OPINION NO. 85-063

Syllabus:

1. Pursuant to R.C. 5111.31(A)(4), a nursing home which participates as a provider in Ohio's Medicaid program may not require a prospective nursing home patient who is, becomes, or who may, as a patient in the home, become a recipient of Medicaid benefits, or the patient's family, to enter into an agreement, as a condition of the patient's admission to the home, wherein the patient or his family agrees to relieve the home from accepting Medicaid payments in lieu of payments at private rates until the patient has resided in the home for a period of one year as a private patient, if less than eighty per cent of the patients in the home are Medicaid recipients, unless the home meets the exception set forth in R.C. 5111.31(E).

2. Pursuant to 42 U.S.C. §1396h(d)(2)(A) and applicable state law, a nursing home that participates as a provider in Ohio's Medicaid program may not require a prospective nursing home patient who is, becomes, or who may, as a patient in the home, become a recipient of Medicaid benefits, or the patient's family, to enter into an agreement, as a condition of the patient's admission to the home, wherein the patient or his family agrees to pay to the home the difference between the private rate established by the home and the amount reimbursed to the home through the Medicaid program for the patient's care.

To: Joyce F. Chapple, Director, Ohio Department of Aging, Columbus, Ohio
By: Anthony J. Celebrezze, Jr., Attorney General, September 24, 1985

I have before me your predecessor's request for my opinion regarding the question whether Ohio nursing homes[1] which participate in the medical assistance

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[1] The term "nursing home," as used in this opinion, comprises the terms "skilled nursing facility," "intermediate care facility," and "dual skilled nursing and intermediate care facility" as those terms are used in R.C. 5111.20-.32. See R.C. 5111.20; 7 Ohio Admin. Code Chapter 5101:3-3.

reimbursement program may require prospective nursing home residents and/or their families to guarantee payment for up to one year at private rates as a condition of admission to such nursing homes. It is my understanding that such guarantees are usually secured by contracts which provide either: (1) that the nursing home provider is not obligated to accept Medicaid payments from the resident in lieu of private rate payments until the resident has resided in the home for a period of one year as a private patient; or (2) that the nursing home provider has the right to credit against the sums due it at private rates from the resident any amounts received by the home on behalf of the resident from the Medicaid reimbursement program. See Glengariff Corp. v. Snook, 122 Misc. 2d 784, 471 N.Y.S.2d 973 (Sup. Ct. 1984).

Before addressing your specific question, I will generally discuss Ohio's medical assistance program, which will hereinafter be referred to as the Medicaid program.

> Medicaid is a federal/state financed program whereby medical, rehabilitative, and other health-related services are furnished, through public and private sources, to eligible families with dependent children and to eligible aged, blind, or disabled individuals whose income and resources are insufficient to meet the cost of necessary medical care.

[1984-1985 Monthly Record] Ohio Admin. Code 5101:3-1-51(A) at 291. See 7 Ohio Admin. Code 5101:3-1-53; 1981 Op. Att'y Gen. No. 81-064 (describing the structure of the Medicaid program and the relationship between the state and the federal government in the administration and regulation of the program). Under the Medicaid program, a nursing home that has been certified by the Ohio Department of Health pursuant to R.C. Chapter 3721 may enter into a contractual agreement with the Ohio Department of Human Services known as a provider agreement. R.C. 5111.21. See R.C. 5111.20(D); R.C. 5111.22. Pursuant to the terms of the provider agreement, the nursing home must agree to provide services to qualified Medicaid recipients, see R.C. 5111.02, in return for which the home will receive a per diem per patient rate for certain actual, allowable costs. See R.C. 5111.22-.25.

Turning to the first of the contract provisions described above, whereby a nursing home provider is not obligated to accept Medicaid payments from the resident until the resident has resided in the home for one year as a private patient, I note that you have drawn my attention to R.C. 5111.31, which states in pertinent part:

> (A) On and after July 1, 1983, every provider agreement with a home shall:
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> (1) Prohibit the home from failing or refusing to retain as a patient any person because he is, becomes, or may, as a patient in the home, become a recipient of assistance under the medical assistance program. For the purposes of this division, a recipient of medical assistance who is a patient in a home shall be considered a patient in the home during any hospital stays totaling less than twenty-five days during any twelve-month period. Recipients who have been identified by the department of public welfare or its designee as requiring the level of care of an intermediate care facility for the mentally retarded shall not be subject to a maximum period of absences during which they are considered patients if prior authorization of the department for visits with relatives and friends and participation in therapeutic programs is obtained under rules adopted under section 5111.02 of the Revised Code.
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> (4) Prohibit the home from failing or refusing to accept a patient because he is, becomes, or may, as a patient in the home, become a recipient of assistance under the medical assistance program if less than eighty per cent of the patients in the home are recipients of medical assistance.
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> . . . .

