

**PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION**

On the Record
2026-D30

PROVIDER –
Memorial Hermann Texas Medical Center

PROVIDER NUMBER – 45-0068

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

RECORD HEARING DATE –
May 20, 2024

**COST REPORTING PERIOD
ENDED –**
June 30, 2014, June 30, 2015, & June 30,
2016

CASE NUMBERS – 18-1493, 19-2284
& 20-0015

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ISSUE STATEMENT:

Whether Memorial Hermann Texas Medical Center's ("Memorial Hermann's" or "Provider's") organ acquisition costs have been understated due to the Medicare Contractor excluding as usable organs those transplanted into beneficiaries enrolled in Medicare Part C, or Medicare Advantage plans, for the cost reporting periods ending June 30, 2014, June 30, 2015, and June 30, 2016.¹

DECISION:

After considering Medicare law, regulations, and program guidance, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds the Medicare Contractor properly calculated Memorial Hermann's Fiscal Year ("FY") 2014, FY 2015, and FY 2016 organ acquisition costs for reimbursement under Medicare Part A on the applicable cost reports.

INTRODUCTION:

Memorial Hermann is an acute care inpatient hospital and certified transplant center ("CTC") located in Houston, Texas.² During the cost reporting periods at issue, the Medicare contractor³ assigned to Memorial Hermann was Novitas Solutions, Inc. ("Medicare Contractor"). The costs for a CTC are reimbursed by Medicare on a reasonable cost basis and not under the Inpatient Prospective Payment System ("IPPS").⁴

For the cost reporting years 2014 through 2016, Memorial Hermann classified organs transplanted into Medicare beneficiaries receiving benefits under Part C of the Medicare Act as "non-Medicare" organs in its cost reports, in accordance with CMS guidance applicable during those periods.⁵ Memorial Hermann protested this classification on its 2014, 2015, and 2016 cost reports,⁶ arguing that CMS'/the Medicare Contractor's treatment of Medicare Part C beneficiaries as "non-Medicare" beneficiaries for purposes of organ acquisition reimbursement was invalid.⁷ The Medicare Contractor disagreed and "made audit adjustments removing the protested items in Audit Adjustments 33 (FY 2014), 27 (FY 2015), and 44 (FY 2016)," respectively.⁸

¹ Stipulations (hereinafter, "Stip.") at ¶ 1 (May 15, 2024).

² *Id.* at ¶ 2.

³ CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare contractor" to refer to both FIs and MACs, as appropriate and relevant.

⁴ 42 C.F.R. § 412.2(e)(4).

⁵ Stip. at ¶ 3. CMS Pub. 15-2, § 4028.3 (instructions for line 63) (2015); *see also* Transmittal 6, PRM, Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS-2552-10 (Sept. 2014) (indicating that revised instructions are applicable to cost reporting periods ending on or after June 30, 2014) (copy at Ex. P-6 at P-0349); Transmittal 471, PRM, Part 1 – Chapter 31, Organ Acquisition Payment Policy (Apr. 1, 2016) (adopting similar provision) (copy at Ex. P-7 at P-0351).

⁶ Stip. at ¶ 4. *See also* Ex. P-2 at P-0010, P-0012, and P-0014.

⁷ Provider's Final Position Paper at 6-7 (Mar. 8, 2024) (hereinafter "Provider's FPP").

⁸ *Id.* at 6; Ex. P-1 at P-0003, P-0005, P-0007.

Memorial Hermann timely appealed the issue to the Board and met the jurisdictional requirements for a hearing. The Board issued a Notice of Consolidated Record Hearing on May 20, 2024. Memorial Hermann was represented by Stephanie Webster, Esq. of Ropes & Gray, LLP. The Medicare Contractor was represented by Joseph J. Bauers, Esq. of Federal Specialized Services.

STATUTORY AND REGULATORY BACKGROUND:

A. Medicare Part A and Part B and Organ Acquisition Reimbursement

The Medicare program has established policies which support organ transplantation by providing payment for the variety of organ acquisition services required to support quality transplant programs. In reference to kidney/renal transplants, 42 C.F.R. § 412.100(a) (2012) states the following:

- (a) Adjustments for renal transplantation centers.
 - (1) CMS adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part for hospitals approved as renal transplantation centers . . . to remove the estimated net expenses associated with kidney acquisition.
 - (2) Kidney acquisition costs are treated apart from the prospective payment rate for inpatient operating costs, and payment to the hospital is adjusted in each reporting period to reflect an amount necessary to compensate the hospital for reasonable expenses of kidney acquisition.

Thus, there are two components of the payment made to a hospital designated as a CTC:

- (1) a prospective payment system payment based on the Diagnostic Related Groups (“DRG”) for the services/discharge related to the actual transplant of the organ into the recipient (excluding the acquisition costs of the organ), and
- (2) an organ acquisition amount to compensate the hospital for the reasonable and necessary costs associated with acquiring the organ (*i.e.*, organ acquisition costs).⁹

Medicare’s current organ acquisition policy is modeled after the kidney acquisition policy that was implemented for kidney transplants following the Social Security Amendments of 1972, which extended Medicare coverage under Parts A and B to certain qualifying individuals with end stage renal disease (“ESRD”).¹⁰ In 1974, CMS (then, the Bureau of Health Insurance) issued the Part A Intermediary Letter No. 74-23, which set forth Medicare policies and

⁹ 42 C.F.R. § 412.2(e)(4); 42 C.F.R. § 412.113(d).

¹⁰ Pub. L. No. 92-603, § 299I, 86 Stat. 1329, 1463-1464 (1972).

procedures for reimbursement of kidney transplants and kidney acquisition costs, many of which remain in place currently.¹¹

In 1978, Congress added § 1881 of the Social Security Act (42 U.S.C. § 1395rr) to further define Medicare coverage of ESRD patients.¹² In particular, this section clarified the Medicare coverage of kidney procurement costs and living donor benefits, including Medicare Part A and Part B coverage for kidney living donors.¹³

In 1995, CMS modeled Medicare Part A reimbursement of the acquisition costs for non-renal organs based on the earlier Medicare Part A kidney acquisition policies.¹⁴ Particularly, when a specific type of non-renal organ transplantation moved from experimental to medically accepted procedures, CMS accordingly issued National Coverage Determinations (“NCDs”) to extend Medicare coverage for transplantation of the non-renal organs such as heart, liver, lungs, pancreas, and intestinal/multi-viscera.¹⁵

In 2005, CMS issued Transmittal 30, which revised Provider Reimbursement Manual, Part I (“PRM-I”) Chapter 27, in part, to update the policies to expand their applicability from kidney procurement and transplant to *all types of organs*.¹⁶ Transmittal 30 also details how CTCs are to be paid –

B. Certified Transplant Centers.--A CTC is paid based on the number of Medicare organ transplants that it performs.

2775.1 Primary Payer.--If a Medicare beneficiary has some group health insurance coverage, determining Medicare transplant status depends on the amount paid by the primary insurance. ***Specifically, if a beneficiary has primary insurance coverage and payment by the primary payer satisfies the liability of the Medicare program, the transplant is considered a non-Medicare transplant for cost reporting purposes. This is consistent with Medicare billing and cost reporting instructions.***¹⁷

In April, 2016, CMS issued Transmittal 471¹⁸ to update, reorganize, and clarify Medicare’s Part A payment policy regarding organ acquisition costs, formerly found in PRM-I Chapter 27, sections 2770 through 2775.4, and created a new chapter in PRM-I, Chapter 31. This new

¹¹ Ex. P-8.

