Neni Prasad, M.D.,F.A.C.P.
2901 Old Jacksonville Rd,
Springfield, Ill. 62704

6-26-2006

Centers for Medicare and Medicaid Servies,
Dept. of Health and Human Services,
Attention CMS-1512-PN
P O Box 8014,
Baltimore, MD 21244-8014

Dear Sir,

I request you to finalize the recommended work RVU increases for evaluation and management (E&M) services for primary care physicians. These changes will help assure continues access to primary care services.

I have been in practice for 34 years in Illinois. Caring for the elderly is a privilege. However, their co morbid conditions, coordination of medical care and high expectations (due to medical marketing) continues to be taxing in time and cognitive effort by primary care physicians.

Please reject any comments that would lower the overall improvements in work RVUs for E/M services.

Thanking you

Sincerely,

Neni Prasad, MD, FACP

2

JUL 6 2006

Southbury Medical Associates
22 Old Waterbury Road Suite #201
Southbury, Connecticut 06488
June 29, 2006

Centers for Medicare and Medicaid Services
Department of Health and human Services
Attention:CMS-1512-PN
P.O.Box 8014
Baltimore, MD 21244-8014

Dear Sirs:

I am an internist practicing in a 5 person group for 35 years. I have primarily a Medicare practice and have seen many changes occur with Medicare. All Medicare changes were made with the intent of increasing primary care physicians reimbursement because of the realization that strong primary care keeps patients out of the hospital and out of the hands of specialists who rely heavily on high tech procedures. Every change, starting with price fixing in 1984, resulted in a decrease in my income. Sometimes this was an absolute decrease and always it was a decrease in relation to specialists' income.

I am affiliated with the Yale teaching program and have residents in my office. In the last few years fewer residents have been interested in going into primary care and it will be difficult to find someone to replace me. Also as local physicians retire it is very difficult to replace them. Several have left practice just to become salaried hospitalists. It is very difficult to absorb their practices. Some residents are becoming hospitalists and others are working in the emergency room. The effect is that outpatient medicine is becoming overburdened and more patients are being shunted to the hospital and the emergency room.

This practice is very expensive and inefficient. Since the hospitals are now full, I can no longer directly admit patients to the hospital and must sent them through the emergency room. Other primary care physicians are no longer seeing their patients in the hospital and referring them to hospitalists. This leads to duplication of tests and expensive procedures which were previously done as out patients.

More and more patients do not have their own physician, because of the shortage of primary care physicians and so these patients go to the hospital and are cared for by residents and hospitalists leaving no resident services for patients covered by their own physicians.

The low reimbursement for E/M services has led to dissatisfaction by practicing physicians and lack of interest of new physicians in cognitive medicine. The result is that medical care gets more expensive and less efficient.

A solution would be to increase reimbursement for E/M services, showing that these services are valued and to encourage young physicians to take the time to listen to patients, get to know their families and their needs and to keep them out of the hospital and out of the emergency rooms.

Ira Mickenberg MD FACP

3

JUL 6 2006

Geisinger
Health System

Heal. Teach. Discover. Serve.

June 26, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention CMS-1512-PN
PO Box 8014
Baltimore, MD 21244-8014

Dear Sir/Madam:

As a practicing general internist, I am writing to congratulate you for the leadership you have taken thus far to reform Medicare payments for physician Evaluation and Management services, and to urge you to finalize the recommended work RVU increases for E/M services.

As you know, the numbers of medically complex patients has increased vastly since 1992, when the initial Medicare fee schedule was implemented. The average age of patients in my Internal Medicine practice is now over 65. My patients have an average of 6 chronic medical conditions, are taking multiple medications, and have numerous preventive care needs, in addition to acute complaints and psychosocial needs like anxiety and depression. I am hoping that these changes, if implemented, will allow me to spend more time managing these complex medical needs, and address the need for increased quality in preventive care measures.

In addition, I have been concerned over the past several years that the number of young physicians choosing Internal Medicine and Family practice has been declining precipitously, just at the time we will need more primary care physicians able to care for our aging population. In order to alleviate this impending collapse of our nation's primary care system, and assure access to care for the nation's elderly, I urge CMS to reject any comments that would lower the overall improvements in work RVUs for E/M services.

Thank you again for your leadership on this important issue.

Sincerely,

Valerie Weber, MD
Director, General Internal Medicine
Geisinger Medical Center

4

JUL 16 2006

PETER D. JONES, M.D., P.C.

