Senate Bill No. 529–Committee on
Human Resources and Education

CHAPTER.....

AN ACT relating to Medicaid; revising certain provisions concerning the recovery from recipients or third parties of certain costs for Medicaid paid by the Department of Health and Human Services; revising certain provisions concerning assessments on nursing facilities; revising certain provisions concerning liability for the submission of a false claim to the State or a local government; providing a penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law provides that the Department of Health and Human Services is subrogated to the right of a recipient of Medicaid when the recipient incurs costs for medical services which are payable by the Department under circumstances which create legal liability for such costs in a third party. (NRS 422.293) **Sections 3, 4, 9 and 10** of this bill revise certain provisions concerning the recovery of such costs by the Department and impose liability for such costs on certain persons who do not comply with the procedures established to protect the right of the Department to recover benefits paid by Medicaid.

Existing law provides for the assessment of fees on nursing facilities to increase the quality of nursing care. (NRS 422.3755-422.379) **Sections 13 and 14** of this bill revise the determination of the amount of the fees to comply with federal law and to allow the recoupment of the fees and any administrative penalties from payments made pursuant to the Medicaid program.

The Federal Deficit Reduction Act of 2005, Public Law 109-171, enacted certain provisions concerning state plans for Medicaid. Section 6031 of the Federal Deficit Reduction Act provides financial incentives for states that enact laws establishing liability for false or fraudulent claims made to the State Plan for Medicaid. To be eligible for these financial incentives, the laws of a state must contain provisions that are at least as effective at rewarding and facilitating qui tam actions for false or fraudulent claims as those described in the Federal False Claims Act, 31 U.S.C. §§ 3730-3732. **Sections 23-27** of this bill amend existing law concerning the filing of false or fraudulent claims to comply with the provisions of section 6031 of the Federal Deficit Reduction Act. (NRS 357.040, 357.070, 357.080, 357.110, 357.170) **Sections 11 and 15** of this bill provide for the recovery of benefits and for criminal penalties for certain fraudulent acts related to public assistance. (NRS 422.29304, 422.410)

Sections 31-36 of this bill amend existing law to comply with the requirements of section 6035 of the Federal Deficit Reduction Act concerning certain providers of health insurance. **Sections 31-36** require providers of health insurance to provide certain information concerning a person who is eligible for assistance under Medicaid to the State upon request. **Sections 31-36** also require providers of health insurance to respond to inquiries by the State concerning a claim for payment for medical assistance not later than 3 years after the date of provision of the medical services. **Sections 31-36** require providers of health insurance to agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim or the form of documentation submitted if the State submits the claim not later than 3 years after the date of the provision of medical assistance and the State

commences any action to enforce its rights with respect to the claim not later than 6 years after submission of the claim. (NRS 689A.430, 689B.300, 695A.151, 695B.340, 695C.163, 695F.440)

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

Section 1. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 9, inclusive, of this act.

Sec. 2. (Deleted by amendment.)

Sec. 3. ***1. A recipient, upon assertion of a claim against a third party to which the Department is subrogated pursuant to NRS 422.293, or his attorney, upon agreeing to represent such a recipient, shall provide written notice to the Department in the manner provided in subsection 2.***

2. The notice provided pursuant to subsection 1 must include, without limitation:

(a) The name of the recipient;

(b) The social security number of the recipient;

(c) The date of birth of the recipient;

(d) The name of the attorney of the recipient, if applicable;

(e) The name of any person against whom the recipient is making a claim, if known;

(f) The name of any insurer of any person against whom the recipient is making a claim, if known;

(g) The date of the incident giving rise to the claim; and

(h) A short statement identifying the nature of the recipient's claim or the terms of any settlement, judgment or award.

3. Any statute of limitations applicable to any claim or action by the Department is tolled until such time as the Department receives the notice required by this section.

4. As used in this section, "claim" means a right to payment, whether or not the right is reduced to judgment, liquidated, unliquidated, fixed, contingent, matured, unmatured, disputed, undisputed, legal, equitable, secured or unsecured.

Sec. 4. ***Upon receiving the notice required pursuant to section 3 of this act, the Department shall, within 30 days, provide written notice to the recipient or his attorney and to the third party. The written notice must include, without limitation, the name of the recipient and the amount of the Department's lien. No lien created pursuant to NRS 422.293 is enforceable unless written***

notice is first given to the person against whom the lien is asserted or his attorney.

Secs. 5-8. (Deleted by amendment.)

Sec. 9. ***1. Except as otherwise provided in subsection 2, any person who fails to comply with the provisions of NRS 422.293 and section 3 of this act is liable to the Department for:***

(a) The total amount of the Department's lien created pursuant to NRS 422.293; and

(b) Any attorney's fees and litigation expenses incurred by the Department in enforcing the Department's rights pursuant to NRS 422.293 and section 3 of this act.

2. A person other than the recipient is not liable to the Department if the court determines that the failure to provide notice was caused by excusable neglect.

Sec. 10. NRS 422.293 is hereby amended to read as follows:

422.293 1. When a recipient of Medicaid or a recipient of insurance provided pursuant to the Children's Health Insurance Program incurs an illness or injury for which medical services are payable by the Department and which is incurred under circumstances creating a legal liability in some person other than the recipient or a division of the Department to pay all or part of the costs of such ***medical*** services, the Department is subrogated to the right of the recipient to the extent of all such ***medical*** costs ~~[.]~~ and may join or intervene in any action by the recipient or his successors in interest to enforce such legal liability.

2. If a recipient or his successors in interest fail or refuse to commence an action to enforce the legal liability, the Department may commence an independent action, after notice to the recipient or his successors in interest, to recover all ***medical*** costs to which it is entitled. In any such action by the Department, the recipient or his successors in interest may be joined as third-party defendants.

