Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Cibola General Hospital
Docket No. A-11-5
Decision No. 2387
June 15, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Cibola General Hospital (Cibola) appealed the August 10, 2010 decision of Administrative Law Judge (ALJ) Alfonso J. Montaño upholding the determination of the Centers for Medicaid & Medicare Services that Cibola is ineligible to participate in Medicare as a critical access hospital (CAH). *Cibola General Hospital*, DAB CR2208 (2010) (ALJ Decision). One relevant requirement for participation as a CAH is that no other hospital be located within a 35-mile drive, and CMS determined that another hospital, Acoma-Canoncito-Laguna Hospital (Acoma), was within a 35-mile drive of Cibola. Cibola argues that Acoma should not be considered a "hospital" for these purposes because Acoma is an Indian Health Services (IHS) facility that does not provide services to non-Indians. CMS contends that Acoma meets the requirements to participate in Medicare as a hospital and that precludes Cibola from qualifying as a CAH.

For the reasons explained below, we conclude that the presence of Acoma's IHS facility within 35 miles of Cibola does not preclude Cibola's certification as a CAH. We therefore reverse the ALJ Decision.

Legal Authority

The CAH designation provides for higher Medicare payments in an effort to maintain the availability of hospital services in rural communities. *See* Social Security Act (Act) §§ 1814(l), 1834(g), 1861(v).[1] States may develop one or more rural health networks, including designated CAHs, as part of the Medicare rural hospital flexibility program. Act § 1820. A state may designate a facility as a CAH if it –

> (i) is a hospital that is located in a county (or equivalent unit of local government) in a rural area . . . and that –
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> > (I) **is located more than a 35-mile drive . . . from a hospital**, or another [CAH]; or
> > (II) is certified before January 1, 2006, by the State as being a necessary

[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm.

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 emergency care services in each area served by a [CAH];
(iii) provides not more than 25 acute care inpatient beds . . . ;
(iv) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area [with listed exceptions]; and
(v) meets the requirements of section 1861(aa)(2)(I) [which relate to quality assurance].

Act § 1820(c)(2)(B) (emphasis added).[2] CMS has issued regulations governing the conditions of participation for CAHs at 42 C.F.R. § 485.601 et seq. Those regulations do not provide any definition of hospital or any elaboration of the CAH proximity requirements set out in the statute. *Cf.* 42 C.F.R. § 485.610(c).

Section 1861(e) defines the term "hospital" for the Medicare Act (except for purposes of certain sections which are listed and which do not include section 1820) as "an institution which –

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff of physicians;

(4) has a requirement that every patient with respect to whom payment may be made . . . must be under the care of a physician . . . ;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times [with an exception not at issue here];

(6)(A) has in effect a hospital utilization review plan which meets the requirements of subsection (k) of this section and (B) has in place a discharge planning process that meets the requirements of subsection (ee);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

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[2] For convenience we sometimes refer to the highlighted language at section 1820(c)(2)(B)(i)(I) as the CAH promixity requirements.

> (8) has in effect an overall plan and budget that meets the requirements of subsection (z); and
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> (9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

Act § 1861(e)(1)-(9) (emphasis added). The remainder of section 1861(e) describes various situations in which, for specified purposes, certain institutions that do not necessarily meet all the definitional provisions of the first sentence may still be included as hospitals for payment under Medicare or situations in which certain institutions which do meet the provisions are nevertheless not included as hospitals for certain purposes (such as CAHs or some psychiatric hospitals).

Medicare payment is generally prohibited to any federal provider of services, but IHS facilities have an explicit exception permitting Medicare payments to be made to them, despite their federal status. Act §§ 1814(c), 1835(d), and 1880.

Undisputed facts

The facts underlying the ALJ Decision are undisputed, although the parties strongly disagree about the correct application of the law to those facts. Cibola is a 25-bed acute-care hospital in a rural area of New Mexico that applied to be and was designated by the State as a CAH. On October 27, 2008, CMS denied CAH certification on the grounds that Cibola did not meet the 35-mile requirement set out above. Cibola sought reconsideration and, on February 19, 2009, CMS affirmed its denial of certification stating that –

> a hospital in full operation [Acoma] is located within the 35 mile radius of [Cibola]. Furthermore, in reviewing the file of the hospital located within the 35 mile radius of [Cibola], we concluded that it meets the definition of a hospital. That hospital has an active Medicare provider agreement and is currently accredited by The Joint Commission (TJC). A hospital accredited by TJC is deemed to meet the Medicare Conditions of Participation.

