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January 27, 2014

George Isham, M.D, and Elizabeth McGlynn, PhD

Co-Chairs, Measure Applications Partnership

The National Quality Forum

1030 15th Street NW

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Washington, DC 20005

## **RE: Measure Applications Partnership Pre-Rulemaking Report: Public Comment Draft**

Dear Co-Chairs Isham and McGlynn:

On behalf of the over 79,000 members of American College of Surgeons (ACS), I am writing to provide feedback to the Measure Applications Partnership (MAP) Pre-Rulemaking Report. The ACS is a scientific and educational association of surgeons, founded in 1913, to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. The ACS has a strong interest in the development and endorsement of consensus standards that will help surgeons improve the quality and safety of their care and thereby improve outcomes for patients. The comments below are listed by report section.

ACS greatly appreciates the cooperative nature of work between the Centers for Medicare & Medicaid Services (CMS) and the MAP during the development of the January 2014 MAP Pre-Rulemaking Report. CMS' engagement and ability to provide data throughout the MAP meetings greatly improved the process for evaluating the Measures Under Consideration (MUC). As a result, Workgroups were able to make better-informed decisions, compared to previous years. We encourage CMS and the MAP to continue to develop this productive and collaborative relationship in future work.

### ***Clinician Performance Measurement Programs***

### **General Feedback to MAP Clinician Workgroup: Recommendations for the Value-based Payment Modifier and Physician Compare**

In the calendar year (CY) 2014 Medicare Physician Fee Schedule final rule CMS provides flexibility in allowing performance on all Physician Quality Reporting System (PQRS) measures to be included in the value-based payment modifier (VBPM); however, ACS has some concerns with the inclusion of inappropriate measures in the

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program. We believe CMS should delay the inclusion of new measures in the VBPM for a year so that problems associated with the measure can be identified.

By way of comparison, measures included in the hospital value-based purchasing program must be selected from the pool of measures already approved for the Hospital Inpatient Quality Reporting (IQR) Program, and these measures must have been displayed on Hospital Compare for at least a year. This allows hospitals to be on notice that these measures could impact their payment and allows any potential issues to surface. For example, in the fiscal year 2014 Inpatient Prospective System rule, CMS removed several measures from the Hospital IQR for reasons including lack of National Quality Forum (NQF) endorsement, recommendation by the MAP for removal, inadequate link to patient outcomes, challenges in validating efficiency, lack of feasibility to implement in light of new practice guidelines, and availability of other more meaningful measures. It is crucial that such inadequate measures are removed prior to being used for payment under the pay-for-performance programs.

While we do not believe it is necessary or helpful to require that all VBPM measures be included on Physician Compare for a year, we do believe that physicians should have the opportunity to report on or otherwise observe how they perform on the measures for a period of time in PQRS before they are used for payment adjustments under the VBPM.

### **General Surgery Measures**

In 2013, ACS and CMS worked together and retooled many general surgery measures that were submitted by ACS for PQRS CY 2014. Both ACS and CMS spent months carefully re-specifying the measures so that they could be reported both individually and as part of the General Surgery Measures Group. The measures were then vetted during the federal rulemaking process and finalized in PQRS.

However, the measures included in the MAP Pre-Rulemaking Report are in their original format and do not reflect the changes made to the measures. ACS is greatly concerned with the lack of coordination between the MAP and CMS in regard the federal rule-making process. This has resulted in a misrepresentation of what is currently finalized in PQRS, and thus very counterproductive for purposes of providing recommendations to the Department of Health and Human Services (HHS). In fact, the MAP's "additional findings" recommend that the general surgery measures "could be included in Physician Compare and VBPM if [they are] made into a composite with other related [surgical procedure] measures." This recommendation is irrelevant because the measures are no longer grouped based on procedures.

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This inconsistency is confusing and counter-productive for all stakeholders involved in both the pre-rulemaking and rulemaking process. Time at the MAP could be better spent if CMS is able to align their timelines and coordinate the work done prior to the publishing of the MUC to ensure that the most current versions of the measures are being reviewed. We strongly urge CMS and the MAP to work together to be sure that the MUC list includes a current list of finalized measures.

Below we comment on the retooled General Surgery Measures Group currently finalized in PQRS.

ACS supports the MAP's "conditional support" for inclusion of the measures included in the General Surgery Measures Group for the VBPM and Physician Compare. However, as discussed in our general feedback to the Clinician Workgroup, we believe inclusion of new measures in the VBPM should be delayed for a year so that problems associated with these measures can be identified. ACS welcomes the opportunity to work with CMS to best present these measures on Physician Compare so patients in need of surgery are able to view information relevant to the care they seek.