¹² Pub. L. 95-292, 92 Stat. 307, 308 (1978).

¹³ *Id.*

¹⁴ 60 Fed. Reg. 6537, 6544 (Feb. 2, 1995).

¹⁵ CMS codified its NCDs relating to solid organ transplants in § 260 of the Medicare NCD Manual, CMS Pub. 100-03, available at <https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms014961> (last visited Sept. 23, 2026). See also 60 Fed. Reg. 6537 (Feb. 2, 1995) (NCD for lung and heart-lung transplants).

¹⁶ CMS PRM-I, § 2775.1 (Rev. 30, Jan. 2005) (emphasis added).

¹⁷ *Id.*

¹⁸ CMS PRM-I, Chapter 31, Organ Acquisition (Apr. 1, 2016), available at <https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r471pr1.pdf> (last visited Sept. 23, 2026).

chapter details the Medicare program policies supporting organ transplantation and Medicare's reimbursement for its share of organ acquisition costs.

In particular, § 3115 of this new chapter details the policy for "Counting Organs," as follows:

OPOs [*i.e.*, Organ Procurement Organizations] and CTCs [*i.e.*, Certified Transplant Centers] are responsible for accurately counting both Medicare and non-Medicare organs to ensure that costs are properly allocated on the [Medicare Cost Report]. The OPO and CTC should count organs procured and transplanted en bloc (two organs transplanted as one unit) as one organ. This can include but is not limited to en bloc kidneys and en bloc lungs.

A. Counting Medicare Usable Organs at CTCs/HOPOs.— Medicare usable organs include organs transplanted into Medicare beneficiaries (***excluding Medicare Advantage beneficiaries***), organs that had partial payments by a primary insurance payer in addition to Medicare, organs sent to other CTCs, organs sent to OPOs and kidneys sent to MRTCs (that have a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988 and approved by the contractor). Medicare usable organs ***do not include*** organs used for research, organs sent to veterans' hospitals, organs sent outside the United States, organs transplanted into non-Medicare beneficiaries, organs that were totally paid by primary insurance other than Medicare, ***organs that were paid by a Medicare Advantage plan***, organs procured from a non-certified OPO and kidneys sent to MRTCs (without a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988 and approved by the contractor).¹⁹

In determining whether an organ will be counted as a Medicare usable organ, PRM-I, § 3104 states:

If a Medicare beneficiary has a primary health insurance coverage other than Medicare, determining whether an organ will be counted as a Medicare usable organ depends on the amount paid by the primary insurance. A provider must submit a bill to Medicare when payment from the primary payer is insufficient to cover the entire cost of a transplant including the DRG and the organ acquisition costs. ***However, when the primary insurance requires the acceptance of their payment in full, a bill is not required, because under the contractual agreement, Medicare has no liability because the primary payer has made the payment in full.***

¹⁹ *Id.* at § 3115. Note that "HOPO" is in reference to a hospital based organ procurement organization.

Accordingly, the organ under the paid in full contractual agreement will not be counted as a Medicare usable organ.

When the provider submits a bill and the primary payer does not require the provider to accept the contractual payment in full, it is necessary to compare the total cost of the transplant, including the DRG and the organ acquisition costs, to the payment received from the primary payer. The provider's remittance advice may or may not show that Medicare has a liability because the bill is only submitted for the transplant portion of the payment. Thus, the provider will need to compare the total Medicare cost (DRG from the transplant and the organ acquisition costs) to the payment from the primary payer to determine whether Medicare has a liability for the organ acquisition costs. ***If the payment from the primary payer is greater than the cost of the DRG and the organ acquisition costs, there is no Medicare liability and the organ cannot be counted as a Medicare usable organ.*** If the payment from the primary payer is less than the DRG and the organ acquisition costs, there is a Medicare liability and the organ can be counted as a Medicare usable organ. The payment from the primary payer is pro-rated between the DRG payment and the organ acquisition payment. If the organ is counted as Medicare usable, the organ acquisition portion of the primary payment should be included on the appropriate line as a revenue offset on the MCR, Form CMS-2552. This is consistent with the Medicare Claims Processing Manual (CMS Pub. 100-04) and cost reporting instructions set forth in CMS Pub. 15, Part 2.²⁰

In September 2014, CMS issued Transmittal 6²¹ which updated Chapter 40 of the Provider Reimbursement Manual, Part II ("PRM-II"), the hospital cost reporting instructions for Form 2552-10. Section 4028.3 of PRM-II, Chapter 40 addresses cost report Worksheet D-4, which addresses the computation of organ acquisition costs. Transmittal 6 "[c]larified the instructions and eliminated the 'other' organ category and check off box from the worksheet [Worksheet D-4]."²² Section 4028.3 explains what should be reported on certain lines of Worksheet D-4, and states, in pertinent part:

Line 62--Enter the number of total usable organs excised and purchased minus all unusable or discarded organs that could not be transplanted (usable organs equals Worksheet D-4, Part IV, line 74, sum of columns 1 and 2, minus Worksheet D-4, Part IV, line

²⁰ (Bold and italics emphasis added).

²¹ Available at <https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2014-transmittals-items/r6p240> (last visited Sept. 23, 2026).

²² *Id.* (copy at Ex. P-6 at 0348-0349 (noting the transmittal updates Chapter 40, Hospital and Hospital Health Care Complex Cost Report, Form CMS-2552-10, "to clarify and correct the existing instructions and incorporate statutory and regulatory changes," with effective dates varying by provision)).

83, sum of columns 1 and 2). For islets since the number of islets cells injected into a recipient will vary depending on the patient, enter the number of patients who received islets injections. Each patient is allowed a maximum of two islet injections per inpatient stay.

