Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

La Paz Regional Hospital
(CCN: 03-0067),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-520

Decision No. CR2883

Date: August 5, 2013

DECISION AND REMAND

Petitioner, La Paz Regional Hospital, was not ineligible for designation as a critical access hospital (CAH) pursuant to section 1820(c)(2)(B) of the Social Security Act (Act) (42 U.S.C. § 1395i-4(c)(2)(B)) or 42 C.F.R. pt. 485, subpt. F,[1] because of its proximity to an Indian Health Service (IHS) facility that was approved by the Centers for Medicare & Medicaid Services (CMS) to participate in the CAH program.

CMS did not complete processing the enrollment application of Petitioner to be certified a CAH. Accordingly, remand to CMS to fulfill the Secretary's statutory duty under section 1820(e) of the Act is required.

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[1] Citations are to the 2012 revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the initial determination, unless otherwise stated.

I. Background

Petitioner submitted an application to enroll and be certified in Medicare as a CAH with swing-beds in February 2012, with subsequent amendments in March and April 2012. Petitioner's Exhibits (P. Exs.) 12 at 7-8; 15;16. CMS provided Petitioner a preliminary decision in July 2012, and advised Petitioner that it would deny its application to enroll as a CAH based on its proximity to the Parker Indian Health Center, which CMS characterized as a Medicare-certified CAH that was less than 2.5 miles from Petitioner. P. Ex. 12 at 9. On January 10, 2013, CMS notified Petitioner that Petitioner's application to enroll as a CAH was denied because Petitioner did not meet the location standard of 42 C.F.R. § 485.610(c) because it was less than 2.5 miles from the Parker Indian Health Center. P. Ex. 1.

Petitioner requested a hearing before an administrative law judge (ALJ) by letter dated March 4, 2013. Petitioner submitted with its request for hearing P. Exs. 1 through 14. The case was assigned to me on March 13, 2013, and an Acknowledgment and Prehearing Order (Prehearing Order) was issued at my direction.

On April 11, 2013, CMS filed a motion for summary judgment (CMS Br.) with CMS Exhibits (CMS Exs.) 1 and 2. CMS advised me by letter dated April 26, 2013, that other than the two exhibits filed with its motion for summary judgment, "CMS [did] not intend to call any witnesses, request subpoenas, file affidavits, additional exhibits, declarations or transcripts of prior testimony or other statements and will not rely on expert witnesses in any fashion."

On May 14, 2013, Petitioner filed its brief in opposition to the CMS motion for summary judgment and its cross-motion for summary judgment (P. Br.). Petitioner also filed P. Ex. 15, 16, and 17. CMS waived the filing of a reply brief by letter dated June 4, 2013.[2]

The parties have not objected to my consideration of CMS Exs. 1 and 2 and P. Exs. 1 through 17, and all are admitted as evidence.

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[2] Although in a technical sense Petitioner's cross-motion is unopposed, I resolve the case upon the motions of the parties and the evidence filed rather than based upon waiver or default.

II. Discussion

A. Issue

Whether Petitioner's application to enroll in Medicare and be certified as a CAH must be denied pursuant to section 1820(c)(2)(B)(i)(I) of the Act and 42 C.F.R. § 485.610(c) based on its proximity to an IHS facility approved by CMS to participate in the CAH program.

B. Applicable Law

1. The Critical Access Hospital Program

A CAH is a facility certified by the Secretary of Health and Human Services (Secretary) pursuant to section 1820(e) of the Act. Act § 1861(mm)(1). Inpatient CAH services are items and services furnished to an inpatient of a CAH. Outpatient CAH services are medical and other health services furnished by a CAH on an outpatient basis. Act § 1861(mm)(2) and (3). A facility enrolled in Medicare as a CAH generally receives higher payments from Medicare than it would if enrolled as a hospital. Act §§ 1814(l), 1834(g), 1861(v). The Medicare Rural Hospital Flexibility Program was enacted by Congress in 1997 to replace a prior program, the Essential Access Community Hospital/Rural Primary Care Hospital program which operated in only seven states. The new program allowed states to designate rural facilities as CAHs and thereby improve access to hospital and other health services for rural residents. Balanced Budget Act of 1997, § 4201, Pub. L. 105-33 (1997) (codified at 42 U.S.C. § 1395i-4) (Act § 1820); 62 Fed. Reg. 45,965, 45,970 (Aug. 29, 1997).

