



MLN Connects®

National Provider Call Transcript



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It is now my pleasure to turn today's program over to Amanda Barnes. Amanda, the floor is yours.

Announcements and Introduction

Amanda Barnes: Thank you, Jen. I am Amanda Barnes from the Provider Communications Group here at CMS. And as today's moderator, I'd like to welcome everyone to this MLN Connects event on the 2015 Mid-Year Quality and Resource Use Reports. MLN Connects are part of the [Medicare Learning Network](#).

During this event, CMS subject matter experts provide an overview of the 2015 Mid-Year QRURs and explain how to interpret and use the information found in the report. Before we get started, there are a few items I'd like to cover quickly.

Today's event uses webcast technology. We recommend streaming the audio live through your computer speakers. Those of you participating via webcast may download a copy of today's slide presentation by clicking the files icon at the bottom left-hand side of your screen.

And finally, please note that this event is being recorded and transcribed. The audio file and transcript of this event will be posted to the event detail page in approximately 7 business days. You can find the event detail page by going to go.cms.gov/npc. Again, that is go.cms.gov/npc. Click on the Calls and Events link on the left navigation bar, and then look for the date of today's event in the list.

At this time, I would like to turn the call over to Sabrina Ahmed. Sabrina?

Presentation

Sabrina Ahmed: Thank you, Amanda, and thank you, everyone, for joining us on this call this afternoon. My name is Sabrina Ahmed, and I'm in the Division of Value-Based Payment in the Center for Medicare.

So, the objectives for today's presentation are to first review the 2017 Value-Based Payment Modifier, or also known as Value Modifier, policy to provide an overview of the recently released 2015 Mid-Year Quality and Resource Use Reports. I will be reviewing how you can access the mid-year report and also provide an overview of the information contained in the report and the accompanying tables. And then at the end of the presentation, we'll have a question-and-answer session.

Overview of the 2017 Value-Based Payment Modifier

Sabrina Ahmed: So, slide 5 provides an overview of the Value Modifier policies that will apply in 2017. Calendar year 2015 is the performance period for the Value Modifier that will apply in 2017.

And in 2017, the Value Modifier will apply to all physicians in groups with two or more eligible professionals and to physicians who are solo practitioners. Group and solo practitioners are identified under the Value Modifier by their Medicare Taxpayer Identification Number, or TIN.

Quality-tiering, which is the methodology that is used to evaluate a group or solo practitioner's performance on quality and cost measures for the Value Modifier, will apply to all groups and solo practitioners that are subject to the Value Modifier in 2017. And under quality-tiering, in 2017, physicians in groups with 10 or more eligible professionals will be subject to upward, neutral, or downward payment adjustments based on their performance in 2015, while physicians in groups with 2 to 9 eligible professionals and physician solo practitioners will be subject only to upward or neutral adjustments under quality-tiering—meaning that these small groups and solo practitioners will be held harmless from downward adjustments under quality-tiering in 2017.

As I'll discuss in the next few slides, groups and solo practitioners that do not avoid the 2017 PQRS payment adjustment will be subject to an automatic downward payment adjustment under the Value Modifier in 2017.

Slide 6 shows how we will be applying the Value Modifiers in 2017 to physicians in groups with two or more eligible professionals and to physician solo practitioners. We will continue to align the Value Modifier with PQRS participation. We will use a two-category approach to classify groups and solo practitioners that are subject to the 2017 Value Modifier based on how they participated in the PQRS in 2015.

Category 1, as shown in the left-hand side of this slide, will include groups with two or more eligible professionals that meet the criteria to avoid the 2017 PQRS payment adjustment as a group practice participating in the PQRS group practice reporting option in 2015. And Category 1 will also include groups with two or more eligible professionals in which at least 50 percent of the groups' eligible professionals meet the criteria to avoid the 2017 PQRS payment adjustment as individuals. Category 1 also includes solo practitioners that meet the criteria to avoid the 2017 PQRS payment adjustment as individuals. All groups and solo practitioners that are in Category 1 will be subject to quality-tiering.

Category 2, as shown in the right-hand side of this slide, will include groups and solo practitioners that are subject to the 2017 Value Modifier and do not fall within Category 1, meaning that these groups did not meet the criteria to avoid the 2017 PQRS payment adjustment as a group and did not have at least 50 percent of the eligible professionals in the group meet the criteria to avoid the 2017 PQRS payment adjustment as individuals. Solo practitioners are in Category 2 if they did not meet the criteria to avoid the 2017 PQRS payment adjustment as individuals.

At the bottom of this slide, you can see the 2017 Value Modifier payment amount for groups and solo practitioners that are in Category 1 and 2 based on their size. And I'll be reviewing these adjustments in more detail in the next two slides.

Slide 7 shows the 2017 payment adjustment amounts under the Value Modifier for physicians and groups with 10 or more eligible professionals. If a group with 10 or more eligible professionals does not meet the criteria to avoid the 2017 PQRS payment adjustment as a group and does not have at least 50 percent of the eligible professionals in the group meet the criteria to avoid the 2017 PQRS payment adjustment as individuals, then the group will be considered Category 2 and we will apply an automatic minus-4-percent downward adjustment to the Medicare Physician Fee Schedule payments for physicians that bill under the group's TIN in 2017.

If the group with 10 or more eligible professionals meet the criteria to avoid the 2017 PQRS payment adjustment as a group, whereas individuals – then the group will be considered Category 1 and we will calculate the group's Value Modifier using the quality-tiering methodology. And under quality-tiering, the maximum upward adjustment will be up to plus-4x, where x represents the upward Value Modifier payment adjustment factor, which is calculated after the performance period has ended. Based on the aggregate amount of downward payment adjustments, and the maximum downward adjustment will be minus-4-percent for poor performance in 2017.

High-performing groups, as marked by the asterisk in the table, will be eligible for an additional plus-1x for treating high-risk beneficiaries.

