

How to Interpret Your Supplemental 2011 QRUR for Groups: Episodes of Care Call Transcript

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[Slide 1] Sheila Roman: Good afternoon, everyone. This is Sheila Roman at the Centers for Medicare & Medicaid Services. I'd like to warmly welcome everyone this afternoon to this conference on how to interpret your 2011 Supplemental QRURs that you received. I'll start out with some opening remarks on episodes of care and the CMS approach.

[Slide 2] The purpose of this presentation is really to provide you background on the episodes of care, discuss our approach at Medicare here, and to introduce the supplemental reports to you on episode-based costs related to the 2011 Group QRURs, which were provided to you because you participated in the GPRO medical groups.

[Slide 3] So what is an episode of care? I'm sure this is not new to those of you on the call. An episode of care consists of medical and/or procedural services addressing a specific medical condition or procedural event delivered to a patient within a defined time period. The information used for grouping is Medicare claims data. An episode grouper is software that organizes claims data into a set of clinically coherent episodes.

[Slide 4] I think some of the challenges in the logic of an episode are determining: When does it begin? What's the clinical trigger event? When does it end? What are the claims that are included in the episodes? What are the related claims with qualifying diagnoses between the beginning and the end?

[Slide 5] This is illustrated for you on slide 5, which shows you a basic model of an episode. Basically, episodes are opened by medical claims coding rules, relevant and related services are identified and grouped to the episode, and unrelated events not involved in the treatment of the condition are not grouped into the episode of care. We've used clinical work groups that are technical expert panels that Brandeis has put together that make these determinations. Finally, each episode is ended after a specified length of time which is dependent on the condition, or as the result of patient death or certain patient-dominant conditions such as end-stage renal disease.

[Slide 6] So why is CMS in the process of developing its own episode grouper? First of all, the Affordable Care Act required the development of a publicly-available episode grouper. Also, research that has been funded by CMS has found commercially available software to be inadequate for Medicare usage because of lack of transparency and high levels of comorbidities, mortality rates, and utilization among the Medicare population.

[Slide 7] So what's been our strategy? CMS had what has been fondly called a "bake-off" here at the agency and evaluated four prototype groupers in 2011. In 2012, Brandeis Consortium was selected to develop the clinical logic supporting each episode constructed by the CMS grouper over a four year period of time. The Consortium, in addition to Brandeis, includes the American Medical Association, the American Board of Medical Specialties, the Health Care Incentives Improvement Institute, and Booz Allen Hamilton. In addition, there are a number of folks at CMS that are managing the project, and include both clinicians and personnel from the Center for Innovation, the Center for Medicare, the Center

for Clinical Standards and Quality, and the Agency for Healthcare Research and Quality. Additionally, Acumen, LLC, is providing contracting support and data support for this project.

[Slide 8] The 2011 Supplemental QRURs report episodes for five common medical conditions. These are referred to as condition types, and they include pneumonia, acute myocardial infarction, coronary artery disease, percutaneous coronary intervention, and coronary artery bypass graft surgery. These can be further sub-classified into acute condition episodes, chronic condition episodes, and procedural episodes.

[Slide 9] Additionally, these five conditions can be further stratified into episode subtypes which are based on complicating medical occurrences that have relevant clinical differences. For instance, pneumonia has been classified into two subtypes: without an inpatient hospitalization and with an inpatient hospitalization. We're particularly interested in your comments about how we broke down these conditions and whether you agree with us in the way we broke them down and whether it provides you with information that's relevant to you and your management and to evaluating the costs of your services. To complete the slide, acute myocardial infarction was further broken down into without PCI or CABG, with PCI, with CABG, and coronary artery disease into without AMI and with AMI.

[Slide 10] Our approach to episode attribution (attribution is obviously a very big methodological deal) and our philosophy for attribution for episode groupers was to have different attribution rules for different episodes. We're particularly interested in your thoughts about this and whether you think it's reasonable or unreasonable. If we look at the five major episode types that are listed in the table here, you'll see that they're based either on physician fee schedule costs, physician fee schedule costs plus E&M visits, E&M visits, or on the physician performing the surgery. For pneumonia and AMI, it's based on physician fee schedule costs and E&M visits. For coronary artery disease, it's E&M visits. For PCI and CABG, it's the physician performing the surgery. The rationale behind that is that we felt this type of attribution really identified the group that was most involved in directing the patient's care. In the case of the surgeons, the group billing for the surgery was assuming the responsibility for that episode of care.

