditions; (3) value-based payment; and (4) cost-conscious consumer behavior for individuals who will be eligible for coverage under the medical assistance program pursuant to the medicaid demonstration waiver.

Sec. 9. (1) The department, with the advice of the Medicaid Redesign Task Force, shall apply to the federal Centers for Medicare and Medicaid Services for a waiver to access enhanced federal matching funds for newly eligible individuals who have an income not more than one hundred thirty-three percent of the federal poverty level and who are nineteen years of age or older and not older than sixty-four years of age to implement the medicaid demonstration waiver. The waiver shall include: (a) A private premium assistance program, utilizing funds of the medical assistance program, for persons with incomes between one hundred percent and one hundred thirty-three percent of the federal poverty level to

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participate in the private insurance marketplace; (b) health care coverage under the medical assistance program for persons with incomes not more than ninety-nine percent of the federal poverty level; and (c) health homes for medically frail persons, superutilizers, and individuals with exceptional medical conditions who have incomes not more than one hundred thirty-three percent of the federal poverty level.

(2) The department, with the advice of the task force, shall develop the medicaid demonstration waiver with patient-centered medical homes as the foundation for newly eligible individuals in both the medical assistance program and the premium assistance program. The waiver shall include health care delivery system models that: (a) Integrate providers and incorporate financial incentives to improve patient health outcomes, improve care, and reduce costs; (b) integrate both clinical services and nonclinical community and social support services utilizing patient-centered medical homes and community care teams as basic components; and (c) incorporate safety net providers into the integrated system, including, but not limited to, federally qualified health centers, rural health clinics, community mental health centers, public hospitals, and other nonprofit and public health care providers that have extensive experience in providing health care for vulnerable individuals.

(3)(a) The department shall consider incorporating additional innovative and integrated health care delivery system models that pioneer new models of health care delivery and payment, including, but not limited to, accountable care communities, accountable care organizations, community care organizations, health homes, managed care organizations, and physician hospital organizations.

(b) Any accountable care organization participating in the medicaid demonstration waiver shall incorporate patient-centered medical homes as a foundation and shall emphasize whole-person orientation and coordination and integration of both clinical services and nonclinical community and social support services that address social determinants of

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health. A participating accountable care organization shall enter into a contract with the department either directly or through a managed care organization under contract with the department to ensure the coordination and management of the health care of members, to produce quality health care outcomes, and to control overall cost.

Sec. 10. As a part of the medicaid demonstration waiver required pursuant to sections 7 and 9 of this act, the department shall, for health care entities providing patient-centered medical homes, create value-based payments that may include a paid-care coordination fee on a per-member, per-month basis plus measure value created by provider and payer on a risk-adjusted basis based on absolute payment and performance improvement. Goals of such payment system shall include, but not be limited to, (1) payment incentives for participation in the patient-centered medical homes system to ensure that providers enter and continue participation in the system and (2) the attainment of specific patient outcomes that promote wellness, prevention, chronic-disease management, immunizations, health care management, and the use of electronic health records.

Sec. 11. The medicaid demonstration waiver required pursuant to sections 7 and 9 of this act shall include health homes for medically frail individuals, superutilizers, and special populations. A health home shall provide intensive care management and patient navigation services by a multidisciplinary team of physicians, physician assistants, nurses, other medical care providers, behavioral health care providers, social workers, and substance abuse treatment providers, led by a dedicated care manager who ensures that each newly eligible individual who is medically frail, a superutilizer, or a member of a special population receives needed medical care, behavioral health care, and social services through a single integrated care entity. A personal provider shall be responsible for providing for all of the patient’s health care and health-related needs or for appropriately arranging health care provided by other

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qualified health care professionals and providers of medical and nonmedical services at all stages of life, including provision of preventive care, acute care, chronic care, services, long-term care, transitional care between providers and settings, and end-of-life care.