Line 63--Enter the total Medicare usable organs that are included on line 62. ***Medicare usable organs include organs transplanted into Medicare beneficiaries (this excludes Medicare Advantage beneficiaries)***, organs sent to military hospitals (that have a reciprocal sharing agreement with the Organ Procurement Organization (OPO) in effect prior to March 3, 1988 and approved by the contractor), organs that had partial payments by a primary insurance payer in addition to Medicare, organs sent to other providers and organs sent to OPOs. ***Do not include*** organs used for research, organs sent to military hospitals (without a reciprocal sharing agreement with the OPO) in effect prior to March 3, 1988 and approved by the contractor), organs sent to veterans' hospitals, organs sent outside the United States, organs transplanted into non-Medicare beneficiaries, organs that were totally paid by primary insurance other than Medicare, ***organs that were paid by a Medicare Advantage plan***, and organs procured from a non-certified OPO.²³

In 2021, CMS also finalized several changes to its organ acquisition payment policy and reorganized the organ acquisition payment regulations under a new Subpart L of Title 42 of the C.F.R.²⁴ In particular, 42 C.F.R. § 413.404 details the procedures for providers to develop its Standard Acquisition Charge ("SAC"), and states, in subsection (a)(1): "the reasonable costs to procure an organ are reimbursable ***when billed in connection with a Medicare covered transplant***."²⁵

B. Medicare Part C and the 21st Century Cures Act

The Balanced Budget Act of 1997 ("BBA")²⁶ established a new "Part C" of the Medicare program (then called the Medicare+Choice (M+C) program, and in 2003, renamed the Medicare Advantage ("MA") program).²⁷ Medicare Advantage offers Medicare beneficiaries an alternative to the original Medicare Parts A and B (the "original Medicare Program"). Specifically, unless an exception applies, an individual entitled to Medicare Part A and enrolled under Medicare Part B can elect to receive benefits either: (1) through the original Medicare program; or (2) through

²³ PRM-II, § 4028.3 (Sept. 2014) (bold and italics emphasis added).

²⁴ 86 Fed. Reg. 73416, 73515-19, 73469-505 (Dec. 27, 2021).

²⁵ *Id.* at 73516 (bold and italics emphasis added).

²⁶ Pub L. 105-33, §§ 4001-4006, 111 Stat. 251, 275-334 (1997); *see also* Medicare Managed Care Manual, CMS Pub. 100-16, Ch. 1, § 10.

²⁷ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub L. 108-173, § 201, 117 Stat. 2066, 2176 (2003).

an MA plan which provides “health benefits coverage offered under a policy or contract by an MA organization.”²⁸

One exception is related to ESRD beneficiaries as, initially, ESRD beneficiaries were not eligible to elect Part C.²⁹ However, in 2016, Congress enacted § 17006 of the 21st Century Cures Act (“Cures Act”) to specifically permit ESRD beneficiaries to choose an MA plan, *effective January 1, 2021*.³⁰ Significantly, § 17006(b) also provides for excluding costs for *kidney* acquisitions from the Medicare Advantage benchmarks, beginning with 2021, as codified in 42 U.S.C. § 1395w-23(k)(5). However, the Cures Act did not exclude any other organ acquisitions (e.g., heart, lung, pancreas, and liver) from Medicare Advantage benchmark/capitation rates.

In the June 2, 2020 Final Rule, CMS finalized its policy to implement § 17006 of the Cures Act and provided that *effective January 1, 2021*, kidney acquisition costs for Medicare Advantage enrollees receiving Medicare-covered renal transplants will be excluded from the Medicare Advantage benchmarks and instead will be reimbursed under Part A of the Medicare program under the reasonable cost methodology.³¹

The relevant Preamble language states, in pertinent part:

c. Exclusion of Kidney Acquisition Costs From Medicare Advantage (MA) Benchmarks (§§ 422.258 and 422.306)

Consistent with how the *original Medicare FFS program* will cover costs of organ acquisitions for kidney transplants for individuals in an MA plan, section 17006(b) of the Cures Act also amended section 1853 of the Act to exclude these costs from the MA benchmarks used in determining payment to MA plans. Specifically, the Secretary, *effective January 1, 2021*, is required to exclude the estimate of standardized costs for payments for organ acquisitions for kidney transplants from MA benchmarks and capitation rates. We are finalizing changes to our regulations at §§ 422.258(d) and 422.306 in accordance with these new statutory requirements.³²

In particular, CMS explained that “effective for the contract year beginning January 1, 2021, *MA organizations* will ***no longer*** be ***responsible*** for costs for organ acquisitions for kidney

²⁸ 42 CFR § 422.2 (providing a definition of “MA plan”).

²⁹ 42 U.S.C. § 1395w-21(a)(3)(B) (prior to the Cures Act amendments in December 2016, this section excluded from “eligible individual” any individual with ESRD unless the individual develops ESRD while already enrolled in a Part C plan). Pub L. 105-33, § 4001, 111 Stat. at 276 (“[Medicare+Choice eligible individual] shall not include an individual medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan”).

³⁰ Pub. L. 114-255, § 17006, 130 Stat. 1033, 1334-38 (Dec. 13, 2016).

³¹ 85 Fed. Reg. 33796, 33796-97 (Jun. 2, 2020).

³² *Id.* at 33797 (bold and italics emphasis added).

transplants for their beneficiaries.”³³ As a result, CMS modified the regulations governing MA capitation rates to specify the exclusion of kidney acquisitions beginning with 2021:

§ 422.306 Annual MA capitation rates.

(d) Exclusion of costs for kidney acquisitions from MA capitation rates. Beginning with 2021, after the annual capitation rate for each MA local area is determined under paragraph (a) or (b) of this section, the amount is adjusted in accordance with section 1853(k)(5) of the Act to exclude the Secretary’s estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this title (including expenses covered under section 1881(d) of the Act) in the area for the year.³⁴

Further, in this Final Rule, CMS explains that its analysis shows that “[e]xcluding kidney acquisition costs from MA benchmarks results in net savings estimated to range from \$594 million in 2021 to \$1,346 million in 2030”³⁵ reflecting costs previously embedded in, and paid for through, the MA benchmark and capitation structure.

Finally, 42 C.F.R. § 422.100 details the general requirements for Medicare Advantage organizations offering MA plans. During the time at issue in this appeal (2014-2016), 42 C.F.R. § 422.100(c) specified that the basic benefits of Medicare Advantage plans must at a minimum include all items and services covered under the original Medicare Parts A and B other than hospice care:

(c)*Types of benefits.* An MA plan includes at a minimum basic benefits, and also may include mandatory and optional supplemental benefits.

(1) ***Basic benefits are all Medicare-covered services***, except hospice services.³⁶

³³ *Id.* at 33887-88 (bold and italics emphasis added).

³⁴ *Id.* at 33907-08.

³⁵ *Id.* at 33888; *see also* 42 C.F.R. § 422.306(d); 42 C.F.R. § 422.258.

³⁶ 42 C.F.R. § 422.100(c) (2013). *See also* 42 U.S.C. § 1395w-22(a)(1)(B)(i) (2010) (defining the term “benefits under the original medicare fee-for-service program option” as “those items and services (other than hospice care) for which benefits are available under parts A and B of this subchapter to individuals entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter, with cost-sharing for those services as required under parts A and B of this subchapter or, subject to clause (iii), an actuarially equivalent level of cost-sharing as determined in this part.”).

