April 8, 2013

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: Medicare and Medicaid Programs; Part II—Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction [CMS-3267-P]

Dear Acting Administrator Tavenner:

On behalf of the physician and medical student members of the Medical Association of Georgia (MAG), we appreciate the opportunity to provide comments on the proposed rule entitled Part II—Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction [CMS-3267-P]. We support the efforts of the Centers for Medicare & Medicaid Services (CMS) to identify and eliminate burdensome regulations. We also strongly support CMS’ proposal to require that each hospital have an organized and individual medical staff that is distinct to that hospital. However, we have serious concerns about CMS’ proposal to remove the current requirement that a medical staff member be included on the hospital governing body, and believe that this proposal could negatively affect patient health and safety. We offer our detailed comment on these proposals and others below.

Individual Medical Staff

We strongly support CMS’ proposal to codify the requirement that each hospital must have an organized and individual medical staff that is distinct to that hospital, and strongly urge CMS to retain and finalize this proposal.

Self-Governance

The fundamental idea behind a medical staff is that it is a self-governing organization that is accountable for the quality of medical care provided to the hospital’s patients. This means that the medical staff is familiar with and understands the unique needs of the hospital, the physicians and other practitioners whom it governs, and the community in which those physicians and other practitioners work. This empowers the medical staff to nimbly respond to health and safety issues that arise with respect to their patients and that hospital. Medical staff self-governance is a basic requirement for The Joint Commission (TJC) accreditation, and is mandated by some states.

1 Joint Commission Standard LD 01.01.01 Element of Performance 2 states, “(t)he organized medical staff is self-governing.”
2 For example, under Oregon Revised Statutes §441.055, “[t]he physicians organized into a medical staff pursuant to [Oregon law] shall propose medical staff bylaws to govern the medical staff.” Under Mississippi Hospitals,
CMS’ proposed requirement that each hospital have an organized and individual medical staff that is distinct to that hospital is absolutely required to maintain and buttress medical staff self-governance. Based on the specific characteristics of their patients, physicians, and clinical activities, medical staffs promulgate the bylaws, rules, and regulations that most appropriately govern their particular hospital and set quality and patient safety standards. Medical staffs have a first-hand understanding of the activities taking place within their own hospital, and govern themselves accordingly, with an open line of communication between the medical staff as a whole, each of its members, and the governing body.

If multi-hospital systems were allowed to have a single, system-wide medical staff, rather than an individual medical staff as CMS has proposed, self-governance would be undermined because the medical staff would not have a meaningful nexus with the medical staff members whom it governs. For example, physicians who practice in a rural hospital that is geographically distant from its sister hospitals could be dislocated from the other medical staff members and the activities of the medical staff. Consequently, the physicians practicing at the rural hospital could be prevented from meaningfully participating in medical staff self-governance.

Similarly, without the individual medical staff requirement, the unique needs of the patients of a hospital within a multi-hospital system could be overlooked. The impact of variables such as geographic location, suite of services rendered, patient demographics, etc., may not be understood by a system-wide medical staff, and may not be appropriately addressed. For example, an underserved urban hospital may be marooned in a multi-hospital system of profitable suburban hospitals. The same could be true for a specialty hospital, geriatric hospital, children’s hospital, rehabilitation hospital, etc.

At issue are the distinctive clinical needs of each hospital’s physicians and patients, the relative power of each hospital within a multi-hospital system, and the medical staff’s ability to effectively self-govern. Without CMS’ proposed language, the physicians practicing at any hospital that is unique among the other hospitals in a multi-hospital system could be put in the disadvantageous position of trying to explain and assert the clinical, quality, and safety needs of its patients to the other members of the at-large medical staff, whose interests may be divergent.

**Oversight**

Another chief attribute of the medical staff is its responsibility for medical professionalism, including the clinical and quality standards for physicians and non-physicians. CMS’ proposal for an individual medical staff at each hospital is essential to ensure that this oversight function is meaningfully exercised in the same hospital in which clinical and quality standards are overseen. Conversely, if a multi-hospital system was allowed to have a single, system-wide medical staff, rather than a medical staff at each individual hospital, the system-wide medical staff would be put in the precarious position of trying to oversee multiple hospitals with divergent local patient populations, resources, historical strengths and weaknesses, and communities. Oversight in this case would be diluted and broad-brushed, unable to respond quickly and effectively to acute issues and concerns in real time.

