Succeeding in the Quality Payment Program:

the Merit Based Incentive Program

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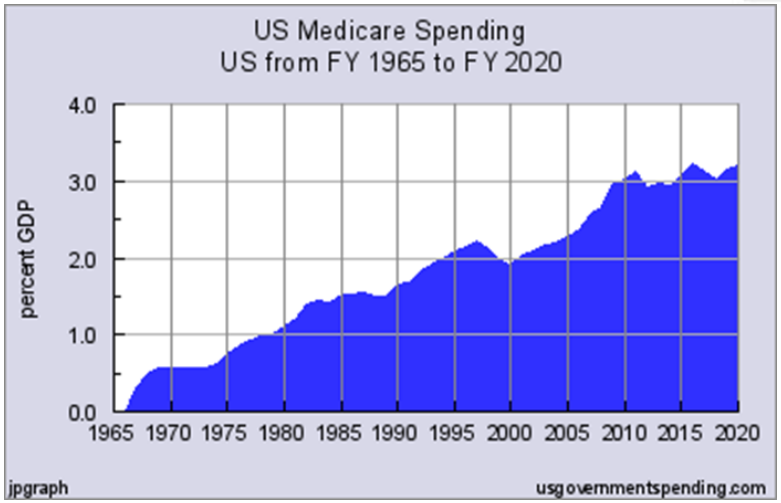
What is MACRA?

Medicare Access and CHIP Reauthorization Act

- A bipartisan bill signed into law in April 16, 2015 - moves away from Fee-for-Service and eliminates the Sustainable Growth Rate (SGR).



The **Quality Payment Program**, initiated by MACRA, is comprised of two pathways in which clinicians will participate in order to receive Medicare payment:

- **The Merit-Based Incentive Payment System (MIPS) and**
- **Advanced Alternative Payment Models (Advanced APMs).**

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Merit-Based Incentive Payment System

- Providers to be rewarded for ***Quality of Care over Quantity of Services***.
- Preventive care, quality and cost-effectiveness to be rewarded.
- Combines existing quality reporting programs into one new program.
  - Physician Quality Reporting System (PQRS)
  - Meaningful Use Incentive
  - Value Modifier Program

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Who Will Participate in MIPS?

- For the 2017 the following clinician types can participate in MIPS:
  - Physicians including:
    - Medicine, Osteopathy, Dental Surgeons, Dentists, Podiatrists, Optometrists, Chiropractors
  - Physician Assistants
  - Nurse Practitioners
  - Clinical Nurse Specialists
  - CRNAs
  - *Any clinician group that includes one of the professionals listed above*

Inclusions/Exclusions for QPP/MIPS

- **Included:** Clinics who bill Medicare more than **$30,000** in Part B allowed charges a year **and** provide care for more than **100** Medicare patients a year are in the QPP program. *You must meet both the minimum billing and the number of patients to be in the program.*

- **Excluded:** Clinicians practicing in RHCs or FQHCs *who provide services billed exclusively under RHC or FQHC payment arrangements* are not required to participate in *MIPS—However, if these providers bill for services under the Physician Fee Schedule they would be included in MIPS.*

- **Excluded:** Newly enrolled clinicians—clinicians enrolled for the 1st time during a performance period.

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QPP.CMS.GOV

Quality Payment
PROGRAM

MIPS
Merit-based Incentive Payment System

APMs
Alternative Payment Models

About
The Quality Payment Program

Modernizing Medicare to provide better care and smarter spending for a healthier America.

Check your participation status

Enter your National Provider Identifier (NPI) number

NPI Number

Check NPI

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Your Status –Name/ NPI / # TINs

If the clinician reports as a individual	If the clinician reports as a group *
Included in MIPS	Included in MIPS
This clinician has billed Medicare for more than $30,000 and has provided care for more than 100 patients at this practice.	This practice has billed Medicare for more than $30,000 and has provided care for more than 100 patients.

