August 31, 2026

VIA ELECTRONIC SUBMISSION

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1850-P
Baltimore, MD 21244-1850

Re CMS-1850-P: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

Dear Dr Oz:

Please accept the following comments from the ASC Quality Collaboration (ASC QC) regarding CMS-1850-P (91 FR 41734, July 7, 2026) Section XIV. Proposed Measure Removal for the Hospital Outpatient Quality Reporting and Ambulatory Surgical Center Quality Reporting Programs and Section XVII. Ambulatory Surgical Center Quality Reporting Program. The ASC QC is a non-profit organization dedicated to advancing high quality, patient-centered care in ambulatory surgery centers (ASCs) through a collaborative membership of ASC stakeholders. Participants include leaders from ASC management companies, industry associations, professional associations, accreditation organizations and information technology companies (please see Appendix A to this letter for a complete listing). Collectively, these organizations represent over 2,200 ASCs.

The ASC QC's commitment to quality is reflected in our ongoing work to enable meaningful quality measurement in ASCs, including developing ASC quality measures and posting free quarterly reports of ASC quality measure benchmarks on our website.[1] These contributions are made possible through the voluntary efforts of our members.

I. Proposed Removal of the Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients (ASC-9) Measure

CMS has proposed to remove the Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure from the ASCQR Program. The measure is also proposed for removal from the Hospital Outpatient Quality Reporting (OQR) Program. For both programs, removal would take effect with the CY 2027 reporting period/CY 2029 payment determination.

[1] ASC Quality Collaboration Quality Report. Available at: https://ascquality.org/benchmarking/.

This measure requires documentation of follow-up recommendations in the colonoscopy report. It has had no impact on the quality of patient care in ASCs. We support its removal.

II. CMS Action Needed Regarding the Risk Standardized Patient-Reported Outcome-Based Performance Measure (PRO–PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the ASC Setting (THA/TKA PRO–PM)

We appreciate CMS efforts to decrease burden for ASCs participating in the ASCQR Program. Further Program modification is urgently needed in this area. The Risk Standardized Patient-Reported Outcome-Based Performance Measure Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA/TKA PRO–PM) in the ASC Setting measure is complex and poses significant implementation challenges.

The measure is intended to report the improvement rate in patient-reported outcomes following elective primary THA/TKA for Medicare beneficiaries aged 65 years and older. ASCs (and HOPDs) currently have the option to report this measure voluntarily for the reporting period that began on January 1, 2026. The measure is now mandatory for the Hospital Inpatient Quality Reporting (IQR) Program.

We believe patient-reported outcomes (PROs) are important, yet cannot support mandatory ASC reporting of the measure, currently scheduled for the CY 2028 reporting period/CY 2031 payment determination. Substantial changes to the measure and its requirements must be made prior to that time. We highlight the most pressing issues below.

A. Measure Specifications Must Be Simplified

Although the measure is built around two brief patient surveys, the six-item Hip dysfunction and Osteoarthritis Outcome Score for Joint Replacement (HOOS, JR) and the seven-item Knee injury and Osteoarthritis Outcome Score for Joint Replacement (KOOS, JR), the amount of patient and other data used to calculate the measure is staggering. As currently specified, facilities must collect and submit a total of 44 to 47 data elements for each THA patient and a total of 46 to 49 data elements for each TKA patient to meet requirements for complete data. This is simply too much to ask.

Most ASCs do not have an electronic health record (EHR). This the result of the exclusion of ASCs from the provisions of the Health Information Technology for Economic and Clinical Health Act of 2009 which gave financial incentives to hospitals and clinicians to encourage adoption of EHRs. As a result, many ASCs do not have certified EHR technology to assist with managing the requirements for the THA/TKA PRO-PM. Most centers will have to use manual processes to complete the distribution and tracking of the necessary surveys, to abstract required data from surveys and charts, and to enter all the data elements into the reporting platform. With the number of data elements ranging from 44 to 49 per patient, the measure imposes unprecedented and unreasonable burden.