Slide 8 shows the 2017 payment adjustment amounts under the Value Modifier for physicians in groups with two to nine eligible professionals and physician solo practitioners. If a group with two to nine eligible professionals does not meet the criteria to avoid the 2017 PQRS payment adjustment as a group and does not have at least 50 percent of the eligible professionals meet the criteria to avoid the 2017 PQRS payment adjustment as individuals, then the group will be considered Category 2, and we'll apply an automatic minus-2-percent Value Modifier downward adjustment to the Medicare Physician Fee Schedule payments for physicians that bill under the group's TIN in 2017. Similarly, if a physician solo practitioner does not meet the criteria to avoid the 2017 PQRS payment adjustment as an individual, then the solo practitioner will be considered Category 2, and we will apply the automatic minus-2-percent downward adjustment to their physician fee schedule payments in 2017.

If the group does meet the criteria to avoid the 2017 PQRS payment adjustment as a group or has at least 50 percent of the EPs in the group meet the criteria to avoid the PQRS payment adjustment, then the group will be considered Category 1. And for Category 1 groups and solo practitioners, we will calculate their Value Modifier, using the quality-tiering methodology. And under quality-tiering, the maximum upward adjustment for groups with two to nine eligible professionals and physician solo practitioners will be up to plus 2x. And these groups and solo practitioners will be held harmless from downward adjustments, under quality-tiering, for poor performance in 2017.

So as I said earlier, we will apply the quality-tiering methodology to all groups and solo practitioners that are in Category 1 for the 2017 Value Modifier. The Value Modifier is based on a quality composite score and a cost composite score. So, slide 9 describes the quality measures that will be used to calculate the cost composite score for the 2017 Value Modifier. To calculate the quality composite for groups that report PQRS data as a group in 2015 and meet the criteria to avoid the 2017 PQRS payment adjustment, we will use the measures reported under the PQRS GPRO.

Alternatively, if at least 50 percent of the EPs in the group report PQRS data as individuals and meet the criteria to avoid the 2017 PQRS payment adjustment, then we will use their individually reported PQRS measures to calculate the quality composite.

For solo practitioners, we will use their individually reported PQRS measures as long as they meet the criteria to avoid the 2017 PQRS payment adjustment.

To calculate the quality composite score for groups with 10 or more eligible professionals, we will also include three quality outcome measures that we calculate using Medicare claims data. These include the all-cause hospital readmission measure, a composite of preventable hospitalizations for acute conditions, and a composite of preventable hospitalizations for chronic conditions.

For groups with two to nine eligible professionals and solo practitioners, we will include only two of these quality outcome measures in their quality composite.

Lastly, we will use the results of the 2015 CAHPS® for PQRS survey to calculate a group's quality composite if the group elected this option when it registered to participate in the 2015 PQRS GPRO.

Slide 11 describes the cost measures that will be used to calculate the quality composite score for the 2017 Value Modifier. The cost composite is based on six specialty adjusted cost measures. The first is the per-capita cost for all attributed beneficiaries measure. The costs included in this measure reflect payments for all Medicare Part A and Part B claims submitted by all providers who treated Medicare Fee-for-Service beneficiaries attributed to the TIN during the performance period.

Then there are four total per capita cost measures for beneficiaries with specific chronic conditions. And the conditions are chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes.

The sixth measure is the Medicare Spending per Beneficiary, or MSPB, measure. Costs for the MSPB measure are based on payments for all Medicare Part A and Part B claims submitted by all providers for care surrounding specified inpatient hospital stays attributed to the TIN during the performance period. All six measures that we use to calculate the cost composite for the Value Modifier are payment standardized, risk adjusted, and adjusted to reflect the specialty mix of the eligible professionals in the group.

In 2017, the Value Modifier will be waived for groups and solo practitioners, as identified by their TIN, if at least one eligible professional who billed for Medicare – physician fee schedule items and services under the TIN, during 2015, participated in either the Pioneer ACO model or the Comprehensive Primary Care initiative in 2015.

Slides 13 and 14 describe how the 2017 Value Modifier will apply to groups and solo practitioners that participated in the Shared Savings Program in 2015. Groups and solo practitioners, as identified by their TIN, that participated in a Shared Savings Program ACO in 2015 will be subject to the 2017 Value Modifier based on the ACO's quality performance in 2015.

So if the ACO fails to successfully report on quality measures via the GPRO Web Interface in 2015, then the participant TINs under the ACO will be subject to an automatic downward adjustment under the 2017 Value Modifier. And the amount of the automatic downward adjustment will depend on the size of the participant TIN. These adjustments were described earlier in slides 7 and 8.

And if the ACO successfully reports on quality measures via the GPRO Web Interface in 2015, then the 2017 Value Modifier for the participant TINs under the ACO will be calculated using the quality-tiering methodology. In this case, the cost composite will be classified as average, and the quality composite will be calculated based on quality data submitted by the ACO through the GPRO Web Interface and the ACO's all-cause hospital readmission measure for the 2015 performance period.

Slide 15 describes the next steps groups and solo practitioners need to follow in order to find out about how the 2017 Value Modifier will apply based on their performance in 2015. First of all, you should download your [2014 Annual QRUR and the 2015 Mid-Year QRUR](#) if you haven't done so already. And then in the fall of this year, please watch out for announcements about the availability of the 2015 Annual QRUR, which will contain information about your 2017 Value Modifier and your 2015 quality and cost performance data. And then download the QRUR when it's available.

The next slide describes what groups and solo practitioners need to do in 2016, which is the performance period for the 2018 Value Modifier. The Value Modifier in 2018 will apply to all physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists in groups with two or more eligible professionals and to those who are solo practitioners. So first, groups need to decide how to participate in the PQRS in 2015. And if a group wants to participate in the PQRS as a group via the PQRS GPRO, then it can register for a 2016 PQRS GPRO reporting mechanism until June 30th of this year. Information on registering to participate in the PQRS GPRO in 2016 is available on the [PQRS GPRO registration](#) website that's listed on this slide. Registration is not necessary if solo practitioners or EPs in groups want to participate in the PQRS as individuals in 2016.

They also need to select a PQRS reporting mechanism and become familiar with the [measures](#) and the data submission timeframe.

They should also review the quality measure benchmark used for the [Value Modifier](#).