The Act provides that a state may submit an application to the Secretary to establish a Medicare rural hospital flexibility program. Act § 1820(a)-(b). The state is required as part of its rural hospital flexibility program to develop at least one rural health network and designate one or more facilities in the state as a CAH. Act § 1820(c). The criteria for a state to designate a facility a CAH are:

> (B) Criteria for designation as critical access hospital.—
> A State may designate a facility as a critical access hospital if the facility—
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> (i) is a hospital that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) or is being treated as being located in a rural area pursuant to section 1886(d)(8)(E) and that—

(I) is 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 another facility described in this subsection; or

(II) is certified before January 1, 2006, by the State as being a necessary provider of health care services to residents in the area;

(ii) makes available 24–hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

(iii) provides not more than 25 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;

(iv) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24–hour basis, but need not otherwise staff the facility except when an inpatient is present;

(II) the facility may provide any services otherwise required to be provided by a full–time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part–time, off site basis under arrangements as defined in section 1861(w)(1); and

(III) the inpatient care described in clause (iii) may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

(v) meets the requirements of section 1861(aa)(2)(I).

Congress provided that the Secretary "**shall certify**" a facility as a CAH if: (1) the facility is located in a state that has a rural hospital flexibility program established in accordance with the Act; (2) the state has designated the facility a CAH; and (3) the facility meets other criteria established by the Secretary. Act § 1820(e) (emphasis added). As already mentioned, a CAH is specifically defined by Congress as a facility certified by the Secretary as a CAH pursuant to section 1820(e) of the Act. Act § 1861(mm)(1).

The Secretary promulgated regulations that establish conditions and standards for a CAH to participate in Medicare. 42 C.F.R. pt. 485, subpt. F. A state with a rural hospital flexibility program may designate one or more facilities as CAHs if the facilities meet the conditions of participation set forth in the regulations. 42 C.F.R. § 485.606(a). CMS is required to certify a facility as a CAH if the facility is designated a CAH by the state in which it is located; the facility has been surveyed by the state survey agency or CMS; and the facility is found to meet the conditions for participation in 42 C.F.R. pt. 485 subpt. F and pt. 489. 42 C.F.R. § 485.606.

State Operations Manual (SOM) provisions related to CAHs are at §§ 2254-62 (rev. 1, May 21, 2004). CMS states that the Medicare Rural Hospital Flexibility Program allows for the creation of CAHs and is designed to promote rural health planning, network development, and improve access to health services for rural residents of the state. CMS states that the program is available to any state with rural facilities which elects to establish a program and submits an acceptable plan to CMS. SOM § 2254A. The SOM describes: the requirement for submission of a state plan; acceptance of the state plan by CMS; the requirements for CAHs; the CAH application process; the CAH survey process; the CAH approval process; the CAH notification procedure; and the CAH effective date of participation. SOM §§ 2254C-56C. The SOM provides that the CAH applicant must show that there is no driving route from the applicant to any other CAH or hospital that is 35 miles or less in length. The CAH applicant bears a similar burden if it seeks application of the 15 mile rule for mountainous terrain. SOM § 2256A.