P. Ex. 1, at 1.

Acoma is an IHS facility less than 19 miles from Cibola and has participated in Medicare since 1981. It is undisputed that IHS facilities are barred from providing services to non-Indians except in certain emergency situations. 42 C.F.R. § 136.12. It is also undisputed that Acoma, as an IHS facility, does not have a current New Mexico license or approval as a hospital and that it is indeed accredited and participating in Medicare as an IHS hospital. CMS Br. at 15-16; Cibola Br. at 18-19. (We discuss below CMS's contentions about early state surveys of Acoma.)

Cibola serves both Indians and non-Indians, with the latter representing 73.5 percent of Cibola's patients and 67.3 percent of the population of its service area.[3] P. Ex. 24, at 3.

ALJ Analysis

Before the ALJ, CMS initially contended that the definition of "hospital" for purposes of section 1820(c) was contained in section 1861(e)(1) of the Act alone. CMS Cross-Motion for Summary Judgment (CMSJ) at 6. CMS argued that it had long interpreted section 1861(e)(1) as the definition of hospital with the rest of section 1861(e) merely setting out the requirements for a hospital to be eligible for Medicare participation. *Id.* at 7, citing State Operations Manual (SOM) § 2020.[4] The ALJ rejected this approach, concluding that a "hospital" for these purposes "means an institution that meets the requirements in paragraphs one through nine of section 1861(e)." ALJ Decision at 6.

The ALJ then concluded that Acoma met all the elements of the definition of a hospital in section 1861(e). He based this conclusion, however, largely on the provisions of section 1865(a), which establish that a hospital accredited by TJC is "deemed to meet" the requirements of section 1861(e)(1)-(5) and (7)-(8). ALJ Decision at 8. He concluded that, although the resulting "presumption" of compliance with the cited requirements of section 1861(e) may be defeated by findings of actual deficiencies, such presumption is "not rebuttable in this context." *Id.* at 9. Further, the ALJ found that Acoma met the requirements of section 1861(e)(6) as a matter of fact (and that CMS has not promulgated additional requirements under section 1861(e)(9) beyond those established by TJC certification). *Id.* at 8-9.

The ALJ also concluded that, to the extent the term "hospital" in the CAH context is ambiguous, "CMS's interpretation of the term 'hospital" – as an institution with a provider agreement to participate in the Medicare program as a hospital – is reasonable." *Id.* at 11.

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[3] CMS does not dispute these figures which appear more relevant than the census data for the county of which the ALJ took notice showing about 60 percent non-Indian population. ALJ Decision at 20.

[4] Section 2020 of the SOM (accessible at http://www.cms.gov/Manuals/) provides as follows:

> A hospital is defined in §1861(e)(1) of the Act. A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. The remainder of §1861(e) defines a hospital eligible for Medicare participation.

In supplemental briefing in response to questions from the ALJ, CMS "clarified" that the term hospital in this context should be treated as meaning an institution with a Medicare provider agreement to participate as a hospital and asserted that the ALJ therefore did not need to decide "whether in other contexts the term hospital may have varying meanings within the Medicare Act or [determine the] applicability of section 2020" of the SOM. CMS Supp. Br. at 4 n.19. Before us, CMS does not revisit its initial claim that "hospital" is defined by section 1861(e)(1) alone. We therefore do not further discuss this SOM provision.

Standard of review

The Board's standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs,* http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html; *Batavia Nursing and Convalescent Inn*, DAB No. 1911, at 7 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App'x 664 (6th Cir. 2005). The Board's standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. *Id.*

Analysis

Our analysis requires discerning what Congress meant by the term "hospital" when it required that a CAH be "located more than a 35-mile drive . . . from a **hospital.**" Act § 1820(c)(2)(B) (I) (emphasis added). Specifically, the question is 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. No specific definition of "hospital" was included in the CAH provisions, leaving the parties and the ALJ to consider how to apply the general Medicare definition of the term.

1. The ALJ erred in concluding that the plain language of the statute established that Acoma was a "hospital" for purposes of the CAH proximity requirements.

As noted above, CMS's initial position in this case was that the applicable definition of "hospital" encompasses any institution that is "primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons." Act § 1861(e)(1). Based on that interpretation, CMS argued that the plain language of the statute would subsume Acoma because it was engaged in offering such services. CMSJ at 6-7.