Overview of the 2015 Mid-Year QRUR

Sabrina Ahmed: So, the remaining presentation will cover what is in the Mid-Year QRUR, how you can access it, and what information is contained in these reports. So in April of this year, CMS made available the 2015 Mid-Year QRURs for groups and solo practitioners nationwide, as identified by their Medicare billing TIN. A QRUR was provided to each TIN. The 2015 Mid-Year QRUR provides interim information to groups and solo practitioners about their performance on the three quality outcome measures and six cost measures that CMS calculates using Medicare claims data. So, these measures are a subset of the measures that will be used to calculate the 2017 Value Modifier.

The performance period used for the Mid-Year QRUR is July 1, 2014, through July 30th, 2015. Please note that the performance period for the 2017 Value Modifier will be calendar year 2015, which is January 1, 2015, through December 31st, 2015.

So, these reports are available currently for information – for informational purposes only and will not affect physician payments under the Medicare Physician Fee Schedule.

Please note that these reports do not contain the following information, such as information about a TIN's 2017 Value Modifier payment adjustment, quality composite and cost composite scores for the 2017 Value Modifier, and performance information on the PQRS GPRO and individual eligible professional PQRS measures, including CAHPS.

The 2015 Annual QRUR, which will be available this fall, will be based on a performance period from January 1, 2015, to December 31st, 2015, and will show the TIN's actual performance on all of the quality measures and cost measures that will be used to calculate the 2017 Value Modifier. Please note that all of the quality outcome and cost measures that are included in the Mid-Year QRURs will be recalculated in the 2015 Annual QRUR, using claims data from calendar year 2015.

So, now I'm on slide 19. So, CMS made available the Mid-Year QRURs to groups and solo practitioners nationwide that had at least one eligible case, during the performance period, for at least one quality outcome measure or cost measure included in the report.

Groups and solo practitioners that did not have at least one eligible case for at least one quality measure or cost measure received a one-page report containing general information about the Mid-Year QRUR and the 2017 Value Modifier.

Accessing the 2015 Mid-Year QRUR

Sabrina Ahmed: The next section of this presentation will cover how you can get an EIDM account in order to access your group or solo practitioner's QRUR. Slide 21 provides an introduction to EIDM. An EIDM account is – with the correct role, is needed to access a TIN's QRURs. So a person can have only one EIDM account, but the account can be associated with multiple groups and solo practitioners. So if you need to access multiple TINs' QRURs, then you would be able to do that if your EIDM account is associated with all of the TINs.

And to find out whether there's already someone who can access your TIN's report, you can contact the QualityNet Help Desk at the number provided in slide 71 and provide your TIN and the name of the group or solo practitioner. If someone was able to access your TIN's 2014 Annual QRUR that was made available last September, or if someone was able to register your group for the 2016 PQRS GPRO, then that same person can also access your 2015 Mid-Year QRUR, using their EIDM user ID and password. You can sign up for a new EIDM account, modify an existing EIDM account to add the correct

role, or reset your EIDM account password on the [CMS Enterprise Portal](#) website listed on this slide.

Slide 22 discusses the EIDM roles that are available for groups. Groups are identified in the EIDM by their Medicare billing TIN.

One person from the group must first sign up for an EIDM account with the Security Official role. And if additional persons are needed to access the TIN's report, then they can request the Security Official role or the Group Representative role in the EIDM. And if you already have an EIDM account, but not one with one of these group roles, then you have to modify your existing account to sign up for one of these roles.

If you're a group that wants to give access to your QRUR to a vendor, to an ACO that you are part of, or to another third party, then that third party may set up an EIDM account by submitting a request to the group's Security Official through the EIDM. And then the Security Official can approve the request in order to give the third party access to the group's report.

So, now I'm on slide 23. So, what does having a Security Official role or a Group Representative role in the EIDM allow you to do? With the Security Official role, you'll be able to access the group's Mid-Year and Annual QRURs, the Supplemental QRUR, and also the PQRS feedback reports. You'll be able to register a group to participate in the PQRS GPRO, in the registration system. And you'll also be able to submit a Value Modifier informal review request on behalf of the group. And, lastly, you'd be able to approve requests for the Group Representative role in the EIDM, for your TINs.

With the Group Representative role, you'll be able to perform Tasks 1, 2, and 3, but not Task 4, which is approving requests for the Group Representative role.

Slide 24 discusses the EIDM roles that are available for solo practitioners. Solo practitioners are identified in the EIDM by their Medicare billing TIN and consist of only one eligible professional.

So one person must first sign up for an EIDM account with the Individual Practitioner role. And if additional people are needed to access a solo practitioner's QRUR, then they can request the Individual Practitioner role or the Individual Practitioner Representative role in the EIDM.

And slide 25 lists the tasks that you'll be able to do with either the Individual Practitioner role or the Individual Practitioner Representative role.

Slide 26 describes the steps you need to follow in order to sign up for a new EIDM account or to modify an existing EIDM account to add a group or solo practitioner role. First of all, you will need to gather all of the required information you need to submit

your request for a new EIDM account or to modify your existing EIDM account. The required information for groups and solo practitioner roles are listed on slides 27 and 28, respectively. And we have guides that provide step-by-step instructions for requesting each of the roles in the EIDM for a new or existing EIDM account on the [How To Obtain a QRUR](#) website that's listed in slide 26.

Slides 27 and 28 list the required information you have to provide when requesting one of the group or solo practitioner roles. Please keep in mind that as long as a group has at least one person with the Security Official role, then that person will be able to access the group's report. And for a solo practitioner, as long as one person has the Individual Practitioner role, then that person will be able to access the solo practitioner's report. All requesters will need to complete the "Your Information" and "Business Contact Information" sections.

If you're requesting the Security Official role, they'll – then you'll need to enter the group's Medicare billing TIN, name, address, phone number, the rendering National Provider Identifiers for two different eligible professionals who bill under the TIN and their corresponding individual Provider Transaction Access Numbers, which is also known as the PTAN. Please note that the PTAN is not the same as the Medicare provider identification number. If you do not know the eligible professional's individual PTAN, then please check the enrollment approval letter they received from the Medicare Administrative Contractor when enrolling in the Medicare Program, or you can directly contact your MAC. Please do not use the group's NPI or the group's PTAN in this section.