Special Status At This Practice

View descriptions of each special status

For this clinician at this practice		For this practice	
Non-Patient Facing	No	Non-Patient Facing	No
Hospital Based	No	Hospital Based	No
Small Practice	Yes	Small Practice	No
Rural	Yes	Rural	Yes
Health Professional Shortage Area (HPSA)	Yes	Health Professional Shortage Area (HPSA)	Yes

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Special Status

- There are special reduced requirements for the **improvement activities** category under MIPS for Small, Rural and Health Professional Shortage Areas (HPSAs):
  - MIPS eligible clinicians in practices with 15 or fewer clinicians and solo practitioners;
  - Clinicians in designated rural areas; and
  - Clinicians working in designated Health Professional Shortage Areas (HPSA).

- Special Status – **Improvement Activity Points Doubled**
  - Each medium-weighted activity is worth **20 points** of the total Improvement Activity performance category score, and
  - Each high-weighted activity is worth **40 points** of the total category score.

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MIPS: Payment Adjustments

MIPS is ***budget neutral***. Penalized providers will subsidize the bonuses for high performing providers.

Reporting Year	Payment Adjustment Year	Negative Adjustment	Bonus Adjustment Expected
2017	2019	- 4%	+ 4%* x incentive
2018	2020	- 5%	+ 5%* x incentive
2019	2021	- 7%	+ 7%* x incentive
2020	2022	- 9%	+ 9%* x incentive

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MIPS Categories

Quality	Improvement Activities	Advancing Care Information	Cost
Replaces PQRS.	New Category.	Replaces the Medicare EHR Incentive Program also known as Meaningful Use.	Replaces the Value-Based Modifier.

The cost category will be calculated in 2017, but will not be used to determine your payment adjustment. In 2018, we will start using the cost category to determine your payment adjustment.

Quality	Improvement Activities	Advancing Care Information	Cost
2017	2017	2017	2018

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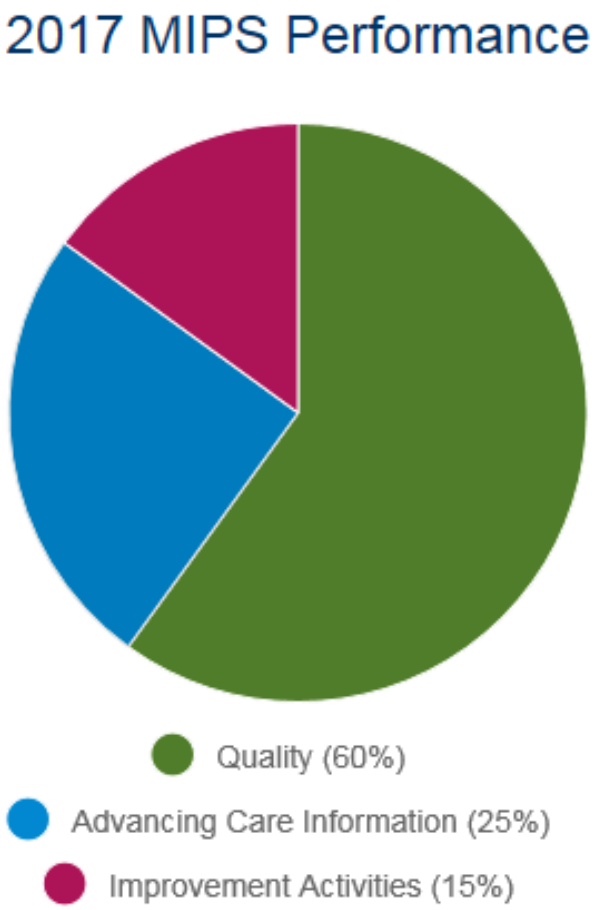
MIPs Category Weights for 2017



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Quality Performance Category

Overview

- Selection of **six measures**
- Must include one **outcome measure**, **intermediate outcome**, ***or another high-priority measure if outcome is unavailable***
- Group may select from individual measures or a specialty measure set
- **Transition Year —Weight 60%**

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- General Practice/Family Medicine

Select Measures

SEARCH BY KEYWORD

Filtered | Search for... | SEARCH

FILTER BY:

High Priority Measure | Data Submission Method | Specialty Measure Set

Clear All Filters | General Practice/Family Medicine

- Administrative Claims
- Claims
- CSV
- CMS Web Interface
- EHR
- Registry

Showing 55 Measures

Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use — REMOVE

Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse) — ADD

Selected Measures

21 Measures Added

Download (CSV) | Clear All

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Measure Available by Method

- General Practice/Family Medicine
  - Registry = 50 measures available (6 outcome measures)
  - EHR = 23 measures available (3 outcome measures)
  - Claims = 21 measures available (2 outcome measures)

- Three most common outcome measures
  - Controlling High Blood Pressure - #236
  - Diabetes A1c > 9% - #1
  - Depression Remission in 12 months - #370 *(not available in claims)*

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Quality Measure Scoring

- Your reported rates are compared to benchmarks
- Download from https://qpp.cms.gov/about/resource-library

Documents & Downloads

Document Name (size)	Type	Date Updated
2017 CAHPS for MIPS Survey – Sample Copy (341KB)	PDF	May 25th, 2017
2017 CAHPS for MIPS Survey Vendors (142KB)	PDF	August 10th, 2017
2017 CMS-Approved Qualified Clinical Data Registries (QCDRs) (1.9MB)	PDF	July 13th, 2017
2017 MIPS Quality Performance Category Scoring for MSSP and Next Generation ACOs (604KB)	PDF	July 13th, 2017
2017 Qualified Registries (977KB)	PDF	July 13th, 2017
2017 Quality Benchmarks (193KB)	ZIP	December 29th, 2016
A Quick Start Guide to the Merit-based Incentive Payment System (MIPS) (568KB)	PDF	July 13th, 2017
Advancing Care Information for Vendors (82KB)	PDF	December 29th, 2016

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Quality Measure Benchmarks

- Benchmarks vary by Reporting Method
- # 236 Controlling High Blood Pressure - Outcome Measure
- *Note: This is a positive outcome measure (higher is better)*

Submission _Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out
Claims	57.69 - 63.44	63.45 - 68.28	68.29 - 72.78	72.79 - 77.06	77.07 - 81.47	81.48 - 86.75	86.76 - 93.42	>= 93.43	No
EHR	50.00 - 55.39	55.40 - 59.72	59.73 - 63.59	63.60 - 67.38	67.39 - 71.00	71.01 - 75.33	75.34 - 80.89	>= 80.90	No
Registry /QCDR	51.00 - 58.20	58.21 - 63.56	63.57 - 68.27	68.28 - 72.40	72.41 - 76.69	76.70 - 82.75	82.76 - 91.06	>= 91.07	No

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Quality Measure Benchmarks

- Note that benchmarks vary by Reporting Method
- #1 - Diabetes Hemoglobin A1c Poor Control (> 9%) – Outcome Measure
  - *Note: This is a negative outcome measure (lower is better)*

Submission Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Topped Out
Claims	35.00 - 25.72	25.71 - 20.32	20.31 - 16.23	16.22 - 13.05	13.04 - 10.01	10.00 - 7.42	7.41 - 4.01	<= 4.00	No
EHR	54.67 - 35.91	35.90 - 25.63	25.62 - 19.34	19.33 - 14.15	14.14 - 9.10	9.09 - 3.34	3.33 - 0.01	0	No
Registry /QCDR	83.10 - 68.19	68.18 - 53.14	53.13 - 40.66	40.65 - 30.20	30.19 - 22.74	22.73 - 16.82	16.81 - 10.33	<= 10.32	No

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Quality Points Based on Deciles

- Each of the six measure are assigned points - added for a maximum of 60 points
- All Cause Readmission rate in large groups adds up to 70 points maximum

Individuals or Groups

3 to 10 points possible for each measure X 6 measures = 60 POINTS

Groups >=16 w/All Cause Readmission Measure

3 to 10 points possible for each measure X 7 measures = 70 POINTS

All Cause Readmissions applicable to provider groups with over 200 attributed hospitalizations