3. In any case where the Department is subrogated to the rights of the recipient or his successors in interest as provided in subsection 1, the Department has a lien upon the proceeds of any recovery from the persons liable, whether the proceeds of the recovery are by way of judgment, settlement or otherwise. Such a lien must be satisfied in full, unless reduced pursuant to subsection ~~[5,]~~ ***4,*** at such time as:

(a) The proceeds of any recovery or settlement are distributed to or on behalf of the recipient, his successors in interest or his attorney; and

(b) A dismissal by any court of any action brought to enforce the legal liability established by subsection 1.

~~[➥ No such lien is enforceable unless written notice is first given to the person against whom the lien is asserted.]~~

4. ~~[The recipient or his successors in interest shall notify the Department in writing before entering any settlement agreement or commencing any action to enforce the legal liability referred to in subsection 1. Except if extraordinary circumstances exist, a person who fails to comply with the provisions of this subsection shall be deemed to have waived any consideration by the Director or his designated representative of a reduction of the amount of the lien pursuant to subsection 5 and shall pay to the Department all costs to which it is entitled and its court costs and attorney's fees.~~

~~5.]~~ If the Department receives notice pursuant to ~~[subsection 4,]~~ ***section 3 of this act,*** the Director or his designated representative may, in consideration of the legal services provided by an attorney to procure a recovery for the recipient, reduce the lien on the proceeds of any recovery.

~~[6.]~~ ***5.*** The attorney of a ~~[recipient:~~

~~(a) Shall]~~ ***recipient shall*** not condition the amount of attorney's fees or impose additional attorney's fees based on whether a reduction of the lien is authorized by the Director or his designated representative pursuant to subsection ~~[5.~~

~~(b) Shall reduce the amount of the fees charged the recipient for services provided by the amount the attorney receives from the reduction of a lien authorized by the Director or his designated representative pursuant to subsection 5.]~~ ***4.***

Sec. 11. NRS 422.29304 is hereby amended to read as follows:

422.29304 1. Except as otherwise provided in this section, the Department shall, to the extent that it is not prohibited by federal law, recover from a recipient of public assistance, the estate of the recipient, the undivided estate of a recipient of Medicaid or a person who signed the application for public assistance ***or admission to a nursing facility*** on behalf of the recipient an amount not to exceed the amount of public assistance incorrectly paid to the recipient, if the person who signed the application:

(a) Failed to report any required information to the Department ***or the nursing facility*** that the person knew at the time he signed the application; ~~[or]~~

(b) ***Refused to provide financial information regarding the recipient's income and assets, including, without limitation, information regarding any transfers or assignments of income or assets;***

(c) Concealed information regarding the existence, transfer or disposition of the recipient's income and assets with the intent of

enabling a recipient to meet any eligibility requirement for public assistance;

(d) Made any false representation regarding the recipient's income and assets, including, without limitation, any information regarding any transfers or assignments of income or assets; or

(e) Failed to report to the Department ***or the nursing facility*** within the period allowed by the Department any required information that the person obtained after he filed the application.

2. Except as otherwise provided in this section, a recipient of incorrectly paid public assistance, the undivided estate of a recipient of Medicaid or a person who signed the application for public benefits ***or admission to a nursing facility*** on behalf of the recipient shall reimburse the Department or appropriate state agency for the value of the incorrectly paid public assistance.

3. The Director or his designee may, to the extent that it is not prohibited by federal law, determine the amount of, and settle, adjust, compromise or deny a claim against a recipient of public assistance, the estate of the recipient, the undivided estate of a recipient of Medicaid or a person who signed the application for public assistance ***or admission to a nursing facility*** on behalf of the recipient.

4. The Director may, to the extent that it is not prohibited by federal law, waive the repayment of public assistance incorrectly paid to a recipient if the incorrect payment was not the result of an intentional misrepresentation or omission by the recipient and if repayment would cause an undue hardship to the recipient. The Director shall, by regulation, establish the terms and conditions of such a waiver, including, without limitation, the circumstances that constitute undue hardship.

Sec. 12. NRS 422.29306 is hereby amended to read as follows:

422.29306 1. The Department may, to the extent not prohibited by federal law, petition for the imposition of a lien pursuant to the provisions of NRS 108.850 against real or personal property of a recipient of Medicaid as follows:

(a) The Department may obtain a lien against a recipient's property, both real or personal, before or after his death in the amount of assistance paid or to be paid on his behalf if the court determines that assistance was incorrectly paid for the recipient.

(b) The Department may seek a lien against the real property of a recipient at any age before his death in the amount of assistance paid or to be paid for him if he is an inpatient in a nursing facility, intermediate care facility for the mentally retarded or other medical institution and the Department determines, after notice and

opportunity for a hearing in accordance with applicable regulations, that the recipient cannot reasonably be expected to be discharged and return home.

2. No lien may be placed on a recipient's home pursuant to paragraph (b) of subsection 1 for assistance correctly paid if:

(a) His spouse;

(b) His child who is under 21 years of age, blind or disabled as determined in accordance with 42 U.S.C. § 1382c; or

(c) His brother or sister who is an owner or part owner of the home and who was residing in the home for at least 1 year immediately before the date the recipient was admitted to the medical institution,

➥ is lawfully residing in the home.

3. Upon the death of a recipient, the Department may seek a lien upon the recipient's undivided estate as defined in NRS 422.054.

4. ***The amount of the lien recovery must be based on the value of the real or personal property at the time of sale of the property.***

5. The Director shall release a lien pursuant to this section:

(a) Upon notice by the recipient or his representative to the Director that the recipient has been discharged from the medical institution and has returned home;

(b) If the lien was incorrectly determined; or

(c) Upon satisfaction of the claim of the Department.

Sec. 13. NRS 422.3775 is hereby amended to read as follows:

422.3775 1. Each nursing facility that is licensed in this State shall pay a fee assessed by the Division to increase the quality of nursing care in this State.

2. To determine the amount of the fee to assess pursuant to this section, the Division shall establish a ~~[uniform]~~ rate per non-Medicare patient day that is equivalent to ~~[6 percent]~~ ***a percentage*** of the total annual accrual basis gross revenue for services provided to patients of all nursing facilities licensed in this State. ***The percentage used to establish the rate must not exceed that allowed by federal law.*** For the purposes of this subsection, total annual accrual basis gross revenue does not include charitable contributions received by a nursing facility.