In the interests of easing these reporting burdens across all affected programs (including the ASCQR, HOQR and HIQR Programs), CMS should consider adopting a related, less complex, alternative measure: Physical Health Outcomes in Total Hip and Knee Arthroplasty (AJRR16). This measure has been added to the physician Quality Payment Program (QPP) for PY 2026 as part of the Qualified Clinical Data Registry (QCDR) Orthopedic measure set. It assesses the percentage of patients with patient-reported meaningful improvement following elective total hip or knee arthroplasty using either the HOOS or KOOS JR. The measure is not risk-adjusted, and the score is calculated as a simple average, greatly simplifying the specifications and reporting requirements.

As a measure developer, we understand the value of risk adjustment and risk standardized measure scores. However, given the need to address the heavy load imposed by the THA/TKA PRO-PM, this is an alternative that both preserves the patient's voice and keeps the focus on reporting statistically significant improvement that meets or exceeds the minimum clinically important difference threshold.

B. Data Completeness Requirement Must Be Revised

Due to the very long delay between the date of surgery and the postoperative patient surveys, CMS should have expected low patient response rates. Instead, CMS set the bar at a level that is clearly out of reach. When mandatory reporting begins, the agency will require ASCs to submit complete and matching preoperative and postoperative PRO data for a minimum of 45 percent of their eligible elective primary THA/TKA procedures. ASCs with completeness levels below that threshold will have their Annual Payment Update reduced in the corresponding payment determination year.

While the 45 percent threshold is slightly less than the 50 percent threshold set for the Hospital IQR and HOQR Programs, it is still much too high. There are several indicators that these expectations are unreasonable.

- Well-established patient surveys such as the OAS CAHPS have demonstrated much lower response rates even though the surveys are administered within a relatively short timeframe following the patient's care. Depending on the survey mode used, the most recent publicly available OAS CAHPS data indicates average response rates varied from 16.1% for telephone only to 34.0% using mail with phone follow-up.[2] If the survey were to be administered 10 to 14 months after the episode of care, as is the case for the post-operative survey for the THA/TKA PRO-PM, response rates would be lower.
- Data from the initial IQR Program voluntary reporting period for the THA/TKA PRO-PM shows low rates of complete response. There were 3171 eligible admissions at the 118 hospitals that participated in the first voluntary reporting period and, of these, only

[2] Centers for Medicare and Medicaid Services. OAS CAHPS Response Rate Percentiles by Mode. April 2026. Available at https://oascahps.org.

14.7% had complete and matched preoperative and postoperative PRO data.[3] Data for the second voluntary reporting period due for release in July 2026 is currently being suppressed, so no public information is available regarding more recent response rates.

- The American Joint Replacement Registry (AJRR) of the American Academy of Orthopedic Surgeons tracks the percentage of patients who complete the general health and joint-specific (e.g., HOOS JR or KOOS JR) functional status assessments within 90 to 0 days prior to surgery *and* the joint-specific functional status assessment 300 to 425 days after surgery. For patients undergoing THA, the complete response rate was approximately 10 percent. For patients undergoing TKA, the complete response rate was approximately 9 percent.[4]
- As the number of surveys Americans receive continues to grow, indications of survey fatigue are increasing simultaneously. Lower response rates, increasing unsubscribe and opt-out rates, lower rates of completed surveys, and fewer, shorter responses to open-ended questions are all being observed. Growing numbers of individuals are concerned about data privacy and security, leading to greater unwillingness to participate in surveys. Reluctance to engage with or respond to telephone, email or text communications from unknown persons or entities is also rising.

The data completeness requirement for the THA/TKA PRO-PM is clearly out of step with current survey response rates. It goes without saying that patients are free to choose whether to participate in surveys, and each person deciding to participate is entitled to decide whether to respond to all the items on each of the instruments requesting their input. These choices must be respected, yet CMS is placing accountability for incomplete surveys on the shoulders of providers. We do not believe patient choices regarding surveys reflect ASC quality. Therefore, those choices should not adversely affect the ability of an ASC to meet Program requirements.