PETER D. JONES, M.D., F.A.C.P.
MARIA J. BRENNAN, MSN, APRN

14 Quarry Street
Willimantic, CT 06226
Telephone: (860) 423-8020
Fax: (860) 456-8288

Monday, June 26, 2006

Dear Sir,

I urge you to finalize the recommended work RVU (relative value units) increases for E/M (evaluation and management) services.

In my own practice the burden of trying to document everything that actually happened in a physician visit would double the length of the visit. Why should I be reimbursed several orders of magnitude more for removing a small skin cancer (a relatively simple procedure) than for cognitive services taking the same time (yet immensely more skilled)?

Multiple problems have made cognitive services more complex over the last 10 years e.g. direct to consumer advertising, alternative health care beliefs, the change from paternalism, to partnership, malpractice, and fitting in preventive care doing routine visits.

If you continue to pay so much more for procedural rather than cognitive care we will become a nation of specialists with even further skyrocketing of health care costs and lack of access to primary care.

Please reject comments that would lower the overall improvements in work RVU's for E/M services.

Yours sincerely,

Peter Jones

Peter D. Jones, M.D.

5

JUL 6 2006

KIM SCOTT, MD

1777 Sun Peak Drive, #150
Park City, Utah 84098
435-645-0800 FAX 435-647-3003

June 27, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
P.O. Box 8014
Baltimore, Maryland 21244-8014

Dear C.M.S:

I am an internist who has been practicing for more than 25 years. This letter is in support of the proposed work RVU increases for evaluation and management services we provide in primary care.

The complexity of patient evaluation has increased dramatically in the past 10 years. We have more opportunity than ever before to diagnose and prevent illness. One of the best examples is cardiovascular illness, the number one cause of death for men and women in this country. We know control of blood pressure, lipids, and blood sugar has a huge effect on prevention of cardiovascular events. Diabetes is one of the fastest growing epidemics in this country. The treatment of diabetes is more complicated and time consuming than ever before. To have a patient ideally managed whether on oral agents or insulin, requires much time to be spent by both physician and management team. There are not enough of us to help with this patient management because we are under compensated. Patients cannot be seen in a timely fashion so they end up in crisis frequently in overcrowded emergency rooms.

Please help make primary care a more attractive choice for new physicians entering. Please improve compensation so that those of us practicing will continue to do the work. We so desperately need more who are willing to do primary care.

Thank you.
Kim E. Scott, M.D.

KS/cjb
D: 06/27/06 T: 06/27/06 dir: 0627ks #675

6

JUL 6 2006

JOHN SCHULTZ MD PC
1601 E 19TH AVE #3700
DENVER CO 80218
(303) 861-7001
(303) 861-8624 fax

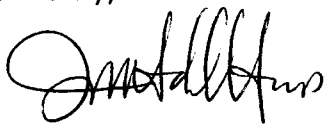
Dear CMS, June 23, 2006

I am a primary care internal medicine physician in private practice in downtown Denver. In the past year there have been four primary care physicians in the prime of their career give up there practice at our hospital (14% of the PCPs at our hospital). In addition, it is almost impossible to get the University of Colorado residents in internal medicine to go into private practice primary care because of the financial risks. My practice was recently evaluated by a consultant and I discovered that I am earning below the 20th percentile for internal medicine despite working 11 hour days. When I asked the consultant why, he replied that I have too many Medicare patients (50% of my practice) and that we spent too much time with our patients. He suggested we see twice as many patients per day and only spend 10 to 20 minutes with them. Most of my patients have three or more chronic illnesses and are on 10 or more meds. I get paid the least for taking care of the sickest and most complex patients in my community.

I have been forced to stop taking new Medicare patients because of these financial realities. I am contemplating dropping out of Medicare.

In order to continue seeing Medicare patients I need two things to happen. First, you need to finalize the recommended work RVU revisions for evaluation and management services. Primary care physicians have very few high profit procedures that we do. Most of what I do is manage medications and patient behaviors in order to avoid procedures. E/M services are the bread and butter of primary care. Second, you must end this threat of 4 - 5% reimbursement decreases and begin giving physicians pay increases that at least keep up with the cost of living increases not to mention that the cost of doing business has increased even more (my overhead costs have increased 40% over the past 6 years).