I'm going to introduce Craig Caplan, my colleague, who will now walk you through the reports themselves and how to read your report.

[Slide 11] **Craig Caplan:** Great, thank you so much, Sheila. We're going to go through a sample report. In the next 21 slides, we'll go through an actual report. You may want to have yours handy as I walk through this. This is the first tab you'll see in the Excel workbook. It's the Overview tab.

[Slide 12] This is pointing out a few things on the Overview tab. "Payment-standardization" and other terms are in bold. These terms are discussed more in the Supplemental QRUR User's Guide, which is included in the link that was sent out as the physician feedback link as well as also on the Acumen website. The bottom shows you can link into five exhibits. The first four we're going to go through in detail. The fifth one is definitions. We're going to go through the reports now, the actual exhibits.

[Slide 13] This is Exhibit 1. This is the first thing you'll see when you open a report. As I'm going through the exhibits, I want you to think about whether the information is useful to you, whether the information is actionable, whether it's understandable. Please think about that as I go through the exhibits. This is Exhibit 1 which is meant to provide a high level overview of your group's mean risk-adjusted costs. It provides just a few pieces of information. It's a list of the 12 episode types that Sheila went through, the number of episodes, the mean risk-adjusted cost for the group, and the percentage difference from the national mean for your group's episodes. By national mean, Acumen took a random

sample of 500,000 Medicare beneficiaries nationwide that had one of the triggering diagnoses or procedures that would have triggered one of the twelve episode types in question. We can see that the first one is just the high level overview. We want to note that this slide provides the group's mean risk-adjusted cost, and we want to note that all costs are payment-standardized and unless noted otherwise, costs are risk-adjusted.

[Slide 14] We're continuing Exhibit 1, and I just want to point out a few things about Exhibit 1. The number you can see in the small box is \$14,150, and it has an asterisk next to it with the term "Low." The asterisk indicates this is statistically significant. The significance is defined more in the User's Guide. The term "Low" means that it's statistically significantly below the national average. I just want to note at the bottom that the results should be interpreted with caution when there are fewer than 10 episodes in an episode type that are attributed to a group.

[Slide 15] We're on Exhibit 2 now. This is the summary of medical group episode costs in comparison to the national benchmark. When we're going through this, again, think about whether this is useful to you, whether the information is understandable and actionable. All the 12 episode types are listed. You can compare the average non-risk-adjusted costs and average risk-adjusted costs to see what risk-adjustment does to your non-risk-adjusted cost. You can also make comparisons with your average risk-adjusted costs to the national sample, and you can also isolate the top 20% of your episodes and how that compares to the national sample. The first thing I want to point out is that all 12 episode types are listed on the left-hand side. Three have subtypes (pneumonia, AMI, and CAD, as Sheila discussed), and then there's PCI and CABG. Pneumonia, for example, is broken down into pneumonia without inpatient hospitalization in the episode and with inpatient hospitalization in the episode.

[Slide 16] Now we're going to look at the average non-risk-adjusted costs and we're going to focus on PCI without AMI in the episode. It's \$15,773, the average non-risk-adjusted cost.

[Slide 17] And we can see what happens as a result of risk adjustment to your average cost. In this case, the risk adjustment brings up the cost slightly. If the average risk-adjusted cost is greater than the average non-risk-adjusted cost that means your patient population is less complex than average. Vice versa; if risk adjustment drops your non-risk-adjusted cost then that means your patient population is more complex than average.

[Slide 18] As I've mentioned you can make comparisons between your average risk-adjusted cost and the nationwide sample. In this case, looking again at the PCI without AMI in the episode, it's \$15,800 for the average risk adjusted cost of the group compared to the nationwide sample. In this case, it's greater than the nationwide sample.

[Slide 19] We're on the last slide of Exhibit 2. As I mentioned, you can isolate the top 20% highest costing episodes. The wider box in the center is your highest cost 20% of the episodes, and so it's pretty much lining all of the episodes attributed to your group from the lowest cost to the highest cost and then chopping it off looking at just the top 20%, so 28 out of 141 PCI without AMI in the episode, looking at the average cost there. You can also look and see how many of your episodes are above the 80th cost percentile nationally. Here we line up all in the national from lowest to highest all the costs and look at the top 20%, the 80th percentile and above. You can see that for PCI without AMI in the episode there are disproportionate numbers, there are 34 compared to the 28 out of 141.