One difficulty with this approach is that subsection 1861(e) sets out as a single sentence the statement that the term "hospital" means "an institution which" has the attributes listed in paragraphs (1) through (9). Act § 1861(e). These nine paragraphs are joined by semicolons and the conjunction "and." Treating only the clause in the first paragraph as definitional does not make grammatical sense. Another problem with treating the first clause alone as governing the definition of "hospital" for CAH proximity purposes is that this approach would make any institution primarily providing inpatient services a "hospital," even if the institution failed to have, for example, clinical records, physician supervision, 24-hour nursing services, a required state license, or a Medicare provider agreement. We therefore agree with the ALJ that the definition of a "hospital" for CAH proximity purposes must include all of the clauses of the definition in section 1861(e).

In any case, perhaps in light of these considerations, CMS "abandoned that position" in a supplemental brief before the ALJ and decided "after further consideration of the statutory language" that "hospital" for purpose of the CAH proximity requirements means "an institution that has a provider agreement to participate in the Medicare program as a hospital (i.e. that meets the requirements in subparagraphs (1) through (9) of section 1861(e))." ALJ Decision at 11, quoting CMS Supp. Br. at 3-4. CMS's reinterpretation, however, fails to note that having a provider agreement and meeting the requirements of section 1861(e)(1) through (9) are not coextensive. The ALJ apparently recognized this incongruity but nevertheless found CMS's interpretation to be "reasonable" because "[p]ossession of such a provider agreement is some evidence that the institution meets the statutory definition of a hospital in section 1861(e)." ALJ Decision at 11. While it is true that having a provider agreement as a hospital is consistent with meeting the statutory definition, not all institutions that meet the requirements at section 1861(e)(1)-(9) choose to have a Medicare provider agreement and furthermore not all institutions with Medicare provider agreements as hospitals are required to meet and do actually meet the definition in section 1861(e)(1) through (9).

An institution may obtain a Medicare provider agreement to participate as a hospital without meeting the requirements of subparagraphs (1) through (9) of section 1861(e) under several sets of circumstances. Section 1861(e) provides for a number of variations from and additions to the basic definition of hospital, many of them limited to specific purposes or eligible only for payment for certain services. (CMS refers to these as "explicit but irrelevant exceptions," but does not explain why some exceptions are irrelevant while others, covering IHS facilities, are relevant. CMS Br. at 14.) For example, a "religious nonmedical health care institution" may receive a provider agreement as a "hospital" even though it may not meet all the elements listed, and indeed does not provide the services identified in section 1861(e)(1) (although it must meet other requirements and is reimbursed only for limited kinds of items and services).[5] Treating every institution with a Medicare provider agreement to participate as a hospital as constituting a "hospital" for purposes of section 1820(c)(2)(B)(i)(I) would thus mean that the existence of a religious nonmedical health care institution in a rural area would preclude designation of a CAH within 35 miles. Yet the religious institution would not be able to meet medical needs for hospital services of Medicare beneficiaries in that area. Similarly, an IHS facility may receive a Medicare provider agreement even where, as a federal facility, it need not, and may well not, meet the definitional requirement of a state license or approval under section 1861(e)(7) and where it is legally prohibited from serving the medical needs for non-emergency hospital services for non-Indian Medicare beneficiaries in the area.

By the same token, an institution may meet all the parameters of the definition of hospital under Medicare law but never apply to participate in Medicare or accept Medicare

[5] For more information about the conditions applicable to such institutions, *see* sections 1821 and 1861(ss)(1) of the Act.

patients. Its presence in a community would do nothing to ensure that Medicare beneficiaries had access to medical hospital services.

Nothing in the plain language of section 1820(c)(2)(B)(i)(I) either limits "hospital" for its purposes to institutions with Medicare provider agreements or extends "hospital" to all institutions that qualify for Medicare provider agreements as hospitals without meeting all the requirements of section 1861(e)(1) to (9). The term "hospital" in the CAH proximity context is thus subject to multiple interpretations. We conclude that the reference to "hospital" in section 1820(c)(2)(B)(i)(I) is ambiguous. We therefore turn next to the question of how to interpret the term in context.

2. CMS has not articulated an authoritative interpretation of "hospital" as used in section 1820(c)(2)(B)(i)(I) of the Act.