(D) No home with which a provider agreement is in effect shall violate the provider contract obligations imposed under this section.

(E) Nothing in divisions (A) and (B) of this section shall bar any home from retaining patients who have resided in the home for not less than one year as private pay patients and who subsequently become recipients of assistance under the medicaid program, but refusing to accept as a patient any person who is or may, as a patient in the home, become a recipient of assistance under the medicaid program, if all of the following apply:

(1) The home does not refuse to retain any patient who has resided in the home for not less than one year as a private pay patient because he becomes a recipient of assistance under the medicaid program, except as necessary to comply with division (E)(2) of this section;

(2) The number of medicaid recipients retained under this division does not at any time exceed ten per cent of all the patients in the home;

(3) On July 1, 1980, all the patients in the home were private pay patients.

As quoted above, R.C. 5111.31(A)(4) requires every provider agreement to contain language prohibiting a nursing home "from failing or refusing to accept a patient" who is a recipient of Medicaid assistance at the time of application for admission or who becomes or may become a recipient following admission, "if less than eighty per cent of the patients in the home are recipients of medical assistance." Although subsection (A)(4) prohibits provider nursing homes from flatly "failing or refusing to accept" enrolled or prospective Medicaid recipients under the conditions set forth in the statute, it does not expressly address the pre-admission agreement under which a provider is not obligated to accept Medicaid payments until a patient has resided in a home for one year as a private patient. It is clear, nevertheless, that by enacting R.C. 5111.31, the legislature intended to prohibit discriminatory actions by nursing homes against enrolled or prospective Medicaid recipients. See Op. No. 81-064, note 3, infra.

Inasmuch as R.C. 5111.31 does not expressly require provider agreements to prohibit the type of agreement that is the subject of this opinion, I must resort to rules of statutory construction to determine whether the statute may be construed to provide an answer to your question. It is a principle of statutory construction that a statute must be construed to give effect to the intention of the legislature in enacting it, and that, in determining that intention, a court must consider the purpose to be accomplished by the statutory enactment. Humphrys v. Winous Co., 165 Ohio St. 45, 133 N.E.2d 780 (1956). As discussed above, the intent of the General Assembly in enacting R.C. 5111.31 was to remove impediments to admission to nursing homes on the part of current or prospective Medicaid beneficiaries. By requiring prospective patients or residents to guarantee payments for up to one year at private rates, a home is, in effect, refusing to accept patients who are Medicaid beneficiaries or who may become Medicaid beneficiaries within one year of admission. I believe that this requirement violates R.C. 5111.31(A)(4) unless eighty per cent or more of the patients in the home are Medicaid recipients. See R.C. 5111.03; R.C. 5111.32 (patient's remedy against a nursing home for breach of provider agreement obligations imposed by R.C. 5111.31).

I note, however, that the prohibition of R.C. 5111.31(A)(4) is inapplicable to the circumstances set forth in division (E) of R.C. 5111.31. Division (E) provides that a home may retain patients who have resided in the home for not less than one year as private pay patients and who subsequently become Medicaid recipients, but refuse to accept a person who is, or may, as a patient in the home, become a Medicaid recipient if: (1) the home does not refuse to retain a patient who has resided for one year or more as a private pay patient because he has become a Medicaid recipient, except as necessary to comply with R.C. 5111.31(E)(2), which provides that the number of Medicaid recipients retained thereunder does not at any time exceed ten percent of the patients in the home; (2) the number of Medicaid recipients retained under R.C. 5111.31(E) does not exceed ten percent of all

the patients in the home; and (3) all the patients in the home were, on July 1, 1980, private pay patients. Thus, any nursing home which falls within the terms of R.C. 5111.31(E) is not prohibited by R.C. 5111.31(A)(4) from refusing to accept patients who are or may become Medicaid recipients, as permitted by R.C. 5111.31(E). It appears that, in such circumstances, the nursing home may require prospective patients to guarantee payments for up to one year at private rates, and if they are unable or unwilling to do so, refuse to accept them.