And if you are requesting the Individual Practitioner role, then you'll need to enter the solo practitioner's Medicare billing TIN, their name, address, phone number, their rendering NPI, and the corresponding individual PTAN.

Slides 29 through 31 show the screens that you have to complete when requesting a Security Official role for a group in the EIDM. All new users, regardless of the role they request, will need to provide the required information in the "Your Information" section that's shown in slide 29. All new users will need to also provide their required information in the "Business Contact Information" section shown in slide 30. And in the screen shown in slide 31, you'll need to enter the group's Medicare billing TIN, the rendering NPIs for the two different eligible professionals who bill under the TIN, and their corresponding individual PTANs. And again, we have guides that provide step-by-step instructions for requesting each of the roles in EIDM on the [How To Obtain a QRUR](#) website that's listed on slide 71.

So after you have an EIDM account with the correct role, you will be able to log in to the [CMS Enterprise Portal](#), as shown in slide 32, to access your QRUR. And for step-by-step instructions on how to access your Mid-Year QRUR, you can refer to the [Guide for Accessing the 2015 Mid-Year QRURs](#). And this guide is available on the [How To Obtain a QRUR](#) website.

Information Contained in the 2015 Mid-Year QRUR

Sabrina Ahmed: So, the remaining slides in this presentation will cover the information contained in the Mid-Year QRUR. So, slide 34 summarizes the information contained in each of the exhibits that are part of the Mid-Year QRUR. You can view each of these sections within the [CMS Enterprise Portal](#) website. Or once you are in the portal, you can also download a PDF document that contains the TIN's entire QRUR. And the instructions for downloading the report as a PDF are provided in the guide that I had mentioned before, which is called the [Guide for Accessing the 2015 Mid-Year QRURs](#). And this guide is available on the [How To Obtain a QRUR](#) website.

Slide 35 summarizes the information contained in the TIN tables that accompany the Mid-Year QRUR. These tables can be downloaded as Excel files. We have a document called [Understanding Your QRUR](#) document for the 2015 Mid-Year QRUR. And this document provides tips on how groups and solo practitioners can use their Mid-Year QRUR and the accompanying tables to understand their performance and to improve quality of care, streamline resource use, and identify care coordination opportunities for their beneficiaries. This document is available on the [2015 QRUR educational documents](#) website that's listed on slide 71.

There's a screenshot of the report's cover page on slide 36. The cover page, basically, provides an overview of the Mid-Year QRUR and the 2017 Value Modifier.

So, Exhibit 1 of the Mid-Year QRUR, as shown in slide 37, displays the counts of the eligible professionals that include both physician and nonphysician eligible professionals in your TIN, as indicated by a query of PECOS on July 10, 2015, and based on the number of eligible professionals submitting claims to Medicare under your TIN between July 1, 2014, and June 30th, 2015, which is the performance period used for the Mid-Year QRUR. So, to determine the size of your TIN for purposes of the Value Modifier, CMS uses the lower of the number of EPs identified in PECOS as having reassigned their billing rights to your TIN and the number of EPs submitting claims to Medicare under your TIN for the performance for the Value Modifier. Because the 2017 Value Modifier uses a different performance period from the Mid-Year QRUR performance period, the number of eligible professionals or services – billing for services under your TIN may change. I would like to note here that both full-time and part-time eligible professionals billing under your TIN are included in this calculation. The number of eligible professionals on which your 2017 Value Modifier will be based will be displayed in your 2015 Annual QRUR.

Slide 38 describes the two-step attribution methodology that is used to attribute beneficiaries to TINs for the five per-capita cost measures and the three quality outcome measures. This attribution methodology is based on the primary care services provided by the physicians, nurse practitioners, physician assistants, and clinical nurse specialists in your TIN.

Exhibit 2 on slide 39 shows the number of Medicare Fee-for-Service beneficiaries who are attributed to your TIN based on primary care services provided. The second and third rows of this exhibit display the number of beneficiaries who are attributed to your TIN in the first and second steps of attribution the back – methodology that was described in the previous slide, slide 38, so that you can review the proportion of beneficiaries attributed to your TIN during each step.

Exhibit 3 presents information on the average number of primary care services provided to beneficiaries attributed to your TIN. It includes the average counts of primary care services provided by the physicians, the NPs, PAs, and CNSs in your TIN and by physicians, NPs, PAs, and CNSs outside of your TIN.

You can refer to Tables 2A and 2B, that I'll go over later in this presentation, for a list of all beneficiaries attributed to your TIN for the three claims-based outcome measures and the cost measures. These tables also contain information about the services in your TIN's – attributed beneficiaries received both inside and outside of your TIN.

Exhibit 4, as shown in slide 40, provides information on the total hospitalization episodes attributed to your TIN for the MSPB measure, as well as the number of unique beneficiaries associated with these attributed episodes. An MSPB episode includes all Medicare Part A and Part B claims with the start date falling between 3 days prior to an inpatient prospective payment system hospital admission, also known as the hospital index, for the episode through 30 days following hospital discharge. And a hospitalization episode is attributed to a TIN if, during the hospitalization, the TIN provided more Part B covered services as measured by Medicare-allowed charges than any other TIN.

Exhibit 5, as shown in slide 41, presents your TIN's performance rate and the number of eligible professionals for the three CMS-calculated claims-based quality outcome measures. You can review each measure within this exhibit to identify those for which your TIN's performance rates compare at least favorably to your TIN's peers. And the lower rates on these measures indicate better performance. If your TIN's performance rates for a measure is higher than the benchmark rate that's shown in this exhibit, then that means that your TIN demonstrated worse performance than your TIN's peers. And conversely, if your TIN's performance rate for a measure is lower than the benchmark rate, then that means that your TIN demonstrated better performance than your TIN's peers. You may use this information to develop a targeted quality improvement strategy.

Exhibit 6, as shown in slide 42, identifies the hospitals that provided at least 5 percent of your TIN's attributed beneficiaries' inpatient stays over the performance period for this report. This exhibit includes only the beneficiaries attributed to your TIN for the three claims-based quality outcome measures and for the five per-capita cost measures.