Sincerely,



John W. Schultz MD
Assistant Clinical Professor of Medicine

7

JUL 6 2006

WICHITA CLINIC

06/24/2006

Centers for Medicare and Medicaid Services Department of Health and Human Services
Attention CMS-1512-PN
Post Office Box 8014
Baltimore, Maryland 21244-8014

RE: E/M services for Medicare patients

To Whom It May Concern:

I am greatly encouraged by the recent proposed increases in E/M services for Medicare patients. I strongly, strongly urge CMS to finalize the recommended increases. Certainly, my own practice has changed dramatically in the last 10 or 15 years, and the patients are all much sicker, much more complex with multiple problems which stem from chronic illnesses that all go together, such as hypertension, diabetes, heart disease, hypercholesterolemia, and all of these require very complicated office visits and multiple medications, adjustments and considerations. Unfortunately, that includes probably 50-60% of my office visits each day.

This will also make it much, much more likely that I can continue to accept and care for Medicare patients. Certainly, seeing new Medicare patients is going to be a daunting situation for all of us, particularly as we all are getting older, and people are continuing to live longer and have multiple medical issues.

I also would strongly urge CMS to reject any thoughts that would lower the overall improvements in work RVUs for the E/M services. Certainly, this is a very needed change, and without it I am afraid that all of us, as we reach Medicare age, will find it harder and harder to find the appropriate care and may not even be able to obtain it.

I thank you for your opportunity to address this situation, and if you need any further information, please let me know.

Sincerely,

Richard W. Shoffner, MD
Murdock Office

nwt/000261993/6610240 D: 06/24/2006 T: 06/25/2006 8:20 A

Signed Electronically by

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Tanana
Valley
Clinic
Family Medical Care
Since 1959

JUL 16 2006

Marvin E. Bergeson, M.D., President • Brian Slocum, FACMPE, Administrator

June 26, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
P.O. Box 8014
Baltimore, MD 21244-8014

Dear Sir or Madam:

The Tanana Valley Clinic has been serving the health care needs of Interior Alaska residents for over 47 years. During that time, our clinic has provided care to residents, regardless of their ability to pay. However, we are finding that this generous policy is difficult to continue. Our costs continue to climb by double digits, while reimbursement is gradually reduced to the point where we are no longer breaking even on the evaluation and management work we do for our patients. In order to continue to function as a viable practice and small business, we need your help.

We urge CMS to finalize the recommended work RVU increases for evaluation and management services. The work RVU's need to be increased in order for us to continue to be able to afford to care for our patients. Our physicians have seen the complexity and work associated with taking care of patients during office and hospital visits and consultations grow dramatically over the past 10 years, even as the reimbursement for these costs have dramatically fallen. Increasing the work RVU will help assure that we can afford to offer our patients continued access to primary care services in Interior

1001 Noble Street • Fairbanks, Alaska 99701
(907) 459-3500 • Fax (907) 459-3583

Alaska. We urge CMS to reject any comments that would lower the overall improvements in work RVU's for E/M services.

If we can offer any additional information that would be helpful in addressing the work RVU issue, please do not hesitate to contact me. Thank you.

Sincerely,

Brian Slocum, FACMPE
Administrator

DIAGNOSTIC CENTER

2205 MCCALLIE AVENUE, CHATTANOOGA, TENNESSEE 37404-3230
(423) 698-2435 FAX (423) 697-6110
Website www.diagctr.com

Main Office
Cardiovascular Diseases
MAURICE S. RAWLINGS, SR., M.D. (RET)
PETER M. DUVOISIN, M.D. (RET)
DANIEL E. CONSTANTINESCU, M.D. (RET)
CHARLES D. McDONALD, JR., M.D.
CAROL L. GRUVER, M.D.

Nuclear Cardiology
CAROL L GRUVER, M.D.

Pulmonary Diseases
B. DANIEL HARNSBERGER, M.D.
Y. GILL JEONG, M.D.
ANDREW N. VERNON, M.D.
DANIEL R. SMITH, M.D.
NATHAN H. MULL, IV, M.D.
DAVID A. ADKINS, M.D.
JOHN W. BOLDT, JR., M.D.
STEPHEN A. CHITTY, IV, M.D.

Internal Medicine
WILLIAM B. MACGUIRE, JR., M.D. (RET)
THOMAS F. MULLADY, M.D.
SELMON T. FRANKLIN, M.D.
ROBERT A. PETERSON, M.D.
EUGENE H. RYAN, M.D.
CHARLES A. CRUMP, M.D.
ANNESOFIE K. DUBECK, M.D.
DABNEY JAMES, M.D
JOHN E. TAPP, II, M.D.
CARLTON M. VOLLBERG, D.O.
TEJAL V. MEHTA, M.D.