2. Indian Health Service

The maintenance and operation of hospital and health facilities for Indians[3] is the responsibility of the Surgeon General and the Public Health Service under the supervision

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[3] The term as used in the statutes and regulations includes Indians in the "Continental United States, and Indians, Aleuts and Eskimos in Alaska." 42 C.F.R. § 136.1. A more specific definition is found at 42 C.F.R. § 137.10.

of the Secretary. 42 U.S.C. § 2001. Congress granted the Secretary authority to promulgate necessary regulations. 42 U.S.C. § 2003. IHS operations are subject to 42 C.F.R. pts. 136, 136a, and 137. "Indian health program" refers to health service programs administered by the IHS, which is part of the Department of Health and Human Services. 42 C.F.R. § 136.1. IHS services are available "to persons of Indian descent belonging to the Indian community served by the local facilities and programs" including non-Indian women pregnant with an eligible Indian's child. 42 C.F.R. § 136.12(a). Individuals not eligible may be provided temporary care and treatment at IHS facilities as an act of humanity in an emergency. 42 C.F.R. § 136.14. Congress and the Secretary recognize the right to self-government based upon the sovereign status of Indian Tribes and Nations. 42 C.F.R. §§ 137.2(a), 137.6. CMS has adopted the policy that the survey and certification of an IHS hospital or skilled nursing facility (SNF) will be done by CMS rather than the state survey agency due to "questions of intergovernmental jurisdiction." SOM, CMS Pub. 100-07, chap. 1 § 1018A (rev. 1, eff. May 21, 2004). The policy provides that the state agency is responsible to determine whether the facility meets Medicaid certification requirements. CMS makes any determinations regarding jurisdiction. SOM § 1018A.

A hospital or SNF of the IHS, whether operated by IHS or an Indian tribe or tribal organization, may be eligible for payments from Medicare so long as the facility meets all conditions and requirements for such payments as are applicable to hospitals or SNFs under Medicare (Title XVIII of the Act) notwithstanding the general prohibition on payments from Medicare to federal facilities. Act § 1880(a). The SOM does not describe any process for an IHS facility to be designated a CAH.

3. Right to Hearing and Judicial Review

The Act requires that the Secretary issue regulations that establish a process to enroll providers and suppliers[4] in Medicare, including the right to a hearing and judicial review in the event of denial or non-renewal. Act § 1866(j) (42 U.S.C. § 1395cc(j)). The

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[4] A "supplier" furnishes items or services under Medicare and the term supplier applies to physicians or other practitioners and facilities that are not included within the definition of the phrase "provider of services." Act § 1861(d) (42 U.S.C. § 1395x(d)). A "provider of services," commonly shortened to "provider," includes hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, and a fund as described in sections 1814(g) and 1835(e) of the Act. Act § 1861(u) (42 U.S.C. § 1395x(u)); 42 C.F.R. § 498.2. The distinction between providers and suppliers is important, as they are treated differently under the Act for some purposes.

procedures for enrollment are found at 42 C.F.R. pt. 424, subpt. P. Pursuant to 42 C.F.R. § 424.505, a provider or supplier must be enrolled in the Medicare program and be issued a billing number to have billing privileges and to be eligible to receive payment for services rendered to a Medicare eligible beneficiary. A provider, such as a hospital, must also enter a provider agreement with CMS as described in 42 C.F.R. pt. 489, subpt. B. A provider must meet the conditions of participation set forth in the regulation. 42 C.F.R. § 489.10(a). CMS may deny enrollment for any of the reasons listed in 42 C.F.R. § 424.530(a), including failure to give satisfactory assurance of compliance with the Act and Medicare enrollment requirements. 42 C.F.R. § 424.530(a)(1).

If enrollment is denied, the prospective provider or supplier has a right to request a hearing before an ALJ following the procedures of 42 C.F.R. pt. 498. Act § 1866(h)(1), (j)(8), 42 C.F.R. § 424.545(a). A provider or supplier whose enrollment and billing privileges have been revoked or not renewed has a right to request a hearing by an ALJ, further review by the Departmental Appeals Board (Board), and judicial review. Act § 1866(h)(1), (j)(8); 42 C.F.R. §§ 424.545, 498.3(b)(17), 498.5, 498.90, 498.95. A hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 748-51 (6th Cir. 2004). The provider or supplier bears the burden to demonstrate that it meets enrollment requirements with documents and records. 42 C.F.R. § 424.545(c).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis.