The General Surgery Measures Group includes the following measures:

- Anastomotic Leak Intervention
- Unplanned Reoperation within the 30 Day Postoperative Period
- Unplanned Hospital Readmission within 30 Days of Principal Procedure
- Surgical Site Infection (SSI)
- Patient-Centered Surgical Risk Assessment and Communication (Patient-Specific Risk Calculator)

General Surgery Measure Group includes the following procedures:

Ventral Hernia, Appendectomy, AV Fistula, Cholecystectomy, Thyroidectomy, Mastectomy +/- Lymphadenectomy or Sentinel Lymph Node Biopsy (SLNB), Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB, Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass, Bariatric Sleeve Gastrectomy, and Colectomy

When recommending these measures for the VBPM and Physician Compare, the MAP provided "conditional support" for certain procedures (Ventral Hernia, Appendectomy, AV Fistula, Cholecystectomy, Thyroidectomy, Mastectomy +/- Lymphadenectomy or SLNB, Partial Mastectomy or Breast Biopsy/Lumpectomy +/- Lymphadenectomy or SLNB) and "do not support" for other procedures (Bariatric Lap Band Procedure, Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass, Bariatric Sleeve Gastrectomy, Colonoscopy, and Colectomy), without providing a clear rationale. For

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the measures that they “do not support” the rationale provided was that the “measure does not adequately address any current needs of the program.” We seek clarity on why only a subset of these measures was deemed to not meet the current needs of the program. CMS included all of the listed procedures as part of the General Surgery Measures Group, and the American Board of Surgery (ABS) deemed all of these general surgery procedures and outcomes to be the most important to measure for individual surgeons. In fact, this is precisely how these procedures were identified – these procedures were the MOST common procedures performed by the ABS diplomats. So, in fact, these measures represent some of the most common procedures performed in the United States, are clinically relevant, and have been developed using the same rigor applied to measures used in the ACS National Surgical Quality Improvement Program (NSQIP). We recommend that the MAP conditionally support all measures in the General Surgery Measures Group for inclusion in the VBMP and Physician Compare.

Additionally, the MAP did not support the inclusion of the Patient-Specific Risk Calculator because the “measure does not adequately address any current needs of the program.” This may be one of the most important measures to include in PQRS that the ACS developed. The ACS believes that objectively assessing patient risk and supporting such communication between surgeons and patients is critical to ensure informed consent and shared decision-making. The Patient-Centered Surgical Risk Assessment “risk calculator” provides a personalized, empirically-based estimate of a patient’s risk of post-operative complications based on their demographics, comorbidities, and indication for an operation. In addition to the clinically meaningful reasons of more appropriately preparing for the multidisciplinary acuity of patient comorbidities in the perioperative period, evidence suggests that sharing numeric estimates of patient-specific risk will engage patients, improve informed consent, and enhance patient trust in providers.<sup>1</sup> This measure is at the core of patient-centered surgical care. To this end, we recommend that MAP conditionally support this measure because it aligns with both the “patient and family engagement” and “communication and care coordination” priorities of the National Quality Strategy.

### **General Surgery Measures Not Included in the MUC**

In addition to the ACS general surgery measures finalized PQRS, ACS submitted general surgery measures that were not included in the MUC list.

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1 Gurmankin AD, Baron J, Armstrong K. The effect of numerical statements of risk on trust and comfort with hypothetical physician risk communication. Medical decision making: an international journal of the Society for Medical Decision Making. May-Jun 2004;24(3):265-271.



These measures include:

- Esophagogastroduodenoscopy (EGD) 2: Unplanned intubation
- Thyroidectomy 1: Recurrent laryngeal nerve injury
- Thyroidectomy 2: Neck hematoma / bleeding
- Colonoscopy 2: Cecal Intubation Rate
- Colonoscopy 4: Examination time during endoscope withdrawal, when no biopsies or polypectomies are performed
- Bleeding requiring transfusion (Hemorrhoidectomy, Bariatric Sleeve Gastrectomy, Bariatric Laparoscopic or Open Roux-en Y Gastric Bypass)
- Vericose Veins: Venous thromboembolism (VTE)
- Percutaneous Central Line Placement: Central line-associated bloodstream infection (CLABSI)
- Percutaneous Central Line Placement: Failure to complete procedure

Similar to the measures included in the General Surgery Measures Group, the American Boards of Surgery and Colon and Rectal Surgery also deemed these procedures and outcomes to be the most important to measure for individual surgeons, and they represent some of the most common procedures performed in the United States. These measures are clinically relevant and have been developed using the same rigor applied to measures used in the ACS NSQIP. Inclusion of these measures in PQRS follows the Clinician Workgroup's Guiding Principles, which supports alignment with MOC programs and registries. ACS recommends that the MAP support these measures for inclusion in PQRS.

