Centers for Medicare & Medicaid Services
Program Year 2010 Quality and Resource Use Reports
Feedback Session 2
National Provider Call
Moderator: Nicole Cooney
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Contents

Operator: At this time I would like to welcome everyone to the Program Year 2010 Quality and Resource Use Reports – Feedback Session 2 call.

All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

Thank you for your participation in today's call. I will now turn the call over to Nicole Cooney.

Thank you, ma'am. You may begin.

Introduction

Nicole Cooney: Thank you, Holley. Hello, I'm Nicole Cooney from the Provider Communications Group here at CMS, and I'll serve as your moderator for today's call.

I would like to welcome you to the Program Year 2010 Quality and Resource Use Reports – Feedback Session 2.

Today we have CMS subject matter experts here to discuss summary findings of these reports, as well as address questions and comments related to the overall report.

We'll have a brief presentation and then we will conduct a section-by-section walk-through of the report, and at this time we will address comments and questions by section.

We are running an Adobe Connect webinar room today. Please note that you do not need to join the Adobe Connect room in order to participate in today's call. You may participate in the audio only, if you prefer.

Before we get started, there are a few items that I need to cover.

The link to the slide presentation for today's call was e-mailed to all registrants earlier this afternoon. If you did not receive this e-mail, please

check your spam or junk mail folders for an e-mail from the CMS National Provider Calls resource box.

Please note that the URL to join today's Adobe Connect webinar room was included in this e-mail.

This call is being recorded and transcribed. An audio recording and written transcript will be posted to the CMS Physician Feedback Program section. The URL for this Web site is located on the final slide of today's presentation.

A direct link to the page where these materials will be posted is also included in the e-mail that went out to registrants earlier today.

I'd also like to thank those of you who submitted comments when you registered for today's call. Your comments were shared with the speakers to help prepare slides and remarks for today's presentation.

As I mentioned, today's call also uses the Adobe Connect webinar technology. For more information on how this will work and what you should see on your screen right now, I'll turn it over to my co-moderator for today, Wendy Hildt. Wendy?

Wendy Hildt: Thank you, Nicole. Hello, my name is Wendy Hildt, and I also work in the Provider Communications Group here at CMS.

As Nicole stated, I will serve as your co-moderator today. I will also be the navigator for those who will be following along via the webinar.

Those of you participating via the webinar, you should see the opening slide, titled "Physician Feedback Program 2010: Individual Physician Quality and Resource Use Reports."

I will navigate through the slide presentation, as well as our review of the 2010 individual QRUR template. This allows you to focus on the presentation details and not navigation since I will be navigating for you.

At this time I would like to introduce our CMS speakers for today.

We are pleased to have with us Dr. Sheila Roman, Senior Medical Officer in the Performance-Based Payment Policy Group in the Center for Medicare.

We also have Michael Wroblewski, Senior Technical Advisor in the Center for Medicare.

And now it is my pleasure to turn the call over to Dr. Roman to begin our presentation.

Presentation

Dr. Sheila Roman: Good afternoon, or good evening, depending on where you are at the moment. First of all, I'd like to say that CMS really appreciates you taking the time to participate in this call and to provide us with your comments and feedback.

I'm not sure that many of you realize, but this four-state dissemination of what we call the QRURs, or the Quality Resource Use Reports, is really our first major dissemination of the QRUR, and we, therefore, are looking for many comments from you. And in particular we are looking for comments on how to make the reports better, how to make the reports more user-friendly for you and also more actionable for you.

Now I'm going to turn to slide two and talk about the purpose of this feedback session. Basically, Michael and I will be providing you an overview of some of the aggregate findings from the 2010 Confidential Physician Quality and Resource Use Reports that CMS prepared for the physicians in the four states, Iowa, Kansas, Missouri, and Nebraska.

As I already stated, we're really looking to solicit input from you, the report recipients, to improve the content and the display of information in the QRURs so they provide meaningful and actionable information to you.

And finally, we will be answering questions about the information and methodologies used in the QRURs.

On the next slide, just a quick review of the agenda. We will – first off, Michael and I will be presenting an overview of the findings from the 2010 Confidential Individual QRURs.