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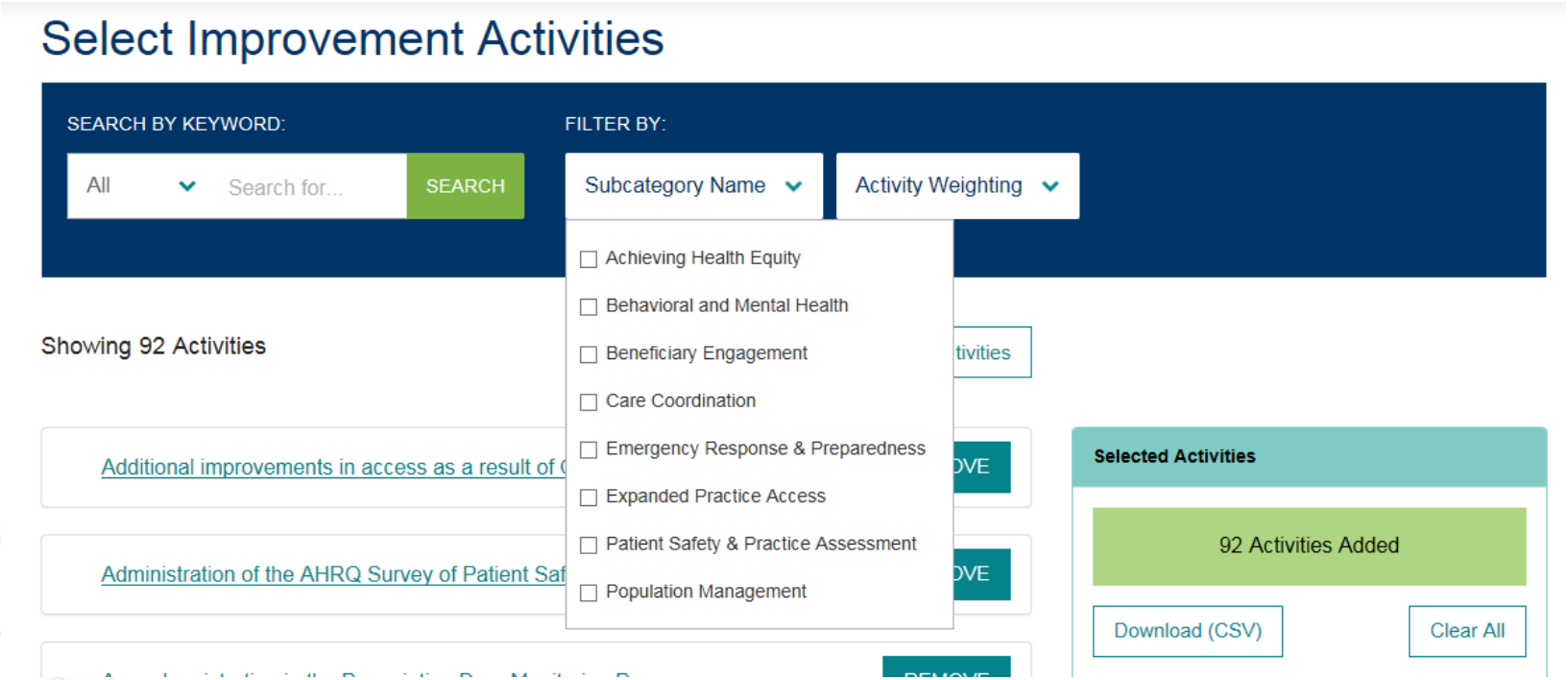
Improvement Activities – Weight 15%

- Flexibility to choose from 92 different Improvement Activities. https://qpp.cms.gov/mips/improvement-activities
- The Improvement Activities require a simple attestation: Must keep documentation for 6 years – must be performed for 90 days



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MIPS Scoring for Improvement Activities

15%

Total points = 40

Activity Weights	Alternate Activity Weights*	Full credit for clinicians in a patient-centered medical home, Medical Home Model, or similar specialty practice
- Medium = 10 points - High = 20 points	- Medium = 20 points - High = 40 points *For clinicians in small, rural, and underserved practices or with non-patient facing clinicians or groups	

Improvement Activities

- Patients with Diabetes

Activity Description	Activity ID	Category	Weight
Engagement with a Quality Innovation Network Quality Improvement Organization, which may include participation in self-management training programs such as diabetes.	IA_BE_3	Bene Engagement	Medium
Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified EHR technology.	IA_BE_15	Bene Engagement	Medium
Provide peer led support for self-management.	IA_BE_18	Bene Engagement	Medium
Use group visits for common chronic conditions (e.g., diabetes).	IA_BE_19	Bene Engagement	Medium
Provide condition -specific chronic disease self management support programs or coaching or link patients to those programs in the community.	IA_BE_20	Bene Engagement	Medium
Provide self-management materials at an appropriate literacy level and in an appropriate language.	IA_BE_21	Bene Engagement	Medium
Provide coaching between visits with follow-up on care plan and goals.	IA_BE_23	Bene Engagement	Medium

Practice Improvement Activities

The Quality Payment Program provides four practice improvement activities that could include immunization-based activities. Most practices will need to attest to four activities.