To draw from the example of a rural hospital, the system-wide medical staff overseeing a multitude of hospitals in addition to a rural hospital would be incapable of assessing the daily challenges and events of the rural hospital. Divorced physically and in perspective from the rural hospital, the system-wide medical staff could do its business...
without a meaningful understanding of the rural hospital’s clinical needs, rendering it incapable of setting and enforcing appropriate professional standards to protect the health and safety of the rural hospital’s patients.

We also note that CMS’ proposal to require an organized and individual medical staff at each hospital is of particular importance because CMS recently finalized a proposal to allow multi-hospital systems to have a single governing body. The governing body and medical staff are mutually responsible for the provision of quality care and a safe environment for patients. The local touch-point of the individual medical staff at each hospital is therefore all the more important to ensure that the work of the governing body is informed and appropriate.

Care Coordination

In this era of payment and delivery reform, hospital medical staffs are increasingly leading and developing innovative care coordination and patient-centered efforts. Following the planning and development of new care coordination activities, the medical staff informs these care improvement initiatives on an ongoing basis as they progress, serving as a vital resource for real-time clinical and practical feedback regarding what does and does not work. For these efforts to be successful, it is essential that a locally organized medical staff oversee care delivery and provide a primary perspective regarding how that hospital’s care coordination efforts are working for that local patient population.

Some opponents of CMS’ proposal to require an organized and individual medical staff at each hospital have charged that this requirement will prevent individual medical staffs from being “unified” or “integrated.” To the contrary, nothing in CMS’ proposal precludes individual medical staffs in a multi-hospital system from working together to improve care for the hospital system overall. In fact, there is an acute need for each individual medical staff within a multi-hospital system to bring the perspective of its local physicians and patient population to bear to appropriately inform initiatives implemented system-wide. Without meaningful touchstones at each individual hospital, hospitals are likely to employ top-down care coordination approaches that are less likely to be successful.

Peer Review

CMS’ proposal to require an individual medical staff at each hospital appropriately retains current parameters for medical staff peer review. At present, peer review is conducted by a physician’s peers who have first-hand knowledge about the standard of care, and can therefore review that physician based on that standard. CMS’ proposal to codify the requirement for an individual medical staff at each hospital, instead of a system-wide medical staff for a multi-hospital system, guards against a situation where a physician could be subject to peer review by a system-wide medical staff that has little familiarity with the standard of care or the needs in that physicians’ community.

We offer the following hypothetical example of what could ensue without the protection of CMS’ proposed language: All Children’s Hospital is located in St. Petersburg, Florida, but is part of Johns Hopkins Medicine, a multi-hospital system. All of Johns Hopkins Medicine’s other member hospitals are within the Baltimore-Washington area. Johns Hopkins Medicine could opt to have a system-wide medical staff, and may desire to do so because all of its other member hospitals are within a closer physical proximity.

Under this example, a pediatrician practicing at All Children’s Hospital could undergo formal proceedings in the Baltimore-Washington area. Patients and staff involved in the proceedings could be compelled to travel from Florida to the Baltimore-Washington area to testify if the physician or the medical staff were counseled by their attorneys that immunity or privilege may not attach to testimony given remotely. The physician at issue could be reviewed by physicians who are members of the system-wide medical staff of Johns Hopkins Medicine, but who have no first-hand experience with All Children’s Hospital or its medical care. The needs of children’s hospitals are very different from other hospitals; in this example, it would be most appropriate for the pediatrician’s peers—other physicians who practice at All Children’s Hospital—to participate in peer review. In situations where physicians practice in very different hospital settings, the conduct of system-wide peer review, as opposed to hospital-based
peer review, creates the potential for aberrant results, which could be even more extreme in larger systems like the Healthcare Corporation of America.