These basic MA benefits include kidney transplants³⁷ as well as certain non-renal organ transplants (*e.g.*, liver, pancreas, heart, and lung).³⁸

STATEMENT OF FACTS:

The majority of the facts of this case are not disputed. Memorial Hermann “protested” or self-disallowed costs related to the treatment of its Medicare Advantage organs on its as-filed cost reports.³⁹ In its Final Position Paper, Memorial Hermann states:

In accordance with what it understood to be CMS’s and the MAC’s policy at the time, the Provider treated 2 kidneys, 9 livers and 5 hearts transplanted into Medicare beneficiaries receiving benefits under part C of the Medicare Act as “non-Medicare” organs on its cost report for the 2014 cost reporting period. *See* Provider Exhibits 4 at P-0032–0105 and 5 at P-0342. The Provider similarly treated 8 kidneys, 6 livers, 2 pancreases and 10 hearts, for the 2015 cost reporting period, Provider Exhibits 4 at P-0107–0204 and 5 at P-0344, and 5 kidneys, 8 livers, and 12 hearts for the 2016 cost reporting period. Provider Exhibits 4 at P-0206–0339 and 5 at P-0346.⁴⁰

As set forth in pertinent parts of the Parties’ Stipulations:

3. For the 2014 through 2016 cost reporting periods at issue here, the Provider treated organs transplanted into Medicare beneficiaries receiving benefits under Part C of the Medicare Act as “non-Medicare” organs on its cost reports, consistent with CMS guidance in effect during those periods. *See* CMS Pub. 15-2, § 4028.3 (instructions for line 63) (2015); *see also* Transmittal 6, PRM, Part 2 (Sept. 2014) (indicating that revised instructions are applicable to cost reporting periods ending on or after June 30, 2014), Provider Exhibit 6 at P-0349; Transmittal 471 (CMS, Pub 15-1) (Apr. 1, 2016) (adopting similar provision), Provider Exhibit 7 at P-0351.

4. The Provider protested the treatment of those organs transplanted into Medicare Part C beneficiaries as “non-Medicare” on its filed cost reports. *See* Provider Exhibit 2 at P-0010, P-0012, P-0014.

³⁷ 42 C.F.R. § 409.18 (specifying Medicare coverage of kidney transplants “performed in a renal transplantation center”).

³⁸ Medicare National Coverage Determinations Manual, CMS Pub. 100-3, §§ 260 to 260.10; *see also* 60 Fed. Reg. 6537 (Feb. 2, 1995) (NCD for lung and heart-lung transplants). Further, NCDs are binding on MA organizations. *See* 42 C.F.R. § 422.109; Medicare Managed Care Manual, CMS Pub. 100-16, Ch. 4, § 90.1.

³⁹ Stip. at ¶ 4.

⁴⁰ Provider’s FPP at 6.

5. The MAC issued notices of program reimbursement (“NPR”) to the Provider dated January 26, 2018, January 23, 2019, and March 28, 2019, for the cost reporting periods ending June 30, 2014, June 30, 2015, and June 30, 2016, respectively.

* * *

10. The MAC contends that usable organs transplanted into beneficiaries enrolled in Medicare Part C or Medicare Advantage plans must be treated as “non-Medicare” organs on the cost report pursuant to the mandates of the Manual and Transmittal.

11. The Provider contends that the Manual and Transmittal are invalid because they 1) are inconsistent with the Medicare statute and regulations; 2) are otherwise arbitrary and capricious; and 3) were not adopted pursuant to the notice-and-comment rulemaking provisions of the Medicare Act.⁴¹

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

The Provider’s Position

With regard to the applicable regulation at issue, Memorial Hermann contends, in its Final Position Paper, that CMS amended PRM-II Section 4028.3 in September 2014 without undertaking public feedback:

It was not until September 2014 that CMS, without undergoing notice-and-comment rulemaking, revised its cost reporting instructions to treat Medicare part C beneficiaries as “non-Medicare” patients. As revised, the cost reporting instructions during the time periods at issue here provided:

Medicare usable organs include organs transplanted into Medicare beneficiaries (this excludes Medicare Advantage beneficiaries) . . . Do not include . . . organs transplanted into non-Medicare beneficiaries [and] organs that were paid by a Medicare Advantage plan . . .⁴²

Memorial Hermann further argues, in its Final Position Paper, that treatment of Medicare Part C enrollees as “non-Medicare” is contrary to the statute, and further notes that Medicare Part C beneficiaries are still entitled to Part A benefits:

⁴¹ Stip. at ¶¶ 3, 4, 5, 10, and 11.

⁴² Provider’s FPP at 5 (quoting CMS Pub. 15-2, § 4028.3 (2015)).

The reimbursement of organ acquisition costs for non-renal organs originated from the Social Security Amendments of 1972, which extended Medicare benefits to individuals with ESRD. In pertinent part, Section 226 extended Medicare part A benefits to individuals who are medically determined to have ESRD.

Nowhere in this statutory scheme does it state or even suggest that Medicare beneficiaries receiving benefits under Medicare part C were to be treated as “non-Medicare” patients for purposes of organ acquisition. The statute expresses quite the opposite, stating that in order to enroll in Medicare part C, or to change from one MA plan to another MA plan offered under part C, a beneficiary must be “entitled to benefits under Part A and enrolled under Part B.”⁴³

Memorial Hermann further contends that CMS’s treatment of Medicare Part C beneficiaries as “Non-Medicare” for organ acquisition purposes is unexplained and conflicts with CMS’ treatment of Part C beneficiaries in other contexts:

When CMS updated the cost reporting instructions in September 2014, the transmittal adopting those new instructions stated that the agency was updating the instructions “to clarify and correct existing instructions and incorporate statutory and regulatory changes.” Transmittal 6, PRM (Part 2) (Sept. 2014), Provider Exhibit 6 at P-0349. With respect to the applicable Worksheet, Worksheet D-4, the transmittal merely noted that CMS had “[c]larified the instructions and eliminated the ‘other’ organ category and check off box from the worksheet.” *Id.* Similarly, two years later when CMS added chapter 31 to the PRM, the accompanying transmittal provided no explanation for the new requirement treating part C beneficiaries as “non-Medicare” beneficiaries. *See* Transmittal 471, PRM (Part I) (Apr. 1, 2016), Provider Exhibit 7 at P-0351. Indeed, the transmittal accompanying the new manual provision made no mention of the new requirement at all.