Sec. 12. (1) The Legislature finds that monthly contributions from newly eligible individuals receiving medical assistance pursuant to the medicaid demonstration waiver required pursuant to sections 7 and 9 of this act (a) offer the individuals financial predictability and certainty with an incentive plan to actively seek preventive health services and engage in healthy behaviors that earn an exemption from monthly contributions and (b) provide the individuals with consistent policies and prepare them to transition to coverage in the private marketplace for which they will be responsible for payment if their income increases above one hundred thirty-three percent of the federal poverty level.

(2) Each newly eligible individual participating under the medicaid demonstration waiver in the private marketplace whose income is between one hundred percent and one hundred thirty-three percent of the federal poverty level and each newly eligible individual participating in the medicaid demonstration waiver who is receiving benefits under the medical assistance program and whose income is between fifty percent and ninety-nine percent of the federal poverty level shall make a monthly contribution of up to two percent of his or her income. The medicaid demonstration waiver shall include exceptions from such contributions for all participants during the initial year of the medicaid demonstration waiver. If a participant completes a program of required preventive care services and wellness activities during the initial year of participation, the monthly contributions required under this subsection shall be waived during the subsequent year of participation. The program of preventive care services and wellness activities shall include, but not be limited to, receiving an annual physical and completing an approved health risk assessment by the primary care provider to identify

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unhealthy characteristics, including chronic disease, alcohol use, substance abuse disorders, tobacco use, obesity, and immunization status. The primary care provider conducting the health risk assessment shall provide the participant with information on and discussion of advance directives within the framework of the individual's religious convictions and values. Failure to make monthly contributions as described in this section shall not result in ineligibility constitutes a debt to the State of Nebraska which may be collected in the manner of a lien foreclosure or sued for and recovered in a proper form of action in the name of the state in the district court of Lancaster County.

(3) The medicaid demonstration waiver shall require no additional copays except in the case of inappropriate utilization of a hospital emergency department which shall not exceed fifty dollars.

Sec. 13. (1) The department shall complete and submit the application for the medicaid demonstration waiver required under sections 7 and 9 of this act to the federal Centers for Medicare and Medicaid Services within twelve months after the effective date of this act. Pending approval of the medicaid demonstration waiver and not later than thirty days after the effective date of this act, the department shall submit a state plan amendment to the federal Centers for Medicare and Medicaid Services for newly eligible individuals. The state plan amendment submitted under this subsection shall be in effect until approval of the medicaid demonstration waiver by the federal Centers for Medicare and Medicaid Services.

(2) Pursuant to the state plan amendment required by this section, newly eligible individuals shall be covered by a benchmark benefit package as defined in section 1937(b)(1) of the federal Social Security Act, 42 U.S.C. 1396u-7(b)(1), as such section existed on January 1, 2015, for Secretary-approved coverage pursuant to 42 U.S.C. 1396u-7(b)(1)(D). The benchmark benefit package shall include: (a) All mandatory and optional coverage under section 68-911 for health care and related

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services in the amount, duration, and scope in effect on January 1, 2015; and (b) any additional benefits as wrap-around benefits required by the federal Patient Protection and Affordable Care Act, 42 U.S.C. 18001 et seq., not included under section 68-911.

(3) The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 300gg-5, as such act existed on January 1, 2015, shall apply to the state plan amendment. If the rate of federal funding under the federal Patient Protection and Affordable Care Act falls below ninety percent, the coverage for newly eligible individuals under the medicaid demonstration waiver or the state plan amendment shall terminate as of the date such federal funding falls below such level.

Sec. 14. The Medicaid Redesign Task Force shall provide a written report of its activities under the Medicaid Redesign Act to the Governor and electronically to the Legislature on December 15 of each year.

Sec. 15. The department may adopt and promulgate rules and regulations to carry out the Medicaid Redesign Act.

Sec. 16. Section 44-4225, Revised Statutes Cumulative Supplement, 2014, is amended to read:

44-4225 (1) Following the close of each calendar year, the board shall report the board's determination of the paid and incurred losses for the year, taking into account investment income and other appropriate gains and losses. The board shall distribute copies of the report to the director, the Governor, and each member of the Legislature. The report submitted to each member of the Legislature shall be submitted electronically.