[Slide 20] The previous slide showed risk-adjusted cost overview and showed you're able to compare with the national benchmark and see the top 20%. This slide, Exhibit 3, and we're going to spend the next seven slides on this, gives the service category breakdown by episode type. You can look at for each episode type which service categories make up the most costs. You can also see what percent of episodes of each type include particular service categories. Also, you can make comparisons with the nationwide sample. And again, please think about whether this is useful information, whether this is informative. First thing I want to point out on this is that the list of all the service types, this is PCI without AMI, the 141 episodes that were talked about. Note at the bottom that this exhibit shows non-risk-adjusted cost because risk-adjustment is done at the whole episode level rather than at the service category/claim level. But the relative proportions of these service categories will remain the same, how they affect costs.

[Slide 21] You can see the first thing is the share of total non-risk-adjusted costs and, for example, inpatient hospital facility services made up 49% of this group's average costs, for its 141 PCI without AMI episodes. Outpatient hospital facility services was 35%. These add up to 100% - these are shares of the total non-risk-adjusted cost.

[Slide 22] We're moving further to the right of Exhibit 3, the percent of episodes with any service use in this category. You see that 53% of the PCI without AMI episodes, the 141 that were attributed to this group, use any inpatient hospital facility services, and 87% use outpatient hospital facility services. You can look at this distribution, and since episodes include multiple service categories, they add up to more than 100%.

[Slide 23] We can also look at the average non-risk-adjusted cost of any service cost of any use. For 53% of the episodes that included inpatient hospital facility service use, the average cost was \$14,484. You can do this for the other service categories as well.

[Slide 24] For example, the inpatient hospital facility services were 49% of the total non-risk-adjusted costs, and compare that to the 46% share of total non-risk-adjusted costs nationwide.

[Slide 25] We are on 6 of 7, slide 25. This can also allow comparison with the nationwide sample of the percent of episodes with any service use in this category. Recall that 53% of the PCI without AMIs attributed to the group used inpatient hospital facility services, which can be compared to the nationwide sample of 50% using inpatient.

[Slide 26] Slide 7 of 7, slide 26. In Exhibit 3, you can also make comparisons to the average non-risk-adjusted cost of service category with any use between the groups and nationwide sample. For inpatient hospital facility services, for example, \$14,484 compared to the nationwide sample \$13,669. So this Exhibit 3 shows you can which service categories attributed most to your cost of the episodes that are attributed to your group. Also you can make comparisons with nationwide of that amount. You can also look at different episodes, different service category types and what percentage of the episodes included that service category and make that comparison to the nationwide sample.

[Slide 27] We are on the last exhibit, which is Exhibit 4. You can download the data on this if you have not done so already. There is a rich set of information. If it is in Excel you can sort the data a number of ways – for example episode ID, episode type – you can click the downward arrow that sorts the data different ways. So this is a big exhibit. This is many rows, there is one for each episode that was attributed to your group. Every episode that was attributed to your group will be listed here. There is also a lot of information, other information – overall information about the episode.

There is also service category breakdown for services delivered by your group, as well as delivered outside your group. I will go through this when we go through the next 5 slides. The first thing I want to point out is we are going to stick with the same episode ID, this 74347 – the one that is boxed – and this is a PCI without AMI episode that was attributed to this group. We can see that the risk adjusted cost percentile in the major episode type and then the risk adjusted cost percentile in the episode subtype nationally the two right hand columns of this figure is both 97% and so this numbers are always going to be the same for PCI and CABG because there are no subtypes for this. For when we went through the episode types of the pneumonia, AMI, and CAD all have different subtypes. And so if it was pneumonia without an inpatient hospitalization and the major episode type would be pneumonia and the subtype would be pneumonia without inpatient hospitalization.

[Slide 28] This exhibit, Exhibit 4, identifies a suggested lead EP for each episode. CMS defines EPs as those paid under the fee schedule. The suggested EP was just provided for information purposes, and only EPs that were clinically appropriate specialties for that episode type were included. There is a lot more detail provided on this subject in the User Guide. Acumen worked hard on defining these clinically appropriate specialties for the episode types.