An alternative to the current data completeness requirement is needed before mandatory reporting begins. As an option, CMS could specify that ASCs (and other providers required to report the measure) meet a certain threshold for issuing the required preoperative and postoperative surveys to eligible patients, removing the impact of patient choice. If the agency is not willing to change its approach, a more reasonable data completeness standard is needed - one supported by current data on response rates.

C. Data Submission Must Be Streamlined

At present, CMS requires data for THA/TKAs performed in a single calendar year be entered during two different data submission periods – one submission for the preoperative data and another for the postoperative data. As a result, for any given May 15 deadline after 2026, ASCs must submit both preoperative data for THA/TKAs performed the *prior year* and postoperative data for THA/TKAs performed *two years prior*. There is no compelling reason to require

[3] Centers for Medicare and Medicaid Services. 2025 Patient-Reported Outcomes (PROs) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TAK) Hospital-Level Performance Measure Updates and Specifications Report – Version 2.0.. April 2025.
[4] American Academy of Orthopedic Surgeons. American Joint Replacement Registry. https://www.aaos.org/registries/american-joint-replacement-registry/. May 2026.

separate submission deadlines for a single year's THA/TKA procedures. Both preoperative and postoperative measure data for THA/TKAs performed in a single calendar year could be entered for the same submission deadline. Having a single submission deadline would avoid the need to enter the six patient-specific "Matching Variables" twice.

It is not possible to know in advance which patients with complete preoperative PRO data will subsequently respond completely to the postoperative PRO survey. Having a single deadline would avoid the extra work needed to enter preoperative data for patients who ultimately choose not to respond completely, or at all, to the postoperative assessment. This is important because any patient with incomplete data is not included in the denominator population. A single data submission period following the postoperative survey would eliminate the need to enter data for patients that will ultimately be excluded.

Although any patient with incomplete PRO data or no PRO data is not included in the measure denominator (cohort), CMS decided to include these patients in the measure methodology for non-response bias weighting.[5] This is a statistical approach used to account for potential non-response bias in the calculation of RSIRs. However, comparison of the measure outcome with and without this statistical approach revealed little impact.[6]

In fact, non-response bias was not demonstrated by the statistical modeling performed for *any* of the various iterations of the THA/TKA PRO-PM. No impact was seen for the clinician/clinician-group level version of the THA/TKA PRO-PM measure. The measure developer indicated "there is not an association between the residuals of the improvement outcome and the probability of response based on our models".[7] Elsewhere, the measure developer stated, "[w]e assessed the non-response bias by the Pearson correlation between the Pearson residuals of the hierarchical outcome model with only clinical risk factors and the probability of response. This correlation among clinicians was - 0.00784 (p-value=0.27) and among clinician groups was -0.00709 (p-value=0.32). This indicates that there is not a significant association between the residuals and the probability of response. The correlation between RSIR unadjusted and inverse probability weighted RSIR is very high (0.9958 for clinicians and 0.9956 for clinician groups) suggesting that the results are not sensitive to our weighting adjustment".[8] The same lack of association was seen for the hospital-level measure.[9]

---

[5] See the Hospital IQR Program transcripts for Voluntary Reporting of the Hospital-Level THA/TKA PRO-Based Performance Measure Presentation dated September 14, 2022, and August 3, 2023.
[6] MUC2022-026 Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA PRO-PM) in the HOPD or ASC Setting
[7] Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome- Based Performance Measures (PRO-PMs) Measure Methodology Report.
[8] National Quality Forum, Measure Worksheet NQF #: 3639 Clinician-Level and Clinician Group-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA and TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM).
[9] Patient-Reported Outcomes (PROs) Following Elective Primary Total Hip and/or Total Knee Arthroplasty: Hospital-Level Performance Measure, Version 1.0 Methodology Report.

Because non-response bias weighting did not have a significant impact on the measure outcome for any version of the measure tested, it is non-essential. ASCs (and other providers) should not be asked to devote resources to submitting data for patients whose PRO responses are incomplete or non-existent when there is no evidence to indicate it makes a meaningful difference in the measure outcome. It creates additional burden where none is needed.