You can use the data presented in the last column of this exhibit to better understand which hospitals most frequently admitted your TIN's attributed beneficiaries. And this information can help you target care coordination efforts more appropriately.

Exhibit 7, on slide 43, identifies the hospitals that were associated with at least 5 percent of the episodes of care attributed to your TIN for the MSPB measure over the performance period for this report. The data presented in the last column of this exhibit enables you to identify the hospitals that were most frequently associated with your attributed MSPB episodes of care. And this information may help you in prioritizing care coordination efforts.

Slide 44 provides information on the six cost measures that are included in the Mid-Year QRUR and will be used to calculate the cost composite score for the 2017 Value Modifier. The five per-capita cost measures are based on payments for all Medicare Part A and Part B claims submitted by all providers who treated the beneficiaries attributed to the TIN, including providers that did not bill under the TIN. And the MSPB measure is based on all Part A and Part B expenditures for services surrounding inpatient hospital stays from 3 days before admission to 30 days after discharge.

As I mentioned earlier, all six measures have been payment-standardized risk-adjusted for specific beneficiary characteristics and adjusted to reflect the specialty mix of the eligible professionals in the group. For detailed information on risk adjustment and specialty adjustment, you can refer to two fact sheets that we have which are available on the [2015 QRUR educational documents](#) website that's listed on slide 71. And these fact sheets are called the [Fact Sheet for Risk Adjustment](#) and the [Fact Sheet for Specialty Adjustment](#) in the 2017 Value Modifier. And more information on the specialty adjustment and risk adjustment of specific measures is also available in the measure information forms that are available on the same website.

Exhibit 8, as shown in slide 45, shows the five per-capita cost measures and the MSPB measure, displaying for each measure that payment-standardized, risk-adjusted, and specialty-adjusted per capita or per episode costs and the number of eligible cases or episodes. So in this exhibit, you can compare your TIN's cost for each measure with the benchmark that's in the third column of this exhibit to better understand how your TIN fared relative to your TIN's peers. For example, if your TIN's per capita costs for the "all attributed beneficiaries" measure are higher than your peers, then you can use the detailed cost information presented in Table 2B and Table 5 to identify the types of costs incurred over the performance period for the beneficiaries attributed to your TIN. Similarly, if the MSPB costs for your attributed beneficiaries are higher than your TIN's peers, then you can use the detailed cost information presented in Table 4 to identify opportunities to improve the care for these beneficiaries.

Exhibit 9, on slide 46, displays the dollar difference between your TIN's payment-standardized, risk-adjusted, and specialty-adjusted per capita costs for your attributed beneficiaries, by selected category, and the corresponding cost for your TIN's peer group. Your TIN's peer group is defined, for each cost category, as all TINs that had at least 20 eligible cases for the measure. And you can use this exhibit to identify potential areas for cost reduction.

Exhibit 10, on slide 47, displays the dollar difference between your TIN's payment-standardized, risk-adjusted, and specialty-adjusted per episode cost performance for the MSPB measure, by selected category, and the corresponding costs for your peer group, defined as all TINs that had at least 25 eligible cases for the measure.

And similar to Exhibit 9, you can use this exhibit to identify potential areas to improve the efficiency of the care that you provide, based upon how your TIN's costs compare to your peers in each of these categories. And you can refer to Table 6 for a more comprehensive breakdown of costs by categories of service, and Table 4 for distribution of costs at the episode level.

Additional Information Contained in the Mid-Year QRUR

Sabrina Ahmed: I mentioned earlier in this presentation that the Mid-Year QRUR also contains 10 tables that can be downloaded as Excel spreadsheets. The remaining slides describe the information contained in these tables. I would also strongly encourage you to review the [Understanding Your QRUR](#) document for the 2015 Mid-Year QRUR, which is located on the [2015 QRUR educational documents](#) website. And this document contains information on how you can use all of the data contained in this report to improve your performance and use the data in your quality improvement efforts.

So slide – Table 1, on slide 49, provides information about the eligible professionals in your TIN during the performance period, based on July 10th, 2015, PECOS data and Medicare claims submitted for your TIN during the performance period for this report. And again, the performance period for this report was July 1, 2014, to June 30th, 2015. So for each eligible professional, this table lists the National Provider Identifier number and their name, whether the eligible professional is a physician or nonphysician, their specialty designation, and whether the provider was identified as part of the TIN through PECOS or Medicare billing over the performance period. And also, the date of last claim billed under the TIN is shown in this table. If you believe this information is not up to date for your TIN, then you may update it in PECOS by contacting your Medicare Administrative Contractor.

Table 2A, as shown in slides 50, 51, and 52, provides information about the Medicare beneficiaries attributed to your TIN for the five per-capita cost measures and the three claims-based quality outcome measures. This table is divided into sections that describe beneficiary characteristics, specific Medicare claims data, the eligible

professionals that billed the most services for the beneficiary inside and outside of your TIN, the date of the last hospital admission for the beneficiary, and whether the beneficiary had one or more of the four chronic conditions requiring additional care.

Table 2B, as shown in slides 53 and 54, provides information about the costs of care provided to the Medicare beneficiaries attributed to your TIN (as shown in Table 2A). Table 2B provides both the beneficiary's total payment-standardized Medicare Fee-for-Service costs and the distribution of these standardized costs across categories of service. You can use this information, as well as the information in Table 3 about the hospitals admitting your TIN's attributed beneficiaries, to learn general information about the types of services used by specific beneficiaries.

Table 3, as shown in slides 55 and 56, provides details about hospitalizations—over the performance period, for beneficiaries attributed to your TIN—for the five total per-capita cost measures and the three claims-based quality outcome measures. The beneficiaries listed in Table 3 are a subset of all the beneficiaries that are attributed to your TIN (as shown in Table 2A).

In this table, the data are broken down by beneficiary and the admitting hospital along with the principle diagnosis associated with admission. The date of discharge and subsequent care environment information are provided in this table. Table 3 also shows whether the hospital admission was the result of an emergency department evaluation, an ambulatory care sensitive condition, or a readmission within 30 days of prior admission.