In sum, I conclude that, pursuant to R.C. 5111.31(A)(4), a prospective nursing home patient who is, becomes, or who may, as a patient in the home, become a recipient of Medicaid benefits may not be required, as a condition of admission, to agree to relieve the home from accepting Medicaid payments in lieu of private rate payments until the patient has resided in the home for a period of one year as a private patient, if less than eighty percent of the patients in the home are Medicaid recipients, unless the home satisfies the exceptions set forth in R.C. 5111.31(E).[2]

I further conclude that a prospective nursing home resident or patient may not by contract waive the protections afforded him by R.C. 5111.31. It is a basic principle of law that no one may lawfully do that which tends to contravene public policy, and that contracts which cause results which the law seeks to prevent are unenforceable as against public policy. See Glengariff Corp. v. Snook; Weber v. Sternad, 69 Ohio App. 258, 39 N.E.2d 623 (Cuyahoga County 1941), aff'd, 140 Ohio St. 253, 43 N.E.2d 227 (1942); Dayton Mortgage & Investment Co. v. Theis, 62 Ohio App. 169, 23 N.E.2d 511 (Montgomery County 1939). Clearly, the public policy expressed in R.C. 5111.31 is that Medicaid patients not be discriminated against for the reason that " 'private pay patients are more lucrative for providers.' "[3] Thus, any contract provision that tends to discriminate against Medicaid patients, as does

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2 R.C. 5111.31(A)(1), quoted above, prohibits a home from failing or refusing to retain a patient because he has become a Medicaid patient, and, as set forth elsewhere in this opinion, I believe that this statute also prohibits a home from refusing to accept Medicaid reimbursement payments on behalf of a patient if he becomes a Medicaid recipient as a patient in the home, and from discharging him for failure to pay the costs of his care at private rates. Such discharge would also be prohibited by 42 C.F.R. §442.311(c)(3), since under this regulation discharge may not occur for reasons of nonpayment where "prohibited by the Medicaid program," and discharge under these circumstances is in fact prohibited by force of R.C. 5111.31(A)(1). See 42 C.F.R. §442.311 (Residents' Bill of Rights); R.C. 3721.13(A)(3) and (28). See also 1981 Op. Att'y Gen. No. 81-064 at 2-265 (Ohio's Medicaid program must be administered and controlled in accordance with federal regulations; "[t]he program is federally controlled in its substance because it has, as its statutory beginning point, Title XIX of the Social Security Act §620, 42 U.S.C. §301 (1974), as amended, rather than state law").

3 Op. No. 81-064 at 2-267, quoting A Program in Crisis: Blueprint For Action, Final Report, Ohio Nursing Home Commission (1979). As my predecessor noted in Op. No. 81-064, the Ohio General Assembly, cognizant of the problems associated with permitting nursing home owners to control the extent to which beds were made available to Medicaid patients, initiated a legislative study of Ohio's nursing home industry and the state's Medicaid program which led to the release of the Report identified above. In this Report, the Commission pinpointed the fact that the ability of Medicaid providers to discriminate against Medicaid patients perpetuated the existence of homes of poor quality for Medicaid patients and homes offering high-quality care for private pay patients. The Commission's recommendations for dealing with such discrimination were incorporated into Am. Sub. H.B. 176, 113th Gen. A. (1979) (eff. July 1, 1980), which contained R.C. 5111.31 in its original form. The prohibitions against discrimination have remained substantially the same since the enactment of Am. Sub. H.B. 176. See Am. Sub. H.B. 291, 115th Gen. A. (1983) (eff. July 1, 1983).

the first type of provision discussed above, is unenforceable as against public policy.[4] Cf. R.C. 3721.13(C) (an attempted waiver of a nursing home resident's rights, which are set forth in R.C. 3721.13(A), is void).

With respect to the second type of provision that may be found in a pre-admission agreement, whereby a nursing home contracts for the right to credit against the amounts due to it from the patient at private rates any amounts reimbursed to the home from the Medicaid program, I conclude that the home's act of entering into a contract containing such a provision appears to be unlawful pursuant to 42 U.S.C. §1396h(d), which provides:

> Whoever knowingly and willfully—
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> (2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this subchapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—
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> (A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or
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> (B) as a requirement for the patient's continued stay in such a facility,
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> when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

I concur with the opinion expressed by the court in Glengariff Corp. v. Snook, 122 Misc. 2d at 788, 471 N.Y.S.2d at 976, which, in discussing the effect of this statute, stated:

> a nursing home operator who required monetary "supplements" from nonfinancially responsible relatives of patients for whom it received Medicaid reimbursement could be found guilty under the cited section. (United States v. Zacher, 586 F2d 912 [dicta].) A violation of this statute occurs whenever a provider of services charges in excess of rates established by the State.