In addition to consolidating the two data submission periods into a single data submission period following the post-operative survey, CMS should ensure that ASCs have the option to submit each year's patient data for the THA/TKA PRO-PM to the HQR System on a schedule that is most convenient for them, whether that be monthly, quarterly, annually or episodically. To allow this flexibility, the HQR System should be configured to accept and save patient data from the beginning of the measure's reporting period through the end of the submission period.

D. CMS Significantly Underestimated the Cost and Resource Use Associated With the THA/TKA PRO-PM Measure

When estimating the burden of information collection for patients completing surveys for this proposed measure, CMS assumed most ASCs would perform the PRO data collection "through a screening tool incorporated into their electronic health record or other patient intake process." For the reasons discussed above, most ASCs will have to collect measure data elements using manual processes. Similarly, the data submission process is likely to require manual input of data for each patient.

CMS has also assumed ASCs can readily get the information they need from surgeon's offices. This is unlikely to be true, as most orthopedic surgeons participating in the physician Quality Payment Program (QPP) do not report on related physician-level THA or TKA measures. The most recently reported dataset shows that, of the nearly 13,000 orthopedists participating in the QPP, less than 7 percent reported the related physician-level THA measure. Less than 4 percent reported the related TKA measure.[10] As a result, ASCs will often need to independently survey patients that have not been seen for 10 to 14 months since the date of their surgery. Collecting post-operative survey data successfully without the benefit of a face-to-face encounter will be challenging, placing further pressure on limited ASC resources.

CMS estimated an ASC would spend 20 minutes annually - 10 minutes apiece for each of the two PRO surveys - to collect and submit *all* the data for *all* the patients eligible for the THA/TKA PRO-PM measure (FR 88 49883). Given the large number of data elements required to calculate the measure, it would clearly take more than 20 minutes of effort to collect and submit data *for each patient*. Our members are finding that the entire process takes *over an hour* for each patient. An estimate of 20 minutes per year per ASC for the entire process of preoperative and postoperative PRO data collection and submission is an egregious understatement of the burden imposed by this measure.

[10] Centers for Medicare and Medicaid Services. 2024 Quality Payment Program Experience Report. Available at data.cms.gov.

CMS estimated a cost of $5,212 for any ASCs choosing to submit measure data via a third-party vendor. Based on industry experience with OAS CAHPS third-party vendors, this estimate is also well below the actual cost. CMS must diligently explore alternatives to help manage the high cost and resource use associated with the current iteration of the measure.

E. An Alternative Approach to THA/TKA PRO Measurement Is Needed

The functional assessments for THA and TKA patients are typically done before and after surgery in physician offices. An alternative approach that leverages PRO data collection where it typically occurs during the care of the patient is needed.

CMS should use a single data collection and submission to develop THA/TKA PRO data for all involved providers, including both physicians and surgical facilities. We recommend the approach used by the American Joint Replacement Registry. They have added a measure data element capturing the provider number of the facility serving as the site of surgery. This single data element makes it possible to tie clinician THA/TKA PRO data with the inpatient hospital, HOPD or ASC where the surgery was performed. With this simple change, CMS could minimize burden across multiple reporting programs and implement an efficient approach to capturing THA/TKA PRO data at both the clinician and facility levels. If adopted for mandatory clinician reporting, results for all involved facilities would be available through a single data collection.

The site of service could be verified using administrative claims and facility preview reports. Having a single overarching measure would also negate the need for both clinicians and facilities to attempt to obtain the same patient PRO data or to coordinate data collection efforts across settings, which under the current method will undoubtedly lead to duplicative patient requests. Further, it could be easily incorporated into typical clinical workflow, with the added benefit of offering assurance to patients through face-to-face visits that the data collection is legitimate and not a scam.

F. Summary

Patient-reported outcomes are valuable. However, as currently specified, the THA/TKA PRO-PM measure is overly complex and poses implementation challenges and performance expectations that are unrealistic. If the measure had been tested in the ASC setting issues such as these could have been identified and addressed prior to adoption. At this point, we urge CMS to make the measure a voluntary one indefinitely, or until a simplified approach can be put in place. Pivoting to the related, but simpler, Physical Health Outcomes in Total Hip and Knee Arthroplasty (AJRR16), including a site of service data element, removing the unnecessary non-response bias weighting, consolidating data submission periods, and normalizing data completeness expectations would go a long way toward making collection and submission of data regarding THA/THA patient-reported outcomes more manageable and less expensive. These changes should be applied across all the agency's quality reporting programs that are or will be required to report the THA/TKA PRO-PM measure. We encourage CMS to use provider feedback to guide modifications to the measure specifications, measure methodology, data submission requirements and performance expectations. We would be happy to work with CMS's measure development contractor in this effort.