Table 4, as shown in slides 57 and 58, displays information on the beneficiaries attributed to your TIN, for the MSPB measure. Data are presented at the beneficiary-episode level. So that means that if a beneficiary has more than one episode that was eligible for the MSPB measure, then that beneficiary will appear in the exhibit for each episode. Table 4 is organized into four sections: beneficiary characteristics, apparent lead eligible professional, features of the episode hospitalization, and the episode cost by category of service.

Table 5, as shown in slides 59 and 60, displays your TIN's attributed beneficiaries' costs for various categories of services performed by providers both within and outside of your TIN. The categories of services in this table are the same as in Table 2, but they include additional subcategories.

Table 6, on slide 61, displays the per episode cost for various categories of services for the episodes of care attributed to your TIN for the MSPB measure. The categories of service are the same as in Table 4, but also include additional subcategories.

So now, I'm on slide 62. So, Tables 7 to 9 mirror Table 5 and – by providing information on the various types of services performed by providers both within and outside of your

TIN for the beneficiaries included in the per capita costs for beneficiaries with specific chronic condition measures.

Resources

Sabrina Ahmed: So, this concludes the formal portion of our presentation today. The last slides that we have here list all of the technical assistance resources that are available for you. If you have questions about your QRURs or the Value Modifier, you can contact the Physician Value Help Desk at the contact number provided on this slide. If you have questions about the PQRS program or how you can set up an EIDM account with the correct role in order to access your report, you can contact the QualityNet Help Desk.

We have also listed on this slide the [2015 QRUR educational documents](#) website where you can find many useable documents that will help you better understand your report and explain how the 2017 Value Modifier will be calculated. And then, the [How To Obtain a QRUR](#) website contains instructions for obtaining an EIDM account and also contains the guide that walks you step by step through the process of how you can access your TIN's QRUR. The websites for the [Value Modifier](#) and [PQRS](#) programs are also listed on this slide at the bottom of the slide. So, this is the end of this presentation. So, now I would like to turn it back over to Amanda.

Amanda Barnes: Thank you so much. Just a few housekeeping items—I wanted to clarify that, on slide 37, it references a date of – that the submitted claims was between July 2014 to June 30th, and that should be 2015. And also we wanted to clarify that slide 71 should technically be slide 64. You'll see there's a discrepancy there.

So at this time, the subject matter experts are going to take your questions about the 2015 Mid-Year QRURs. So at the Q&A session, you'll be – we're going to be asking webcast participants to provide feedback about their experience with the technology used today. Please remember to disable your pop-up blockers for best results. And we're going to start our Q&A session by fielding a few questions that we've received from webcast participants, and then we'll alternate to questions from the phone and then some asked through the Q&A queue.

Question-and-Answer Session

Amanda Barnes: Jen, can you go ahead and send out polling question number 1? And we'll get started with a question that we received from Q&A registration.

And the question is: Are the value-based – the VBMs, excuse me, purely based off the costs from claims, or are they also related to the PQRS that is reported?

The answer to that question is that CMS calculates the Value Modifier using the following data sources: They use PQRS quality measures; CAHPS for PQRS, if applicable, and also Medicare claims.

Another question that came from registration is: Can you explain the difference between attributed beneficiaries and your TIN's eligible cases?

So, the answer to that is: The difference is due to measure-specific inclusion and exclusion criteria, for example, three quality measures and five cost measures. CMS attributes beneficiaries to TINs using a two-step process based on primary care services. However, for any given measure, only a subset of these attributed beneficiaries will be included as eligible cases for the measure, depending on the inclusion and exclusion criteria of the measure. For example, the eligible cases for the per capita cost for beneficiaries with diabetes measure includes only the attributed beneficiaries who have diabetes.

So, could you go ahead and prompt the telephone users and – to begin to compile Q&A roster?

Operator: Certainly. At this time if you would like to ask an audio question, please press star and the number 1 on your telephone keypad. Again, that's star 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

Amanda Barnes: Okay, and while you compile that roster, we'll go ahead and start taking some questions from the webcast. Our first question comes from Chris Hendry.

On Tables 5 through 10, there is an All Services line item at the top. The over- and under-performance in the line items beneath it do not add up to all the services over and under. What else is included in the All Services line?

Wilfredo Lim: And this is Wilfredo Lim, and I can address that question. So, the amount by which your TIN's costs were higher or lower compared to the benchmark should add up to the All Services line for the – all the high-level categories. So, the high-level categories would be: outpatient evaluation and management services, procedures, and therapy (excluding emergency department), ancillary services, hospital inpatient services, emergency services not included in a hospital admission, post-acute services, hospice, and all other services. It's possible that there could be slight differences due to rounding, but otherwise, I guess if that doesn't clarify the calculation, I would suggest contacting the help desk with a specific example to help. In terms of the – sorry, the first part of the – or the second part of the question—and I'm forgetting it right now. Sorry, let me see if I can remember that. What else is included in the All Services line? So, the All Services line includes all Medicare Part A and Part B services. Thank you.

Amanda Barnes: Okay, great. Thank you. Jen, did we have any questions come in on the line yet?

Operator: Yes, we have a question from the line of Richard Fairley.

Richard Fairley: Thanks for taking my call. The – I'm having a hard time distinguishing what the difference is between Exhibits 6 and 7. I don't know if you could give an example of – seems like the hospital should end up on both lists. I'm not sure – I kind of need to think through why it would be on one list and not on the other. It seems like their criteria are very similar.

Amanda Barnes: Mathematica, could you go ahead and address that question for us, please?

Wilfredo Lim: Sure. So, the reason for the differences between the two exhibits is because they apply to different measures. So, Exhibit 6 will capture a hospital admissions for beneficiaries that were attributed to the TIN based on primary care services, whereas Exhibit 7 will present information for hospital admissions for, I guess, episodes that were attributed to the TIN for the Medicare Spending per Beneficiary measure. So, because beneficiaries/episodes were attributed to the TIN through two different mechanisms, that would account for the different hospital admissions described in those exhibits.

Amanda Barnes: Okay, great. Thank you so much. We're going to answer questions from the webcast. The next one is going to come from Marilee Cole.