Improvement Activity	Activity ID	Activity Weight (Points)	Activity Examples
Additional improvements in access as a result of QIN-QIO Technical Assistance	IA_EPA_4	Medium (10 points)	Expanded hours for patients to receive vaccinations, holding a flu clinic, allowing walk-in vaccinations or another recommended action to improve access to vaccinations.
Chronic care and preventative care management for empanelled patients	IA_PM_13	Medium (10 points)	Using the registry functions of your electronic health record (EHR) to identify patients due for vaccinations and sending reminders electronically, by phone, or mail.
Use of decision support and standardized treatment protocols	IA_PSPA_16	Medium (10 points)	Turning on EHR notifications or reminders for vaccinations or implementing a standing orders protocol empowering nursing staff to give vaccinations.
Implementation of formal quality improvement methods, practice changes or other practice improvement processes	IA_PSPA_19	Medium (10 points)	Engage all staff in identifying and testing immunization-based practices changes; Designate regular team meetings to review immunization data and plan improvement cycles.

Improvement Activities

Activity Description	Activity ID	Category	Weight
Performance of regular practices that include providing specialist reports back to the referring MIPS eligible clinician or group to close the referral loop or where the referring MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the certified EHR technology.	IA_CC_1	Care Coordination	Medium
Develop pathways to neighborhood/community based resources to support patient health goals that could include one or more of the following: Maintain formal (referral) links to community based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information; and/or Provide a guide to available community resources.	IA_CC_14	Care Coordination	Medium
For outpatient Medicare beneficiaries with diabetes and who are prescribed **antidiabetic agents** (e.g., insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having: For the first performance year, at **least 60 percent** of medical records with documentation of an individualized glycemic treatment goal that: a) Takes into account patient specific factors, including, at least 1) age, 2) comorbidities, and 3) risk for hypoglycemia, and b) Is reassessed at least annually. The performance threshold will increase to **75** percent for the second performance year and onward. Clinician would attest that, 60 percent for first year, or 75 percent for the second year, of their medical records that document individualized glycemic treatment represent patients who are being treated for at least 90 days during the performance period.	IA_PM_4	Population Management	High

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Advancing Care Information – 25%

- Advancing Care Information Performance Category is broken into three sections:
  - Base Score,
  - Performance Score, and
  - Bonus Score.

- **Option 1:**
  - Advancing Care Information - 15 measures

- **Option 2:**
  - 2017 Advancing Care Information Transition - 11 measures

- **Transition Year Weight—25%**

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Advancing Care Information: ACI

Option 1: ACI

Base Score—50 points

- e-Prescribing
- Patient Access *
- Request/Accept Summary of Care *
- Security Risk Analysis
- Send a Summary of Care *

* Performance Score up to 10%

Option 2: ACI Transition

Base Score—50 points

- e-Prescribing
- Patient Access *
- Security Risk Analysis
- Send a Summary of Care *

* Performance Score up to 20%

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Advancing Care Information: ACI

Option 1 - Performance 90 points

- Clinical Data Registry Reporting
- Clinical Information Reconciliation ***
- Electronic Case Reporting
- Immunization Registry Reporting *
- Patient-Generated Health Data *
- Patient-Specific Education *
- Public Health Registry Reporting
- Secure Messaging *
- Syndromic Surveillance Reporting
- View, Download and Transmit (VDT)*

*Performance

*** More than just medications, includes allergies, diagnoses of a new patient.

Option 2 – Performance 90 points

- Specialized Registry Reporting ***
- Medication Reconciliation *
- Immunization Registry Reporting *
- Patient-Specific Education *
- Secure Messaging *
- Syndromic Surveillance Reporting
- View, Download, or Transmit (VDT) *

*Performance

*** 5% Bonus if specialized registry is a public health data or clinical data registry.

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https://qpp.cms.gov/docs/QPP_ACI_Fact_Sheet.pdf
qpp.cms.gov
File Edit Go to Favorites Help
HHQI - Home Small Business Marketing ... Community Commons S... AHRQ R18 Grant - Home

How is the Performance Score Calculated?