* * *

The new interpretation is also arbitrary and capricious because of the inconsistent treatment of part C beneficiaries for organ

⁴³ *Id.* at 8-9.

acquisition purposes and for other payment purposes, such as the [disproportionate share hospital] payment calculation.⁴⁴

Memorial Hermann also argues that CMS must comply with the procedural requirements to change the substantive legal standard governing organ acquisition payment. Memorial Hermann contends that the “treatment of Medicare Part C beneficiaries as ‘non-Medicare’ for purposes of the organ acquisition payment violates the notice-and-comment rulemaking requirement of the Medicare Act.”⁴⁵

Finally, Memorial Hermann contends that, separate and apart from the notice-and-comment requirement, due process requires that it be given “fair notice, with the ascertainable certainty that due process requires,” of the Medicare Contractor’s interpretation before that interpretation could be applied to disallow costs on the cost reports at issue.⁴⁶

The Medicare Contractor’s Position

As stipulated, the Medicare Contractor contends that “usable organs transplanted into beneficiaries enrolled in Medicare Part C or Medicare Advantage plans must be treated as ‘non-Medicare’ organs on the cost report pursuant to the mandates of the Manual and Transmittal.”⁴⁷ In its Final Position Paper, the Medicare Contractor opines “[t]he Provider is misguided in its attempt to portray CMS as treating Medicare beneficiaries enrolled in Medicare Advantage (Part C) plans as ‘non-Medicare’ for cost reimbursement purposes.”⁴⁸

The Medicare Contractor cites Transmittal 471, and the existing PRM-I § 3115, which was relevant at the time of the fiscal years at issue. The Medicare Contractor confirms that “[t]he Provider acknowledges in its position paper that the above Transmittal 471 is a clarification of prior regulations. . . .”⁴⁹ Further, the Medicare Contractor argues that “Per PRM 15-I Chapter [sic] 2775.1, the MAC has been properly excluding Medicare Advantage organs from the usable organ count well before Transmittal 471.”⁵⁰

The Medicare Contractor further contends:

CMS only reimburses organ acquisition costs associated with Medicare Part A or Part B covered transplants. The Medicare Advantage (Part C) plan has separate payment rules for the organ transplant and acquisition services that are at issue in this appeal.

⁴⁴ *Id.* at 11-12.

⁴⁵ *Id.* at 14 (citing *Allina Health Servs. v. Price*, 863 F.3d 937, 972-45 (D.C. Cir. 2017) (“*Allina*”), *aff’d sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1810-14 (2019) (“*Allina II*”).

⁴⁶ *Id.* at 17-18 (citing *Christopher v. Smithkline Beecham Corp.*, 567 U.S. 142, 155-59 (2012); *Gen. Elec. Co. v. U.S. EPA*, 53 F.3d 1324, 1329 (D.C. Cir. 1995); *Hosp. of the Univ. of Pa. v. Sebelius*, 847 F. Supp. 2d 125, 135-42 (D.D.C. 2012)).

⁴⁷ *Stip.* at ¶ 10.

⁴⁸ Medicare Administrative Contractor’s Consolidated Final Position Paper, 7 (Apr. 4, 2024).

⁴⁹ *Id.* (citing Provider’s FPP at 5).

⁵⁰ *Id.*

The Medicare Advantage plans are required to pay the full Medicare allowed costs for an organ acquisition for one of their own members. Therefore, the Medicare Advantage payment satisfies the liability of the Medicare program, and the transplant is considered a non-Medicare transplant for cost reporting purposes. Medicare Advantage organs should not be considered as an unusable Medicare organ.⁵¹

The Medicare Contractor further asserts that allocating reasonable costs of organ acquisitions to patients with Part C, in opposition to § 3115, would result in duplication of amounts already included in the negotiated Part C payment.⁵²

The Medicare Contractor argues that, despite the Memorial Hermann's assertion, the changes made by Transmittal 471 did not require notice-and-comment-rulemaking, unlike in *Allina*, because it did not change any substantive legal standard governing payment. The Medicare Contractor also asserts that the Memorial Hermann's claim is unsubstantiated, as no valid evidence was presented to demonstrate that the transmittal changed a substantive legal standard governing payments.⁵³

Board Analysis

The core disputes between the parties pertain to the treatment of a Medicare Advantage beneficiary in relation to organ acquisition reimbursement under Medicare Part A, and whether the PRM updates to the organ acquisition payment policies in 2014 and 2016, respectively, should have been subject to notice-and-comment rulemaking prior to their application to the cost reporting periods at issue herein. The Medicare Contractor notes that Memorial Hermann contends that "the provider community at large was denied the opportunity to question the policy through challenging comments in [organ acquisition] rulemaking."⁵⁴ The Medicare Contractor, however, contends that "[t]he Provider offers no valid evidence showing that Transmittal 471 Section 3115 was a change to the 'substantive legal standard governing ... the payment for services[.]'"⁵⁵

Memorial Hermann cites to the two changes to the PRM guidance on organ acquisition costs which it contends did not follow notice-and-comment. The first occurred in September 2014, when CMS updated PRM-II Chapter 40, which included the following revisions:

Worksheet D-4: Clarified the instructions and eliminated the "other" organ category and check off box front the worksheet.⁵⁶

⁵¹ *Id.* at 8.

⁵² *Id.*

⁵³ *Id.* at 9-10.

⁵⁴ *Id.* at 9.

⁵⁵ *Id.* at 10.

⁵⁶ Ex. P-6 at 0348-0349.

The second occurred when CMS issued Transmittal 471 in April 2016, which eliminated PRM-I sections 2770-2775.4, and created Chapter 31 to update, reorganize and clarify Medicare's payment policy regarding organ acquisition costs. Relevant here, § 3115 notes:

Counting Medicare Usable Organs at CTCs/HOPOs.--***Medicare usable organs include organs transplanted into Medicare beneficiaries (excluding Medicare Advantage beneficiaries),*** organs that had partial payments by a primary insurance payer in addition to Medicare, organs sent to other CTCs, organs sent to OPOs and kidneys sent to MRTCs (that have a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988 and approved by the contractor). ***Medicare usable organs do not include*** organs used for research, organs sent to veterans' hospitals, organs sent outside the United States, organs transplanted into non-Medicare beneficiaries, organs that were totally paid by primary insurance other than Medicare, ***organs that were paid by a Medicare Advantage plan,*** organs procured from a non-certified OPO and kidneys sent to MRTCs (without a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988 and approved by the contractor).⁵⁷

While Memorial Hermann's interpretation is that it should be able to count Medicare Advantage transplants for its calculations of organ acquisition reimbursement under Medicare Part A, the Board finds that the law at Pub. L. 92-603 (1972) and Pub. L. 95-292 (1978) governing Medicare Part A's payment for kidney acquisition/transplant payment pre-dated the creation of the Medicare Advantage (Part C) program. Further, since 2005, the PRM has been clear, noting that § 2775.5 stated, in 2005:

Specifically, if a beneficiary has primary insurance coverage and payment by the primary payer satisfies the liability of the Medicare program, the transplant is considered a non-Medicare transplant for cost reporting purposes.⁵⁸

Part C/Medicare Advantage is a primary insurance, as it pays as primary instead of Part A/Part B. Further, the Board notes that Part A and Part B trust funds are used to settle the cost report, while Part C does not use these same funds. Thus, the Board finds that organs which have a payment from a payer ***other than*** Medicare Part A or Part B, should not be included in Medicare's share of organ acquisition reimbursement for the cost reporting periods in question.