CMS’ proposal to require an individual medical staff at each hospital also allows for appropriate deference to state law protections governing peer review.³ All 50 states and the District of Columbia have enacted immunity statutes. State statutes vary significantly regarding the extent of immunity provided and which parties may enjoy immunity.⁴ Allowing a system-wide medical staff for a multi-hospital system could create a choice of law problem. To follow the example above, would the All Children’s Hospital pediatrician enjoy the immunity protection of Florida or Maryland peer review law? We are cognizant that this issue may be decided in the bylaws of the system-wide medical staff, but submit that this would inevitably create a situation where a physician who formerly enjoyed the robust immunity protections of State A could now, under a system-wide medical staff structure, be less protected under the laws of State B. We think this could have a chilling effect on peer review, thwarting a process that is meant to buttress clinical oversight.

We strongly urge CMS to finalize their proposal to require that each hospital have an organized and individual medical staff that is distinct to that hospital. This requirement is needed to protect local medical staff self-governance and oversight, support care coordination and peer review activities, and ensure that the distinct clinical needs of each hospital and its community are met.

Medical Staff Member on the Governing Body

We strongly oppose CMS’ proposal to rescind its requirement that a medical staff member be included on the governing body. We strongly urge CMS to retain the current requirement that a medical staff member be included on the governing body.

Inclusion of the Medical Staff

Inclusion of a medical staff member on the hospital governing body is absolutely essential to ensure patient health and safety. As we noted earlier in our comments, the governing body and the medical staff share a mutual responsibility for the provision of quality care and a safe environment for patients. CMS’ current requirement that a common member sit on both the medical staff and the governing body promotes greater coordination between the two entities and serves as a vital check on patient health, safety, and care coordination initiatives within the hospital.

While the corporate executives, attorneys, civic leaders, and other non-clinicians who sit on the governing body often bring relevant expertise to the overall management of the hospital, as non-clinicians, they are not equipped to evaluate and guide patient care at the facility. When included on the governing body, medical staff members bring this clinical perspective to the activities of the governing body, improving and enriching the policies promulgated by the governing body by offering a clinical perspective.

While we are cognizant that CMS is responding to the concerns voiced by hospitals that some state laws may conflict with the inclusion of medical staff members on the governing body, we recommend that CMS resolve this

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³ The Health Care Quality Improvement Act (HCQIA) immunity for entities and participants engaged in peer review activities is limited to damages, and provides neither privilege nor confidentiality protections for peer review deliberations or records.
⁴ While every state provides immunity from civil damages, many states extend immunity beyond civil damages—for example, by providing immunity from injunctive or equitable relief. Some statutes confer immunity from both civil and criminal liability on peer review participants. State law also differs widely regarding which parties may enjoy peer review immunity. While all states immunize peer review committee members, most statutes extend immunity to a wider class of individuals, e.g., persons providing consultation to the committee. Some statutes confer immunity on the entities within which review communities operate. Most statutes also provide immunity for entities and/or individuals providing information to peer review committees.
issue by deferring to state law. Instead of CMS’ proposed revision at §481.12, CMS should revise the current regulatory text as follows to address conflicting state law:

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. The governing body (or the persons legally responsible for the conduct of the hospital and carrying out the functions specified in this part that pertain to the governing body) must include a member, or members, of the hospital’s medical staff, unless legally prohibited or otherwise rendered infeasible by state or local law governing the manner in which members of the governing body are selected.

The current requirement that a medical staff member be included on the governing body is of even greater importance following CMS’ recent decision to allow a single governing body for a multi-hospital system. Multi-hospital systems may now have a single governing body overseeing all of the hospitals in the system, regardless of how geographically distant they may be, or how divergent their patient populations or range of services. These multi-hospital system governing bodies may be particularly vulnerable to missing quality or safety issues at the many hospitals that they are charged with overseeing, and therefore require the meaningful input and inclusion of medical staff members.

Direct Consultation

In lieu of its requirement that a medical staff member be included on the governing body, CMS proposes to require a hospital’s governing body to directly consult with the individual responsible for the organized medical staff of the hospital, or his or her designee.