3. The Division shall calculate the fee owed by each nursing facility by multiplying the total number of days of care provided to non-Medicare patients by the nursing facility, as provided to the Division pursuant to NRS 422.378, by the ~~[uniform]~~ rate established pursuant to subsection 2.

4. A fee assessed pursuant to this section is due 30 days after the end of the month for which the fee was assessed.

5. The payment of a fee to the Division pursuant to NRS 422.3755 to 422.379, inclusive, is an allowable cost for Medicaid reimbursement purposes.

Sec. 14. NRS 422.379 is hereby amended to read as follows:

422.379 ***1.*** The Division shall establish administrative penalties for the late payment by a nursing facility of a fee assessed pursuant to NRS 422.3755 to 422.379, inclusive.

2. The Division may recoup any payments made to nursing facilities providing services pursuant to the Medicaid program up to the amount of the fees owed as determined pursuant to NRS 422.3775 and any administrative penalties owed pursuant to subsection 1 if a nursing facility fails to remit the fees and administrative penalties owed within 30 days after the date they are due. Before recoupment of payments pursuant to this subsection, the Division may allow a nursing facility that fails to remit fees and administrative penalties owed an opportunity to negotiate a repayment plan with the Division. The terms of the repayment plan may be established at the discretion of the Division.

Sec. 15. NRS 422.410 is hereby amended to read as follows:

422.410 1. Unless a different penalty is provided pursuant to NRS 422.361 to 422.369, inclusive, or 422.450 to 422.590, inclusive, a person who knowingly and designedly, by any false pretense, false or misleading statement, impersonation ***,*** ~~[or]~~ misrepresentation, ***or concealment, transfer, disposal or assignment of money or property*** obtains or attempts to obtain monetary or any other public assistance, or money, property, medical or remedial care or any other service provided pursuant to the Children's Health Insurance Program, having a value of $100 or more, whether by one act or a series of acts, with the intent to cheat, defraud or defeat the purposes of this chapter ***or to enable a person to meet or appear to meet any requirements of eligibility prescribed by state law or by rule or regulation adopted by the Department for a grant or an increase in a grant of any type of public assistance*** is guilty of a category E felony and shall be punished as provided in NRS 193.130. In addition to any other penalty, the court shall order the person to pay restitution.

2. For the purposes of subsection 1, whenever a recipient of Temporary Assistance for Needy Families pursuant to the provisions of this chapter and chapter 422A of NRS receives an overpayment of benefits for the third time and the overpayments have resulted from a false statement or representation by the

recipient or from the failure of the recipient to notify the Division of Welfare and Supportive Services of the Department of a change in his circumstances which would affect the amount of assistance he receives, a rebuttable presumption arises that the payment was fraudulently received.

3. For the purposes of subsection 1, "public assistance" includes any money, property, medical or remedial care or any other service provided pursuant to a state plan.

Sec. 16. NRS 425.360 is hereby amended to read as follows:

425.360 1. Any payment of public assistance pursuant to this chapter creates a debt for support to the Division by the responsible parent, whether or not the parent received prior notice that his child was receiving public assistance.

2. The Division is entitled to the amount to which a dependent child or a person having the care, custody and control of a dependent child would have been entitled for support, to the extent of the assignment of those rights to support pursuant to NRS 425.350, and may prosecute or maintain any action for support or execute any administrative remedy existing under the laws of this State to obtain reimbursement of money expended for public assistance from any liable third party, including an insurer, group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 ***,*** ~~[(]~~ 29 U.S.C.A. § 1167(1) ***,*** ~~[),]~~ service benefit plan, ***self-insured plan*** or health maintenance organization. If a court enters judgment for an amount of support to be paid by a responsible parent, the Division is entitled to the amount of the debt created by that judgment to the extent of the assignment of rights to support pursuant to NRS 425.350, and the judgment awarded shall be deemed to be in favor of the Division to that extent. This entitlement applies to, but is not limited to, a temporary order for spousal support, a family maintenance order or an alimony order, whether or not allocated to the benefit of the child on the basis of providing necessaries for the caretaker of the child, up to the amount paid by the Division in public assistance to or for the benefit of a dependent child. The Division may petition the appropriate court for modification of its order on the same grounds as a party to the action.

3. If there is no court order for support, or if the order provides that no support is due but the facts on which the order was based have changed, the amount due is the amount computed pursuant to NRS 125B.070 and 125B.080, using the Nevada average wage, determined by the Employment Security Division of the Department of Employment, Training and Rehabilitation, if the gross income of the responsible parent cannot be otherwise ascertained.

4. Debts for support may not be incurred by a parent or any other person who is the recipient of public assistance for the benefit of a dependent child for the period when the parent or other person is a recipient.

5. If a state agency is assigned any rights of a dependent child or a person having the care, custody and control of a dependent child who is eligible for medical assistance under Medicaid, the person having the care, custody and control of the dependent child shall, upon request of the state agency, provide to the state agency information regarding the dependent child or a person having the care, custody and control of a dependent child to determine:

(a) Any period during which the dependent child or a person having the care, custody and control of a dependent child may be or may have been covered by an insurer; and

(b) The nature of any coverage that is or was provided by the insurer, including, without limitation, the name and address of the insured dependent child or a person having the care, custody and control of a dependent child and the identifying number of the policy, evidence of coverage or contract.

Sec. 17. NRS 108.850 is hereby amended to read as follows:

108.850 1. A petition to the district court for the imposition of a lien as described and limited in NRS 422.29306 to recover money owed to the Department of Health and Human Services as a result of payment of benefits for Medicaid must set forth:

(a) The facts concerning the giving of assistance;

(b) The name and address of the person who is receiving or who received the benefits for Medicaid;

(c) A description of the property, sufficient for identification ***;*** ~~[,~~ ~~and its estimated value;]~~

(d) The names, ages, residences and relationship of all persons who are claiming an interest in the property or who are listed as having any interest in the property, so far as known to the petitioner; and

(e) An itemized list of the amount owed to the Department of Health and Human Services as a result of payment of benefits for Medicaid.