More specifically, in order for a violation of 42 U.S.C. §1396h(d)(2)(A) to occur, a provider must "knowingly and willfully. . .(2) [charge]. . .in addition to any amount otherwise required to be paid under a State plan. . .money. . .or other consideration. . .(A) as a precondition of admitting a patient to a [nursing home]." "Charge" means, "[t]o impose a burden, duty, obligation, or lien. . . ." Black's Law Dictionary 211 (5th ed. 1979). Whenever a nursing home which participates as a provider in the Medicaid program requires a prospective nursing home patient or his family, as a condition of the patient's admission to the home, to agree to pay the difference between the private rate established by the home and the amount reimbursed to the home through the Medicaid program for the patient's care, the patient or his family assumes a burden or incurs an obligation, and is therefore, charged an amount in addition to the amount for which the home is reimbursed for the patient's care through the Medicaid program. Such a charge provides a basis for establishing a violation of the statute. See generally Sparks v. George A. Sawaya, M.D., Inc., 9 Ohio App. 3d 275, 276, 459 N.E.2d 901, 903 (Franklin County 1983) ("the medicaid regulations and the provider agreement both require the provider to accept as full payment the amount received from medicaid. . . .Additional payments cannot be accepted from the recipient or her

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[4] Again, however, Ohio law does permit a nursing home to consider a patient's status under Medicaid if eighty per cent or more of the patients in the home are recipients of Medicaid, R.C. 5111.31(A)(4), or if the home satisfies the conditions set forth in R.C. 5111.31(E)(1)-(3).

family. . .and the patient cannot be billed for additional amounts in excess to that received from medicaid").

42 C.F.R. §447.15 further provides in part that: "A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual." I believe that R.C. 5111.31(A)(1) and (4) may be interpreted as prohibiting a provider from charging a patient or his family the difference between the private rate and the amount reimbursed through Medicaid, since such an arrangement, in effect, prohibits a person who is or who may become a recipient of Medicaid from receiving the full benefit of Medicaid assistance if he wishes to be admitted to or remain in the nursing home. Further, R.C. 5111.03(A) provides that, "[n]o provider shall willfully receive payments to which the provider is not entitled, or willfully receive payments in a greater amount than that to which the provider is entitled." See R.C. 5111.03(B)-(F) (setting forth the penalties and other consequences imposed upon one who violates R.C. 5111.03(A)). 7 Ohio Admin. Code 5101:3-1-55(A)(2) states that a provider must agree in the provider agreement to, "[a]ccept as payment in full the amounts paid in accordance with state law. . .and make no additional charge to the patient, any member of the family or to any other source for any supplement." See [1984-1985 Monthly Record] Ohio Admin. Code 5101:3-1-58(A)(5) at 293 (provider fraud or abuse may include a "[v]iolation of provider agreement by requesting or obtaining additional payment for the services rendered from either the recipient or recipient's family"). See generally R.C. 5111.02(C) and R.C. 5111.22-.25 (providing for the manner and amount of reimbursement to be made to Medicaid providers). In sum, 42 U.S.C. §1396h(d)(2) and the various applicable state provisions prohibit a nursing home provider from requiring a prospective nursing home patient who is, becomes, or who may become, a recipient of Medicaid benefits, as a condition of the patient's admission to the nursing home, to enter into an agreement wherein the patient or his family agrees to pay to the home the difference between the private rate and the amount reimbursed to the home from Medicaid. Again, I believe that a prospective nursing home resident may not waive the protections afforded him by federal and state law, since such a waiver would be in apparent violation of public policy. See Glengariff Corp. v. Snook.

In conclusion, it is my opinion, and you are advised, that:

1. Pursuant to R.C. 5111.31(A)(4), a nursing home which participates as a provider in Ohio's Medicaid program may not require a prospective nursing home patient who is, becomes, or who may, as a patient in the home, become a recipient of Medicaid benefits, or the patient's family, to enter into an agreement, as a condition of the patient's admission to the home, wherein the patient or his family agrees to relieve the home from accepting Medicaid payments in lieu of payments at private rates until the patient has resided in the home for a period of one year as a private patient, if less than eighty per cent of the patients in the home are Medicaid recipients, unless the home meets the exception set forth in R.C. 5111.31(E).

2. Pursuant to 42 U.S.C. §1396h(d)(2)(A) and applicable state law, a nursing home that participates as a provider in Ohio's Medicaid program may not require a prospective nursing home patient who is, becomes, or who may, as a patient in the home, become a recipient of Medicaid benefits, or the patient's family, to enter into an agreement, as a condition of the patient's admission to the home, wherein the patient or his family agrees to pay to the home the difference between the private rate established by the home and the amount reimbursed to the home through the Medicaid program for the patient's care.