Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Iroquois Memorial Hospital,
(CCN: 140167),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-16-169

Decision No. CR5005

Date: January 8, 2018

DECISION

Petitioner, Iroquois Memorial Hospital, applied to participate as a "critical access hospital" under the Medicare Rural Hospital Flexibility Program. Initially and on reconsideration, the Centers for Medicare and Medicaid Services (CMS) denied its application. Petitioner appeals. The parties agree that no material facts are in dispute and have filed cross-motions for summary disposition.

I agree that this case presents no genuine dispute of material facts and turns on a question of law. For the reasons set forth below, I find that CMS is entitled to judgment as a matter of law. I therefore grant CMS's motion and deny Petitioner's.

Background

Section 1820 of the Social Security Act (Act) establishes the Medicare Rural Hospital Flexibility Program, which requires participating states to develop at least one rural health network and to have at least one facility in the state designated as a critical access hospital. Act § 1820(c)(1). A critical access hospital is eligible for higher levels of reimbursement than other facilities. *See* Act §§ 1814(l)(1), 1820(g)(1)(D), 1834(l),

1861(v). Regulations implementing the statutory provisions are found at 42 C.F.R. Part 485, subpart F. To be designated a critical access hospital, a hospital must meet all statutory and regulatory requirements. 42 C.F.R. § 485.601(b).

Iroquois Memorial Hospital is an acute care hospital, located in Watseka, Illinois. On April 29, 2015, it applied for "critical access hospital" (also referred to as a "CAH") status. CMS Ex. 6. In a letter dated July 30, 2015, CMS denied Petitioner's request, and Petitioner sought reconsideration. CMS Exs. 7, 8. By letter dated November 2, 2015, CMS again denied Petitioner's request, finding that the Iroquois Memorial did not satisfy the proximity requirements for a critical access hospital because it is within a 35-mile drive of another hospital. P. Ex. 1.

Petitioner timely requested a hearing before an administrative law judge.

The parties have filed cross-motions for summary disposition. With its motion and brief (CMS Br.), CMS submits 11 exhibits (CMS Exs. 1-11). With its motion and brief (P. Br.), Petitioner submits 11 exhibits (P. Exs. 1-11). CMS filed a reply (CMS Reply). Petitioner filed a sur-reply (P. sur-reply) and three additional exhibits (P. Exs. 12-14).

Issues

The parties agree that no material facts are in dispute and that the case can be decided on summary disposition.

On the merits, the sole issue before me is whether Petitioner qualifies as a critical access hospital. Specifically, does Iroquois Memorial satisfy the proximity requirement for a critical access hospital?

Discussion

> ***CMS is entitled to summary judgment because the undisputed facts establish that Iroquois Memorial Hospital is less than a 35-mile drive from two other hospitals and does not otherwise meet the proximity requirement for a critical access hospital. 42 C.F.R. § 485.610(c).***[1]

CMS will not designate Iroquois Memorial as a critical access hospital because it is too close to other hospitals. A critical access hospital must be "located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from ***a*** hospital or [critical access hospital]." Act § 1820(c)(2)(B)(i)(I) (emphasis added); 42 C.F.R. § 485.610(c). In a manual provision, CMS makes plain that, to qualify, a critical access hospital "must be located more than a

[1] I make this one finding of fact/conclusion of law.

35-mile drive from ***any*** hospital or other [critical access hospital]." State Operations Manual (SOM) § 2256A (Rev. 90, eff. 08/30/13) (emphasis added), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R90SOMA.pdf; *see also* CMS Ex. 11 at 4.[2]

The parties agree that Iroquois Memorial is within a 35-mile drive of three other hospitals:

- Regional Community Hospital in Hoopeston, Illinois, is about 25 miles from Iroquois Memorial, but that distance must be traveled over secondary roads. The parties agree that, if this were the only other hospital in the area, Petitioner would meet the proximity requirement.

- Presence St. Mary's Hospital, in Kankakee, Illinois, is 32 to 33 miles from Iroquois Memorial; two-thirds of that distance can be traveled over primary roads.

- Riverside Medical Center, also in Kankakee (and within a mile of Presence St. Mary's) is just under 33 miles from Iroquois Memorial; two thirds of that distance can be traveled over primary roads.

CMS Exs. 3, 4, 5; P. Exs. 3, 5, 6, 7; *see* CMS Br. at 3, 5-6; P. Br. at 5, 7. Thus, based on the plain language of the statute and regulations, CMS must deny Iroquois Memorial's request for status as a critical access hospital. It is less than a 35-mile drive from two other hospitals, traveling mostly over primary roads, and thus does not meet the proximity requirements set forth in the statute and regulations. Act § 1820(c)(2)(B)(i)(I); 42 C.F.R. § 485.610(c).

Petitioner nevertheless argues that I should disregard the two hospitals that are mainly accessible over primary roads (Presence St. Mary's and Riverside). In Petitioner's view, CMS may consider only the geographically *nearest* hospital when it determines whether a hospital qualifies as a critical access hospital.