III. Request for Information on Stratification of the All-Cause Hospital Transfer/Admission Measure (ASC-4)

The All-Cause Hospital Transfer/Admission measure assesses the rate of patients receiving care in an ASC who require transfer to or admission to a hospital upon discharge from the ASC. Currently, the measure does not specify when a transfer occurred during the process of care.

CMS is considering whether adding stratification tied to the phase of care during the patient encounter (for example, pre-procedure, intra-procedure, and post-procedure) could improve the interpretability and usefulness of the measure. CMS *has not* indicated it is considering excluding any of the phases of care from the measure. The agency has stated, "[i]t is important to measure and monitor transfers/admissions that occur pre-procedure, intra-procedure, and post-procedure, as each stratum could provide insight into care processes".

The agency has requested input on clinically meaningful and operationally feasible approaches for incorporating stratification for the measure, and is seeking input on potential frameworks, including appropriate time anchors and their operational definitions.

As you know, the ASC QC is the measure developer and steward for this measure. Our members have often expressed interest in stratifying the measure data and we have had many discussions regarding feasible and reliable approaches to doing so. We are currently exploring an approach based on pre-, intra- and post-procedure categories. Members began to collect and submit stratified data to our internal dataset last year. Currently, over 1000 centers are participating. The results for millions of admissions suggests that approximately 20 percent of transfers occur pre-operatively, approximately 10 percent are initiated in the intraoperative period, and approximately 70 percent occur post-operatively. These rates represent aggregated totals across all facility types, including both single-specialty and multi-specialty centers performing the full spectrum of ASC services.

The ASC QC's aggregated phase-based totals contrast sharply with those reported in the literature by one single-specialty ophthalmology ASC. This center, reporting on approximately 25,000 admissions, found that approximately 75 percent of transfers were for issues noted prior to the induction of anesthesia, while approximately 25 percent were for issues temporally related to anesthesia or surgery.[11] There is significant variance in these facility-specific rates from those we have observed in the aggregate. Although the same categories were not used, the differences still raise questions about CMS's suggestion that stratification "would improve attribution and interpretability across the diverse range of ASCs services" and that a "phase of care stratification may also provide more comprehensive information to support beneficiary decision-making and patient safety monitoring".

[11] Stange, N. R., & Rauen, M. P. (2025). Evaluating ASC-4 transfer rates in cataract surgery: insights into timing and causes of hospital transfers. *Journal of cataract and refractive surgery*, *51*(5), 376–381.https://doi.org/10.1097/j.jcrs.0000000000001613.

The disparities in the phase-related rates of transfers/admissions seen in these two datasets suggest that stratification by phase of care alone would not be meaningful. It appears that other factors may have a significant impact on the outcomes. Actionable data may require further levels of stratification, such as by single specialty/multi-specialty, case type, and characteristics of the patient population typically cared for by the ASC.

Keeping in mind that CMS appears to be planning to retain all phases of care in the measure, we question whether the new burdens that would be imposed by any future stratification of measure data by phase-of-care based approach) would add information that is sufficiently useful and valuable to warrant the additional effort involved.

IV. ASCQR Program Measures Should Be Reported Across Surgical Settings of Care

We are disappointed the agency did not propose to adopt ASC-1, ASC-2, ASC-3 and ASC-4 for the Hospital OQR Program. In CMS-1717-P, CMS sought public comment on the potential future adoption of these measures for the Hospital OQR Program, which does not include measures of this type. As we have discussed in the past, moving to adopt these measures would increase the alignment of measures between the Hospital OQR and ASCQR Programs and, most importantly, would allow consumers more opportunities to compare quality and safety across settings of care.