### **Perioperative Care Measures**

The MAP did not support the direction of the following PQRS perioperative care measures for inclusion in the VBPM and Physician Compare.

These measures include:

- Perioperative Care: Selection of Prophylactic Antibiotic: First OR Second Generation Cephalosporin (NQF# 0268)
- Perioperative Care: Timing of Prophylactic Parenteral Antibiotics – Ordering Physician (NQF #0270)
- Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures) (NQF #0271)
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (NQF #0239)

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The rationale provided by the MAP is that the “measure(s) does not adequately address any current needs of the program.” However, maintaining the perioperative care measures is critical for reducing antibiotic resistance, which is closely related to the outcome of surgical site infection (SSI). These measures have been time-tested in the PQRS program and have proven valid, reliable, and feasible. Furthermore, inclusion of these measures will ensure that a wide range of surgeons from multiple specialties are able to participate in Physician Compare and the VBPM, which will drive participation. The perioperative care measures follow the Clinician Workgroup’s Guiding Principles which support NQF-endorsed measures, measures that have been reported in a national program for at least one year, and focus on process measures that are proximal to outcomes.

### **S-CAHPS**

ACS supports the MAP’s conclusion and rationale to “support” the inclusion of the “Patient Experience with Surgical Care Based on the Consumer of Healthcare Providers and Systems Surgical Care Survey (S-CAHPS),” (NQF # 1741) measure for the inclusion in PQRS, Physician Compare and the VBPM. We would like to note that the MAP “supported” the S-CAHPS for inclusion in PQRS in last year’s Pre-Rulemaking Report but CMS did not include this measure in PQRS, despite the MAP’s support, as well as broad support from the surgical specialty societies. The rationale that CMS provided was that “the S-CAHPS survey measures must be submitted to the MAP for review.”<sup>2</sup> ACS would like to highlight this oversight to be sure that CMS clearly understands the MAP’s continuous support of the S-CAHPS measure.

S-CAHPS more closely assesses the patient experience during an episode of surgical care compared to CG-CAHPS by expanding on the CG-CAHPS to focus on aspects of surgical quality. S-CAHPS is the only NQF-endorsed measure designed to assess surgical quality from the patient’s perspective. Therefore inclusion of S-CAHPS in PQRS, and the VBPM will allow surgeons to report on a measure that more accurately reflects the care they deliver, and patients in need of surgery should be able to view information relevant to the care they seek on Physician Compare.

### **Medicare Spending Per Beneficiary**

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2 Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014, Final Rule. Federal Register 78 (10 December 2013): 74750. Online.



ACS does not support the MAP's recommendation for conditional support of the Medicare Spending Per Beneficiary (MSPB) for inclusion in the VBPM. This measure is currently finalized in the IQR and VBP hospital programs. The MSPB measure is triggered by an inpatient hospitalization and includes all Medicare Part A and Part B payments during an MSPB episode which is three days prior to the index admission and 30 days post-discharge. The rationale that CMS provides for inclusion of this measure in the VBPM is that Medicare spending post-hospital discharge is a significant source of variation in MSPB measure rates, and the measure will enable CMS to assess groups of physician's performance related to post-acute care spending.

ACS has concerns regarding the validity of the MSPB measure. The measure is currently only NQF-endorsed for hospital analysis and should not be calculated as part of the VBPM cost composite prior to NQF-endorsement at the clinician level of analysis. In addition, we believe CMS should delay the inclusion of the MSPB in the VBPM in order to first see how it performs in PQRS for a year to identify problems associated with the measure. The MAP has similar concerns, noting that the measure is not ready for implementation because it requires modification or further development, it should receive NQF-endorsement, and it does not align with the program's data sources.

### *Hospital Performance Measure Programs*

#### **Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)**

ACS does not support the MAP's conditional support for the inclusion of the Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) (NQF #1789) in the Hospital Readmissions Reduction Program (HRRP). MAP's rationale for conditional support is that the measure is not ready for implementation because it needs further experience or testing before being used in the program. As part of the MAP's additional findings, they noted the need to "balance improvement for all patients with the risk of unintended consequences for safety net hospitals that may be more likely to experience payment reduction."

ACS does not agree with MAP's rationale. We have previously provided comments to NQF and CMS that we do not support the inclusion of this measure because the effect of case mix on this measure is currently unproven. The measure does not adequately account for socioeconomic factors and resource use of heavily burdened hospitals that care for disadvantaged populations—factors that may unfairly impact safety net hospitals. Additionally, in surgical care, readmission is most closely related to postoperative complications. Therefore, if we have a readmission measures in surgery, in addition to a complication measure, surgeons could be "dinged" twice for the same

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issue which could create greater hardship. ACS seeks clarity on how CMS will manage these scenarios and implement this measure to avoid double jeopardy.