(2) The Comprehensive Health Insurance Pool Distributive Fund is created. Commencing with the premium and related retaliatory taxes for the taxable year ending December 31, 2001, and for each taxable year thereafter, any premium and related retaliatory taxes imposed by section 44-150 or 77-908 paid by insurers writing health insurance in this state,

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except as otherwise set forth in subdivisions (1) and (2) of section 77-912, shall be remitted to the State Treasurer for credit to the fund. The fund shall be used for the operation of and payment of claims made against the pool. Any money in the fund available for investment shall be invested by the state investment officer pursuant to the Nebraska Capital Expansion Act and the Nebraska State Funds Investment Act.

(3) The board shall make periodic estimates of the amount needed from the fund for payment of losses resulting from claims, including a reasonable reserve, and administrative, organizational, and interim operating expenses and shall notify the director of the amount needed and the justification of the board for the request.

(4) The director shall approve all withdrawals from the fund and may determine when and in what amount any additional withdrawals may be necessary from the fund to assure the continuing financial stability of the pool.

(5)(a) No later than May 1 in 2015 and 2016 ~~, 2002, and each May 1 thereafter~~, after funding of the net loss from operation of the pool for the prior premium and related retaliatory tax year, taking into account the policyholder premiums, account investment income, claims, costs of operation, and other appropriate gains and losses, the director shall transmit any money remaining in the fund as directed by section 77-912, disregarding the provisions of subdivisions (1) through (3) of such section. Interest earned on money in the fund prior to May 1, 2016, shall be credited proportionately in the same manner as premium and related retaliatory taxes set forth in section 77-912.

(b) No later than May 1, 2017, and each May 1 thereafter, after funding of the net loss from operation of the pool for the prior premium and related retaliatory tax year, taking into account the policyholder premiums, account investment income, claims, costs of operation, and other appropriate gains and losses, the director shall transmit any money remaining in the fund to the State Treasurer for credit to the various

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funds as follows:

(i) Fifty percent of the money remaining to the Insurance Tax Fund;

(ii) Sixteen and one-half percent of the money remaining to the General Fund;

(iii) Twenty-three and one-half percent of the money remaining to the Health Care Access and Support Fund; and

(iv) Ten percent of the money remaining to the Mutual Finance Assistance Fund.

(6) Interest earned on money in the Comprehensive Health Insurance Pool Distributive Fund beginning May 1, 2016, shall be credited proportionately in the same manner as provided in subdivision (5)(b) of this section.

Sec. 17. Section 68-901, Revised Statutes Cumulative Supplement, 2014, is amended to read:

68-901 Sections 68-901 to 68-974 and section 18 of this act shall be known and may be cited as the Medical Assistance Act.

Sec. 18. The Health Care Access and Support Fund is created. The fund shall be used to support the medical assistance program, including participants pursuant to the state plan amendment and all waivers granted by the Centers for Medicare and Medicaid Services pursuant to the Medicaid Redesign Task Force Act. Any money in the fund available for investment shall be invested by the state investment officer pursuant to the Nebraska Capital Expansion Act and the Nebraska State Funds Investment Act. Any unexpended balance remaining in the fund at the close of the biennium shall be reappropriated for the succeeding biennium.

Sec. 19. Section 68-906, Revised Statutes Cumulative Supplement, 2014, is amended to read:

68-906 For purposes of paying medical assistance under the Medical Assistance Act and sections 68-1002 and 68-1006, the State of Nebraska accepts and assents to all applicable provisions of Title XIX and Title XXI of the federal Social Security Act. Any reference in the Medical

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Assistance Act to the federal Social Security Act or other acts or sections of federal law shall be to such federal acts or sections as they existed on January 1, 2015 ~~2010~~.

Sec. 20. Section 68-908, Revised Statutes Cumulative Supplement, 2014, is amended to read:

68-908 (1) The department shall administer the medical assistance program.