Similarly, the Board disagrees with Memorial Hermann's characterization of Part C beneficiaries and the claim that, during the years at issue, organ acquisition costs associated with transplants furnished to Part C beneficiaries should be reimbursed under Medicare Part A as a pass-through cost. The Board recognizes that Medicare beneficiaries who have elected Part C remain entitled

⁵⁷ (Bold and italics emphasis added).

⁵⁸ (Bold and italics emphasis added.)

to Part A and potentially Part B. However, that fact is not relevant in resolving the issue presented in these cases.⁵⁹ Rather, the focus is on how Medicare benefits for Part C beneficiaries are administered and how hospitals are reimbursed for transplantation services, including organ acquisition costs, furnished to Part C beneficiaries. As discussed *supra*, MA plans provide all Part A (Hospital Insurance) and Part B (Medical Insurance) coverage, including organ acquisition costs associated with Medicare covered transplants. MA organizations are reimbursed using a capitated payment system, where the Medicare program pays the MA organization a fixed monthly fee per enrollee based on benchmarks set by CMS. Therefore, the Board finds that Medicare program has already reimbursed the organ acquisition costs at issue through the capitation amount paid to the MA plans, since the Medicare Advantage benchmark rates include benefits for Medicare-covered organ transplantation services, and related expenses furnished to MA beneficiaries.

Indeed, Memorial Hermann appears to acknowledge in its Final Position Paper that payment for its organ acquisition costs associated with Part C enrollees was to occur under Part C but fails to explain whether that payment was made under Part C by the relevant MA plans:

As stated above, Title XVIII establishes both Medicare part A and part C. *See* [42 U.S.C.] §§ 1395c to 1395i, 1395w-21 to 1395w-29. ***In both cases***, the reasonable cost of organ acquisition must be included in the hospital's allowable organ acquisition costs regardless of whether the patient is enrolled in and covered by part C. *See id.* (providing that reasonable cost provisions apply to beneficiaries "covered by the insurance programs established under" Title XVIII).⁶⁰

In this respect, the Board notes that there is no evidence in the record to establish that Memorial Hermann was not reimbursed by the relevant Medicare Advantage plans for the organ acquisition costs at issue (consistent with Provider Exhibit P-4).⁶¹ Moreover, a provider is generally required to accept the MA plan payment as payment in full.⁶² Additionally, the Board reviewed Provider Exhibit P-4, which includes supporting documentation for Memorial Hermann's Medicare managed care patients during the three fiscal years. The documentation

⁵⁹ The Board recognizes that the calculation of the DSH adjustment for eligible hospitals is based on a statutory formula that uses the term "entitled to Medicare Part A" and that term has been interpreted and applied to encompass Part C enrollees. However, the DSH adjustment is a special payment add-on or adjustment to the DRG payments made under IPPS. 42 C.F.R. § 412.2(f). While the formula for calculating the DSH add-on payments includes Part C enrollees, the DRG payments to which the DRG adjustment is associated can only made for inpatient services furnished to Medicare Part A beneficiaries (*i.e.*, to beneficiaries who have **not** made an election to opt out of receiving their Medicare Part A and B benefits through traditional Medicare). That is because hospitals are paid for inpatient hospital services furnished to Part C beneficiaries through their MA plan in which those beneficiaries are enrolled.

⁶⁰ Provider's FPP at 9.

⁶¹ As part of their Consolidated Final Position Papers filed for these 3 cases, Memorial Hermann included an Exhibit 4 providing "Supporting Documentation for Organ Acquisition Managed Care Patients" and this documentation suggests that the relevant MA plans were billed for the organ acquisition costs.

⁶² If the provider is a noncontracted provider, 42 U.S.C. §§ 1395w-22(k), 1395cc(a)(1)(O), and 42 C.F.R. § 422.214 require the noncontracting provider to accept from the MA plan as payment in full the amounts that could have been collected if the beneficiary were enrolled in original Medicare.

provided shows patient Medicare beneficiary cards, managed care insurance cards, and remittance advices outlining claims submitted to the managed care organizations during the three fiscal years in question. All instances indicate payment by the Medicare Managed Care company.

The Board further finds that the Medicare regulations and guidance do not support Memorial Hermann's position. Memorial Hermann focuses on the fact that 42 CFR § 413 (as in effect during the time at issue) uses the term "Medicare beneficiary" and suggests that, based on the definition of "beneficiary" set forth in 42 C.F.R. § 400.200,⁶³ that term includes Part C enrollees.⁶⁴ However, Memorial Hermann is mistaken. The term "Medicare beneficiary" or simply "beneficiary" is used throughout both Parts 412 and 413 of Title 42 of the Code of Federal Regulations, and in these other contexts, the term "beneficiary" specifically does not reflect Part C enrollees.⁶⁵ Rather, it refers to Medicare beneficiaries who remain in Part A and have not elected to have their original Medicare Part A and B benefits administered under Medicare Part C.⁶⁶ The Board notes that payment through the IPPS DRG system is only made to

⁶³42 CFR 400.200 states, "In this chapter, unless the context indicates otherwise — ... *Beneficiary* means a person who is entitled to Medicare benefits and/or has been determined to be eligible for Medicaid." See also 48 Fed. Reg. 12526, 12535 (Mar. 25, 1983).

⁶⁴ Provider's FPP at 10.

⁶⁵ E.g., 42 CFR § 412.1(a)(1) (2013) (stating in part: "This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services *furnished to Medicare beneficiaries* in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services *furnished to Medicare beneficiaries* in cost reporting periods beginning on or after October 1, 1991." (emphasis added)); 42 CFR § 412.2(a) (2013) (stating in part: "Under both the inpatient operating and inpatient capital-related prospective payment systems, hospitals are paid a predetermined amount per discharge for inpatient hospital services *furnished to Medicare beneficiaries*." (emphasis added)); 42 CFR § 413.5 (, 2013) ("In formulating methods for making fair and equitable reimbursement for services *rendered beneficiaries of the program*, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. . . . Furthermore, the share of the total institutional cost that is borne by the program is related to the care *furnished beneficiaries* so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services *to beneficiaries* as such costs vary from institution to institution. However, payments to providers of services for services *furnished Medicare beneficiaries* are subject to the provisions of §§ 413.13 and 413.30." (emphasis added)); 42 CFR § 413.64(f)(1) (2013) (stating in part: "Actual costs reimbursable to a provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period to bring the interim payments made to the provider during the period into agreement with the reimbursable amount payable to the provider for the services *furnished to program beneficiaries* during that period." (emphasis added)).