2. No defect of form or in the statement of facts actually existing voids the petition for the lien.

Sec. 18. NRS 132.185 is hereby amended to read as follows:

132.185 "Interested person" includes ***, without limitation,*** an heir, devisee, child, spouse, creditor, beneficiary and any other person having a property right in or claim against a trust estate or the estate of a decedent ~~[.]~~ ***, including, without limitation, the***

Director of the Department of Health and Human Services in any case in which money is owed to the Department of Health and Human Services as a result of the payment of benefits for Medicaid. The term includes a person having priority for appointment as a personal representative and other fiduciaries representing interested persons. The meaning as it relates to particular persons must be determined according to the particular purposes of, and matter involved in, a proceeding.

Sec. 19. NRS 159.113 is hereby amended to read as follows:

159.113 1. Before taking any of the following actions, the guardian shall petition the court for an order authorizing the guardian to:

(a) Invest the property of the ward.

(b) Continue the business of the ward.

(c) Borrow money for the ward.

(d) Except as otherwise provided in NRS 159.079, enter into contracts for the ward or complete the performance of contracts of the ward.

(e) Make gifts from the ward's estate or make expenditures for the ward's relatives.

(f) Sell, lease, place into any type of trust or surrender any property of the ward.

(g) Exchange or partition the ward's property.

(h) Obtain advice, instructions and approval of any other proposed act of the guardian relating to the ward's property.

(i) Release the power of the ward as trustee, personal representative, custodian for a minor or guardian.

(j) Exercise or release the power of the ward as a donee of a power of appointment.

(k) Change the state of residence or domicile of the ward.

(l) Exercise the right of the ward to take under or against a will.

(m) Transfer to a trust created by the ward any property unintentionally omitted from the trust.

(n) Submit a revocable trust to the jurisdiction of the court if:

(1) The ward or the spouse of the ward, or both, are the grantors and sole beneficiaries of the income of the trust; or

(2) The trust was created by the court.

(o) ***Pay any claim by the Department of Health and Human Services to recover benefits for Medicaid correctly paid to or on behalf of the ward.***

(p) Take any other action which the guardian deems would be in the best interests of the ward.

2. The petition must be signed by the guardian and contain:

(a) The name, age, residence and address of the ward.

(b) A concise statement as to the condition of the ward's estate.

(c) A concise statement as to the advantage to the ward of or the necessity for the proposed action.

(d) The terms and conditions of any proposed sale, lease, partition, trust, exchange or investment, and a specific description of any property involved.

3. Any of the matters set forth in subsection 1 may be consolidated in one petition, and the court may enter one order authorizing or directing the guardian to do one or more of those acts.

4. A petition filed pursuant to paragraphs (b) and (d) of subsection 1 may be consolidated in and filed with the petition for the appointment of the guardian, and if the guardian is appointed **,** the court may enter additional orders authorizing the guardian to continue the business of the ward, enter contracts for the ward, or to complete contracts of the ward.

Sec. 20. NRS 159.115 is hereby amended to read as follows:

159.115 1. Upon the filing of any petition under NRS 159.078 or 159.113, or any account, notice must be given:

(a) At least 10 days before the date set for the hearing, by mailing a copy of the notice by regular mail to the residence, office or post office address of each person required to be notified pursuant to subsection 3;

(b) At least 10 days before the date set for the hearing, by personal service;

(c) If the address or identity of the person is not known and cannot be ascertained with reasonable diligence, by publishing a copy of the notice in a newspaper of general circulation in the county where the hearing is to be held, the last publication of which must be published at least 10 days before the date set for the hearing; or

(d) In any other manner ordered by the court, for good cause shown.

2. The notice must:

(a) Give the name of the ward.

(b) Give the name of the petitioner.

(c) Give the date, time and place of the hearing.

(d) State the nature of the petition.

(e) Refer to the petition for further particulars, and notify all persons interested to appear at the time and place mentioned in the notice and show cause why the court order should not be made.

3. At least 10 days before the date set for the hearing, the petitioner shall cause a copy of the notice to be mailed to the following:

(a) Any minor ward who is 14 years of age or older or the parent or legal guardian of any minor ward who is less than 14 years of age.

(b) The spouse of the ward and other heirs of the ward who are related within the second degree of consanguinity so far as known to the petitioner.

(c) The guardian of the person of the ward, if the guardian is not the petitioner.

(d) Any person or care provider having the care, custody or control of the ward.

(e) Any office of the Department of Veterans Affairs in this State if the ward is receiving any payments or benefits through the Department of Veterans Affairs.

(f) ***The Director of the Department of Health and Human Services if the ward has received or is receiving any benefits from Medicaid.***

(g) Any other interested person or his attorney who has filed a request for notice in the guardianship proceeding and served a copy of the request upon the guardian. The request for notice must state the interest of the person filing the request, and his name and address, or that of his attorney. If the notice so requests, copies of all petitions and accounts must be mailed to the interested person or his attorney.

4. An interested person who is entitled to notice pursuant to subsection 3 may, in writing, waive notice of the hearing of a petition.

5. Proof of giving notice must be:

(a) Made on or before the date set for the hearing; and

(b) Filed in the guardianship proceeding.

Sec. 21. NRS 239A.070 is hereby amended to read as follows:

239A.070 This chapter does not apply to any subpoena issued pursuant to title 14 or chapters 616A to 617, inclusive, of NRS or prohibit:

1. Dissemination of any financial information which is not identified with or identifiable as being derived from the financial records of a particular customer.

2. The Attorney General, district attorney, Department of Taxation, ***Director of the Department of Health and Human Services,*** public administrator, sheriff or a police department from requesting of a financial institution, and the institution from responding to the request, as to whether a person has an account or accounts with that financial institution and, if so, any identifying numbers of the account or accounts.

3. A financial institution, in its discretion, from initiating contact with and thereafter communicating with and disclosing the financial records of a customer to appropriate governmental agencies concerning a suspected violation of any law.