These measures are straightforward and could readily be applied to HOPDs with some simple modifications. They create minimal burden because data can be collected during the episode of care on the date of service. HOPDs are likely to be collecting this data in some form for internal use, because information regarding the events evaluated by these measures is essential to assuring quality and safety in the outpatient surgical setting.

As you are aware, CMS has selected measures that were not specified for the ASC setting and finalized them for inclusion in the ASCQR Program. Given these precedents, it is clear CMS could take measures not originally specified for the HOPD setting and propose them for inclusion in the Hospital OQR Program. We encourage the agency to do so in the next rulemaking cycle.

V. Public Reporting of ASCQR Program Data

We have discussed our dissatisfaction with the way CMS publicly reports ASCQR Program data repeatedly. Despite many requests for improvement, we remain disappointed in the presentation of ASC quality data. This information is intended to inform patient choice, yet patients are unable to access it easily and it is not readily understandable in its current form.

Participating ASCs put a significant amount of effort into collecting and submitting quality data to CMS. The agency is solely responsible for ensuring this information is shared in a manner that is readily available and in a form that is understandable and helpful to the lay public. Although ASCs perform most of the outpatient surgical and procedural services in the United States, CMS continues to fall short in fulfilling this responsibility.

As you know, Medicare beneficiaries and consumers are most likely to look for information about quality of care on the CMS Medicare.gov Care Compare website. Despite this, there is no ASC data on the site. The Care Compare site has a link to ASC data (which is presented on a completely different website), but it is buried under the "Hospitals" button, where it is unlikely to be found.

Until such time as ASC data is presented on the Care Compare website, major improvements are needed in the presentation of ASC data on the cms.data.gov website. There are no clear and intuitive paths to ASC data from Provider Data Catalog homepage. ASC data should be displayed in a way that helps consumers understand and use the information presented. Currently, measure scores are listed under column titles such as "ASC-4 Rate", making it difficult to understand what measure data is being displayed and what it means. Explanatory material is presented separately on different pages than measure data. And instead of being consolidated, Program data is presented in different areas of the website. Finally, there is no easy way to compare measure data between individual ASCs or across ASCs and HOPDs.

We urge CMS to improve its public reporting of ASC data. We hope this will be the year the agency makes this responsibility a priority.

VI. Closing Remarks

We reiterate our deep concern regarding the challenges posed by the THA/TKA PRO-PM. The measure should be voluntary until the heavy burdens it imposes can be addressed satisfactorily. We urge the agency to carefully consider the changes recommended above.

Thank you for considering these comments. We look forward to an ongoing dialogue with CMS regarding the ASCQR Program.

Sincerely,

Nina Goins

Nina Goins, MSN, RN
Executive Director
ASC Quality Collaboration

Appendix A:
Current Participants in the Activities of the ASC Quality Collaboration

Accreditation Association for Ambulatory Health Care
Accreditation Commission for Health Care
Ambulatory Healthcare Strategies
Ambulatory Surgery Center Association Foundation
AMSURG
Arizona Ambulatory Surgery Center Association
Association of periOperative Registered Nurses
California Ambulatory Surgery Association
Colorado Ambulatory Surgery Center Association
DNV
ECRI
Florida Society of Ambulatory Surgery Centers
HST Pathways
Indiana Federation of Ambulatory Surgery Centers
Joint Commission
Kaiser Permanente
Merritt Healthcare
Michigan Ambulatory Surgery Association
New Jersey Association of Ambulatory Surgery Centers
New York State Association of Ambulatory Surgery Centers
NueHealth
Oregon Ambulatory Surgery Center Association
OrthoForum
Proliance Surgeons
QUAD A
Regent Surgical Health
RFX Solutions
SCA Health
Sovereign Healthcare
Specialist Management Solutions
Specialty Alliance
Surgery Partners
Surgery Ventures powered by HCA Healthcare
Surgical Investors
Surgical Management Professionals
SurgLogs
Tenet Healthcare/United Surgical Partners International
Texas Ambulatory Surgery Center Society
UC Health
US Heart and Vascular