And then our plan is to run through the reports section by section. And we'll do that in three sections. Initially, the first two pages of the report, and then the quality section, and the cost section.

So, if you can arrange to get in the queue with questions related specifically to the sections, and then, at the end, we'll have a general question period.

And then we'll make some final closing remarks at the end of that walk-through.

On slide four, just a short discussion about what are the QRURs? The QRURs provide comparative information so that physicians can view examples of the clinical care their Medicare Fee-for-Service patients received and the total per capita cost for these patients in relation to the average clinical care and cost of other physicians' Medicare Fee-for-Service patients.

The 2010 QRURs did not use minimum case size thresholds. For some physicians, therefore, the QRUR may only display information about a few Fee-for-Service beneficiaries if that's all a physician treated in 2010.

We've been asked to make a comment about Physician Compare and the individual reports. CMS has announced plans to place group practice, not individual physician, performance data on the CMS Physician Compare Web sites.

We've also been asked about the relationship of these reports to the value-based modifier. And I think these reports should be viewed as examples of the types of information that we would be using to calculate a Value-Based Payment Modifier in the future.

On the next slide, who received the 2010 Confidential Feedback Report? CMS prepared 23,730 individual physician reports. One report for each

physician in Iowa, Kansas, Missouri, and Nebraska that provided services to at least one Medicare Fee-for-Service beneficiary in 2010.

What should physicians do with these reports? The reports enable you to compare the quality and cost of your Medicare Fee-for-Service patients' care with that of Medicare patients treated by physicians in your specialty for cost comparison and by all physicians in Iowa, Kansas, Missouri, and Nebraska for quality comparison.

The reports highlight your degree of involvement with all patients you treated based on claims you submitted to Medicare. Patients were attributed to you based on your professional claims and professional costs.

And you'll hear a more descriptive – a better description of how we attributed patients as we talk about the cost measures shortly.

Right now I'm going to move to slide seven and talk about the two types of quality and care information that appeared in your reports.

First, I'll talk about the claims data that was submitted through PQRS, and this is exhibit two on the reports that you received.

Of the 23,730 physicians, 5,891, or about 25 percent, participated in PQRS through the claims-based reporting methodology.

We did not include the EHR or registry option methodologies in these reports, so that if you participated in either of these two PQRS options, you would not have seen PQRS data for you in your reports.

Approximately 23 percent of the PQRS participants were primary care physicians. Specialties with the highest participation rates were ophthalmology, anesthesiology, pathology, and geriatric medicine.

On slide eight, I've selected some PQRS claims measures and shown the mean performance rates. I've made an attempt to select measures that were similar to the claims-based measures that all of you received in your reports.

And I think the point of looking at the mean performance rate is that you'll see some very high performance rates, as for spirometry evaluation at 91 percent, and some that are on the lower side, as for ischemic vascular disease: low density lipoprotein control at 40 percent.

And I think the major take-home here is that from the claims data submitted through PQRS, we know that from those measures there is certainly room for improvement.

On slide nine, I'm going to talk briefly about the administrative claims-based measures. That is exhibit one in your report.

Exhibit one appears in all reports and provides performance rates on up to 28 quality measures, with 13 sub-measures, for a total of 41 measures, depending upon whether the physician treated at least one beneficiary that was eligible for the measure.

On average, a physician had information on 30 of 41 measures. These measures show whether the beneficiary received the indicated treatment during 2010.

The reports provide this information for any beneficiary for whom the physician provided at least one service even if the physician did not provide the indicated treatment.

This is an important point. He did not need to have provided the service for the patient to receive the feedback on the quality measure.

CMS believes that it is important to inform physicians about the quality of care that their beneficiaries received from primary care and preventative services and from other physicians who may have provided those services.

Currently, physicians may be unaware of whether the beneficiaries they treated received all the recommended care that they should have. The reports provide this important information for the Fee-for-Service beneficiaries the physician provided services to in 2010.

I also want to make the point that all but one of these measures were NQF-endorsed. And that they were vetted by internal and external physician experts.

And again, in the next slide, you'll see some of the – you'll see the quality measure categories for the administrative claims-based quality data grouped by category and a mean performance rate on measures in the clinical category for physicians in the four states.