4. Disclosure of the financial records of a customer incidental to a transaction in the normal course of business of the financial institution if the director, officer, employee or agent of the financial institution who makes or authorizes the disclosure has no reasonable cause to believe that such records will be used by a governmental agency in connection with an investigation of the customer.

5. A financial institution from notifying a customer of the receipt of a subpoena or a search warrant to obtain his financial records, except when ordered by a court to withhold such notification.

6. The examination by or disclosure to any governmental regulatory agency of financial records which relate solely to the exercise of its regulatory function if the agency is specifically authorized by law to examine, audit or require reports of financial records of financial institutions.

7. The disclosure to any governmental agency of any financial information or records whose disclosure to that particular agency is required by the tax laws of this State.

8. The disclosure of any information pursuant to NRS 425.393, 425.400 or 425.460.

9. A governmental agency from obtaining a credit report or consumer credit report from anyone other than a financial institution.

Sec. 22. NRS 239A.075 is hereby amended to read as follows:

239A.075 Upon presentation of a death certificate, affidavit of death or other proof of death, a financial institution shall provide ***the Director of the Department of Health and Human Services or*** a public administrator with a statement which sets forth the identifying number and account balance of any accounts on which only the name of the deceased person appears. A financial institution may charge a reasonable fee, not to exceed $2, to provide a public administrator with a statement pursuant to the provisions of this section.

Sec. 23. NRS 357.040 is hereby amended to read as follows:

357.040 1. Except as otherwise provided in NRS 357.050, a person who, with or without specific intent to defraud, does any of the following listed acts is liable to the State or a political subdivision, whichever is affected, for three times the amount of damages sustained by the State or political subdivision because of the act of that person, for the costs of a civil action brought to

recover those damages and for a civil penalty of not less than ~~[$2,000]~~ ***$5,000*** or more than $10,000 for each act:

(a) Knowingly presents or causes to be presented a false claim for payment or approval.

(b) Knowingly makes or uses, or causes to be made or used, a false record or statement to obtain payment or approval of a false claim.

(c) Conspires to defraud by obtaining allowance or payment of a false claim.

(d) Has possession, custody or control of public property or money and knowingly delivers or causes to be delivered to the State or a political subdivision less money or property than the amount for which he receives a receipt.

(e) Is authorized to prepare or deliver a receipt for money or property to be used by the State or a political subdivision and knowingly prepares or delivers a receipt that falsely represents the money or property.

(f) Knowingly buys, or receives as security for an obligation, public property from a person who is not authorized to sell or pledge the property.

(g) Knowingly makes or uses, or causes to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the State or a political subdivision.

(h) Is a beneficiary of an inadvertent submission of a false claim and, after discovering the falsity of the claim, fails to disclose the falsity to the State or political subdivision within a reasonable time.

2. As used in this section, a person acts "knowingly" with respect to information if he:

(a) Has knowledge of the information;

(b) Acts in deliberate ignorance of whether the information is true or false; or

(c) Acts in reckless disregard of the truth or falsity of the information.

Sec. 24. NRS 357.070 is hereby amended to read as follows:

357.070 The Attorney General ~~[may]~~ ***shall*** investigate any alleged liability pursuant to this chapter and may bring a civil action pursuant to this chapter against the person liable.

Sec. 25. NRS 357.080 is hereby amended to read as follows:

357.080 1. Except as otherwise provided in this section and NRS 357.090 and 357.100, a private plaintiff may maintain an action pursuant to this chapter on his own account and that of the State if money, property or services provided by the State are involved, or on his own account and that of a political subdivision if

money, property or services provided by the political subdivision are involved, or on his own account and that of both the State and a political subdivision if both are involved. After such an action is commenced, it may be dismissed only with leave of the court, taking into account the public purposes of this chapter and the best interests of the parties.

2. If a private plaintiff brings an action pursuant to this chapter, no other person may bring another action pursuant to this chapter based on the same facts.

3. An action may not be maintained by a private plaintiff pursuant to this chapter:

(a) Against a member of the Legislature or the Judiciary, an elected officer of the Executive Department of the State Government, or a member of the governing body of a political subdivision, if the action is based upon evidence or information known to the State or political subdivision at the time the action was brought.

(b) If the action is based upon allegations or transactions that are the subject of a civil action or an administrative proceeding for a monetary penalty to which the State or political subdivision is already a party.

4. A complaint filed pursuant to this section must be placed under seal and so remain ***for at least 60 days or*** until the Attorney General has elected whether to intervene. No service may be made upon the defendant until the complaint is unsealed.

5. On the date the private plaintiff files his complaint, he shall send a copy of the complaint to the Attorney General by mail with return receipt requested. He shall send with each copy of the complaint a written disclosure of substantially all material evidence and information he possesses.

6. An action pursuant to this chapter may be brought in any judicial district in this State in which the defendant can be found, resides, transacts business or in which any of the alleged fraudulent activities occurred.

Sec. 26. NRS 357.110 is hereby amended to read as follows:

357.110 1. Within ~~[120]~~ ***60*** days after receiving a complaint and disclosure, the Attorney General may intervene and proceed with the action or he may, for good cause shown, move the court to extend the time for his election whether to proceed. The motion may be supported by affidavits or other submissions in chambers.

2. If the Attorney General elects to intervene, the complaint must be unsealed. If the Attorney General elects not to intervene, the private plaintiff may proceed and the complaint must be unsealed.

Sec. 27. NRS 357.170 is hereby amended to read as follows:

357.170 1. An action pursuant to this chapter may not be commenced more than 3 years after the date ~~[of discovery of the fraudulent activity by]~~ ***on which*** the Attorney General ***discovers, or reasonably should have discovered, the fraudulent activity*** or more than ~~[5]~~ ***6*** years after the fraudulent activity occurred, ~~[whichever is earlier.]~~ ***but in no event more than 10 years after the fraudulent activity occurred.*** Within those limits, an action may be based upon fraudulent activity that occurred before ~~[October 1, 1999.]~~ ***July 1, 2007.***

2. In an action pursuant to this chapter, the standard of proof is a preponderance of the evidence. A finding of guilt in a criminal proceeding charging false statement or fraud, whether upon a verdict of guilty or a plea of guilty or nolo contendere, estops the person found guilty from denying an essential element of that offense in an action pursuant to this chapter based upon the same transaction as the criminal proceeding.