1. Summary judgment is appropriate.

The Act and regulations make a hearing before an ALJ available to Petitioner. As noted above, a hearing on the record, also known as an oral hearing, is required under the Act. *Crestview Parke Care Ctr.,* 373 F.3d 743, 748-51. A party may waive appearance at an oral hearing, but must do so affirmatively in writing. 42 C.F.R. § 498.66. In this case, Petitioner does not waive the right to oral hearing or otherwise consent to decision based only upon the submissions or pleadings. The parties have filed cross-motions for summary judgment and disposition on the written record may be permissible if disposition by summary judgment is appropriate.

Summary judgment is not automatic upon request but is rather limited to certain specific conditions. Summary judgment is appropriate and no hearing is required where either: there are no disputed issues of material fact and the only questions that must be decided involve application of law to the undisputed facts; or, the moving party must prevail as a matter of law even if all disputed facts are resolved in favor of the party against whom the motion is made. When confronted with a properly supported motion for summary

judgment, the nonmoving party "may not rest upon the mere allegations or denials of his pleading, but . . . must set forth specific facts showing that there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986), quoting *First Nat'l Bank of Arizona v. Cities Serv. Co.*, 391 U.S. 253 (1968); *see also* Fed. R. Civ. P. 56(c); *Garden City Med. Clinic*, DAB No. 1763 (2001), *Everett Rehab. and Med. Ctr.*, DAB No. 1628, at 3 (1997) (in-person hearing required where non-movant shows there are material facts in dispute that require testimony); *Big Bend Hosp. Corp., d/b/a Big Bend Med. Ctr.*, DAB No. 1814, at 13 (2002) (in some cases, any factual issue is resolved on the face of the written record because the proffered testimony, even if accepted as true, would not make a difference); *Cherrywood Nursing and Living Ctr.*, DAB No. 1845 (2002). In opposing a motion for summary judgment, the opposing party bears the burden of showing that there are material facts that are disputed either affecting the prima facie case or that might establish a defense. *Everett Rehab.,* DAB No. 1628; *Cherrywood,* DAB No. 1845. It is insufficient for the opposing party to rely upon mere allegations or denials to defeat the motion and proceed to hearing. Petitioner must, by affidavits or other evidence which set forth specific facts, show that there is a genuine issue for trial. If a party opposing a motion for summary judgment cannot show by some credible evidence that there exists some genuine issue for trial, then summary judgment is appropriate and the movant must prevail as a matter of law. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247. A test for whether an issue is regarded as genuine is if "the evidence [as to that issue] is such that a reasonable jury could return a verdict for the nonmoving party." *Id.* at 248. In evaluating whether there is a genuine issue as to a material fact, an ALJ must view the facts and the inferences to be drawn from the facts in the light most favorable to the nonmoving party. *See Pollock v. Am. Tel. & Tel. Long Lines*, 794 F.2d 860, 864 (3rd Cir. 1986).

I conclude after reviewing the parties' briefs and documentary evidence that summary judgment is appropriate in this case. As discussed hereafter, there are no disputed issues of material fact and resolution of the issue before me requires interpretation and application of the Act and regulations to the undisputed facts.

2. Petitioner's proximity to Parker Indian Health Center does not constitute noncompliance with 42 C.F.R. § 485.610(c).

3. Parker Indian Health Center is not a CAH within the meaning of section 1820 of the Act.

4. Parker Indian Health Center is not a hospital within the meaning of section 1820 of the Act.

5. Remand is necessary to permit CMS and its contractors to complete processing Petitioner's application to enroll in Medicare and be certified as a CAH with swing beds.

a. Facts.

Neither party disputes the assertions of fact in the opposing party's pleadings or documentary evidence. The parties were advised by the Prehearing Order § II.G that "a fact alleged and not specifically denied, may be accepted as true for purposes of a motion or cross-motion for summary judgment [and] evidence will be considered admissible and true unless specific objection is made to its admissibility or accuracy."