[Slide 29] We are on now, 3 of 5 of Exhibit 4, continuing the inventory of the episodes attributed to this group. Now we are going to look at the Exhibit 4A, sticking with the same episode ID, the 74347 row. We can look at the service category breakdown for claims billed for your medical group practice. For this medical group practice we can see, for example, that 44% of the costs were for professional E&M services in all non-emergency settings and 47% were for procedures in all non-emergency settings. These numbers add up to 100%.

[Slide 30] This is Exhibit 4B, which is again scrolling further to the right on Exhibit 4. This is the percent of all service category costs from claims billed by other medical group practices and facilities. There are so many different service types that can be billed outside the group that this had to continue onto two slides. If it was on one slide, you couldn't read it.

[Slide 31] For example, this episode, the same episode ID, 52% of the costs billed by other medical group practices or facilities in this episode were for inpatient hospital facility services, and 14% were for outpatient hospital facility services.

[Slide 32] You can see that this continues onto this slide. For example, 11% were for home health, and 10% were for ambulance, so all these costs add up to 100% billed outside the medical group practice or facility.

[Slide 33] This brings us to the concluding slides. We really look forward to receiving feedback from the groups. Sheila mentioned a couple of areas that we really want feedback on, such as how we divided up certain episode types like pneumonia and CAD and AMI, and do those make clinical sense, as well as any thoughts on the appropriateness of the attribution, and also we want a lot of feedback on the usefulness of this report. This is an early prototype, and there is still time to incorporate feedback on these reports and on the grouper. The next week, August 1st, next Thursday, we will have a follow up call to present a high level overview of findings as well as we want your feedback to the Supplemental QRURs. The last bullet is that the CMS Episode Grouper will continue to evolve over the next 3 years. There will also be other opportunities to provide feedback to the grouper.

Thank you so much for participating, and I will hand this back to Acumen.

Camille Chicklis: Ok, great. I think we have time left for questions. Everyone's line should be unmuted.

Phillip Bongiorno: I have a question.

Camille: Sure. Please, for everyone's benefit, identify yourself and what group you are associated with.

Phillip Bongiorno: Sure. This is Phil Bongiorno, I'm with the Society of Thoracic Surgeons. I just had a question just on the source of your data relative to risk adjustment. What data are you using to determine risk when you talk about risk adjustment?

Camille: This is Camille Chicklis from Acumen. We're using claims data for the beneficiaries prior to the start of the episode. So all of their Medicare claims history.

Phillip Bongiorno: So you are not using any data from clinical registries? Correct?

Camille: That's correct. It is just Medicare claims.

Phillip Bongiorno: Ok. Thank you.

Jason Shropshire: Hi, this is Jason Shropshire. I have a question.

Camille: Sure, go ahead.

Jason Shropshire: How are we to provide feedback to you? Email, or who do we contact?

Camille: Sure, we have two methodologies. If you're from one of the groups that received a Supplemental QRUR, you can use the discussion board through the same web portal through which you downloaded your report. That's one option. Otherwise, if you're not from one of those groups, you can email the QRUR episodes inbox, which is QRUREpisodes@AcumenLLC.com. I think that email address should be included in the webinar invite.

Jason Shropshire: Thank you!

Sheila: This is Sheila Roman. You can obviously call myself or Craig Caplan directly. My email would be Sheila.Roman@CMS.HHS.gov, and Craig's is Craig.Caplan@CMS.HHS.gov.

Karen McKnight: Sheila, this is Karen McKnight. Can you repeat those?

Sheila: So our emails here at CMS would be, mine would be Sheila.Roman@CMS.HHS.gov. For Craig: Craig.Caplan@CMS.HHS.gov. And obviously if you have any initial thoughts, and your initial reaction to these reports.

Mark Briesacher: Hi, this is Mark Briesacher from Intermountain Health Care. Could you repeat for me the size of the sample that was performed, and also could you share with us what the upper and lower control limits are for statistical significance based on that sample size?

Camille: Sure, this is Camille Chicklis from Acumen. The sample of beneficiaries for the groups was about 540,000 fee-for-service beneficiaries, and the national sample that it was compared against was 547,000 fee-for-service Medicare beneficiaries. We did statistical testing at the 5% level.