The performance score is calculated by using the numerators and denominators submitted for measures included in the performance score, or for one measure, by the yes or no answer submitted.

The potential total performance score is 90%. For each measure with a numerator/denominator, the percentage score is determined by the performance rate. Most measures are worth a maximum of 10 percentage points, except for two measures reported under the 2017 Transition measures, which are worth up to 20 percentage points.

Performance Rates for Each Measure Worth Up to 10%	
Performance Rate 1-10 = 1%	Performance Rate 51-60 = 6%
Performance Rate 11-20 = 2%	Performance Rate 61-70 = 7%
Performance Rate 21-30 = 3%	Performance Rate 71-80 = 8%
Performance Rate 31-40 = 4%	Performance Rate 81-90 = 9%
Performance Rate 41-50 = 5%	Performance Rate 91-100 = 10%

Example: If a MIPS eligible clinician submits a numerator and denominator of 85/100 for the Patient-Specific Education measure, their performance rate would be 85%, and they would earn 9 out of 10 percentage points for that measure.

The only performance score measure that is yes/no is the Immunization Registry Reporting measure. MIPS eligible clinicians in active engagement with a public health agency to submit immunization data who submit a "yes" for this measure would receive the full 10%.

Advancing Care Information: Bonus

Option 1 - Bonus – 15%

- Syndromic Surveillance Reporting
- Electronic Case Reporting
- Public Health Registry Reporting
- Clinical Data Registry Reporting

10% Bonus

Report certain Improvement Activities using CEHRT

Option 2 - Bonus - 15%

- Syndromic Surveillance Reporting
- Specialized Registry Reporting

10 % Bonus

Report certain Improvement Activities using CEHRT

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Advancing Care Information: Scoring

- Use of CEHRT in Improvement Activities - ***10% Bonus for any one activity***

Improvement Activity Category	Activity	Weight	Related ACI Measures
Glycemic Management Services	Documentation of an individualized glycemic treatment goal 60% first year, 75% second year	High	• Provide Patient Access • Secure Messaging • Care Coordination through Patient Engagement measures
Care Coordination	Implementation of use of specialist reports back to referring clinician to close referral loop	IA_CC_1 Medium	• Send a Summary of Care • Request/Accept Summary of Care • Clinical Information Reconciliation
Beneficiary Engagement	Use of certified EHR to capture patient reported outcomes	IA_BE_15 Medium	• Provide Patient Access • Patient Specific Education • Care Coordination through Patient Engagement measures
Population Management	Implement chronic and preventive care management on empaneled patients	IA_PM_13 Medium	• Send a Summary of Care • Request/Accept Summary of Care • Clinical Information Reconciliation

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Cost Use Category – 0%

- Cost Category replaces the Value Based Modifier program.

- CMS calculates cost based on claims data so there are ***no reporting requirements*** for providers.
  - Calculates total cost per capita for all attributed Medicare beneficiaries.
  - Calculates Medicare spending per beneficiary
  - Calculates Episodes of care.
  - Risk Adjusted —so remember coding must accurately reflect your patient population! Comorbidities, associated diagnoses, and highest level of specificity will determine the benchmark.