Petitioner represents in its brief that it is a 25-bed acute care hospital located in Parker Arizona. P. Br. at 4. A document submitted by Petitioner indicates, however, that when it applied to enroll as a CAH and swing bed facility it was licensed for 39 beds with a plan to reduce the number of beds to 25 to meet the requirements for a CAH with swing beds. P. Ex. 15 at 91. Petitioner's Arizona license issued August 1, 2011 also indicates a capacity of 39 beds. P. Ex. 15 at 21. Whether Petitioner had 39 or 25 beds at the time of application does not affect the decision in this case and it is not a fact that requires resolution. Petitioner is the only general acute care hospital serving La Paz County, Arizona, an area of 4,518 square miles, 10,417 households, plus 20,000 visitors to the area each winter. According to the 2010 census, the average age of the population of La Paz is the oldest in the United States. P. Br. at 4. According to Petitioner's application, Petitioner was incorporated on June 1, 2000.[5] P. Ex. 15 at 5; P. Ex. 16 at 8. On December 29, 2000, Petitioner was granted federal income tax exemption. P. Ex. 2; P. Ex. 15 at 22. Petitioner is located less than 15 miles from the Parker Indian Health Center.[6] P. Ex. 8; P. Br. at 4; CMS Br. at 4-5.

The Parker Indian Health Center is located in Parker Arizona. CMS submitted evidence that on January 10, 2003, CMS approved the Parker Indian Health Center to participate in the "Critical Access Hospital Program." CMS Ex. 1. The January 10, 2003 letter from Steven Chickering, Manager, Hospital and Community Care Operations, Division of State Operations, CMS, to Robert A. Hallowell, Chief Executive Officer, Parker Indian Health Center, 12033 Agency Road, Parker, AZ, states that the Joint Commission on the Accreditation of Healthcare Organizations completed an accreditation and deeming

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[5] Policy documents submitted by Petitioner reflect an effective date of December 5, 1988, indicating Petitioner may have been in operation as early as 1988. P. Ex. 15 at 50, 74. I need not resolve exactly when Petitioner began operations as a hospital as that fact would not affect the decision in this case.

[6] The assertions regarding the exact distance differ and Petitioner's evidence shows that the distance may only be 1.4 miles. But there is no dispute that Petitioner is less than 15 miles from the Parker Indian Health Center, which is the material fact.

survey on November 7, 2002; that the CMS Regional Office granted approval to participate in the CAH Program; that Parker Indian Health Center's current enrollment would be voluntarily terminated effective January 31, 2003; and its enrollment as a new CAH would be effective February 1, 2003. CMS Ex. 1. The evidence does not suggest that the location of either Petitioner or Parker Indian Health Center was different in 2003 than at present. CMS Exs. 1, 2; P. Exs. 15, 16. Therefore, the CMS evidence shows that CMS approved Parker Indian Health Center to participate as if it was a CAH despite the fact that Petitioner was operating as a hospital approximately 1.4 miles from Parker Indian Health Center.

Petitioner submitted the affidavit of the Honorable Wayne Patch, Sr., Chairman of the Tribal Council of the Colorado River Indian Tribes. The Tribe includes 4,000 members in or near Parker Arizona. Chairman Patch states that he has knowledge of the services provided by Parker Indian Health Center, which is operated by the IHS, based on his position as Chairman of the Tribal Council. He states that Parker Indian Health Center does not provide any services to persons who are not Tribal members except in emergencies and prenatal care for women pregnant with Indian babies. He states that Parker does not maintain a blood supply, does not maintain a surgery department, does not provide 24-hour ultrasound, does not have equipment to perform a CAT scan or MRI, and does not have a cardiac care unit or cardiac catheterization laboratory. Non-Tribal members and Tribal members requiring services not available at Parker Indian Health Center are transported to Petitioner for treatment. P. Ex. 17. A letter from the prior Tribal Chairman, Eldred Enas, indicates that the Colorado River Indian Tribes are federally recognized as a Native American Tribe and sovereign nation composed of the Mohave, Chemehuevi, Navajo, and Hopi members. Chairman Enas also states that Parker Indian Health Center is an IHS facility that is limited to treatment of Tribal members; Parker does not provide services to the general public; and Parker cannot provide all necessary hospital services. P. Ex. 15 at 82-83, 86-87.