Mark Briesacher: Great, thank you!

Tom Yaeger: This is Tom Yaeger from Guthrie Health. Would you discuss how you determined the duration of attribution? Depending on the measure, it went from 30 days to 365 days, and that didn't quite make sense how you came up with duration of attribution.

Camille: Sure. The duration of episodes was determined by clinical working groups at Brandeis and the other organizations listed. Certain episodes were considered to be chronic and ongoing such as CAD while others were more short term - PCI, for example. This is basically what informed the length of the episode window. Did that answer your question?

Tom Yaeger: It does. The CAD though, these patients were sometimes hospitalized, and I assume it was for something like chest pain without MI. It seemed like there was some cross-over between the groups. I guess I'm still trying to ponder how you would ever close an episode.

Sheila: This is Sheila Roman. I think you're bringing up a good point about CAD. For instance, AMI, PCI, CABG would also open an episode for CAD. And, Camille correct me if I'm wrong, but I think every time there was an episode trigger for an episode of CAD, the window was a year. But, every episode kept extending it another year.

Tom Yaeger: Were patients in more than one group? So if they have PCI, they also have CAD. Or were the groups mutually exclusive?

Sheila: The groups were not mutually exclusive. You could be in more than one episode at the same time.

Tom Yaeger: Okay.

Sheila: Do you think that's appropriate, or do you think that's problematic?

Tom Yaeger: I guess I would group them all as CAD. Given how PCI works now, once they've had a successful stent in place, they're basically treated like they've got CAD. So, I don't really see why the duration of attribution would be much different between PCI and CAD.

Camille: Sure. This is Camille from Acumen. Each of those episode types (PCI, CABG, and AMI) automatically open an episode of CAD. So, if the patient has a PCI, they also will have a CAD episode open at the same time, and we look at those episodes separately so that we can see the costs of the chronic ongoing condition and the costs of the acute episode of PCI. But, you're quite right; both of those episodes will be open for that patient.

Tom Yaeger: Okay, that helps a lot.

Sheila: And, this is Sheila Roman, you should be able to verify that in your report.

Tom Yaeger: This is Tom Yaeger from Guthrie again. Given the enormity of the data, I'm wondering how other groups would use this to analyze their costs. Especially the call about who the assigned physician is. In our data, we have nurse practitioners listed, and they weren't the drivers of the cost for anyone who was in the hospital.

Sheila: So, you're suggesting that the nurse practitioner was the suggested lead EP?

Tom Yaeger: In some cases, yes. But that would have been the follow-up provider, while the nurse practitioner midlevel might have been responsible for the plurality of visits, they weren't responsible for the plurality of costs, which happened in the hospital.

Sheila: I hear you. That's a fair point. Did you have a suggestion on how we should do it differently?

Tom Yaeger: So, what you'd really like to do is to avoid the episode at all. So, since you said in another context you could identify data before the beginning of the episode, it seems you'd want to identify the plurality of visits before the episode as an approximate measure of who the PCP was. So, if it's a

cardiologist managing CAD, was that preventable. So I would use the same methodology and just go before the episode.

Sheila: I understand what you're saying. I think that again that's a fair point. Did people think that the group attribution was okay, was fair?

Jonathan: Hi, this is Jonathan B-. We actually had a question about the group attribution. So, for the ones where you're using physician fee schedule costs and E&M visits, how are you using those in conjunction with one another?

Camille: Hi, this is Camille from Acumen. So, in those cases, we're checking to see which group had either the plurality or shared majority of physician fee schedule costs or the plurality or shared majority of E&M visits. So, episodes can be attributed to more than one medical group.

Jonathan: Oh, okay. So, you're actually using both methodologies. So, I guess it depends on how this data will be used in the future. I think that's potentially problematic if episode were attributed to multiple group practices.

Sheila: What's your reasoning?

Jonathan: Well, again it depends on how the data is being used. But, if you're seeking to determine one group practice who's responsible for patients' care, then I think it's very challenging for a group to mobilize and try to improve care, to reduce cost, if we don't know if we're the ones responsible for that patient's care and if the patient is in someone else's denominator, if you will, as well. That also aligns with other programs like PQRS.

Sheila: Thanks for the comment.

Craig: This is Craig Caplan. We want to find out, is this what you expected? Is this what you wanted of this session? Or in the reports?