I reject Petitioner's position because it is not consistent with the statute and regulations and because it undermines the legislative goals of the Medicare Rural Hospital Flexibility Program. The statutory and regulatory language is unambiguous: the applicant cannot qualify as a critical access hospital if it is located less than 35 miles from "*a* hospital or [critical access hospital]." Act § 1820(c)(2)(B)(i)(I); 42 C.F.R. § 485.610(c). The word "nearest" does not appear anywhere in the statute or regulation, and, contrary to

[2] CMS cited to an earlier version of section 2256A, which was revised on August 30, 2013. SOM § 2256A (Rev. 32, eff. 09/07/07), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf. However, the revisions were not material to the issue before me.

Petitioner's repeated suggestions, the word "a" does not mean "nearest." If the meaning of "a hospital" were at all ambiguous (which it is not) the State Operations Manual settles the matter: "a hospital" means "any hospital." SOM § 2256A. I find this a reasonable – perhaps the only reasonable – interpretation of the statutory language and therefore entitled to deference. *See Baylor Cnty. Hosp. Dist*., DAB No. 2617 at 4 (2015), *aff'd Baylor Cnty. Hosp. Dist. v. Price*, No. 16-10310 (5th Cir. 2017).

Petitioner points to several administrative and court decisions which, in determining whether an applicant institution satisfies the proximity requirement, refer to its distance from "the nearest hospital." But these cases focus on CMS's classification of roads as "primary" versus "secondary" and how CMS calculates distances between the applicant institution and the nearby hospital that jeopardizes its eligibility. Not one of the cases cited involved more than one hospital in relatively close proximity to the applicant institution. And the hospital that disqualified (or threatened to disqualify) the applicant institution was, not surprisingly, the "nearest." The adjudicator was simply describing the location of the relevant hospital, not creating an entirely new standard (inconsistent with the statute and regulations) for assessing whether an applicant meets the proximity requirements.[3]

Indeed, given the purpose of the Medicare Rural Hospital Flexibility program, it would be very unusual – perhaps unheard of – to find three hospitals within 35 miles of a critical access hospital. As the Departmental Appeals Board has noted, the funding for critical access hospitals was "narrowly targeted to a subset of rural hospitals that were *less accessible and more isolated* from other sources of hospital care than other such hospitals." *Baylor*, DAB No. 2617 at 5 (emphasis added).

Where, as here, two easily-accessible hospitals lie within a relatively short distance of the applicant institution, the area's Medicare beneficiaries have access to hospital services without need for an additional critical access hospital. That a third hospital is technically closer, but more difficult to get to, does not make the two hospitals any less accessible to

[3] Petitioner also finds significant some language in CMS's brief and notice letters that, rather than referring to the statutory and regulatory term ("a hospital"), say "nearest hospital." P. Br. at 8-10. While CMS could certainly have been more precise, such sloppy language cannot be used to change the statute's plain meaning. Unfortunately, CMS's attempt to justify its use of the word "nearest" is inaccurate and confusing. It argues that "nearest" applies to hospitals accessible by secondary roads. CMS Reply at 5. But nothing in the statute, regulations, or manual provisions distinguishes the "nearest" hospital from any other hospital within the distance requirements, whether the distances are measured over primary or secondary roads. CMS would have done well to acknowledge that its use of the word "nearest" was ill-advised.

Medicare beneficiaries. *See Cibola Gen. Hosp.*, DAB No. 2387 at 10 (2011) (acknowledging the statute's "overarching goal of preserving the access of rural Medicare beneficiaries to hospital services").[4]

Finally, Petitioner complains that CMS reversed an earlier determination that Iroquois Medical met the distance requirements for a critical access hospital. Relying on CMS's representations, Petitioner purportedly took steps to meet other regulatory requirements, including arranging for an on-site survey by an accrediting body. P. Br. at 4. Whether the government can ever be estopped from enforcing a statute and valid regulations is highly questionable. *Heckler v. Cmty. Health Servs. Of Crawford Cnty.*, 467 U.S. 51, 63 (1984). But estoppel is not even an issue here. In asking CMS for a determination, Petitioner represented that "our hospital's location between the Kankakee [Riverside Medical] and Hoopeston [Regional Community] facilities requires traveling over more than 15 continuous miles of ***rural, secondary highway*** in either direction." CMS Ex. 1 at 1 (emphasis in original). This is plainly inaccurate: Riverside Medical and one other hospital (which Petitioner did not mention) were accessible by means of *primary* roads. Petitioner can hardly claim that it is entitled to equitable relief when it was responsible for any errors.

Conclusion

I find that this case presents no genuine dispute of material facts, and that CMS is entitled to judgment as a matter of law. I therefore grant CMS's motion for summary disposition.

/s/
Carolyn Cozad Hughes
Administrative Law Judge

[4] I note that *Cibola* accurately describes the proximity requirement: "that *no other* hospital be located within a 35-mile drive". DAB No. 2387 at 1 (emphasis added).