The question is: The group added a physician in October of 2015. That took the EPs under the TIN to a total of 10. So, how is the EP count for group size calculated, reporting as of calendar yearend?

Wilfredo Lim: Sure. So, the group size for the Value Modifier is based on the smaller of two counts, so it's the number of eligible professionals that are associated with the TIN in PECOS as of 10 days after the close of registration. So for the Mid-Year QRUR, that's July 10th, 2015. But it's also based on – but the size is also based on the number of eligible professionals that bill Medicare Part B during the performance period. Yes, so it's those two, so the first one—it is on a specific date, and then the second way of counting is based on Medicare Part B claims during the entire performance period.

Amanda Barnes: Thank you so much. Another question from the webcast comes from the line of Alicia Reedy. The question is: Is the TIN reported based on admitting physicians, or attending physicians? Mathematica, could you go ahead and take that for us, too, please?

Jeff Ballou: Sure. Could you repeat that? Is the TIN reported based on admitting or attending physicians? Did I...

Amanda Barnes: Yes.

Jeff Ballou: ...hear that right?

Amanda Barnes: Yes.

Jeff Ballou: So, basically what we do is: We look for professional claims—I guess I'm not entirely following the question, so I'll give you the best answer I can. For the purposes of assigning patients to physicians, we look for professional claims that are provided by rendering physicians. Once we've assigned patients or attributed patients to physicians for the purposes of calculating cost measures and also for the purposes of calculating the claims-based outcome measures, we look at all costs associated with those beneficiaries, whether provided by attending, admitting, ordering, rendering, etc., physicians.

Amanda Barnes: Thank you so much. Can we get another polling question up, Jen, please? Okay, and the next question is going to come from the webcast from Toni Ambrosy.

Groups of two or nine EPs, calculation of quality composite for VM, individual PQRS measures reported by at least 50 percent of EPs and group—can the group choose which doctor's measure reporting is going to be used for the VM calculation?

Sabrina Ahmed: Hi, this is Sabrina Ahmed. The answer to that question is: No. So if a group is reporting through the PQRS GPRO option as a group and submits measures through one of the GPRO reporting mechanisms, then we would use all of the measures that the group reports through their chosen reporting mechanism. And similarly, if an – if EPs report individually, then we would use the measures – all of the measures that their EPs report as long as the measure successfully met the PQRS reporting criteria. So, groups are not able to choose which specific doctor's results would be included in the Value Modifier quality composite calculation.

Amanda Barnes: Thank you. Can we go ahead and take a question from our phone line, please?

Operator: Yes. Your next question comes from the line of Laurie Brown.

Laurie Brown: Hi, I think my research as you've been talking is answering my question. But it was: Are the CAHPS surveys for physicians' clinics being administered now, and if so, how? Hello?

Amanda Barnes: I am sorry. Could you repeat that one more time for us, please?

Laurie Brown: Yes. Are the CAHPS surveys—assessment of health care providers—being administered now, and if so, how?

Sabrina Ahmed: Hi, this is Sabrina Ahmed. So, I would like to suggest that you contact the [QualityNet Help Desk](#). They would be able to help address your question. We don't have...

Laurie Brown: Okay.

Sabrina Ahmed: ...the subject matter experts here who can address your question at this moment.

Amanda Barnes: So, that Help Desk—you can find that information on slide 64 for the [QualityNet Help Desk](#), and they'll definitely be able to help you.

Laurie Brown: Thank you.

Amanda Barnes: Sure. So we're going to take a question from the webcast now. And this comes from Cathy Nelson.

So, if the eligible professional reported PQRS using measures' groups instead of individual measures in 2015, will they get credit for the 2017 Value Modifier reporting?

Fiona Larbi: Hi, this is Fiona Larbi from CM. Yes, providing you meet the PQRS reporting requirements and avoid the PQRS payment adjustments. Whether you report via measures group or individual measures, you will get – that will be used to calculate your Value Modifier.

Amanda Barnes: Okay, thank you.

The next question we have here is that if a TIN – this is going to be for Mathematica – if a TIN changes in July 2016, will they be subject to a Value Modifier adjustment, either negatively or positively?

Wilfredo Lim: Sure. So, the Value Modifier is applied to the TIN. So, as an example, if the TIN is subject to the 2018 Value Modifier adjustment based on performance in 2016, then physician fee-for-service payments billed under that TIN in 2018 would be subject to that TIN's Value Modifier adjustment. So, related to this question, if claims are no longer billed under that TIN in 2018, then no claims would be subject to that TIN's adjustment.

Amanda Barnes: Thank you.

We have a question in our webcast about downloading the QRURs through the portal. And the question is: Is there an instruction sheet on how to pull the reports?

Slide 64 does have a link to [How To Obtain a QRUR](#), and that will be available for you to walk you through that.

The next question is going to come from the line of Laura Joyner. If the cost is adjusted by specialty, how is a small multispecialty practice handled when it has primary care and specialists under the same TIN?

Wilfredo Lim: Sure. So, specialty adjustment compares the TIN's actual risk-adjusted cost to the TIN's expected risk-adjusted cost based on its specialty mix. The expected cost is based on the proportion of each specialty's Part B payments in the TIN. So, as an example, if primary care physicians make up 75 percent of Part B payments and 25 percent of the payments are made up by cardiologists, then the expected costs for this TIN would be a weighted average of 75 percent of the expected costs for primary care physicians and 25 percent of the expected costs for cardiologists.

Amanda Barnes: Okay, thank you. Before we move on to our next question, Jen, can you please open poll question number 3?

And then our next question is going to come from Lance Donkerbrook. How can ACOs that reported GPRO get a QRUR for all participating TINs? Current process in the portal seems that each TIN does not individually and that it is extremely inefficient for ACOs that report in GPRO.