We begin our effort to discern the interpretation of "hospital" in this context by considering whether CMS has issued or articulated any authoritative interpretation. Cibola argues that CMS provided no public statement of any interpretation or guidance suggesting that IHS facilities that receive Medicare provider agreements as hospitals are to be considered "hospitals" for CAH proximity purposes, and, indeed, that CMS and its contractor took actions and made statements inconsistent with the existence of any such interpretation. Cibola Br. at 24.

The ALJ rejected Cibola's assertion that CMS's current position conflicted with its actions in prior cases. ALJ Decision at 13. He recognized that the evidence indicated that at least eight facilities had been certified over the years as CAHs even though they were located within 35 miles of IHS hospital facilities. *Id.* He pointed out, however, that, at the time that seven of the eight hospitals were certified (prior to January 2006), states were permitted to waive the proximity requirement by certifying hospitals as "necessary providers" and that Cibola did not prove that such waivers were not applied in those seven cases. *Id.* Thus, he found those cases inadequate to show that CMS previously "formulated a clear position" inconsistent with denying certification to Cibola. *Id.* In the case of one facility designated as a CAH after 2006 despite the documented proximity of IHS facility, the ALJ concluded that this prior designation did not suffice to demonstrate that CMS had determined that "an IHS facility cannot, *as a matter of law*, be regarded as a hospital within the meaning of the 35-mile requirement," as opposed to simply relying on some factual circumstances unique to that situation. *Id.* at 14 (emphasis in original). For these reasons, the ALJ concluded that Cibola failed to prove that CMS had deviated from a clear prior interpretation and that CMS's position in the current litigation was therefore "worthy of deference." *Id.*

We disagree. The issue is not whether CMS had once formulated a clear position contrary to the interpretation on which it presently relies but whether CMS has articulated any consistent interpretation of the term "hospital" in the CAH proximity context. The Board has held that it will defer to an agency's reasonable and permissible interpretation of ambiguous statutory language so long as the party against whom the agency seeks to

apply the interpretation had adequate notice. *See, e.g., Ark. Dep't. of Health and Human Res.*, DAB No. 2201, at 12 (2008). Even in the absence of actual notice, the Board will nevertheless apply an agency interpretation so long as the party adversely affected cannot show that it actually relied on a reasonable alternative interpretation. *Missouri Dep't of Soc. Servs.*, DAB No. 2184, at 27-35 (2008).

It is true, as the ALJ noted, that an agency interpretation may be articulated through the process of case-by-case adjudication rather through than formal rulemaking or written guidance. *Conn. Dep't. of Soc. Svcs.*, DAB No. 1982, at 21 (2005). However, the Board has held that the degree of deference properly accorded "to a particular CMS interpretation depends on a number of factors, such as whether it has been published and in what form, how widely and at what level it has been distributed, what authority the source within CMS has, whether the interpretation is consistent with other issuances, and whether the interpretation is a long-standing one or appears to be a position adopted in litigation which the agency seeks to enforce retroactively." *Alaska Dept. of Health and Social Svcs.*, DAB No. 1919, at 14 (2004). Here, however, CMS not only failed to promulgate any written explanation of the meaning of the term "hospital" in the CAH proximity context, but has identified no longstanding or official interpretation, and has put forward multiple, mutually inconsistent interpretations even in the course of this proceeding. The Board has previously declined to view as authoritative CMS's purported interpretation "when CMS itself has not offered a consistent interpretation even for purposes of this litigation." *Community Northview Care Center*, DAB No. 2295, at 14 (2009). Similarly here, we do not agree with the ALJ that an authoritative agency interpretation exists to which we could or should defer.

The ALJ variously characterized the CMS interpretation to which he deferred as that "hospital" should be interpreted "to include Acoma" or should be interpreted to mean "an institution with a provider agreement to participate in the Medicare program as a hospital." ALJ Decision at 11. He found those interpretations to be "reasonable." *Id.* CMS's position that Acoma is a "hospital" is not an interpretation of the term but an application of it. As we have noted earlier, the interpretation of "hospital" to mean any institution with a Medicare provider agreement as a hospital is not consistent with the definition of "hospital" in section 1861(e)(1)-(9). Yet, the ALJ did not address how he reconciled the interpretation that "hospital" for CAH proximity purposes means any institution that has a Medicare provider agreement as a hospital with his earlier holding (and CMS's additional assertion) that, as used in section 1820(c)(2)(B(i)(I), "'*hospital' means an institution that meets the requirements in paragraphs one through nine of section 1861(e).*" ALJ Decision at 6 (italics in original). Given that meeting those

requirements permits but does not require an institution to obtain a Medicare provider agreement, the two interpretations are not co-extensive.[6]