Sec. 28. NRS 361.585 is hereby amended to read as follows:

361.585 1. When the time allowed by law for the redemption of a property described in a certificate has expired, and no redemption has been made, the tax receiver who issued the certificate, or his successor in office, shall execute and deliver to the county treasurer a deed of the property in trust for the use and benefit of the State and county and any officers having fees due them.

2. The county treasurer and his successors in office, upon obtaining a deed of any property in trust under the provisions of this chapter, shall hold that property in trust until it is sold or otherwise disposed of pursuant to the provisions of this chapter.

3. Notwithstanding the provisions of NRS 361.595 or 361.603, at any time during the 90-day period specified in NRS 361.603, or before the public notice of sale by a county treasurer, pursuant to NRS 361.595, of any property held in trust by him by virtue of any deed made pursuant to the provisions of this chapter, any person specified in subsection 4 is entitled to have the property reconveyed upon payment to the county treasurer of an amount equal to the taxes accrued, together with any costs, penalties and interest legally chargeable against the property. A reconveyance may not be made after expiration of the 90-day period specified in NRS 361.603 or after commencement of posting or publication of public notice pursuant to NRS 361.595.

4. Property may be reconveyed pursuant to subsection 3 to one or more of the persons specified in the following categories, or to

one or more persons within a particular category, as their interests may appear of record:

(a) The owner.

(b) The beneficiary under a deed of trust.

(c) The mortgagee under a mortgage.

(d) The person to whom the property was assessed.

(e) The person holding a contract to purchase the property before its conveyance to the county treasurer.

(f) ***The Director of the Department of Health and Human Services if the owner has received or is receiving any benefits from Medicaid.***

(g) The successor in interest of any person specified in this subsection.

5. Any agreement to locate, deliver, recover or assist in the recovery of any property held in trust by a county treasurer by virtue of any deed made pursuant to the provisions of this chapter:

(a) Must:

(1) Be in writing.

(2) Be signed by one or more of the persons identified in subsection 4.

(3) Include a description of the property.

(4) Include the value of the property.

(b) Must not impose a fee that is more than 10 percent of the total value of the property.

6. The provisions of this section apply to land held in trust by a county treasurer on or after April 17, 1971.

Sec. 29. NRS 439B.360 is hereby amended to read as follows:

439B.360 1. The Director shall evaluate the effectiveness of the program established pursuant to NRS 439B.350 annually. The evaluation must include, without limitation ~~[:~~

~~(a) Determining the total number of children under the age of 13 years who reside in this State and the number of such children who have received health care services through a federal, state or local governmental program during the previous year; and~~

~~(b) Measuring]~~ ***, measuring*** the effectiveness of the content, form and method of dissemination of information through the program.

2. The Director shall make any necessary recommendations to improve the program based upon his evaluation.

3. On or before December 31 of each year, the Director shall provide a written report to the Interim Finance Committee concerning the results of the evaluation and any recommendations made to improve the program.

Sec. 30. NRS 449.188 is hereby amended to read as follows:

449.188 1. In addition to the grounds listed in NRS 449.160, the Health Division may deny a license to operate a facility for intermediate care, facility for skilled nursing or residential facility for groups to an applicant or may suspend or revoke the license of a licensee to operate such a facility if:

(a) The applicant or licensee has been convicted of:

(1) Murder, voluntary manslaughter or mayhem;

(2) Assault with intent to kill or to commit sexual assault or mayhem;

(3) Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;

(4) Abuse or neglect of a child or contributory delinquency;

(5) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS, within the past 7 years;

(6) A violation of any provision of NRS 200.50955 or 200.5099;

(7) ***A violation of any provision of NRS 422.450 to 422.590, inclusive;***

(8) Any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property, within the immediately preceding 7 years; or

~~[(8)]~~ ***(9)*** Any other felony involving the use of a firearm or other deadly weapon, within the immediately preceding 7 years; or

(b) The licensee has continued to employ a person who has been convicted of a crime listed in paragraph (a).

2. In addition to the grounds listed in NRS 449.160, the Health Division may deny a license to operate an agency to provide personal care services in the home or an agency to provide nursing in the home to an applicant or may suspend or revoke the license of a licensee to operate such an agency if the licensee has continued to employ a person who has been convicted of a crime listed in paragraph (a) of subsection 1.

Sec. 31. NRS 689A.430 is hereby amended to read as follows:

689A.430 1. An insurer shall not, when considering eligibility for coverage or making payments under a policy of health insurance, consider the availability of, or eligibility of a person for, medical assistance under Medicaid.

2. To the extent that payment has been made by Medicaid for health care, an insurer, ***self-insured plan,*** group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 **,** ~~[(]~~ 29 U.S.C.A. § 1167(1) **,** ~~[),]~~ service

benefit plan ~~[, health maintenance organization]~~ or other organization that has issued a policy of health insurance:

(a) Shall treat Medicaid as having a valid and enforceable assignment of an insured's benefits regardless of any exclusion of Medicaid or the absence of a written assignment; and

(b) May, as otherwise allowed by the policy, evidence of coverage or contract and applicable law or regulation concerning subrogation, seek to enforce any right of a recipient of Medicaid to reimbursement against any other liable party if:

(1) It is so authorized pursuant to a contract with Medicaid for managed care; or

(2) It has reimbursed Medicaid in full for the health care provided by Medicaid to its insured.

3. If a state agency is assigned any rights of a person who is:

(a) Eligible for medical assistance under Medicaid; and

(b) Covered by a policy of health insurance,

➥ the insurer that issued the policy shall not impose any requirements upon the state agency except requirements it imposes upon the agents or assignees of other persons covered by the policy.

