



**Association of  
American Medical Colleges**  
2450 N Street, N.W., Washington, D.C. 20037-1127  
**T** 202 828 0400 **F** 202 828 1125  
www.aamc.org

**VIA ELECTRONIC SUBMISSION**

November 20, 2007

Kerry Weems  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

Attention: **CMS-1533--FC**

Dear Mr. Weems:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS or the Agency) final rule with comment period entitled "*Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems [IPPS] and Fiscal Year 2008 Rates.*" 72 Fed. Reg. 47130 (August 22, 2007). The Association's Council of Teaching Hospitals and Health Systems (COTH) comprises nearly 300 general acute nonfederal major teaching hospitals and health systems that receive Medicare payments under the IPPS. The Association also represents all 126 accredited U.S. allopathic medical schools; 94 professional and academic societies; 90,000 full-time clinical faculty; and the nation's medical students and residents. As specified in the rule, our comments are limited to section V, "Capital IPPS Payment Adjustments."

According to the final rule with comment period, CMS seeks to eliminate the capital indirect medical education (IME) adjustment beginning in federal fiscal year (FFY) 2009. According to the rule, the IME adjustment would be reduced by 50 percent in FFY 2009 and eliminated altogether in FFY 2010 and beyond. If implemented, this decision would result in an annual aggregate payment cut to teaching hospitals of \$375 million. A payment cut of this magnitude is not warranted. We urge CMS to reconsider this decision and retain the current IME adjustment level in the capital PPS system until a more thorough examination is conducted.

In the final rule, CMS states that the Agency agrees with the Medicare Payment Advisory Commission (MedPAC) that the “appropriateness of the teaching adjustment should be seriously reexamined.” Yet, the very next sentence reads “the record of high and persistent positive margins for teaching hospitals indicates that the current teaching adjustment is unnecessary . . .” (72 Fed. Reg. at 47401).

We believe that any decision that results in the complete elimination of a payment adjustment should not be entered into lightly. This is particularly true in the context of IME payments. An analysis by Vaida Consulting shows that eliminating the capital IME adjustment would result in an aggregate capital margin that is only 1.7 percent for major teaching hospitals—and this analysis is based on capital payments and costs in 2004, a year that many observers believe is part of a lower-spending phase of the capital cycle (which results in higher margins). If this analysis were conducted during a higher-spending period of time, eliminating capital IME payments would likely result in a negative aggregate margin. Consequently, we believe it is unwise to determine that the adjustment should be reduced or even eliminated at a time when capital spending could be at, or near, its nadir. Rather, like MedPAC, we urge the Agency to do a more complete reexamination of this adjustment before making any IME reduction determinations. Given that the capital cycle is roughly twenty years, such an examination should include modeling the impact of IME cuts under various “capital spending” scenarios (ie, higher-spending periods versus lower spending periods).

As we stated in our comments on the FFY 2008 proposed rule, we strongly dispute CMS’s views that teaching hospitals’ capital PPS payment levels are “too high” (72 Fed. Reg. at 47401). Positive margins are necessary and a desirable outcome of the capital PPS and, in our view, reflect that teaching hospitals are acting responsibly in terms of preserving payments for future capital needs.

Moreover, a decision to cut Medicare capital IME payments should not be viewed solely from a Medicare lens. Because major teaching hospitals’ total margins (from all payment sources) often hover near zero, payment cuts from any source affect the fiscal condition of these institutions, which influence all aspects of their operations. Operations that include providing education for all types of health care professionals; providing an environment in which clinical research can flourish; and offering highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services. Most recently, major teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and require sufficient financial resources to fulfill that role.

We urge CMS to delay a final decision regarding whether to cut IME payments, and by how much, until more analyses are conducted. If CMS rejects this comment, we believe that rather than eliminating these payments altogether, the more prudent course of action would be to implement a much smaller reduction in FFY 2009 and monitor the policy over time to determine whether additional reductions are warranted. Given the fragile overall financial condition of many major teaching hospitals, if further reductions are contemplated, they should be accompanied by a significant transition period.

Kerry Weems  
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If you have questions concerning these comments, please do not hesitate to contact me or Karen Fisher, Senior Associate Vice President. We may be reached at (202) 828-0490, or [rdickler@aamc.org](mailto:rdickler@aamc.org) and [kfisher@aamc.org](mailto:kfisher@aamc.org).

Sincerely,



Robert M. Dickler  
Senior Vice President  
Division of Health Care Affairs

cc: Karen Fisher, AAMC