b. Analysis

Petitioner applied to enroll in Medicare and be certified as a CAH with swing beds in February 2012. P. Ex. 15 at 26-27. CMS issued a preliminary determination in July 2012 that Petitioner could not enroll as a CAH because Parker Indian Health Center was a CAH and less than 2.5 miles from Petitioner. CMS Ex. 12 at 9. On January 10, 2013, CMS denied the enrollment application on grounds that Petitioner did not meet the standard for participation at 42 C.F.R. § 485.610(c) because Petitioner is less than 2.5 miles from Parker Indian Health Center, which CMS considers a Medicare-certified CAH. CMS stated that it had no authority to waive the standard. P. Ex. 1.

CMS argues that it is undisputed that Petitioner is within 3 miles of an existing CAH, the Parker Indian Health Center, and therefore Petitioner is not in compliance with the standard established by 42 C.F.R. § 485.610(c). CMS Br. at 4. CMS argues that I am

bound by the applicable law, including the Act and regulations, and may not invalidate either and that I have no authority to grant equitable relief. CMS Br. at 4, 6. I agree with CMS that the Secretary, CMS, the Board and I are all bound to comply with the provisions of the Act and regulations. I also agree with CMS that it is not within my authority or that of the Board to grant equitable relief. CMS argues that if a provision of the Act is subject to more than one interpretation, CMS's reasonable interpretation is entitled to deference. CMS Br. at 4-5. There is no question that in certain circumstances the courts have held that an executive agency's interpretation of its enabling statutes is entitled to deference. CMS concedes that for deference to apply its interpretation must be reasonable. No deference is due CMS in this case because the provision of the Act at issue is not subject to more than one interpretation and the interpretation proposed by CMS is not only not reasonable, it is plainly incorrect.[7] CMS argues that the statutory and regulatory provisions at issue do not permit CMS any option but to deny Petitioner's application, and only Congress can change the Act. CMS Br. at 6-7. CMS is correct that only Congress can amend the Act. However, CMS errs in concluding that section 1820 of the Act has any application to the Parker Indian Health Center. CMS argues that Congress did not exempt IHS facilities from application of section 1820 of the Act. CMS Br. at 8. However, as discussed in more detail hereafter, section 1820 of the Act clearly does not apply to IHS facilities and, therefore, no exception for IHS facilities was necessary in section 1820. I conclude that CMS is in error in its interpretation and application of section 1820 of the Act and 42 C.F.R. § 485.610 because Parker Indian Health Center is not a hospital or a CAH within the meaning of section 1820.

CMS denied Petitioner's application to enroll as a CAH because CMS concluded that Petitioner did not meet the location standard of 42 C.F.R. § 485.610(c), which provides:

> (c) *Standard: Location relative to other facilities or necessary provider certification.* The CAH is 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 another CAH, or before January 1, 2006, the CAH is certified by the State as being a necessary provider of health care services to residents in the area. A CAH that is designated as a necessary provider on or before December 31, 2005, will maintain its necessary provider designation after January 1, 2006.

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[7] I do not accept the CMS implication that an ALJ or the Board is bound to follow whatever interpretation of the Act or regulations that CMS might wish to advance. If that were true, the right to administrative review granted by Congress pursuant to sections 1866(h) and (j) would be meaningless.