4. If a state agency is assigned any rights of an insured who is eligible for medical assistance under Medicaid, an insurer shall:

(a) Upon request of the state agency, provide to the state agency information regarding the insured to determine:

(1) Any period during which the insured, his spouse or dependent may be or may have been covered by the insurer; and

(2) The nature of the coverage that is or was provided by the insurer, including, without limitation, the name and address of the insured and the identifying number of the policy, evidence of coverage or contract;

(b) Respond to any inquiry by the state agency regarding a claim for payment for the provision of any medical item or service not later than 3 years after the date of the provision of the medical item or service; and

(c) Agree not to deny a claim submitted by the state agency solely on the basis of the date of submission of the claim, the type or format of the claim form or failure to present proper documentation at the point of sale that is the basis for the claim if:

(1) The claim is submitted by the state agency not later than 3 years after the date of the provision of the medical item or service; and

(2) Any action by the state agency to enforce its rights with respect to such claim is commenced not later than 6 years after the submission of the claim.

Sec. 32. NRS 689B.300 is hereby amended to read as follows:

689B.300 1. An insurer shall not, when considering eligibility for coverage or making payments under a group health policy, consider the availability of, or eligibility of a person for, medical assistance under Medicaid.

2. To the extent that payment has been made by Medicaid for health care, an insurer, ***self-insured plan,*** group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 **,** ~~[(]~~ 29 U.S.C.A. § 1167(1) **,** ~~[), health maintenance organization]~~ or other organization that has issued a group health policy:

(a) Shall treat Medicaid as having a valid and enforceable assignment of an insured's benefits regardless of any exclusion of Medicaid or the absence of a written assignment; and

(b) May, as otherwise allowed by the policy, evidence of coverage or contract and applicable law or regulation concerning subrogation, seek to enforce any rights of a recipient of Medicaid to reimbursement against any other liable party if:

(1) It is so authorized pursuant to a contract with Medicaid for managed care; or

(2) It has reimbursed Medicaid in full for the health care provided by Medicaid to its insured.

3. If a state agency is assigned any rights of a person who is:

(a) Eligible for medical assistance under Medicaid; and

(b) Covered by a group health policy,

➥ the insurer that issued the policy shall not impose any requirements upon the state agency except requirements it imposes upon the agents or assignees of other persons covered by the policy.

4. If a state agency is assigned any rights of an insured who is eligible for medical assistance under Medicaid, an insurer shall:

(a) Upon request of the state agency, provide to the state agency information regarding the insured to determine:

(1) Any period during which the insured, his spouse or dependent may be or may have been covered by the insurer; and

(2) The nature of the coverage that is or was provided by the insurer, including, without limitation, the name and address of the insured and the identifying number of the policy;

(b) Respond to any inquiry by the state agency regarding a claim for payment for the provision of any medical item or service not later than 3 years after the date of the provision of the medical item or service; and

(c) Agree not to deny a claim submitted by the state agency solely on the basis of the date of submission of the claim, the type

or format of the claim form or failure to present proper documentation at the point of sale that is the basis for the claim if:

(1) The claim is submitted by the state agency not later than 3 years after the date of the provision of the medical item or service; and

(2) Any action by the state agency to enforce its rights with respect to such claim is commenced not later than 6 years after the submission of the claim.

Sec. 33. NRS 695A.151 is hereby amended to read as follows:

695A.151 1. A society shall not, when considering eligibility for coverage or making payments under a certificate for health benefits, consider the availability of, or eligibility of a person for, medical assistance under Medicaid.

2. To the extent that payment has been made by Medicaid for health care, a society:

(a) Shall treat Medicaid as having a valid and enforceable assignment of an insured's benefits regardless of any exclusion of Medicaid or the absence of a written assignment; and

(b) May, as otherwise allowed by its certificate for health benefits, evidence of coverage or contract and applicable law or regulation concerning subrogation, seek to enforce any reimbursement rights of a recipient of Medicaid against any other liable party if:

(1) It is so authorized pursuant to a contract with Medicaid for managed care; or

(2) It has reimbursed Medicaid in full for the health care provided by Medicaid to its insured.

3. If a state agency is assigned any rights of a person who is:

(a) Eligible for medical assistance under Medicaid; and

(b) Covered by a certificate for health benefits,

➥ the society that issued the health policy shall not impose any requirements upon the state agency except requirements it imposes upon the agents or assignees of other persons covered by the certificate.

4. If a state agency is assigned any rights of an insured who is eligible for medical assistance under Medicaid, a society that issues a certificate for health benefits, evidence of coverage or contract shall:

(a) Upon request of the state agency, provide to the state agency information regarding the insured to determine:

(1) Any period during which the insured, his spouse or dependent may be or may have been covered by the society; and

(2) The nature of the coverage that is or was provided by the society, including, without limitation, the name and address of

the insured and the identifying number of the certificate for health benefits, evidence of coverage or contract;

(b) Respond to any inquiry by the state agency regarding a claim for payment for the provision of any medical item or service not later than 3 years after the date of the provision of the medical item or service; and

(c) Agree not to deny a claim submitted by the state agency solely on the basis of the date of submission of the claim, the type or format of the claim form or failure to present proper documentation at the point of sale that is the basis for the claim if:

(1) The claim is submitted by the state agency not later than 3 years after the date of the provision of the medical item or service; and

(2) Any action by the state agency to enforce its rights with respect to such claim is commenced not later than 6 years after the submission of the claim.

Sec. 34. NRS 695B.340 is hereby amended to read as follows:

695B.340 1. A corporation shall not, when considering eligibility for coverage or making payments under a contract, consider the availability of, or any eligibility of a person for, medical assistance under Medicaid.

2. To the extent that payment has been made by Medicaid for health care, a corporation:

(a) Shall treat Medicaid as having a valid and enforceable assignment of benefits of a subscriber or policyholder or claimant under him regardless of any exclusion of Medicaid or the absence of a written assignment; and

(b) May, as otherwise allowed by the policy, evidence of coverage or contract and applicable law or regulation concerning subrogation, seek to enforce any rights of a recipient of Medicaid against any other liable party if:

(1) It is so authorized pursuant to a contract with Medicaid for managed care; or

(2) It has reimbursed Medicaid in full for the health care provided by Medicaid to its subscriber or policyholder.