We do not accept the premise that “direct consultation,” no matter how frequent or in what form, is an adequate substitution for medical staff representation on a hospital’s governing body. At a minimum, CMS should strengthen its proposed language concerning consultation to require direct medical staff participation in hospital governance activities.

CMS’s proposed consultation requirement would not achieve the stated intent of promoting dialogue between the medical staff and the governing body. Despite its label, the purportedly “direct” consultation required by the proposed rule is in fact anything but direct, as it establishes a significant barrier of “middle men” between the members of the medical staff and the members of the governing body. Under the letter of the proposed rule the governing body need not consult with a representative of the medical staff, but may instead simply consult with a hospital-designated medical staff member, such as a hospital medical director or non-practicing physician. Additionally, even if the governing body elects to consult with a true representative of the medical staff, the voice of the medical staff will not be heard directly by the full governing body, but only indirectly as a report from the governing body member or members assigned the duty of consulting with the medical staff. Two-way communication between the medical staff and the governing body would be more effectively and efficiently advanced by the attendance at and participation in governing body meetings of a representative of the medical staff, even if that representative does not have a vote. TJC has outlined standards for medical staff participation in hospital governance which we believe would better promote meaningful communication and collaboration between the medical staff and the governing body. Specifically, TJC standard LD.01.03.01 requires the following:

- The governing body provides the organized medical staff with the opportunity to participate in governance.
- The governing body provides the organized medical staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one of more of its members, as selected by the organized medical staff.
- Organized medical staff members are eligible for full membership in the hospital’s governing body, unless legally prohibited.
If CMS decides to rescind the current requirement that the governing body include a member of the medical staff, we would suggest that CMS finalize alternative language modeled after the above TJC standard. At a minimum, a representative selected by the medical staff should be invited to attend each meeting of the full governing body to present a report and participate in any ensuing discussion.

**Non-Physician Practitioners on the Medical Staff**

CMS proposes to slightly amend its regulation at §482.22(a) to provide that the medical staff must be composed of physicians, and, in accordance with state law, including state scope of practice laws, the medical staff may also include other categories of non-physician practitioners who are determined to be eligible for appointment by the governing body.

We understand CMS’ proposed amendment here to clarify, as CMS states in the proposed rule, that practitioners other than MDs and DOs, such as dentists, podiatrists, optometrists, and chiropractors, may be allowed, but are not required to be included, on the medical staff, pursuant to medical staff bylaws, rules, and regulations, and appointment by the governing body. We do not interpret CMS’ amended text at §482.22(a) to mean that medical staffs must include non-MDs or non-DOs as a matter of course; we would oppose such a proposal.

**Food and Dietetic Services**

CMS proposes at §482.28 that all patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietician as authorized by the medical staff and in accordance with state law.

As a general matter, we disagree with CMS’ assertion as stated in the proposed rule preamble that registered dieticians are the professionals best qualified to assess a patient’s nutritional status and to design and implement a nutritional treatment plan. We also disagree with CMS’ statement that physicians often lack the training and educational background to manage the sometimes complex nutritional needs of patients with the same degree of efficiency and skill as registered dieticians.

To the contrary, we believe that in some cases, such as post-abdominal surgery care, the physician is best suited to determine patient diet. CMS notes the importance of dietician consultation with the patient’s interdisciplinary care team. We urge CMS to make clear in its final rule that in some cases, per medical staff directive, the dietician must defer to or consult with the physician responsible for the care of the patient.

We are supportive, however, of CMS’ deference to the authorization of the medical staff at §482.28. The medical staff is responsible for medical professionalism, including clinical and quality standards for physicians and non-physicians. Accordingly, the medical staff should be the arbiter of policies regarding when a dietician is qualified to order patient diets in the hospital.

**Outpatient Services**

CMS proposes to modify the outpatient services conditions of participation to allow practitioners who are not on the medical staff to order outpatient services for their patients when authorized by the medical staff and allowed by state law. We support the proposed language’s deference to policies adopted by the medical staff, and suggest that the language be modified as follows to ensure practitioners not appointed to the medical staff must be authorized in accordance with state law and policies adopted by the medical staff.

