Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Baylor County Hospital District d/b/a Seymour Hospital
Docket No. A-14-120
Decision No. 2617
January 21, 2015

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Baylor County Hospital District d/b/a Seymour Hospital (Seymour) appealed the July 18, 2014 decision of an Administrative Law Judge (ALJ) upholding the determination of the Centers for Medicare & Medicaid Services (CMS) that Seymour is ineligible to participate in Medicare as a Critical Access Hospital (CAH). *Baylor Cty. Hosp. Dist. d/b/a Seymour Hosp.*, DAB CR3301 (2014) (ALJ Decision). CMS determined that Seymour did not qualify as a CAH because Seymour is located less than a 35-mile drive from another hospital via a highway that, based on published CMS guidance, is not a secondary road. As it did before the ALJ, Seymour argues that CMS's interpretation of what constitutes a secondary road is unreasonable and not entitled to deference. For the reasons discussed below, we disagree. We therefore affirm the ALJ Decision.

Background

The CAH designation provides for higher Medicare payments in an effort to maintain the availability of hospital services in rural communities. *Cibola General Hosp.*, DAB No. 2387, at 1 (2011), citing Social Security Act (Act) §§ 1814(l), 1834(g), 1861(v)[1]; *see also* 72 Fed. Reg. 42,628, 42,806 (2007) (stating that the "intent of the CAH program is to maintain hospital-level services in rural communities while ensuring access to care"). The Act limits this enhanced funding to hospitals that fall within specific qualifications. Thus, under section 1820(c)(2)(B)(i)(I) of the Act, in order for a hospital to qualify as a CAH, it 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 another [CAH]." An implementing regulation at 42 C.F.R. § 485.610(c) repeats the statutory language.

[1] The current version of the Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp. Table.

Seymour does not claim that its location is mountainous but does argue that more than 15 miles of the road connecting it to the nearest other hospital should be considered "secondary." Neither the statute nor the implementing regulation defines the term "secondary road." However, CMS has published guidance in its State Operations Manual (SOM) that defines the term "primary road" and explains that roads that do not meet the definition of a primary road constitute secondary roads.[2] The SOM provides, in pertinent part:

> **Application of the more than 15-mile drive standard, based on secondary roads**
>
> To be eligible for the lesser distance standard due to the secondary road criteria under §485.610(c) the CAH must document that there are more than 15 miles between the CAH and any hospital or other CAH where there are no primary roads. A primary road is:
>
> • A numbered federal highway, including interstates, intrastates, expressways or any other numbered federal highway; or
>
> • A numbered State highway with 2 or more lanes each way; or
>
> • A road shown on a map prepared in accordance with the U.S. Geological Survey's Federal Geographic Data Committee (FGDC) Digital Cartographic Standard for Geologic Map Symbolization as a "primary highway, divided by median strip."
>
> A CAH may qualify for application of the "secondary roads" criterion if there is a combination of primary and secondary roads between it and any hospital or other CAH, so long as more than 15 of the total miles from the hospital or other CAH consists of areas in which only secondary roads are available. . . .

SOM Ch. 2, § 2256A (emphasis in original).

The following facts are undisputed. Seymour is located approximately 32 miles from Throckmorton County Memorial Hospital (Throckmorton). CMS Ex. 1, at 2-9. At least 28 miles of the road between Seymour and Throckmorton is designated as U.S. Highway 183/U.S. Highway 283. *Id.* Thus, Seymour is less than 35 miles from another hospital

[2] The SOM is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html?DLPage=1&DLSort=0&DLSortDir=ascending.

and, according to CMS's interpretation in the SOM of what constitutes a secondary road, less than 15 miles of the distance between Seymour and Throckmorton is in an area where only secondary roads are available.

Based on these facts, CMS denied Seymour's application to participate in Medicare as a CAH. CMS Ex. 1, at 1. Seymour sought reconsideration of the denial, but CMS reaffirmed its determination that Seymour failed to qualify as a CAH based on Seymour's proximity to Throckmorton. After unsuccessfully seeking reconsideration of the denial, Seymour requested a hearing before an ALJ to challenge CMS's determination.[3] CMS moved for summary judgment.