And I think there's the same take-home message here as from the PQRS data. And that is that you'll see that there are some higher, as in the cancer performance, and some lower performance, as for HIV, the basic take-home message being that there is room for improvement on these measures.

On the next slide, which is slide 11, we show, on average, the reports contain the following number of measures by broad specialty classification for those physicians that had at least ten cases.

So, for primary care, there were a mean number of administrative claims-based quality measures of 19. For surgeons, 18 measures; medical specialists, 27; emergency medicine physicians, 26; and others, 30.

Others, there were a large number of radiologists, anesthesiologists, and pathologists for whom one would expect a lot of services.

And I'm going to turn the slides and the presentation over now to Michael Wroblewski.

Michael Wroblewski: Thank you, Sheila. I wanted to give you just a couple of remarks – some high-level remarks regarding how we attributed beneficiaries for calculating the cost measures – the per capita cost measures that we included in the reports.

We tried a new approach this year in which we classified each Medicare – each physician's Medicare Fee-for-Service beneficiaries into three groups.

Now, these groups are shown on exhibit three of your individual QRUR. And the three groups that we made were – the first group was what we call the Directed group.

And in this case, the physician billed for 35 percent or more of the patient's office or other outpatient evaluation and management, or E and M, visits.

The second category is what we called Influenced. In this category, the physician billed for fewer than 35 percent of the patient's outpatient E and M visits, but for more than 20 percent of the patient's total professional cost.

And the last group was really what we call the Contributed group. And in this category, the physician billed for fewer than 35 percent of the patient's outpatient E and M visits and for less than 20 percent of the patient's total professional cost.

The point that I want to make here is we were trying to look at all of the patients that a physician submitted at least one claim on. We recognize that physicians have different degrees of involvement for patients, and we tried to classify them into these three buckets.

The other point I wanted to make was that these are based on Part B claims. These are not based on Part A institutional claims.

So if physicians are, say, in a Critical Access Hospital or a Rural Health Center in which Medicare reimburses services using an institutional claim, those physicians would not have been classified.

So if you're – what we learned on Tuesday when we did this call for the first group is-- there are a number of Critical Access Hospitals and Rural Health Clinics that indicated that their reports looked a little a funny to them.

And it's because the professional services that we classified here were based on Part B claims, not Part A claims.

Turning to the next slide, I wanted just to provide you just kind of what a typical report looked like in terms of how these attribution methodologies worked.

In this chart, we looked – we broke down – the left-hand side are types of physicians. We broke them into five broad categories. Primary care, medical specialist, surgeon, emergency medicine, and other.

And then we looked to see what was the mean number of attributed beneficiaries. You'll see the Primary Care physicians were attributed 200 hundred – in total, 279 beneficiaries.

Of which, reading along that top row, 81 of them were Directed, 17 were Influenced, and 181 were Contributed.

You'll see that medical specialists had, on average, 471 attributed beneficiaries. And you can see the rest of the breakdowns, 45 for Directed, 46 for Influenced, but 380 for Contributed care.

So you'll see all – I'm not going to read the rest of the numbers.

But what I wanted to point out was if you look at the other categories, and as Sheila indicated, the "other" category picked up specialties such as radiology, pathology, anesthesiology, and you'll see that those physicians, on average, had a very high number of beneficiaries attributed that were in the Contributed category, 834, which is down in that bottom right-hand corner.

The way we determined specialty for these types of physician classifications were based on the plurality of CMS specialty codes on all the professional claims billed to Medicare for which the physician was listed as the performing provider determined by the physician's medical specialty.

On to the next slide, these next three slides give a little bit more information about the three categories of beneficiaries.

So this first one looks at the Directed beneficiaries and their relationship with the physician to whom they were attributed. I think that – that what I kind of really concentrate on are the two columns on the right-hand side of the slide.

On average, if a physician was attributed to what we call a Directed beneficiary, they saw that beneficiary on average three times during the year, three E and M visits.

And on average, for primary care, they billed – the physician billed almost, for primary care, almost 90 percent of total professional cost, at 89.8 in that upper right-hand corner.

You'll see that the average number of visits per physician for Directing care was around three, 3.6 for primary care, three visits on average for medical specialists, et cetera. And the average percent of professional cost billed were in the eighties.