Even if we could discern a single clear interpretation by CMS that required IHS facilities with Medicare provider agreements to be treated as "hospitals" for purposes of precluding certification of a CAH designated by a state, CMS points to no source of timely or adequate notice to Cibola (or to New Mexico which designated Cibola) of such an interpretation. We would therefore have to consider whether Cibola, or New Mexico in proceeding to designate Cibola as it did, relied on an alternative reasonable interpretation of the term "hospital" in this context. Cibola presented some evidence in this regard, including a letter from the New Mexico Department of Health (DOH) stating that DOH "held discussions" with CMS's Regional Office about whether Cibola would need to qualify under the "Necessary Provider provisions" (which permitted a state more leeway prior to January 1, 2006 to designate certain hospitals) and was "assured by CMS staff that Federal hospitals, including [IHS] facilities . . . were not to be considered in calculating the 35-mile distance requirements" for CAH designation. P. Ex. 22, at 1. DOH further stated that, had it "**not been advised otherwise by CMS we would have included [Cibola] in our State Plan as a Necessary Provider facility, and assisted [Cibola] in receiving CAH status under this provision prior to the sunset of these procedures**." *Id.* (bold in original).[7] Cibola also provided a November 30, 2007 letter to DOH from the applicable CMS contractor recommending approval of Cibola's conversion to a CAH. P. Ex. 23.

The ALJ rejected Cibola's claim that this evidence proved that CMS "lulled" it into "foregoing pursuit" of necessary provider status. ALJ Decision at 18. To a large extent, the ALJ's discounting of this evidence reflected his understanding that Cibola sought to rely on such alleged CMS "assurances" to obtain equitable estoppel, a form of relief which the ALJ correctly recognized was not within his authority to grant, if it may ever lie against the federal government. *Id.* at 18-19. The evidence, however, here goes not to whether CMS is estopped from denying Cibola CAH status but whether CMS may enforce against Cibola a current interpretation of the statute where Cibola relied on a

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[6] CMS might reasonably decide to restrict "hospital" for CAH proximity purposes to institutions that both meet the definitional requirements of section 1861(e)(1)-(9) and that do in fact obtain Medicare provider agreements. Such an approach would make sense in light of the purposes of the CAH program which we discuss in the next section, in that only an institution with a Medicare provider agreement could provide Medicare beneficiaries with meaningful access to hospital services. In this section, however, we address whether CMS has actually adopted an authoritative interpretation of the term "hospital," and we find that CMS never provided any explanation of an interpretation requiring both compliance with paragraphs (1) and (9) and possession of a current Medicare provider agreement.

[7] The ALJ discounted the evidence offered by Cibola of assurances and communications from CMS or its contractor suggesting that the existence of the IHS facility was not a bar on the grounds that Cibola did not prove that any of the communications occurred prior to April 2007 when Cibola submitted its CAH application, much less prior to January 2006 when the state lost the authority to grant necessary provider status. ALJ Decision at 18. The ALJ apparently did not credit DOH's assertion that it made the decision not to proceed under the necessary provider law before its sunset because the DOH assertion was contained in a letter to Cibola sent in 2009. *Id.* For the reasons explained in the text, we need not revisit the details of these communications and time frames.

reasonable understanding of the statutory language in the absence of notice that CMS would interpret it differently.

In any case, we need not definitively resolve whether Cibola actually relied on an alternative reasonable interpretation of "hospital" in light of our conclusion that CMS has offered multiple interpretations even in the present case.