Before the ALJ, Seymour conceded that CMS's determination was consistent with CMS's interpretation in the SOM of the term "secondary road." Seymour argued, however, that CMS's interpretation was not entitled to deference and should not be followed because, as applied to Seymour, it was unreasonable and conflicted with the text and intent of the CAH statute. Pet. Prehr. Br. at 7.

Seymour acknowledged that the CMS interpretation "may appear" reasonable and consistent with the Act, but argued that this appearance was "illusory." Pet. Prehr. Br. at 7. Seymour contended that CMS's interpretation unreasonably failed to take into account the qualitative aspects of particular roads and how those characteristics affected the accessibility of hospitals that must be reached via those roads. According to Seymour, for example, the stretch of the road at issue is one lane in each direction, without a median strip, and would be considered secondary but for its federal highway designation. *Id.* at 8-10. Furthermore, Seymour argued that Throckmorton provides only limited hospital services, so anyone in the area with serious medical problems must travel to Seymour for care, thus implying that the distance standards should be applied differently based on the nature of the alternative hospital. *Id.* at 10-11.

The ALJ rejected Seymour's arguments, concluding that CMS's decision to treat all numbered federal highways as primary roads was not inconsistent with the regulatory or statutory language and constituted a reasonable policy determination. ALJ Decision at 3-4. Accordingly, the ALJ granted summary judgment to CMS and upheld CMS's determination that Seymour did not qualify as a CAH.

Seymour timely appealed the ALJ Decision to the Board.

[3] Before the Board, Seymour moved to resubmit its Request for Hearing (Request), believing that the copy of the Request transmitted to the Board was incomplete. The Request consists of a two-page request letter and six pages of attachments. The List of Materials in the Record prepared by the Civil Remedies Division when Seymour appealed the ALJ Decision reflects the length of the attachment, not the total length of the submission. Because the entire document is already in the record, Seymour's motion is denied as unnecessary.

Analysis

The resolution of this case turns on whether we determine that it is appropriate to defer to CMS's interpretation of the term "secondary road." Seymour is located less than a 35-mile drive from Throckmorton, so under section 1820(c)(2)(B)(i)(I) of the Act and 42 C.F.R. § 485.610(c), Seymour can qualify as a CAH only if more than 15 miles of the road between the two hospitals constitutes a secondary road. As noted above, neither the statute nor the regulation defines "secondary road," but CMS has published its interpretation of the term in the SOM. Under CMS's interpretation, any numbered federal highway is a primary road, and the majority of the road between Seymour and Throckmorton is designated as U.S. Highway 183/U.S. Highway 283. Thus, if we defer to CMS's interpretation, Seymour cannot qualify as a CAH.

It is well-settled that as guidance issued by CMS, the SOM is instructive but does not constitute controlling authority. *Green Oaks Health & Rehab. Ctr.*, DAB No. 2567, at 11 (2014); *Agape Rehab. of Rock Hill*, DAB No. 2411, at 19 (2011); *Foxwood Springs Living Ctr.*, DAB No. 2294, at 8-9 (2009). It is also well-settled that the Board will defer to an agency's interpretation of ambiguous statutory or regulatory language, so long as the agency's interpretation is reasonable and the party against whom the agency seeks to apply the interpretation had adequate notice. *E.g., Cibola*, DAB No. 2387, at 7-8. Seymour does not dispute that it had adequate notice of CMS's interpretation of what constitutes a secondary road. Instead, Seymour argues that CMS's interpretation is unreasonable.

Seymour emphasizes that the different mileage requirements in the CAH statute for primary and secondary roads should be interpreted in light of the purpose to ensure reasonable access to hospital services in rural areas. As Seymour did before the ALJ, Seymour argues that CMS's interpretation is contrary to the intent of the statute and therefore unreasonable because it fails to take into account the qualitative differences in individual roads that impact the accessibility of hospital services. Seymour maintains that under CMS's interpretation, the same road would be treated as primary or secondary based solely on whether it carries a federal or state highway designation, and asserts that federal and state highway designations "have nothing to do with the qualitative aspects of roads or accessibility to the hospital." Req. for Rev. (RR) at 8.