(4) Is authorized in accordance with policies adopted by the medical staff and state law, and approved by the governing body, to order the applicable outpatient services. This applies to the following:

(i) All practitioners who are appointed to the hospital's medical staff and who have been granted privileges to order the applicable outpatient services.
(ii) All practitioners not appointed to the medical staff, but who satisfy the above criteria for authorization by the medical staff and the hospital for ordering the applicable outpatient services for their patients.

Critical Access Hospitals

CMS proposes to revise the bi-weekly Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) presence requirement for critical access hospitals (CAHs). While we are cognizant of CMS’ desire to remove bi-weekly MD or DO presence requirement for cases where CAHs do not require a MD or DO to ensure patient health or safety, we suggest that CMS consider that CAHs are varied in the services that they provide, and some may require MD or DO presence on a bi-weekly or more frequent basis. Accordingly, CMS notes in the preamble that “for CAHs that offer a wide range of complex services, have more than one physician on staff, and have busy emergency departments and/or extensive outpatient services, a visit by a physician only once every 2 weeks could be grossly inadequate.” Because CMS’ proposed regulatory text does not address the great variation in the size of populations that CAHs serve, or the range and extent of services that they offer, we suggest that CMS offer greater guidance in the final rule regarding what expectations the agency has for MD or DO presence in the diverse range of CAHs to which the amended regulation will apply.

Rural Health Clinics and Federally Qualified Health Centers

CMS proposes to make a number of revisions to the conditions for certification for rural health clinics (RHCs) and the conditions of coverage for federally qualified health centers (FQHCs).

First, CMS proposes to expand the definition of “physician” at §491.2 governing RHCs and FQHCs beyond MDS and DOs to also include those practitioners listed in §1861(r) of the Social Security Act, namely, dentists, optometrists, podiatrists, and chiropractors. While we are cognizant that this revision is intended to align with the definition of physician at §1861(r), we urge CMS to consider that the definition at §1861(r) primarily corresponds to Medicare reimbursement, rather than to scope of practice, licensure, or accreditation. In our view, the term “physician” is a descriptor that should be limited to individuals who have received a MD or DO degree, or an equivalent degree of medicine following successful completion of a prescribed course of study from an international school of medicine. Other practitioners with significantly less training than MDs and DOs are increasingly advertising themselves as “physicians” and even “surgeons” with the inevitable result that patients are confused about the limits of the training and qualifications of these other practitioners. CMS’ proposal to extend the definition of physician beyond MDs and DOs to non-physician practitioners would exacerbate this problem.

CMS’ proposal would also affect the safety and oversight responsibilities of physicians through the conditions of certification for RHCs and the conditions of coverage for FQHCs. For example, §491.7(a)(1) requires that “the clinic or center is under the medical direction of a physician.” Further, §491.8(b)(1) prescribes “physician responsibilities” to be “providing medical direction for the clinic’s or center’s health care activities and consultation for, and medical supervision of, the health care staff.” §491.8(b)(2) requires that a physician “periodically reviews the clinic’s or center’s patient records, provides medical orders, and provides medical care services to the patients of the clinic or center.” By altering the definition of physician at §491.2, CMS is both extending the scope of practice for certain non-physician practitioners in RHCs and FQHCs, and eliminating the requirement for medical direction and oversight by MDs and DOs in these settings. RHCs and FQHCs should always be under the medical direction of MDs or DOs.

We urge CMS to consider the health and safety implications for patients under CMS’ proposal to expand the definition of physician for RHCs and FQHCs to non-physician practitioners. Should this proposal be finalized, these facilities could be without any medical direction or oversight by MDs and DOs. MDs and DOs are educated and trained in all organ systems, including the important aspects of preventive, acute, chronic, continuing, rehabilitative, and end-of-life care. This wide-ranging curriculum prepares medical students to enter any field of graduate medical education upon graduation from medical school. The more restricted nature of dentists, optometrists, podiatrists, and chiropractors’ education and training in oral, ocular, podiatric, and musculoskeletal
health, respectively, simply do not prepare these health professionals to provide the oversight essential for ensuring patient safety and the quality of care for the full range of services provided in RHCs and FQHCs.