The regulation is based on section 1820(c)(2)(B) of the Act which provides:

> (2) State designation of facilities.—
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> * * * *
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> (B) Criteria for designation as critical access hospital.—A State may designate a facility as a critical access hospital if the facility—
>
> (i) is a hospital that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) or is being treated as being located in a rural area pursuant to section 1886(d)(8)(E) and that—
>
> (I) is 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 another facility described in this subsection; or
>
> (II) is certified before January 1, 2006, by the State as being a necessary provider of health care services to residents in the area;

CMS erred in its application of the foregoing provisions of the Act and regulation, because Parker Indian Health Center is not a CAH or a hospital within the meaning of those provisions.

(i) Parker Indian Health Center is not a CAH within the meaning of the Act.

Congress established a very specific definition for a CAH as a facility certified by the Secretary as a CAH pursuant to section 1820(e) of the Act. Act § 1861(mm)(1). Section 1820(e) requires that the Secretary certify a facility as a CAH when: (1) the facility is located in a **state** that has established a Medicare rural hospital flexibility program in accordance with section 1820(c) of the Act; (2) the **state** has designated the facility a CAH; and (3) the facility meets other criteria established by the Secretary. The statute is clear that the Secretary's authority to designate a facility a CAH is dependent upon the **state** having designated the facility a CAH. In this case, the Parker Indian Health Center is administered by the federal government through the IHS for the benefit of Tribal members and a limited number of non-Tribal members, and the undisputed evidence is that Parker is part of a sovereign Indian nation, not the State of Arizona. P. Ex. 15 at 82-

83, 86-87, P. Ex. 17. Therefore, the State of Arizona had no authority to designate the Parker Indian Health Center a CAH. Because the State of Arizona had no authority to designate Parker a CAH, the Secretary had no authority to certify Parker a CAH under section 1820(e) of the Act.

It is not clear from the CMS evidence by what authority CMS declared Parker Indian Health Center to be part of the CAH program. CMS does not specifically state the source of CMS's authority in its brief, other than a reference to section 1880 of the Act. Section 1880 permits Medicare to pay IHS hospitals and SNFs, as an exception to the prohibition on Medicare payments to federal facilities, if the facilities meet the conditions and requirements for participation generally applicable to hospitals and SNFs. Section 1880 does not refer to CAHs or section 1820 of the Act or specifically grant the Secretary authority to designate an IHS facility a CAH.

The CMS evidence suggests that CMS did not intend to designate Parker Indian Health Center a CAH. The CMS letter to Parker Indian Health Center dated January 10, 2003, stated that Parker was approved "to participate in the Critical Access Hospital Program." CMS Ex. 1. The letter does not state that Parker was certified by the Secretary or CMS as a CAH as required for CAH status by section 1820(e) of the Act. Thus, the CMS letter from 2003 could be read to authorize Parker to receive the higher CAH payment rates pursuant to the authority of section 1880, without certification of Parker as a CAH because there was no authority for such a certification under either section 1820 or section 1880.

I also note that because Parker Indian Health Center was less than 15 miles from Petitioner it would have been a clear violation of section 1820(c)(2)(B)(i)(I) of the Act for CMS to certify Parker Indian Health Center a CAH within the meaning of section 1820 of the Act. The explanation that is consistent with finding no violation by CMS is that CMS merely approved Parker Indian Health Center to receive the higher CAH rates under authority of section 1880, even though Parker could not be certified by the Secretary as a CAH under section 1820.

I conclude that Parker Indian Health Center cannot be, and is not, a CAH within the meaning of sections 1861(mm)(1) and 1820 of the Act.

(ii) Parker Indian Health Center is not a hospital within the meaning of section 1820 of the Act.

Because Parker Indian Health Center is not a CAH there remains an issue as to whether or not Parker's status as a hospital caused Petitioner not to be in compliance with section 1820(c)(2)(B) of the Act and 42 C.F.R. § 485.610(c).

In *Cibola General Hospital*, DAB No. 2387 (2011), an appellate panel of the Board concluded that the presence of an IHS facility within 35 miles of Cibola General Hospital did not preclude certification of Cibola as a CAH. I find the Board's analysis in *Cibola* persuasive for the case before me.