⁶⁶ By contrast to the 1983 definition of "beneficiary" in 42 C.F.R. 413.202, in the Balanced Budget Act of 1997, Congress amended the Basic Freedom of Choice statute (SSA §1802 and at 42 U.S.C. § 1395a(b)(5)(A) stated, "Definitions.—In this subsection: (A) Medicare beneficiary.—The term "medicare beneficiary" means an individual who is entitled to benefits under part A or enrolled under part B." Balanced Budget Act of 1997, PL 105-33, § 4507, 111 Stat 251, 441 (1997). Simultaneously, Congress established the Part C (Medicare + Choice) program and amended SSA § 1851 by adding a new section at 42 U.S.C. § 1395w-21, which stated, in pertinent part:

SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH
MEDICARE+CHOICE PLANS.—

"(1) IN GENERAL.—Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

Part A patients and payments through the OPPS system are only made to Part B patients. Similarly, cost reports are only used to settle claims under Part A and Part B, as Part C claims are settled, according to the individual contract with the Managed Care company, by the Managed Care company. Regulations and guidance referring to PPS or cost reports do not, therefore, reflect the payment structure or the beneficiaries of Part C. To this end, the Board finds that the reference to Medicare beneficiary in 42 C.F.R. § 413.203 was not intended to include Part C beneficiaries.⁶⁷ Indeed, the references at 42 C.F.R. §413.203 refers to actual cost report settlement calculations (Part A and Part B) made regarding organ acquisition costs and organ counts.

With the above in mind, the Board reviewed the Medicare guidance. The Board notes that PRM-I § 3104 addresses the accounting for the cost of Medicare secondary payors and states, in pertinent part:

A provider must submit a bill to Medicare when payment from the primary payer is insufficient to cover the entire cost of a transplant including the DRG and the organ acquisition costs. However, when the primary insurance requires the acceptance of their payment in full, a bill is not required, because under the contractual agreement, Medicare has no liability because the primary payer has made the payment in full. ***Accordingly, the organ under the paid in full contractual agreement will not be counted as a Medicare usable organ.***⁶⁸

As Memorial Hermann has submitted no additional evidence or internal accounting records to support that it was dissatisfied with the primary payer payment, or that it submitted a bill to Medicare, the Board contends that Memorial Hermann accepted the primary payer payment as payment in full.

“(A) through the original medicare fee-for-service program under parts A and B,
or
“(B) through enrollment in a Medicare+Choice plan under this part.

(3) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—

“(A) IN GENERAL.—In this title, subject to subparagraph (B), the term ‘Medicare+Choice eligible individual’ means an individual who is entitled to benefits under part A and enrolled under part B.

“(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan.

Id. at § 4001, 111 Stat. at 276 (emphasis added).

⁶⁷ In this respect, the Board notes that this regulation was promulgated/finalized on August 15, 1997 (62 Fed. Reg. 43657, 43674) and that this was 10 days after the President had signed the legislation in the BBA that created Part C. See <https://www.congress.gov/bill/105th-congress/house-bill/2015/all-actions>. As a result, the August 15, 1997 final rule did not reflect the BBA addition of Part C and Memorial Hermann’s reliance on that final rule in its Consolidated Final Position Paper at 9-10 is misplaced.

⁶⁸ PRM-I § 3104 (bold and italics emphasis added).

Additionally, the Board looks to PRM-I § 2775.1, issued via Transmittal 30 and in effect during the fiscal years in question. Section 2775.1 discusses the process for determining what constitutes a Medicare transplant for the purposes of reporting on the Medicare Cost Report:

If a Medicare beneficiary has some group health insurance coverage, determining Medicare transplant status depends on the amount paid by the primary insurance. ***Specifically, if a beneficiary has primary insurance coverage and payment by the primary payer satisfies the liability of the Medicare program, the transplant is considered a non-Medicare transplant for cost reporting purposes.*** This is consistent with Medicare billing and cost reporting instructions.⁶⁹

Further, the Board notes that Memorial Hermann has not provided any contracts with the Medicare Advantage plans, or any additional patient accounting records documenting all payments it received for these fiscal years.

The Board looks to PRM-I § 3101 which provides guidance on the two payment components for organ transplantation, instructs CTCs to develop standard acquisition charges, and outlines the procedures for claiming organ procurement costs:

CTCs must develop two standard acquisition charges (SACs) based on costs expected to be reasonably and necessarily incurred in the acquisition of an organ:

- The SAC for acquiring a living donor organ; and
- The SAC for acquiring a cadaveric donor organ.

The SAC does not represent the acquisition cost of an individual organ. Instead, it is a charge which reflects an average of the total actual costs associated with procuring either a cadaveric donor organs or a living donor organs, by type of organ (e.g., heart, kidney or lung). When a CTC/HOPO provides an organ to another CTC or OPO, it must bill its SAC or its standard departmental charges reduced to cost. ***When a CTC bills Medicare for the transplant, it must use its SAC for the procured organ and its DRG charge for the transplant.***

The costs of procuring an organ cannot be billed directly to the Program because the procurement of an organ is not a covered service when performed independent of a Medicare covered transplant. However, the reasonable costs of procuring an organ are reimbursable when incurred in procuring the organ for a

⁶⁹ CMS PRM-I, § 2775.1 (Rev. 30, Jan. 2005) (emphasis added).

Medicare covered transplant. The costs are paid on an interim basis and reconciled through the MCR at the end of the CTC's cost reporting period.⁷⁰

Memorial Hermann did not supply contractual or patient accounting information in the record to support whether or not it billed procurement costs to the Medicare Advantage organization during the cost reporting periods in question. However, if Medicare Advantage organs were counted as Medicare organs for purposes of Medicare organ acquisition reimbursement on the cost report, the Board notes Memorial Hermann would be paid twice – once by the Medicare Advantage organization, and second by Medicare.

Moreover, Memorial Hermann's argument that its Medicare Advantage organs should be counted as Medicare organs stems from its reading of Medicare Part C beneficiaries' entitlement to Medicare Part A and Part B, along with the usage of broad definitions of a Medicare beneficiary in the regulations. The Board disagrees with Memorial Hermann's contentions and notes that, specifically for counting Medicare usable organs on the Medicare Cost Report, the regulations have been clear surrounding Medicare's liability when payment from an organization other than Medicare has been received. In the instant cases, for the cost reporting periods in question, Memorial Hermann received payments from organizations other than Medicare.