On the next slide, we provide the same information, but we do it for what we call the Influenced beneficiaries. And the two things that I want to point out on this particular slide are that in contrast to the prior slide, is that the average number of visits per physician for – for a physician who was Influencing care – dropped from three of the Directed beneficiaries to about one for Influenced beneficiaries.

But interestingly, the percent – average percent of professional cost billed by the physician Influencing care did not really drop that much, from – in the upper eighties to the lower eighties for the five different types of physicians.

So, the contrast between Directed beneficiaries and Influenced beneficiaries was a Directed beneficiary had on average more visits, but the physician in both instances had above 80 percent, on average, of the total professional cost for that – those beneficiaries.

I'll contrast this to the next slide, which is the analysis of Contributed beneficiaries. You'll see that, again, looking at the right two most columns,

the average number of visits per year for physicians Contributing to care is a little bit lower than one.

But what the striking difference is that how the average percent of professional cost billed for physician Contributing care drops from above 80 percent down to 20 and even lower than 20, meaning that these types of beneficiaries had multiple physicians providing services to them.

And this really is showing – that last remark is really shown in what the mean total per capita costs were for the three types of beneficiaries.

If we just look at the chart and in the primary care row, which is the top row, you'll see the average cost of a beneficiary attributed to a primary care physician was about $16,580.00.

But when you break that down between the Directed, Influenced, and Contributed, you'll see that Directed and Influenced beneficiaries had much lower costs on average, 9700, and maybe almost 6800 for Influenced.

But you'll see that the Contributed beneficiaries are almost at $20,000.00 for primary care, showing that multiple physicians are providing services to these beneficiaries.

And I'm not going to read the rest of the numbers, but you'll see that the Contributed cost average total – average per capita cost for Contributed beneficiaries is substantially higher than the average per cost for Directed or Influenced beneficiaries.

All cost data that were in the reports has been standardized in order to make comparisons of the services. Service use within or across geographic area is fair. So we've taken out any geographic differences, and we've also risk-adjusted the cost to account for differences in expected health costs of individuals.

The risk model that CMS uses, uses beneficiary demographic characteristics and prior-year diagnoses to predict relative Part A and Part B Medicare fee-for-service payments.

The last, kind of, informational slide that I'd like to present was really – what was the mean of average total per capita cost for beneficiaries for specific conditions?

And you'll see that – that patients that had heart failure or COPD on average had about $30,000 – total per capita cost for about $30,000 on average for those beneficiaries. Much higher than beneficiaries who have chronic diabetes or coronary artery disease.

Again, all these cost data have been standardized and risk adjusted.

On the last slide that I have is, hopefully, that the information that's shown in the reports can be used for one, for quality improvement; two, physicians have a general idea of where they have been doing well and areas where they can improve; both based on the administrative claims as well as the measures that they've reported for the PQRS system.

Hopefully it will enable care coordination for those areas in which you may not – a physician may not be responsible for care. But identifying areas where care could be coordinated better.

Hopefully there will be an awareness of resource tips and total per capita use and an understanding of what's driving that by the type of patients you have and your degree of involvement with them.

And then once again, as Sheila mentioned earlier, this is a type of candidate data that could be used in calculating the value modifier that begins in 2015.

And with that, I'll turn it back over to Nicole to start our run-through of the section-by-section report.

Polling

Nicole Cooney: Thank you, Michael. At this time we'll pause for just a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today.

Please note there may be moments of silence while we tabulate the results. Holley, we're ready to start the polling.

Operator: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line.

Today we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in.

If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling.

Thank you for your participation, this completes the keypad polling session of the call. I'll turn the call back over to Nicole Cooney.

Question and Answer Session

Nicole Cooney: Thank you, Holley. At this time, we're going to begin our section-by-section walk-through of the report template.

As Sheila mentioned – Dr. Roman mentioned, we will take comments and questions in three sections.

During the first section, we'll take comments and questions on the first two pages of the report. The second section will address questions on exhibits one and two as illustrated on pages three, four, and five, which deal with quality. Our final section will address comments and questions dealing with information presented on page six through to the end of the report, which deals with cost.

I'd like to remind everyone that the purpose of today's call is to listen to and address general comments and questions about the report.