Infectious Disease
MARK D. ANDERSON, M.D.
HAL E. HILL, M.D.
PAUL CORNEA, M.D.

Endocrinology/Diabetology
DIANNE C. ROLAND, M.D.
ANA CORNEA, M.D.

Diagnostic Center for Sleep Disorders
Sleep Specialists
DANIEL R. SMITH., M.D.
ANDREW N. VERNON, M.D.
DAVID A. ADKINS, M.D.
NATHAN H. MULL, IV, M.D.
JOHN W. BOLDT, JR., M.D.

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June 26, 2006

JUL 6 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS-1512-PN
P. O. Box 8014
Baltimore, Maryland 21244-8014

Dear Sirs:

I was pleased to read of the proposed changes to the RVUs for E/M services for January 2007. As a busy internist, more than 50% of my patients are on Medicare. In my 25 years of practice I have noted an increased amount of time needed to be spent in caring for my older patients due to increased paperwork involved, new technologies available, and the general aging of the population.

Many of my patients have multiple medical problems including diabetes mellitus, hypertension, chronic pulmonary disease, degenerative arthritis, heart disease, cancer and they are on multiple medications to treat these problems. Caring for these patients requires a lot of time spent in careful prescribing, titrating dosages, and monitoring for toxicity of these drugs.

My office overhead has steadily risen while I have seen a freeze on my reimbursements and even a decline in some instances making it increasingly difficult to keep my practice productive.

I urge CMS to finalize the recommended work RVU increases for evaluation and management services.

Such changes will help assure continued access to primary care services, so crucial in directing our patients' healthcare through the maze of technologies and specialty services available, i.e. being the "quarterback" for our patients. As it is, fewer young doctors are going into primary care and many older primary care doctors are contemplating early retirement, a trend which will leave the nation in dire shortage in the next few years.

I urge CMS to reject any comments that would lower the overall improvements in work RVUs for E/M services.

Sincerely,

Dabney James, M.D., FACP

DJ:tsm

9-1

DIAGNOSTIC CENTER

2205 MCCALLIE AVENUE, CHATTANOOGA, TENNESSEE 37404-3230
(423) 698-2435 FAX (423) 697-6110
Website www.diagctr.com

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DAVID A. ADKINS, M.D.
NATHAN H. MULL, IV, M.D.
JOHN W. BOLDT, JR., M.D.

June 30, 2006

JUL 6 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS-1512-PN
P. O. Box 8014
Baltimore, Maryland 21244-8014

Dear Sirs:

I was pleased to read of the proposed changes to the RVUs for E/M services for January 2007. As a busy internist, more than 50% of my patients are on Medicare. In my practice I have noted an increased amount of time needed to be spent in caring for my older patients due to increased paperwork involved, new technologies available, and the general aging of the population.

Many of my patients have multiple medical problems including diabetes mellitus, hypertension, chronic pulmonary disease, degenerative arthritis, heart disease, cancer and they are on multiple medications to treat these problems. Caring for these patients requires a lot of time spent in careful prescribing, titrating dosages, and monitoring for toxicity of these drugs.

My office overhead has steadily risen while I have seen a freeze on my reimbursements and even a decline in some instances making it increasingly difficult to keep my practice productive.

I urge CMS to finalize the recommended work RVU increases for evaluation and management services.

Such changes will help assure continued access to primary care services, so crucial in directing our patients' healthcare through the maze of technologies and specialty services available, i.e. being the "quarterback" for our patients. As it is, fewer young doctors are going into primary care and many older primary care doctors are contemplating early retirement, a trend which will leave the nation in dire shortage in the next few years.

I urge CMS to reject any comments that would lower the overall improvements in work RVUs for E/M services.

Sincerely,

Tejal Mehta

Tejal V. Mehta, M.D.

TVM/jk

10

JUL 6 2006

Tanana Valley Clinic
Family Medical Care
Since 1959

Dept. of Internal Medicine
1001 Noble St. Fairbanks, AK 99701
907-459-3570 fax 907-459-3510
mswenson@tvcclinic.com

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
P.O. Box 8014, Baltimore, MD 21244-8014

Dear Madam or Sir,

I am writing to support the recommended work RVU increases for evaluation and management (E/M) services as proposed in CMS-1512-PN. I work as a general internist in Fairbanks, Alaska. While the average age of our population here is lower than the rest of the US, I am still seeing a gradual increase in patients over the age of 65 who rely on Medicare as their sole resource for health care. Most of the other internists in Fairbanks have stopped seeing new Medicare patients. While we at Tanana Valley Clinic continue to see and to provide excellent care to Medicaid and Medicare patients, we realize that we will not be able to continue doing so at the current rate of reimbursement.