The Board also disagrees with Memorial Hermann's argument that CMS' treatment of Part C beneficiaries as "non-Medicare" for organ acquisition purposes is arbitrary because it is inconsistent with CMS' treatment of Part C beneficiaries in other contexts (like DSH), violating the "notice and comment rulemaking" in *Allina*.⁷¹ In *Allina*, CMS instituted a new policy to include the Part C days in the Medicare DSH fraction. The circumstances here are materially different. Unlike the DSH policy change in *Allina*, CMS' treatment of Part C organ acquisition costs as non-Medicare for cost-reporting purposes was not first announced in Transmittal 6 or Transmittal 471. Rather, the Medicare Contractor correctly notes that PRM-I § 2775.1 governed the primary-payer question — that a transplant is treated as a "non-Medicare transplant for cost reporting purposes" whenever a primary payer's payment satisfies Medicare's liability in full — well before Transmittal 471 was issued in 2016. The Board's own review of the record confirms this provision traces to Transmittal 30, issued in January 2005, nearly a decade before the cost reporting periods at issue. This principle, not newly announced in 2014 or 2016, has governed the treatment of any beneficiary with primary insurance coverage ***other than traditional Medicare fee-for-service, including but not limited to Medicare Advantage***. Neither Transmittal 6 and nor Transmittal 471 established a new substantive standard; rather, they clarified existing organ-counting policy and do not trigger notice-and-comment obligations. Further, Memorial Hermann has not identified any prior CMS guidance, cost reporting instruction, or agency practice that allowed CTCs to count organs transplanted into Medicare Advantage beneficiaries as Medicare usable organs. Unlike the hospitals in *Allina*, which relied on CMS' regulations and practices of excluding Part C days from the DSH fraction, Memorial Hermann has not shown that it previously relied on a contrary interpretation that Transmittals 6 and 471 then reversed.

⁷⁰ PRM-I § 3101 (bold, italics and underline emphasis added).

⁷¹ Provider's FPP at 11-16.

Without such reliance, Memorial Hermann's notice-and-comment argument lacks the essential predicate present in *Allina*, where an actual change to a substantive legal standard occurred.

Memorial Hermann separately argues that, independent of the notice-and-comment requirement, due process required that it receive "fair notice, with the ascertainable certainty that due process requires,"⁷² of the Medicare Contractor's interpretation before that interpretation could be applied to disallow costs on the cost reports at issue. The Board is not persuaded. The fair-notice doctrine applies where an agency's interpretation of an ambiguous statute or regulation is not one a regulated party could have reasonably anticipated, such that applying it retroactively would penalize the party for conduct it had no reason to know was noncompliant. That is not the circumstance here. As discussed above, PRM-I § 2775.1 — in effect since 2005, nearly a decade before the earliest cost reporting period at issue — put providers on notice that a transplant is treated as a "non-Medicare transplant for cost reporting purposes" whenever payment from a primary payer other than traditional Medicare satisfies Medicare's liability in full. Because a Medicare Advantage organization's payment to a CTC for one of its enrollees' transplants satisfies that liability, the underlying principle applicable to Medicare Advantage organs was ascertainable from published agency guidance well before Memorial Hermann filed the cost reports at issue. Memorial Hermann has not identified any prior agency guidance, cost reporting instruction, or practice on which it affirmatively relied that would have led it to believe Medicare Advantage organs were countable as Medicare usable organs. Absent such a showing, Memorial Hermann's fair-notice argument, like its notice-and-comment argument, fails for lack of the necessary predicate: a regulated party reviewing PRM-I § 2775.1, during the cost reporting periods at issue, *did* have ascertainable notice of the Medicare Contractor's interpretation.

Finally, the Board looks to recent major provisions that Congress enacted and CMS has implemented. Specifically, Congress enacted the Cures Act⁷³ to expand enrollment options for Medicare Advantage plans to allow individuals who obtained Medicare due to end stage renal disease to opt out of receiving Medicare Part A and B benefits through the original Medicare and instead elect to receive them through a MA plan beginning on or after January 1, 2021. As part of the Cures Act, Congress specified that, beginning January 1, 2021, kidney organ acquisition costs associated with Medicare covered renal transplants furnished to Part C beneficiaries are excluded from Medicare Advantage benchmarks and providers are to be paid under Medicare Part A.⁷⁴ In 2020, CMS implemented the Cures Act and finalized its changes to provide for reimbursement of organ acquisition costs for MA kidney transplants, also effective January 1, 2021, under Medicare Part A as a pass-through cost.⁷⁵ The Board notes that while these provisions were significant, the Board disagrees with Memorial Hermann's contention that the PRM-I and PRM-II Transmittal updates were new substantive legal standards. Specifically, the Board disagrees that CMS' 2021 rule change supports Memorial Hermann's contention that

⁷² *Id.* at 17.

⁷³ Pub. L. 114-255, § 17006(a), 130 Stat. 1033, 1334-38.

⁷⁴ *Id.*

⁷⁵ 85 Fed Reg. 33796-97 (Jun. 2, 2020) and 42 C.F.R. §§ 422.50(a)(2), 422.52, 422.110 (codifying the Cures Act § 17006(a) removal of the ESRD enrollment prohibition, effective for plan years beginning January 1, 2021); 42 C.F.R. § 422.322 (codifying the Cures Act § 17006(c) shift of kidney acquisition cost coverage from MA plans to Medicare FFS).

CMS' treatment of Part C organ acquisition costs has been arbitrary and unexplained.⁷⁶ To the contrary, the 2021 rule confirms the consistency of CMS' underlying policy that prior to 2021, Medicare Advantage organizations received capitated payments.⁷⁷ Because capitation payments already accounted for organ acquisition costs, a CTC's separate reasonable-cost reimbursement for the same costs through the Medicare cost report would result in duplicate payment for the same service — once through the MA capitation rate, and again through the CTC's organ acquisition cost report. Simply put, Memorial Hermann is not entitled to be paid twice for the same service or cost. This reading is confirmed by 42 C.F.R. § 422.306(d), which expressly required, beginning in 2021, that the annual MA capitation rate be adjusted to exclude the standardized costs of kidney organ acquisitions — a carve-out, and an accompanying projected federal savings of \$594 million to \$1,346 million, that would have been superfluous if those costs were not already embedded in the capitation rate prior to that date.⁷⁸

Indeed, as this carve-out only pertains to kidney organ acquisitions, it is clear that the organ acquisition costs associated with non-renal organs continue to be included in the Medicare Advantage benchmarks. This fact further highlights why Memorial Hermann's position is unsupported.

DECISION:

After considering Medicare law, regulations, and program guidance, the arguments presented, and the evidence admitted, the Board finds the Medicare Contractor properly calculated Memorial Hermann's FY 2014, FY 2015 and FY 2016 organ acquisition costs for reimbursement under Medicare Part A on the applicable cost reports.

BOARD MEMBERS:

Kevin D. Smith, CPA
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FOR THE BOARD:

9/24/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA

Board Chair

Signed by: KEVIN D. SMITH -A

⁷⁶ Similar to what it did in the Cures Act as it relates to kidney organ acquisition costs, Congress enacted the Medicare Improvements for Patients and Providers Act ("MIPPA") of 2008, Pub. L. 110-275, § 161, 122 Stat. 2494, 2568 (2008) to direct CMS to eliminate IME payments from the Part C capitation rates and instead pay for IME associated with Part C enrollees through Medicare Part A. *See also* 63 Fed. Reg. 34968, 35048-49 (June 26, 1998) (discussing the implementation of the removal of IME and GME from M+C capitated payments).

⁷⁷ *See* 42 C.F.R. § 422.100(c)(1).

⁷⁸ 42 C.F.R. § 422.306(d). *See also supra* n.35 and accompanying text.