3. Acoma is not a "hospital" within the meaning of section 1820(c)(2)(B(i)(I) of the Act.

CMS is not precluded from, in the future, adopting an authoritative interpretation of "hospital" as it applies to CAH certification decisions, but, in the absence of such an interpretation or any statutory or regulatory history explaining the intended meaning of the term, we must interpret the term reasonably in light of the purpose of the statute in which it was included. One of the express purposes of the rural hospital flexibility program (of which CAH designation is a central element) is to improve "access to hospital and other health services for rural residents . . ." Act § 1820(b)(1)(A)(iii). In developing regulations relating to necessary-provider-status CAHs, CMS expressed its "belief that the intent of the CAH program is to maintain hospital-level services in rural communities while ensuring access to care." 72 Fed. Reg. 42,628, 42,806 (Aug. 2, 2007); *see also* 72 Fed. Reg. at 42,807 ("We have consistently taken the position that the intent of the CAH program is to keep hospital-level services in rural communities, thereby ensuring access to care . . . ."). CMS nevertheless took the position in this litigation that it was "not free to ignore the plain meaning of the statutory language, even if it appears to be counter-productive to the purpose of the statute." CMS Reply Br. in C-09-401, at 3; CMS Resp. Br. at 17. We have concluded above, however, that the plain meaning does not preclude a reading that is in tune with the statutory intent. Neither CMS nor the Board is therefore confronted with the dilemma of plain language compelling a "counterproductive" result.

The ALJ opined that the Secretary's ability to "promote access to rural hospital services by certifying facilities as CAHs" is "constrained by the 35-mile requirement." ALJ Decision at 19. Certainly, the statute does not provide enhanced reimbursement for all hospitals in rural areas, and does place proximity constraints to identify those hospitals that are critical to maintaining access to hospital services. That observation, however, does not provide any clear answer to the question of how broadly or narrowly Congress intended the term "hospital" to be construed in applying the proximity constraints. As stated above, we do not agree that treating IHS facilities as "hospitals" in evaluating proximity to a proposed CAH is demanded by the statutory language setting the 35-mile limit. Since the statute emphasizes the overarching goal of preserving the access of rural Medicare beneficiaries to hospital services, where the statutory language is subject to more than one interpretation, it makes sense to construe the proximity constraint

language narrowly to foster the statutory goals.[8] We therefore read the term "hospital" for CAH proximity purposes to refer to institutions meeting the requirements of section 1861(e)(1)-(9) with Medicare provider agreements as hospitals and offering meaningful access to hospital services to Medicare beneficiaries generally in the applicable rural area.

In general, no Medicare payments may be made to any federal provider of services. Act §§ 1814(c), 1835 (d). We note that CMS does not dispute that non-IHS federal hospitals (such as those operated by the Department of Veterans Affairs) are excluded from the meaning of "hospital" for CAH proximity purposes, even though they would have qualified under CMS's original interpretation relying only on section 1861(e)(1) and they may well serve persons who are also Medicare beneficiaries. This exclusion is consistent with understanding "hospital" for CAH proximity purposes to refer to institutions that offer hospital services to all Medicare beneficiaries, i.e., not limited to a subset such as those who qualify as veterans. This understanding is supported by the simplest and most natural reading of the term to encompass those institutions that *both* meet the general Medicare definition of "hospital" at section 1861(e)(1)-(9) and provide general hospital services to Medicare beneficiaries.

In 1976, Congress created an exception to the bar to Medicare payments for federal providers to permit IHS facilities to receive payment as hospitals or skilled nursing facilities. Act § 1880(a); *see* CMSJ at 3 (providing legislative history citations); CMS Br. at 7-8. There is evidence that one purpose of this exception was to channel Medicare funds to provide supplemental financial resources to improve conditions in IHS facilities to bring them to the same standards as non-Indian Medicare facilities. *See* Act § 1880(b)-(c). Prior to the law, although Indians were entitled to services under both Medicare and Medicaid on the same basis as other Americans, they were often unable to benefit from these programs since the services available to them as a practical matter, particularly on reservations, were frequently limited to those provided by federal IHS facilities for which neither program would make payment. *See* CMSJ at 3. CMS argued below that Congress recognized that IHS facilities "are not required to be licensed by States or localities" but instead counted on the Secretary to ensure that IHS facilities certified to participate in Medicare would meet equivalent health and safety standards. *Id.* at 5, quoting H.R. Rep. No. 94-1026(II) (1976) (report on Pub. L. No. 94-437, Indian Health Care Improvement Act), reprinted in 1976 U.S.C.C.A.N. 2652, 2776. CMS opined that there "is nothing in the legislative history, regulations, or guidance to suggest that the IHS hospital must be treated *exactly* like all other hospitals participating in Medicare in order to qualify as hospitals under the statute." CMSJ at 5 (emphasis in original). Despite thus acknowledging that the participation of IHS facilities in Medicare is exceptional in various respects, CMS goes on to insist that such facilities must nevertheless be treated exactly like other hospitals for purposes of barring nearby hospitals from certification as CAHs.