Unidentified: I have to actually sit down and go through this now with some other people. I wasn't able to interpret the report when I first downloaded it and had to wait until today's session, so I'll have to spend some time with the report before I can really answer that.

Craig: Okay, that's actually what today's session was for: to help you wade through the report.

Unidentified: I mean we're supposed to use this as a basis to decide whether to participate in the quality tiering, and I hope that we'll be able to make that decision after we go through our report.

Sheila: This is Sheila Roman again, and I would caution you that actually this information was not provided to you for that purpose at all. Really, it's the information within your QRURs that you received at the end of the year that you should be looking at to inform you whether you want to do quality tiering. I would caution you that this is really the earliest prototype of our episode grouper, and this is really our first experience with putting the data together and grouping it. So, really the intention is not to use this data for your decision on quality tiering.

Unidentified: Which report are we supposed to use?

Sheila: You will be receiving a report of your 2012 data on September 16th. It's really that data that you should be using to make your quality tiering decision. It's really the best data for you to be using.

Unidentified: Okay.

Sheila: Additionally that QRUR will contain the quality composite and the cost composite. So, it will show you how you will tier.

Unidentified: Okay, thanks.

Brett Grady: Hi, this is Brett Grady with Mercy Health System. I have a quick question about Exhibit 4. I noticed under Exhibit 4A there is no inpatient hospital services, but under 4B there is. Can you explain that?

Craig: Yeah, 4A is just billed by your medical group practice and so the medical group practice would have to own the hospital.

Brett Grady: In our case, we do. We're all one. So I guess where I get confused, I'm looking at some of our highest cost cases, and the suggested lead EP would be doctors that only practice in the hospital, only inpatient, yet our costs in 4A are very low and then our costs in 4B are very high. We may be set up differently than others, but within our health system are three hospitals.

Craig: Acumen, do you have any input?

Sajid: This is Sajid Zaidi from Acumen. The way the claims data are structured, the inpatient claims are a facility claim and there isn't an easy way to map the tax ID for that facility to the physician claims, so in 4A we're just looking at professional claims which have the tax ID identifier on them.

Brett Grady: So, let's say I have a critical care doctor who's showing up here a lot in 4A. So you're saying that his professional claims aren't getting through and that his facility claims are separate?

Sajid: Yes, exactly, the facility claims are a separate category and we didn't link those back to the physician tax ID.

Brett Grady: Okay, so it looks to me like a lot of our costs are outside of the system whereby maybe they're just in the hospital.

Sajid: Yeah.

Brett Grady: Thank you, that helps.

Sajid: In 4B you can also look at the physician costs that were outside your group. So you can get at what other physicians were treating the patient.

Brett Grady: Great, thank you!

Craig: We have another 5 minutes. Does anyone have any additional questions?

Shaifali Ray: This is Shaifali Ray from UHC. I have a question as well about Exhibits 4A and 4B. In regards to the All Services Costs, I noticed that they're non risk adjusted, but it's showing the costs for the whole episode. Is there a reason why that's not risk adjusted, and would there be an opportunity to get that risk adjusted in the future?

Craig: This is Craig Caplan. I'll have Acumen jump in, but I think because the risk adjustment happened at the overall episode level, it's not done at the service category level, so you have to use the non-risk-adjusted costs. I mean, the share of costs will be the same, just the dollar amounts will be different due to risk adjustment, but the shares will be the same whether you use non risk adjusted or risk adjusted costs because risk adjustment is done at the whole episode level. Acumen, do you have anything to add?

Camille: No, that's correct. Thanks, Craig.

Sharon McIlrath: This is Sharon McIlrath at AMA, on the risk adjustment, I'm sure this is in the User Guide which I haven't had time to go through, but is the risk adjuster the HCC model or is there a different risk adjuster?

Camille: Hi, this is Camille from Acumen. The risk adjustment model uses CMS's CCs instead of the HCCs as well as several other indicators of health status that Brandeis developed independently. If you do get a chance to look at the User's Guide, this is in the appendix in section A4. The health status measures include 54 of the CCs, typical condition indicators, complication indicators, and procedures.

Sharon McIlrath: Thank you.

Craig: Well, I think we're almost out of time. We want to thank you for this very informative discussion, and the next call is going to be next Thursday, August 1st.