Cibola General Hospital was a 25-bed acute care hospital in rural New Mexico. Cibola was designated to be a CAH by the State of New Mexico and Cibola filed an application to enroll in Medicare as a CAH. CMS denied the application because Acoma, an IHS facility that had participated in Medicare since 1981, was less than 19 miles from Cibola. *Cibola,* DAB No. 2387, at 3. Before the ALJ, CMS argued that Acoma was a hospital for purposes of section 1820(c)(2)(B)(i)(I) of the Act. The ALJ concluded that Acoma was a hospital and that Cibola did not meet the location requirement to be certified as a CAH. *Cibola*, DAB No. 2387, at 4. The Board focused upon the meaning of the term "hospital" as used in section 1820(c)(2)(B)(i)(I) of the Act and specifically "whether an IHS facility that has a Medicare provider agreement but lacks a state license and cannot serve non-Indian patients (except in emergencies) meets the definition of 'hospital' for purposes of disqualifying a nearby general purpose hospital from CAH designation." *Cibola* , DAB No. 2387, at 5. The Board concluded that Acoma, the IHS facility, was not a hospital within the meaning of section 1820(c)(2)(B)(i)(I) of the Act and Cibola was not disqualified from certification as a CAH due to its proximity. *Cibola*, DAB No. 2387, at 10-14. The Board reasoned that ensuring the availability of hospital services to rural Medicare beneficiaries was the purpose of the Rural Flexibility Program and the state designation of CAHs under that program and, therefore, Congress must have intended the term hospital to refer to an institution that offers meaningful access to hospital services to Medicare beneficiaries in the rural area. *Id*. at 10-11. An IHS facility is limited by law to offering services to a limited Medicare population and does not offer hospital services to the general Medicare beneficiary population in the rural area. Thus, concluding that the presence of an IHS facility disqualifies an otherwise qualified hospital from being designated a CAH is inconsistent with the purpose of Congress.

The Board's analysis in *Cibola* is persuasive in this case. There is no dispute that Parker Indian Health Center is operated by the IHS, is part of a sovereign Indian nation, and not subject to state regulation. There is no dispute that, as a matter of law and fact, Parker can only deliver services to Tribal members, non-Tribal women who carry Tribal babies, and limited emergency services to non-Tribal members. There is no dispute that Parker's services are more limited than those available from Petitioner and that Medicare-eligible Tribal members seek treatment from Petitioner that is not available from Parker. Applying the analysis of the Board in *Cibola* to the case before me, I conclude that Parker Indian Health Center is not a hospital within the meaning of section 1820(c)(2)(B)(i)(I) or 42 C.F.R. § 485.610(c). Accordingly, I conclude that the proximity of Parker Indian Health Center to Petitioner does not disqualify Petitioner from certification as a CAH.

(iii) Remand is required to permit CMS to comply with section 1820(e) of the Act.

The CMS letter to Petitioner dated January 10, 2013, notifying Petitioner of the denial of its application states that because Petitioner did not meet the "threshold" standard of 42 C.F.R. § 485.610, no onsite survey was completed to assess compliance with other conditions of participation that Petitioner must meet in order to be certified a CAH. P. Ex. 1. CMS implies in argument that I cannot order CMS to certify Petitioner a CAH. CMS Br. at 4. I agree. However, having concluded that CMS erroneously found Petitioner ineligible to be certified a CAH, it is necessary to remand the case to CMS to fulfill the Secretary's statutory duty under section 1820(e) of the Act:

> (e) Certification by the Secretary.—The Secretary shall certify a facility as a critical access hospital if the facility—
>
> (1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (c);
>
> (2) is designated as a critical access hospital by the State in which it is located; and
>
> (3) meets such other criteria as the Secretary may require.

III. Conclusion

For the foregoing reasons, this matter is remanded to CMS for further processing of Petitioner's application to enroll in Medicare as a CAH and certification as a CAH if all conditions for participation under the Act and regulations are satisfied.

/s/
Keith W. Sickendick
Administrative Law Judge