If you have questions specific to the data contained within your own confidential report, please e-mail it to the address noted on slide 21 of today's presentation for appropriate research and response.

And in the interest of addressing as many comments and questions as possible, I'd like to ask you to limit your comments to one.

And if you'd like to ask followup questions or if you have additional comments, please press star one to get back into the queue and we'll continue to address as many comments as we can in the time allotted.

So, with that, Holley, we're ready to take comments and questions on our first section, which deals with pages one and two of the report.

Operator: OK, to ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key.

Please state your name and organization prior to asking a question and pick up your handset before asking your question to assure clarity.

Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Once again, to ask a question, press star one.

And, Nicole, at this time there are no questions.

Nicole Cooney: OK, we'll move on to the second section. If you have a comment or a question dealing with exhibits one and two as illustrated on pages three, four, and five which deal with quality we can take those comments and questions now.

Operator: And to ask a question or make a comment press star one.

At this time there are no questions.

Nicole Cooney: OK. We'll move on to the final section then. If you have a comment or question starting on page six through to the end of the report which deals with costs, we'll hear those comments and questions now.

Operator: Again, to ask a question or make a comment, press star one. Again, to ask a question, press star one.

And, Nicole, at this time there are no questions.

Nicole Cooney: OK, we're willing to address any questions, any questions or comments that you might have on the reports, dissemination of the report, your ability to access the report, any comments or questions.

Operator: Again, that's star one.

You do have a question that has come through from the line of Maria Tiberend.

Maria Tiberend: Hi, my name's Maria Tiberend, and I work in the state of Missouri for a physician group. And I'm curious – we have physicians on the Illinois side as well – and I'm curious as to when we could expect to see the QRURs for those providers?

Michael Wroblewski: Hi, Maria, it's Michael Wroblewski, thanks for participating this afternoon. We are in the process of deciding how we – who we are going to disseminate the QRURs to later this year based on 2011 data.

Maria Tiberend: OK.

Michael Wroblewski: And that should be forthcoming. But thank you. I can't tell you right now, but something will be in the works soon.

Maria Tiberend: OK, thank you.

Michael Wroblewski: You're welcome.

Operator: Again, to ask a question, press star one.

And your next question comes from the line of Kristen Prenger.

Kristen Prenger: Hi, I was wanting to know a little bit more information as far as, you're stating that CMS has announced plans to place group practice performance data on the Physician Compare Web site. How are you going to define group practice?

Michael Wroblewski: Hi, Kristen, it's Michael Wroblewski. That's a great question. We indicated in – last year that a group practice would be one that participated in the Physician Quality Reporting System, PQRS, GPRO option, which is the Group Practice Reporting Option.

In 2010, 35 groups participated in that reporting option. And it – there are more based on 2011, and the first year of performance that will be posted will be performance based on 2012. So folks who are participating in the PQRS GPRO option, as it's known, based on 2012 performance.--that data will be the first that goes up on – that performance data will be the first data that goes up on the Physician Compare sometime in 2015.

Kristen Prenger: OK, great. Thank you.

Michael Wroblewski: You're welcome.

Operator: And your next question comes from the line of Dorothy Gallagher.

Dorothy Gallagher: Hello, my name's Dorothy, I'm with an anesthesia group. And I'm wondering how the costs are calculated for anesthesia?

Well I see, you know, one of the reports, better or equal or average of 17 out of 32, or worse, 15 out of 32. How are anesthesia costs calculated?

Michael Wroblewski: Yes, that's a great question, what – the page that you were referring to was the – I think, page two.

Dorothy Gallagher: Yes.

Michael Wroblewski: And that really is a summary page. And what we were doing there was we were looking at the – you asked about anesthesiology costs. What we did is we looked at not – we didn't look at anesthesiology costs or any particular costs in this for this summary page. We were looking at total per capita costs.

What we did is we looked at the total per capita costs for each of the beneficiaries that were attributed to a particular physician and then we as – the cost information is actually in the third section there on the highlights page.

And we looked to see if the physician's costs were on average higher or lower than other specialists in the – or for other physicians in that same specialty.

So the comparison there is a total per capita cost for the patients that are attributed to a particular physician.