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[8] We note that the statute reduces the 35-mile proximity constraint to only 15 miles in situations involving mountainous terrain or poor roads. Act § 1820(c)(2)(B)(i)(I). While not dispositive, this provision further illustrates the statutory focus on practical and meaningful access to hospital care.

It is undisputed that Acoma does not meet the requirement of section 1861(e)(7) to have a state license if the state licenses hospitals (which New Mexico does). CMS argues the reason that Acoma does not have a state license is that IHS hospitals are exempt from the state licensing requirements, so that no license was required. *Id.* at 15. We find this reasoning circular. Notably, the definitional provision of section 1861(e)(7) does not merely require that an institution have a state license as a hospital if the state requires it to have a license but rather requires that, to be considered a hospital, the institution must have a state license whenever state law "provides for the licensing of hospitals."[9] Thus, contrary to CMS's argument on appeal, the fact that IHS facilities do not require state licenses to operate lawfully in New Mexico because of their federal status does not establish that such a facility is a "hospital" for purposes of section 1861(e)(7).

The statute alternatively allows state approval "by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing . . . ." Act § 1861(e)(7)(B). The legislative history suggests that "certification approval" was intended to be accepted as an alternative "where such procedures are State or local law equivalents to licensing ." CMS Ex. 19, at 2 (excerpt from S. Rep. No. 404 to Social Security Amendments of 1965). New Mexico responded to a record request relating to Acoma that "the State of New Mexico does not license or otherwise survey [Acoma], therefore we have no records applicable to this request."[10] The record does not establish that Acoma has either licensing or equivalent approval by the New Mexico state licensing agency.

CMS nevertheless insists that Acoma met the definition of a hospital for purposes of section 1820(c)(2)(B)(i)(I) "because it had a Medicare provider agreement and was accredited by the Joint Commission (JC)." CMS Br. at 2. CMS argues that this accreditation resolved "[a]ny legal issue regarding Acoma's lack of licensure." CMS Br. at 17. CMS also argues that we have no "jurisdiction to 'look behind' CMS's approval of Acoma as a Medicare hospital." CMS Br. at 9. CMS further contends that the Board should defer to its reasonable determination that Acoma was eligible for its Medicare

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[9] CMS's suggestion that the Board has held that licensing is part of the definition only where the state law makes it "applicable" misstates the relevant cases. In *John Hopkins Health System*, DAB No. 1712 (1999), the Board concluded that an oncology center was part of a hospital and covered by common licensing. In *Kings View Hospital*, DAB CR442 (1996), an ALJ decision to which CMS cited, the ALJ found that an institution must either be licensed by the state as hospital "to the extent that license is required under State law" or "receive authority to operate from a State in lieu of license, in order to meet the statutory definition of a hospital . . . ." DAB CR442, at 4. The ALJ's explanation, while not binding, is consistent with our interpretation that the requirement for either licensing or approval from a state licensing agency is part of the statutory definition of hospital.

[10] Before the ALJ, CMS contended that New Mexico "approved" Acoma in the 1980s, but referenced a state survey agency certification for federal Medicare certification rather a state licensing agency approval proceeding. *See* CMS Supp. Br. at 6, citing CMS Ex.9. The cited document does not identify the state or agency involved; Cibola subsequently provided evidence that the Texas Department of State Health Services performed a complaint survey of Acoma in 2007 and reported deficiencies to CMS. P. Ex. 28. On appeal, CMS refers to the 1980s documentation as relating to "the state survey agency" surveys of Acoma, without naming which State conducted them. CMS Br. at 3-5; CMS Exs. 9-11. CMS presented no information about whether the state survey agency involved was also the state agency responsible for state licensing.

provider agreement. *Id.* at 14-19. The ALJ agreed, rejecting Cibola's argument below that CMS's admission that Acoma lacked a state license rebutted the "'presumption' of compliance with section 1861(e)'s requirements" created by Acoma's TJC accreditation. ALJ Decision at 9. The ALJ concluded that any such presumption could not be rebutted except where a facility loses its deemed status by virtue of a validation survey finding significant health and safety deficiencies. *Id.* at 20, citing 42 C.F.R. §§ 488.7, 488.10(b)-(c).