3. If a state agency is assigned any rights of a person who is:

(a) Eligible for medical assistance under Medicaid; and

(b) Covered by a contract,

➥ the corporation that issued the contract shall not impose any requirements upon the state agency except requirements it imposes upon the agents or assignees of other persons covered by the same contract.

4. If a state agency is assigned any rights of a subscriber or policyholder who is eligible for medical assistance under Medicaid, a corporation shall:

(a) Upon request of the state agency, provide to the state agency information regarding the subscriber or policyholder to determine:

(1) Any period during which the subscriber or policyholder, his spouse or dependent may be or may have been covered by a contract; and

(2) The nature of the coverage that is or was provided by the corporation, including, without limitation, the name and address of the subscriber or policyholder and the identifying number of the contract;

(b) Respond to any inquiry by the state agency regarding a claim for payment for the provision of any medical item or service not later than 3 years after the date of the provision of the medical item or service; and

(c) Agree not to deny a claim submitted by the state agency solely on the basis of the date of submission of the claim, the type or format of the claim form or failure to present proper documentation at the point of sale that is the basis for the claim if:

(1) The claim is submitted by the state agency not later than 3 years after the date of the provision of the medical item or service; and

(2) Any action by the state agency to enforce its rights with respect to such claim is commenced not later than 6 years after the submission of the claim.

Sec. 35. NRS 695C.163 is hereby amended to read as follows:

695C.163 1. A health maintenance organization shall not, when considering eligibility for coverage or making payments under a health care plan, consider the availability of, or eligibility of a person for, medical assistance under Medicaid.

2. To the extent that payment has been made by Medicaid for health care, a health maintenance organization:

(a) Shall treat Medicaid as having a valid and enforceable assignment of benefits due an enrollee or claimant under him regardless of any exclusion of Medicaid or the absence of a written assignment; and

(b) May, as otherwise allowed by its plan, evidence of coverage or contract and applicable law or regulation concerning subrogation, seek to enforce any rights of a recipient of Medicaid to reimbursement against any other liable party if:

(1) It is so authorized pursuant to a contract with Medicaid for managed care; or

(2) It has reimbursed Medicaid in full for the health care provided by Medicaid to its enrollee.

3. If a state agency is assigned any rights of a person who is:

(a) Eligible for medical assistance under Medicaid; and

(b) Covered by a health care plan,

➥ the organization responsible for the health care plan shall not impose any requirements upon the state agency except requirements it imposes upon the agents or assignees of other persons covered by the same plan.

4. If a state agency is assigned any rights of an enrollee who is eligible for medical assistance under Medicaid, a health maintenance organization shall:

(a) Upon request of the state agency, provide to the state agency information regarding the enrollee to determine:

(1) Any period during which the enrollee, his spouse or dependent may be or may have been covered by the health care plan; and

(2) The nature of the coverage that is or was provided by the organization, including, without limitation, the name and address of the enrollee and the identifying number of the health care plan;

(b) Respond to any inquiry by the state agency regarding a claim for payment for the provision of any medical item or service not later than 3 years after the date of the provision of the medical item or service; and

(c) Agree not to deny a claim submitted by the state agency solely on the basis of the date of submission of the claim, the type or format of the claim form or failure to present proper documentation at the point of sale that is the basis for the claim if:

(1) The claim is submitted by the state agency not later than 3 years after the date of the provision of the medical item or service; and

(2) Any action by the state agency to enforce its rights with respect to such claim is commenced not later than 6 years after the submission of the claim.

Sec. 36. NRS 695F.440 is hereby amended to read as follows:

695F.440 1. An organization shall not, when considering eligibility for coverage or making payments under any evidence of coverage, consider the availability of, or eligibility of a person for, medical assistance under Medicaid.

2. To the extent that payment has been made by Medicaid for health care **,** a prepaid limited health service organization:

(a) Shall treat Medicaid as having a valid and enforceable assignment of benefits due a subscriber or claimant under him

regardless of any exclusion of Medicaid or the absence of a written assignment; and

(b) May, as otherwise allowed by its evidence of coverage or contract and applicable law or regulation concerning subrogation, seek to enforce any rights of a recipient of Medicaid against any other liable party if:

(1) It is so authorized pursuant to a contract with Medicaid for managed care; or

(2) It has reimbursed Medicaid in full for the health care provided by Medicaid to its subscriber.

3. If a state agency is assigned any rights of a person who is:

(a) Eligible for medical assistance under Medicaid; and

(b) Covered by any evidence of coverage,

➥ the prepaid limited health service organization that issued the evidence of coverage shall not impose any requirements upon the state agency except requirements it imposes upon the agents or assignees of other persons covered by any evidence of coverage.

4. If a state agency is assigned any rights of a subscriber who is eligible for medical assistance under Medicaid, a prepaid limited health service organization shall:

(a) Upon request of the state agency, provide to the state agency information regarding the subscriber to determine:

(1) Any period during which the subscriber, his spouse or dependent may be or may have been covered by the organization; and

(2) The nature of the coverage that is or was provided by the organization, including, without limitation, the name and address of the subscriber and the identifying number of the evidence of coverage;

(b) Respond to any inquiry by the state agency regarding a claim for payment for the provision of any medical item or service not later than 3 years after the date of the provision of the medical item or service; and

(c) Agree not to deny a claim submitted by the state agency solely on the basis of the date of submission of the claim, the type or format of the claim form or failure to present proper documentation at the point of sale that is the basis for the claim if:

(1) The claim is submitted by the state agency not later than 3 years after the date of the provision of the medical item or service; and

(2) Any action by the state agency to enforce its rights with respect to such claim is commenced not later than 6 years after the submission of the claim.

Sec. 37. This act becomes effective on July 1, 2007.