- Transition Year Weight—0%

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Cost Category

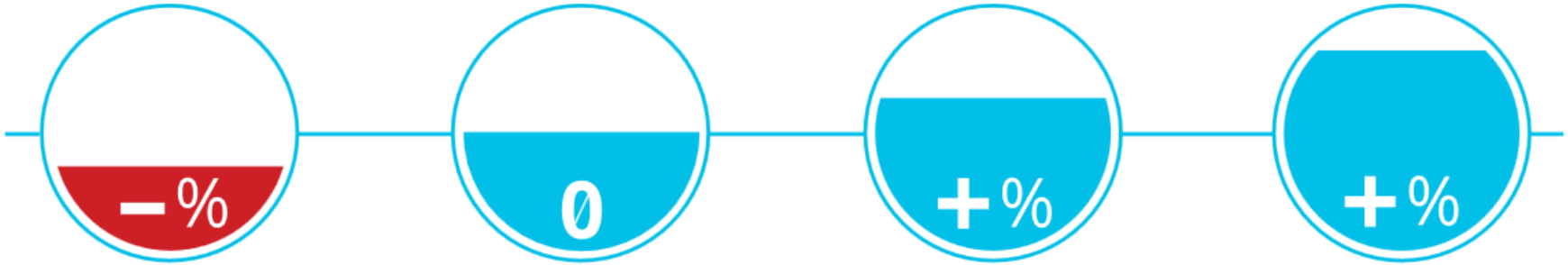
- Take advantage of the delay!
  - Although Medicare is delaying scoring in Cost Category they will continue to collect claims data. Postponing the scoring requirements will allow providers to analyze cost data and future QRUR's to correct deficiencies in value.

- HCCs focus on precise documentation of all of the patient's conditions that are now affecting, or have the potential to affect their health status.
  - Accurate coding, or effective clinical documentation improvement will be the key to maximize reimbursements.

- ***Remember***—the Cost category is about ensuring that quality care continues to be delivered to the patient and paying the physician accordingly for that care…***Quality of Care over Quantity of Services.***

CMS Pick Your Pace Program

- CMS has offered a **"Pick Your Pace"** program that will allow providers to choose how they "ease into" MIPS: The options include:



Don't Participate | **Submit Something** | **Submit a Partial Year** | **Submit a Full Year**

Not participating in the Quality Payment Program:
If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

Test:
If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

Partial:
If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment.

Full:
If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment.

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Pick Your Pace

- Test
  - Report on a single MIPS category:
    - One Quality Measure
    - One Improvement Activity Measure
    - Four Advancing Care Information Measures

- No bonus, however also no penalty

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Pick Your Pace

- Submit for Partial Year:
- Report for 90 days *Must start by MONDAY (October 2)*
  - Report on a single MIPS category ***or*** all three categories:
    - Six Quality Measures
    - Four Improvement Activity Measures
    - Five Advancing Care Information Measures

- No penalty, **neutral with the possibility of a slight bonus**
- Must report on all measures for minimum of 90 days

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Pick Your Pace

Submit for Full Year:

- Report on all three MIPS categories:
  - Six Quality Measures
  - Four Improvement Activity Measures
  - Five Advancing Care Information Measures

- No penalty, possibility of **highest bonus**

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QPP Short Training Videos

- We have created a number of new, self-paced educational videos that are now available on YouTube (Go.cms.gov/QPPvideos) and our Events page. These videos help to explain aspects of the Quality Payment Program in approximately 10 minutes or less.
- We think our stakeholders will greatly benefit from this form of on-demand learning that allows them to choose their educational pace.
- ***Quick general overview:*** What is the Quality Payment Program?
- Introduction to the Merit-based Incentive Payment System (MIPS)
- Who participates in the Merit-based Incentive Payment System?
- How do eligible clinicians participate in the Merit-based Incentive Payment System?
- The Merit-based Incentive Payment System performance categories
- What is the scoring methodology for the Merit-based Incentive Payment System?

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MLN – CME Courses

- **https://learner.mlnlms.com/Default.aspx**

- Quality Payment Program Overview
- Quality Payment Program 2017 Merit-based Incentive Payment System: Improvement Activities Performance Category
- Quality Payment Program 2017: Merit-based Incentive Payment System (MIPS) Quality Performance Category
- Quality Payment Program in 2017: Pick Your Pace

- Keep checking the Learning Management System for updates on new courses. This course offers CME credit.

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Additional Resources: Websites

CMS Quality Payment Program https://qpp.cms.gov/

CEUs for Learning about QPP – MLN - Quality Payment Program in 2017: Pick Your Pace Web-Based Training Course — New

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techassist@qsource.org

QPP Small & Underserved Contract

www.tmf.org/QPP

1-844-317-7609

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Questions?

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