Sabrina Ahmed: This is Sabrina Ahmed. So as mentioned in the question, ACOs currently are not able to directly download all of their participant TINs' QRURs. But, you know, as I had mentioned on slide 22, if a participant TIN wants to give access to the ACO, then it can do that. The ACO would need to submit a request for one of the group or solo practitioner roles, depending on whether the participant TIN is a group or a solo practitioner. And then the Security Official from the group or solo practitioner would need to approve the ACO's role request, and only after that point would the ACO be able to access the participant TINs' QRURs. And the ACO would, you know, – currently, as the system is set up, the ACO would need to do that – follow that process with all of the participant TINs under the ACO in order to be able to access their reports.

Amanda Barnes: Thank you. Can we take a question from the phone, please?

Operator: Yes, your next question comes from the line of Trinh Dang.

Trinh Dang: Hi, thank you for holding this. This is really, really helpful. I think I'm just kind of a little bit confused. All of the beneficiaries here that I'm looking at were – they're coming from the PQRS report that we submitted. And that's my first question, right?

And then my second question is: When I'm looking at Exhibit 1, I am seeing my EPs, but when I'm looking at my number identified in claims, it's below 10, and that – numbers don't match with my beneficiary numbers. So, can you explain a little more on where these numbers are coming from?

Amanda Barnes: Mathematica, could you take that for us?

Wilfredo Lim: Sure. And I am trying to understand the first question. So, for the Mid-Year QRUR beneficiaries – so for the two – so for all the measures, beneficiaries are either attributed to your TIN based on the two-step attribution rule discussed today or for the Medicare Spending per Beneficiary measure based on hospital episodes. So, PQRS does not factor into the Mid-Year QRURs. But please weigh in if I understood your question incorrectly.

Now for the second part of your question about the eligible professionals associated with your TIN—so, there are two counts—one based on PECOS (and I think that sounded fine); the eligible professionals are associated with their TIN based on those that have any claims records – Medicare Part B claims records during the performance period. So it's not based on PQRS; rather, it's based on claims.

Trinh Dang: Okay, I'm just unsure how, for my eligible professionals, my number of identified claims is only six. So I'm just curious as to where the claims are being pulled from.

Wilfredo Lim: Sure. So it sounds like, given the specific elements of your situation, that it may be beneficial to contact the help desk with your inquiry.

Jeff Ballou: And this is Jeff Ballou at Mathematica. Just to add on to what Wil is talking about, for the number identified in claims, we identify professional claims during the period of performance for this mid-year report—this would be the July 1st through the next June 30th. And so, we've got a certain number for your group or your practice that we see in Medicare claims billings. And again, those often, but do not always, exactly match up with the number of professionals that your group has listed in PECOS, when we look at how many folks you have in PECOS in July.

Trinh Dang: Okay, thank you.

Amanda Barnes: Thank you so much.

Our next question is going to come from the line of Terri Kilgore. The question is that they are an outpatient rehab facility, and when they accessed the Mid-Year QRURs, it stated that a report was not generated for the TIN, because the TIN did not have at least one eligible case for at least one quality outcome or cost measure. When she called, she

was told it was because the providers do not report PQRS measures and that these are not factored into the mid-year reports for outpatient rehab. Is this correct?

Fiona Larbi: This is Fiona from CMS. The Mid-Year QRUR does not include any PQRS measures. They're only included in the Annual QRUR.

Amanda Barnes: Thank you. Jen, can you please push out poll question number 4?

And we'll take, let's see, questions from the webcast. Why are 100-plus GPROs mandated to participate and pay for CAHPS, but allowed to select whether to include CAHPS scores in the VM calculation?

Sabrina Ahmed: This is Sabrina Ahmed. So under PQRS, it is a requirement for groups with 100 or more eligible professionals to report on the CAHPS or PQRS survey measures. However, for the Value Modifier calculation groups – these same groups—groups with 100 or more eligible professionals, or actually any group that elects to select or are required to report on the CAHPS measures—they can choose – they can decide whether they want to include their CAHPS results in the calculation of their Value Modifier. So even though it's required for a group with 100 or more EPs to report on the CAHPS measures, it's – the group has the ability to decide whether they want to include those results in the group's Value Modifier calculation. And the group would need to make that election in the registration system when they register to participate for the PQRS GPRO.

Amanda Barnes: Okay, great. We have time for one more question.

The question is: What if PECOS and the NPIs associated with the VBM QRUR does not match? The specialty practice – or the practice has a nurse practitioner on the QRUR that's not listed in PECOS, and they wanted to see what they could do with that. Mathematica, do you have that?

Jeff Ballou: We do. This is Jeff Ballou at Mathematica. I think – when I was looking at the question and it just disappeared on me, but I think the – it's not super unusual to have a little bit of a mismatch between PECOS and billings. Again, we look at, you know, which providers are listed in PECOS as of a certain date and time, which is July 10th of the year. However, we look at billings during the period of performance for the report. And if someone joined a practice after we looked at PECOS and then started billing under that practice, that's one way that you could see a mismatch. Alternatively, we might see someone in PECOS who has stopped billing under a particular group practice's tax identification number, and that's another way you could see this sort of mismatch.

Amanda Barnes: Okay, great. Thank you so much.

I'm going to answer one more question from registration, and then we'll conclude today's webcast. The question is: How can you achieve 100 percent in a measure and be considered average?

The answer is that – please note that average quality is not determined at the measure level. Instead CMS determines the TIN's quality using composite scores that take performance across all quality measures into consideration. Please also note that a TIN's performance on individual measures at the composite level are assessed relative to a peer group. So even if a TIN scores 100 percent on a given measure, this may not result in a large measure of level standardized score if the measure has a relatively high benchmark, that is, if other TINs also performed well on the measure or relatively large standard deviation.

Additional Information

Amanda Barnes: Unfortunately, that is all the time we have for questions today. On slide 64, you'll find it – I'm sorry, not on slide 64, on slide 67, you will find information on how to evaluate your experience with today's call. We're also going to push out the link to the evaluation for our webcast participants. Evaluations are anonymous, confidential, and voluntary, but we'll hope you'll take a few moments to evaluate your experience with today's event. As a reminder, please disable your pop-up blockers for the best results.

I'd like to thank our subject matter experts and all participants who joined us for today's [MLN Connects Call](#). Have a great day, everyone.

Operator: This concludes today's event. Presenters, please hold.

-END-