(2) The department may (a) enter into contracts and interagency agreements, (b) adopt and promulgate rules and regulations, (c) adopt fee schedules, (d) apply for and implement waivers and managed care plans for services for eligible recipients, including services under the Nebraska Behavioral Health Services Act, and (e) perform such other activities as necessary and appropriate to carry out its duties under the Medical Assistance Act. A covered item or service as described in section 68-911 that is furnished through a school-based health center, furnished by a provider, and furnished under a managed care plan pursuant to a waiver does not require prior consultation or referral by a patient's primary care physician to be covered. Any federally qualified health center providing services as a sponsoring facility of a school-based health center shall be reimbursed for such services provided at a school-based health center at the federally qualified health center reimbursement rate.

(3) The department shall maintain the confidentiality of information regarding applicants for or recipients of medical assistance and such information shall only be used for purposes related to administration of the medical assistance program and the provision of such assistance or as otherwise permitted by federal law.

(4)(a) The department shall prepare an annual summary and analysis of the medical assistance program for legislative and public review, including, but not limited to, a description of eligible recipients, covered services, provider reimbursement, program trends and projections,

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program budget and expenditures, the status of implementation of the Medicaid Reform Plan, and recommendations for program changes.

(b) ~~The department shall provide a draft report of such summary and analysis to the Medicaid Reform Council no later than September 15 of each year. The council shall conduct a public meeting no later than October 1 of each year to discuss and receive public comment regarding such report. The council shall provide any comments and recommendations regarding such report in writing to the department no later than November 1 of each year.~~ The department shall submit a final report of such summary and analysis to the Governor and ~~,~~ the Legislature~~, and the council~~ no later than December 1 of each year. The report submitted to the Legislature shall be submitted electronically. ~~Such final report shall include a response to each written recommendation provided by the council.~~

Sec. 21. Section 68-909, Revised Statutes Cumulative Supplement, 2014, is amended to read:

68-909 (1) All contracts, agreements, rules, and regulations relating to the medical assistance program as entered into or adopted and promulgated by the department prior to July 1, 2006, and all provisions of the medicaid state plan and waivers adopted by the department prior to July 1, 2006, shall remain in effect until revised, amended, repealed, or nullified pursuant to law.

(2) Prior to the adoption and promulgation of proposed rules and regulations under section 68-912 or relating to the implementation of medicaid state plan amendments or waivers, the department shall provide a report to the Governor and ~~,~~ the Legislature~~, and the Medicaid Reform Council~~ no later than December 1 before the next regular session of the Legislature summarizing the purpose and content of such proposed rules and regulations and the projected impact of such proposed rules and regulations on recipients of medical assistance and medical assistance expenditures. The report submitted to the Legislature shall be submitted

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electronically. ~~Any changes in medicaid copayments in fiscal year 2011-12 are exempt from the reporting requirement of this subsection and the requirements of section 68-912.~~

~~(3) The Medicaid Reform Council, no later than thirty days after the date of receipt of any report under subsection (2) of this section, may conduct a public meeting to receive public comment regarding such report. The council shall promptly provide any comments and recommendations regarding such report in writing to the department. Such comments and recommendations shall be advisory only and shall not be binding on the department, but the department shall promptly provide a written response to such comments or recommendations to the council.~~

(3 4) The department shall monitor and shall periodically, as necessary, but no less than biennially, report to the Governor and ~~,~~ the Legislature~~, and the Medicaid Reform Council~~ on the implementation of rules and regulations, medicaid state plan amendments, and waivers adopted under the Medical Assistance Act and the Medicaid Redesign Act and the effect of such rules and regulations, amendments, or waivers on eligible recipients of medical assistance and medical assistance expenditures. The report submitted to the Legislature shall be submitted electronically.

Sec. 22. If any section in this act or any part of any section is declared invalid or unconstitutional, the declaration shall not affect the validity or constitutionality of the remaining portions.

Sec. 23. Original sections 44-4225, 68-901, 68-906, 68-908, and 68-909, Revised Statutes Cumulative Supplement, 2014, are repealed.

Sec. 24. The following sections are outright repealed: Sections 68-948 and 68-949, Reissue Revised Statutes of Nebraska.

Sec. 25. Since an emergency exists, this act takes effect when passed and approved according to law.