Lastly, it is important to note that during the MAP Hospital Workgroup meeting, the Committee vote was split and therefore required a re-vote at which point they decided to send the measure to the Coordinating Committee for vote. This measure was also very narrowly passed for NQF-endorsement. Throughout the NQF process, there has been a clear lack of consensus on the HWR measure, which brings into question its reliability across different types of hospitals. For these reasons, we recommend that the MAP delay their conditional support until the measure is tested further and receives broader support from stakeholders. ACS remains vigilant in following the plans for the implementation of the HWR measures as part of the HRRP.

### General Comments

#### Off-Cycle Work

During the Coordinating Committee Meeting, the Workgroup was asked to discuss the process for the review and evaluation of measures that are off-cycle. Off-cycle refers to measures for programs that cannot be reviewed as part of the MUC for the MAP Pre-Rulemaking Report due to the timing of a given program, such as Meaningful Use. The Coordinating Committee agreed that the implementation of measures should not be delayed because of the timing of the MAP Pre-Rulemaking and these measures should be reviewed off-cycle.

ACS also agrees that off-cycle review of measures is critically important and should not be delayed to meet the Map Pre-Rulemaking timelines. However, because this work is not part of the December MUC list, it is crucial that the MAP promote public awareness of off-cycle projects, and does so in a very transparent manner. The MAP must be sure that the off-cycle measures are being reviewed with the same amount of rigor as the MAP Pre-Rulemaking process. Additionally, we recommend a continuous open comment period for off-cycle measures so that stakeholders will have the opportunity to add value to the process and not be caught off guard if they miss a two-week comment period.

Increased transparency and a continuous open comment period will be even more important for the off-cycle review of e-measures. Because e-measures have the ability to include more clinical data than measures which are not e-specified, and because there is little experience implementing e-measures, it is critical that the review and development of these measures are clinician- and patient-led so that they are clinically

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valid, lead to quality improvement, are meaningful to the end user, and will help patients in selecting a provider.

### **Qualified Health Plans in the Health Insurance Marketplaces**

Provisions in the Affordable Care Act (ACA) require HHS to create a national Health Insurance Marketplace to offer health insurance to the public. As part of this provision, HHS is required to develop a Quality Rating System (QRS) for Qualified Health Plans.<sup>3</sup> HHS contracted with NQF to provide input on the measures, organization, and hierarchical structure of the QRS. MAP convened a task force to advise the MAP and produce a report on their input. The draft report was open for comment beginning December 23, 2013 – January 6, 2014 and had very few public comments, most likely because the comment period fell over the holiday season. Therefore, we recommend that NQF reopen the comment period to allow for a more transparent review of the recommendations.

If measures are going to be used to rank providers to determine provider inclusion or exclusion in networks, they must be developed with input from providers, and meet the highest standards of validity and reliability to avoid the misclassification. ACS does not support any process that ranks providers or systems on cost in the absence of quality. Measures must be specifically assessed for ranking, must be clinically relevant, fair, and ultimately promote patient access. Without measure adequacy, providers and systems are at significant risk of misclassification, which will have detrimental effects to our national healthcare system, including limiting access to care.

The process for determining the variation between providers and systems, and establishing which data is appropriate for making these determinations, must include multi-stakeholder consensus prior to QRS application. An additional aspect that must be addressed along with measure adequacy regarding network design based on rankability is the challenge of networks having to match the providers (Part B) and the delivery system facilities (Part A). For example, if a surgeon is narrowed out and/or the hospital is narrowed, where will the patient receive care? It will be critical that exchanges have matched rankability. In its initial implementation, the QRS must be very limited in order to test for a variety of unintended consequences. ACS strongly believes that the current measures are not adequate for use in ranking providers and delivery systems. ACS also believes that there was insufficient provider input when

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3 National Quality Forum. Measure Applications Partnership Input on the Quality Rating System for Qualified Health Plans in the Health Insurance Marketplaces: DRAFT REPORT. Available at: [http://www.qualityforum.org/map/task\\_forces/](http://www.qualityforum.org/map/task_forces/).



creating the QRS, which is critical for successful implementation and therefore must be resolved.

### Conclusion

We are very appreciative of the opportunity to provide feedback and recognize the volume of work and the strict timeline under which the MAP operates. However, we strongly believe that a two-week comment period is not a reasonable amount of time for public comment for the MAP Pre-Rulemaking Report. A thirty-day comment period would allow for more thoughtful public comment and greater provider participation.

ACS looks forward to continuing dialogue with the MAP on these important issues. If you have any questions about our comments, please contact Jill Sage, Senior Quality Associate in the Division of Advocacy and Health Policy for questions. She can be reached at [jsage@facs.org](mailto:jsage@facs.org) or at (202) 672-1507.

Sincerely,

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