With the move away from prolonged hospitalizations in recent years, the outpatient management of patients with multiple medical problems has become increasingly complex, and more of my time is required to care for my Medicare and Medicaid patients. Any increases that can be made in the RVU reimbursement for E/M services would be great help, both in keeping my medical practice financially viable and in making sure that Medicare and Medicaid patients continue to have access to primary care services.

Thank you very much for your consideration.

Sincerely,

Michael D. Swenson, MD, FACP

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JUL 6 2006

Lowcountry
Medical Associates
Internal Medicine
Robert W. Cain, M.D.
Keith W. Lackey, M.D.
William F. Maguire, Jr., M.D.

6/26/06

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS- 1512- PN
P.O. Box 8014
Baltimore, MD 21244-8014

Dear Sirs:

Recently I have been made aware of the fact that CMS has proposed RVU changes for E/M services. I am a general internist and have been in practice since 1989. I am happy to hear about the proposed changes for a few reasons:

1-- The complexity of Medicare patient care has increased in the past several years. One reason for this is that there are so many more more options available in testing and pharmaceuticals for diagnosis and treatment. As people live longer the number of real or perceived conditions which they might acquire increases. With some merit, people expect more because of what they hear from various media, whether it's an advertisement, the latest news flash or university patient newsletter. There is no such thing as a simple office visit for a person over the age of 65.

2-- Hospitalized patients are generally more complicated and acutely ill than before, owing in part to the fact we are keeping them alive longer, and also because there has been so much pressure to treat them as outpatients. While this many times makes sense, it puts more pressure on us and our staff to manage things this way.

3-- Overhead costs have increased due to the increased complexities of the business of medicine. These costs have continued to rise significantly as the income has remained static or even decreased. We are feeling discouraged and sometimes desperate. I am working 50% harder and making less money than I made a dozen years ago. I can't work any harder. WE NEED HELP!

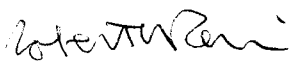
Please finalize the recommended work RVU increases for evaluation and management services. Access to primary care for the growing elderly population is at risk. It is time to acknowledge what we have known for a long time: The ability to render quality clinical judgment and care and get reimbursed for it will reduce the need for referrals and procedures.

615 Wesley Drive, Suite 300
Charleston, South Carolina 29407
Phone (843) 266-4400 • Fax (843) 577-0455

Lowcountry
Medical Associates
Internal Medicine
Robert W. Cain, M.D.
Keith W. Lackey, M.D.
William F. Maguire, Jr., M.D.

Thank you.

Sincerely,



Robert W. Cain, MD

615 Wesley Drive, Suite 300
Charleston, South Carolina 29407
Phone (843) 266-4400 • Fax (843) 577-0455

12

Foothills Internal Medicine

JUL 6 2006

Diplomates of
The American Board
of Internal Medicine

Barry R. Swiger, M.D.
Calvin M. Snipes, M.D., F.A.C.P
Geanice Holton, M.D.
Lisa G. Harding, M.D.

June 26, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS–1512–PN
P. O. Box 8014
Baltimore, MD 21244-8014

TO WHOM IT MAY CONCERN:

I have been practicing internal medicine in South Carolina for over 21 years. As with other primary care providers, office overhead has increased dramatically, making it quite difficult to maintain a level of care for our patients that they deserve. Over the past several years, a number of events have contributed to this increased cost of providing health care. These include declining reimbursement from Medicare, Medicaid, and private insurers in relation to cost of living and inflation, the double digit increases in the cost of malpractice insurance for our physicians and health insurance benefits for our employees, the necessity to purchase electronic health record systems, and the increased time and office expense of working with patients to explain government mandates such as Medicare Part D and HIPAA. During this time, physicians in our group have taken substantial pay and benefit cuts in order to remain in business. We are extremely concerned, as are other providers, not only with our own situations but for the future of primary care medicine in general.

I was heartened by the possibility that relative value units (RVU) could be increased this year which would assist greatly in our ability to maintain our private practice of medicine. If these RVU's were increased to a reasonable level, it is almost certain this would allow us to continue to provide access to care for our Medicare patients now and in the future.