We conclude that CMS's interpretation is not unreasonable or inconsistent with the intent of the CAH statute. As the ALJ recognized, the Secretary of Health and Human Services and CMS "lack the resources and capacity for making case-by-case judgments about the driving characteristics of every stretch of highway in the United States," and, even if that was not the case, such case-by-such judgments likely would be subjective. ALJ Decision at 4. CMS's interpretation provides a bright-line rule for what constitutes a primary road,

based on objective criteria. CMS could reasonably assume that federal highways are likely to be bigger, better-maintained, and more well-traveled than state highways, and that state highways are more likely to have those characteristics than undesignated roads. Given those general expectations, CMS could reasonably require that state highways and undesignated roads be treated as equivalent to federal highways only when they demonstrated specific characteristics typical of most federal highways. Thus, CMS's decision to categorize as primary roads all federal highways, but only state highways with two or more lanes in each direction, and only "primary highways" divided by a median strip, is reasonable.

Furthermore, while the Act does seek to provide additional financial support to certain rural hospitals to increase access to care, the imposition of the mileage requirements itself illustrates that this purpose was not intended to benefit every hospital located in a predominantly rural environment. Instead, funding was to be 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. In meeting these combined goals, CMS was not required to conduct case-by-case surveys of all the characteristics and traffic patterns of each stretch of road connecting two rural hospitals. Administrative efficiency justified developing a bright-line rule that would balance the goals without individual inquiry into each case. In doing so, CMS could reasonably consider that the process of designating important roads in rural areas to serve as federal highways (while not perhaps based on identical considerations) was a useful proxy for identifying roads that serve as primary transportation channels for patients seeking medical care in rural areas.

We are not persuaded by Seymour's argument that CMS should have adopted a bright-line rule that treated only those parts of federal highways with two or more lanes in each direction or median strips as primary. Pet. R. Br. at 8. The fact that CMS could have constructed other bright-line rules, using different approaches, does not mean that the rule it chose to adopt is unreasonable.

Seymour further asserts that CMS's application of its guidance here is contrary to statutory intent because the alternative hospital that CMS determined to be too close to allow Seymour to qualify as a CAH is inadequate. Seymour alleges that Throckmorton "lacks most of the basic services that comprise the standard of care for hospitals," and that Seymour "has all of the services lacking in Throckmorton and more." RR at 9. Seymour suggests that because it provides more comprehensive hospital services than Throckmorton, it is unreasonable that CMS's interpretation prevents Seymour from qualifying as a CAH. In its reply, Seymore denies that it is requesting "an exception" to the rules based on the quality of Throckmorton's services, asserting that it merely seeks to show that the result of applying the "arbitrary criteria" in CMS's interpretation leads to a poor outcome in this case. Pet. R. Br. at 8.

Any attempt to interpret the distinction between primary and secondary roads by objective and general criteria instead of case-by-case assessments of particular roads and travel conditions could result in a hospital failing to qualify as a CAH based on the proximity of a hospital which does not provide the same services. Congress could have, but did not, include an exception to proximity requirements where the nearest alternative hospital does not meet particular service or quality standards. Seymour's critiques of Throckmorton simply have no relevance to the reasonableness of how CMS interpreted the meaning of primary roads.

Moreover, Seymour's argument ignores the fact that the statute clearly requires a CAH to be located more than 35 miles away from another hospital, except in circumstances where there is mountainous terrain or only secondary roads are available, regardless of the level of care offered at the other hospital. Although states initially were able to waive the minimum distance eligibility requirement by certifying that a CAH was a "necessary provider," effective January 1, 2006 Congress closed this loophole. *See* Medicare Prescription Drug, Improvement, & Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2269, § 405(h); *see also* 72 Fed. Reg. at 42,806 (discussing statutory change). Thus, the relative level of hospital services provided by Seymour and Throckmorton is irrelevant for purposes of determining whether the road between the two hospitals constitutes a secondary road, and CMS's interpretation is not unreasonable simply because it leads to the conclusion that Seymour does not qualify as a CAH, despite the high-level hospital services that Seymour provides. Indeed, this statutory change emphasizes that the legislature intended that the limits on the rural hospitals which would benefit from CAH status should be enforced so as to properly target resources to the intended categories of hospitals.

Therefore, we defer to CMS's interpretation of the term "secondary road" in section 1820(c)(2)(B)(i)(I) of the Act and 42 C.F.R. § 485.610(c), and we conclude that Seymour does not qualify as a CAH.

Conclusion

For the reasons stated above, we affirm the ALJ Decision.

/s/
Stephen M. Godek

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member