Lastly, as we noted in our above comments concerning CAHs, we suggest that CMS consider the varying size and scope of RHCs and FQHCs, and whether removal of the bi-weekly physician presence requirement for RHCs and FQHCs is appropriate in all cases, or if CMS should provide additional guidance in the final rule in regard to that revision.

Access to Telehealth

MAG is generally supportive of appropriate uses of telemedicine and telehealth services as long as they are consistent with state laws such as state licensure that allow regulators to protect public health and safety. In this proposed rule, CMS is seeking comments on methods to allow RHC practitioners to furnish distant site telehealth services and do so in a manner that will not result in duplicate payment. The agency is particularly interested in whether this is a viable option for mental health services, but is soliciting comments on whether changes should apply to all services that could potentially be provided through telehealth.

MAG agrees that there are challenges to the provision of medical care in geographically remote areas that are underserved and certain technologies may facilitate access if appropriate policies are in place to ensure patients do not receive comprised medical care. To ensure that the goals of access and quality are promoted through such technologies, expansion of telehealth services should be based on rigorous and scientific evidence that patient access and health outcomes are improved and the very policies designed to achieve the foregoing do not result over time in a lower quality of care or a two tier system of health care.

As a general matter, MAG strongly urges CMS to rely upon and identify the underlying evidence (including findings generated by pilots) that support delivery of the various types of health services utilizing telehealth technologies in the settings and in the manner proposed by the agency. Furthermore, MAG supports policies and the use of technology in a manner that facilitates the delivery of quality medical care and improves patient outcomes by involving the patient’s medical team (including their treating physician(s)). The following are the broad principles that MAG supports to guide how CMS and others structure telehealth delivery and policies:

- Physicians are responsible for, and retain the authority for, the safety and quality of services provided to patients by non-physician providers through telemedicine.
- Physician supervision (e.g., regarding protocols, conferencing, and medical record review) is required when non-physician providers or technicians deliver services via telemedicine in all settings and circumstances.
- Physicians should visit the sites where patients receive services from non-physician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the non-physician providers utilized.
- The supervising physician should have the capability to immediately contact non-physician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting.
- Non-physician providers who deliver services via telemedicine should do so according to the applicable non-physician practice acts in the state where the patient receives such services.
- The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services.
- Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, non-physician providers, and technicians.
- The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving non-physician providers or technicians.

MAG understands that there is a compelling need to expand capacity and enhance the reach of the medical team to deliver care in geographically remote areas that are underserved. To that end, we urge CMS to work with stakeholders to carefully consider and implement policies to ensure that physicians remain part of a patient’s
medical team and the technology is used to enhance the delivery of medical care. We support a methodical and evidence-based approach to expanding services and sites for telehealth purposes. To the extent that CMS concludes additional services beyond mental health would be added, we would welcome the opportunity to comment based on the evidence generated to support the expansion of such services.

**CLIA**

CMS has proposed a number of clarifications and changes to regulations governing proficiency testing referrals under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). CMS has stated that the changes should eliminate confusion about the appropriate treatment by laboratories of proficiency testing samples, in particular those that under normal circumstances would be referred to another laboratory for testing based on the protocol for patient specimens. The current regulation subjects laboratories to significant enforcement actions when staff follow protocols for referral (which is prohibited in the context of proficiency testing) inadvertently. CMS has proposed a measured alternative that would allow the agency greater discretion in addressing such referrals when done so inadvertently. MAG generally supports this more measured approach to enforcement discretion.

**Conclusion**

We support CMS’ efforts to identify and eliminate burdensome regulations. We also strongly support CMS’ proposal to require that each hospital have an organized and individual medical staff that is distinct to that hospital. However, as our comments detail, we have very serious concerns about CMS’ proposal to remove the current requirement that a medical staff member be included on the hospital governing body, and believe that this proposal could have a negative effect on patient health and safety. Should you have any questions, please contact Susan Moore, Director, Third Party Payer Advocacy at 678-303-9275 or smoore@mag.org.

Sincerely,

W. Scott Bohlke, M.D.
President

WSB/dg
cc: Donald J. Palmisano, Jr., MAG CEO