Primary care specialists depend on E/M services and payments as we are not procedurally oriented physicians, and I would hope that the Centers for Medicare and Medicaid Services would reject any comments or ideas that would potentially lower the relative value unit increases proposed by other groups.

I would like to thank you for your efforts on behalf of internal medicine and primary care medicine overall.

Sincerely,

Calvin M. Snipes, M.D., F.A.C.P.

cct

1648 Gentry Memorial Highway • Easley, South Carolina 29640 • 864/855-1331 • Fax 864/855-1602

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JUL 16 2006

ONCOLOGY CARE CONSULTANTS

P. GREGORY RAUSCH, M.D., F.A.C.P. • BRIAN M. O'CONNOR, M.D. • ELHAMY D. ESKANDER, M.D., F.A.C.P.
PATRICIA A. RICE, C.R.N.P.
(301) 662-8477 • FAX (301) 662-4293

June 27, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CNS-1512-PN
P.O. Box 8014
Baltimore, MD 21244-8014

Ladies and Gentlemen:

This letter is to strongly support the proposed adjustment to the work RVUs for CPT codes covering office and hospital visits and consultations for E&M services. I strongly support the proposed changes.

Physicians have traditionally been underpaid for cognitive services rendered to Medicare patients. This has resulted in decreased availability of internists and medical subspecialists for these patients and forced limitation of Medicare patients in our offices. This has resulted in decreased access for Medicare clients.

The proposed changes will help alleviate these problems, and I therefore urge the leadership to approve them as proposed.

On behalf of myself and our patients, thank you for this proposal.

Sincerely yours,

P. Gregory Rausch, M.D., F.A.C.P.

PGR/dwe

cc: Representative Roscoe Bartlett
Senator Barbara Mikulski
Senator Paul Sarbanes

June 25, 2006

JUL 6 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1512-PN
P.O. Box 8014, Baltimore, MD 21244-8014

To Whom It May Concern,

I am a practicing general medicine physician in Vermont. I am a Clinical Assistant Professor at the University of Vermont and work closely with Internal Medicine Residents and Medical Students. I work as a hospitalist on the inpatient/hospital service and precept the residents in their outpatient clinic. I have been staunchly committed to primary care since starting medical school. I have grave concerns about our current and impeding health care crisis and the future of Primary Care. I see first hand how the payment structure of medicine is driving physicians away from primary care into subspecialties and how the abundance of and reliance on subspecialty care drives up the health care costs without improving quality and health outcomes.

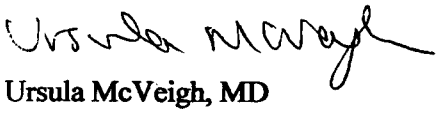
The ideals of treating the whole patient and working to prevent disease and maintain health have led me to Internal Medicine. I had many friends in medical schools who entered with the same ideals but in the end forgo primary care because the field is burdensome with long hours, complex patients and the work is grossly under compensated. I had 3 friends who entered medical school with plans of being an Internist, a Family Practioner and a Pediatrician, respectively. They are now all Dermatologists. We each did the same duration of training (4 years, as I was a chief resident following 3 years of residency), yet they earn more than twice my salary for less hours of work. They are reimbursed more for removing a mole than I am for evaluating dypnea in a complicated octogenarian with dementia. We all left school with large loan burdens. I have been practicing 3 years since I completed my residency and live at the same standard of living as I did while a resident because ½ of my take home paycheck is going towards my loans. Can we really blame medical students for pursuing subspecialty vocations when they undergo such long and arduous training through medical school and residency and carry such a loan burdens upon completion? In the end, we can only blame ourselves for allowing such skewed valuation of work.

I fear for our medical system where costs are ballooning out of control without improving health outcomes. We're taught in medical school that 90% of the diagnosis is in the history. In our current medical paradigm, ordering a costly test is favored over taking a thorough history. And treatment of disease is "valued" over prevention. It has been well studied and established that primary-care based health systems provide improved health outcomes at a lower cost to society. But this is not the system our country supports.

I am in strong support for changing health policies to reorient our healthcare system to support Primary Care. Our health payments need to recognize the value of patient centered, comprehensive and coordinated care. The current CMS proposed changes to

increase the RVUs assigned to office and hospital visits (E/M codes) is am important first step I applaud your efforts to address this problem and urge you to finalize the recommended changes.

Sincerely,



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