Dorothy Gallagher: And that is particular to specialty?

Michael Wroblewski: They were done by specialty, so the comparisons are by specialty.

Dorothy Gallagher: So with anesthesiology, what are the direct costs? We – you know, we bill for the anesthesiologists, obviously. They practice at the hospital. Do you include supplies or drugs used by the anesthesiologists to come up with a cost?

Michael Wroblewski: Yes, if you look – if you look at, I'm going to say, exhibit four.

Dorothy Gallagher: Do you know what page it's on?

Michael Wroblewski: Page – it's on page seven.

Dorothy Gallagher: Page seven, OK. OK, I'm here.

Michael Wroblewski: OK, does it say per capita cost of patients whose care you Directed?

Dorothy Gallagher: Yes.

Michael Wroblewski: OK, so those are the patients – what we listed there were total per capita costs. So these are all the costs that were billed for the patients that were attributed to that physician.

So if you just turn back one page, looking at – on your page, look at page six, exhibit three, and you can see how many patients were Directed.

So you can see maybe it was 20, maybe it was 50. It doesn't really matter, then for those we added up all of the – all the costs and we had an average. And then we broke them down into all those categories.

Now I'll ask Dr. Jeff Ballou, who is with Mathematica Policy Research, is a contractor who's helping us with this. And I have to ask him exactly where anesthesiology costs are in that breakdown.

I'm assuming that they are in the inpatient and outpatient facility services. Is that right, Jeff?

Jeff Ballou: Well, Michael, there – if to the extent there are inpatient and outpatient facility charges associated with them, then that's correct. But many anesthesiology expenses, you know, aside from those billed, for example, by the physician, would fall into the "all other services" line at the bottom of exhibits four, seven, and nine.

So, there's a panel that says "other services," and the very last line is "all other services," and that would include – and there's a detailed list of what

those – what's included in "all other services" in the terms and definitions glossary at the back of the report.

But among other things, anesthesia, materials, and supplies.

Dorothy Gallagher: I see, OK, thank you.

Nicole Cooney: Thank you for your questions. Next question, Holley.

Operator: At this time there are no further questions.

Nicole Cooney: OK, any other comments? It doesn't have to be a question, if you have a comment, something that you'd like to share with CMS, we're here to listen.

Operator: And at this time, we have no one in queue.

Additional Information

Nicole Cooney: OK, give us one second here. All right, thank you so much, everyone. If you think of any additional comments or if you have a comment that you'd like to share with CMS, but you'd rather not speak up on the phone, we certainly can understand that.

If you do have a comment you want to share with us, you could send it to the mailbox: qrur@cms.hhs.gov, which is also listed on slide 21 of today's presentation.

And that's qrur@cms.hhs.gov. If you are sending in a question to the Mathematica e-mail address, that's also listed on that slide for research into specific questions about the data contained within your confidential report.

Please allow appropriate time for the necessary research and response for your questions.

On slide 22 of today's presentation, you'll find information and a URL to evaluate your experience with today's call.

Evaluations are anonymous and strictly confidential. I should also point out—that all registrants for today's call will receive a reminder e-mail from the

CMS National Provider Calls resource box within two business days regarding opportunities to evaluate this call. You may disregard this e-mail if you have already completed the evaluations. We appreciate your feedback.

And at this time, I'm going to see if, Michael, if you had any closing thoughts that you wanted to…

Michael Wroblewski: We appreciate you taking time out to participate in today's call. We hope it was informative and, again, if you have any specific questions or any concerns about the reports, please use the qrur@cms.hhs e-mail box and we'll respond. Thanks very much.

Nicole Cooney: And we'd like to thank everybody for participating today. An audio recording and written transcript of today's call will be posted to the Physician Feedback Program page on the CMS Web site, which is located at the URL – the URL is located on the final slide of today's presentation.

It'll be under the CMS Teleconferences and Events tab in approximately two weeks.

Again, my name is Nicole Cooney and it's been a pleasure serving as your moderator today.

I'd like to thank my co-moderator Wendy Hildt, as well as Dr. Sheila Roman, Michael Wroblewski, and Jeff Ballou for their participation.

Have a great evening everyone.

Operator: Thank you. This does conclude today's conference call. You may now disconnect.