CMS's arguments and the ALJ's analysis mistake the issue. It is not contested that Acoma is TJC accredited. Cibola does not argue that Acoma is not properly participating in Medicare.[11] We do not question that Acoma was properly "deemed" to meet the requirements to participate in Medicare as a hospital under section 1865(a). We need not engage in any review of the validity of its accreditation or determine whether the presumption of compliance created by accreditation has been or may be rebutted in this context. We are not reviewing or looking behind CMS's determination to certify Acoma to participate in Medicare. It does not follow, however, that the term "hospital" in section 1820(c)(2)(B)(i)(I) must be interpreted to embrace every institution that may be permitted to participate in Medicare without meeting all the definitional requirements in section 1861(e) (1)-(9).

CMS argues that the Medicare Act elsewhere refers to IHS facilities as hospitals and skilled nursing facilities and suggests that such references reinforce its position that an IHS facility that is certified to participate in Medicare as a hospital must be considered a "hospital" for purposes of section 1820(c)(2)(B)(i)(I). CMS Br. at 16, citing Act § 1880. We reject this argument. The Medicare Act refers in several places to CAHs as "hospitals," too. Yet, section 1861(e) expressly excludes CAHs from the definition of "hospital," unless "the context otherwise requires." Clearly, the use of the word "hospital" in the Medicare Act occurs in a wide variety of contexts and, while having a general definition, must be read reasonably in context. In short, we cannot agree with CMS that an "unambiguous" meaning of "hospital" in section 1820(c)(2)(B)(i)(I) compels CMS to overlook the unreasonable implications of treating an institution closed to non-Indian Medicare beneficiaries as a "hospital" in the context of the CAH provisions that seek to foster access to hospital services for rural beneficiaries. *Cf.* CMS Br. at 17.

CMS also argues that Congress could have expressly excluded IHS hospitals from consideration in determining CAH eligibility. CMS Resp. Br. at 18. The ALJ suggested that it was impossible to know what Congress "actually thought, if anything," about whether to account for IHS facilities, although the ALJ speculated that denying Cibola certification might not "undermine the legislative purpose" if Congress believed that "the IHS and non-IHS facilities would *collectively* ensure that all of the rural area's residents," Indian and non-Indian, could get hospital access. ALJ Decision at 19-20 (italics in original). We see no reason that Congress would need to expressly exclude IHS facilities

[11] We thus find no basis for CMS's argument that Cibola cannot "appeal" CMS's 30-year old decision to grant Acoma a Medicare provider agreement because the decision is final and Cibola is not a party to it. CMS Br. at 9-10. Acoma's provider agreement is not the issue on appeal here.

from its reference to "hospital" in section 1820(c)(2)(B)(i)(I) when such facilities do not meet the core definition of "hospital" applicable to Medicare, which CMS has identified as the requirements of section 1861(e)(1)-(9) (even though hospital services provided by IHS facilities do qualify for Medicare payment based on exceptions to the usual bar on Medicare payments to federal facilities, exemptions from state licensing or approval requirements, and deeming by accrediting authorities). We see no basis to speculate about how Congress might have reconciled barring CAH status to any hospital within 35 miles of a facility closed to all non-Indian beneficiaries with the overriding goals of the CAH program. In any case, the relevant inquiry is not whether Acoma and Cibola "collectively" ensure hospital access for Indians and non-Indians, but what the effect would be on hospital access for all Medicare beneficiaries if Cibola were to close as a result of not receiving CAH reimbursement rates. In such an event, although Indian beneficiaries would continue to have access to some hospital services (albeit losing Cibola as an alternative source), non-Indians would have no access (with the possible exception of some emergency care). We find no basis in the statute or in the legislative history cited by the parties to conclude that this outcome was intended by Congress.

Given our resolution of these issues, we need not reach Cibola's additional contentions, such as that the statutory language compels reading "hospital" to exclude IHS facilities, that CMS failed to establish a separate criteria requiring CAHs to be 35 miles from any IHS facility, or that CMS was obliged to adopt an interpretation through formal rulemaking rather than through informal guidance or case-by-case adjudication.

Conclusion

For the reasons explained above, we conclude that Acoma is not a "hospital" with the meaning of section 1820(c)(2)(B(i)(I), and therefore its presence within 35 miles of Cibola does not preclude Cibola's certification as a CAH. We therefore reverse the ALJ Decision.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member