Quality Payment
PROGRAM

MIPS 101 FOR THE 2019 PERFORMANCE YEAR

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Topics

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) 101
- Overview of the Quality Payment Program
- Overview of the Merit-based Incentive Payment System (MIPS) in Year 3
  - Eligibility Criteria
  - Reporting Options
  - Performance Category Requirements
  - Performance Thresholds and Payment Adjustments
- Help and Support
- Question & Answer Session

MACRA OVERVIEW

MACRA 101

What is MACRA?

MACRA stands for the Medicare Access and CHIP Reauthorization Act of 2015, which is bipartisan legislation signed into law on April 16, 2015.

Why do I Need to Know about MACRA?

- MACRA:
  - **Repealed** the Sustainable Growth Rate (SGR) formula
  - **Changed the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for value over volume
  - **Required CMS by law to implement an incentive program** which is referred to as the Quality Payment Program

MACRA 101

Medicare Payment Prior to MACRA

Fee-for-Service (FFS) payment system, where clinicians received payment based on volume of services, not **value**.

What was the Sustainable Growth Rate Formula?

- Each year, Congress passed temporary "doc fixes" to avert cuts to Medicare payments

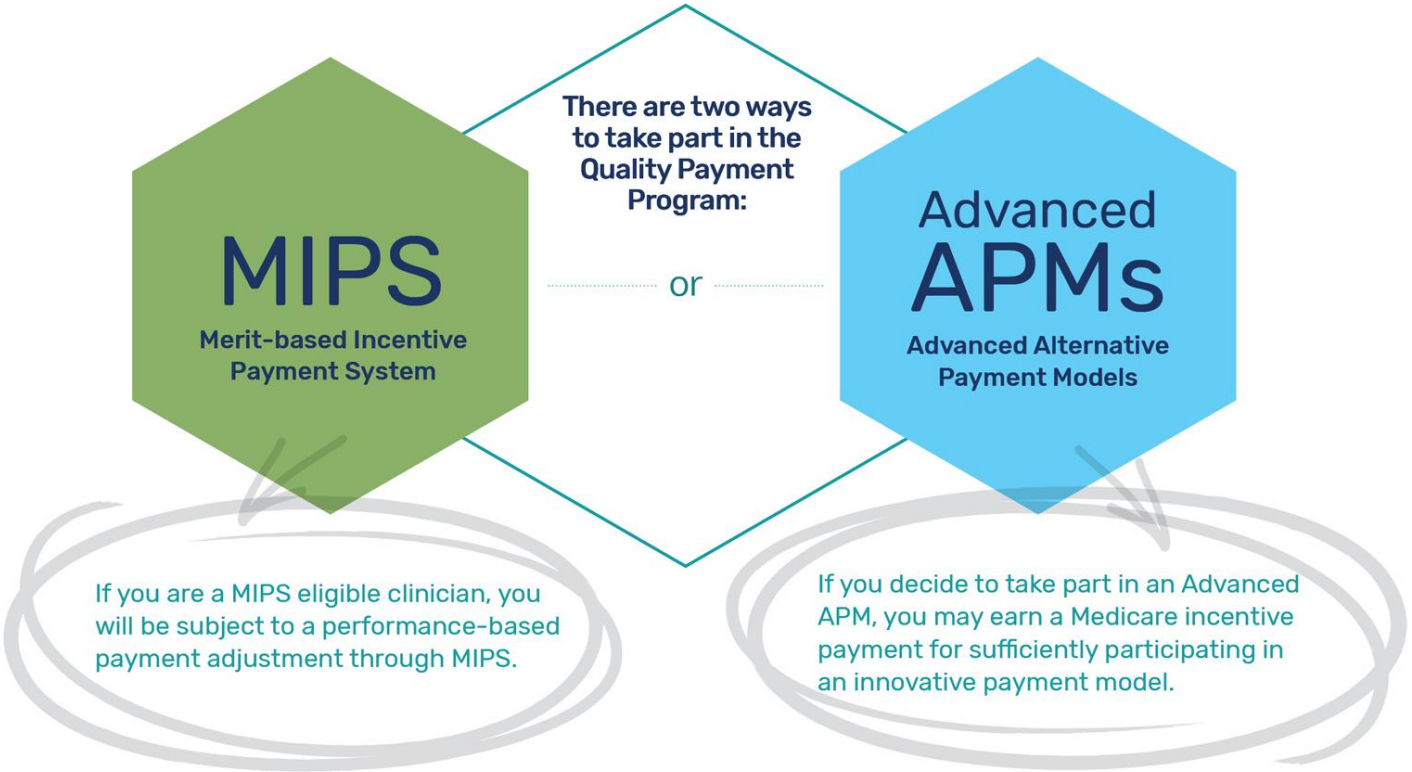
- No "fix" in 2015 would have resulted in a 21% cut in Medicare payments to clinicians

How Does MACRA Help?

- MACRA replaces the SGR with a more predictable payment program, known as the Quality Payment Program, that incentives value over volume

Quality Payment Program

The Quality Payment Program consists of two participation tracks for clinicians:



Quality Payment Program

Considerations

Improve beneficiary outcomes

Reduce burden on clinicians

Increase adoption of Advanced APMs

Maximize participation

Improve data and information sharing

Ensure operational excellence in program implementation

Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Overview

Merit-based Incentive Payment System (MIPS)

Terms and Timelines

Key Terms to Know…

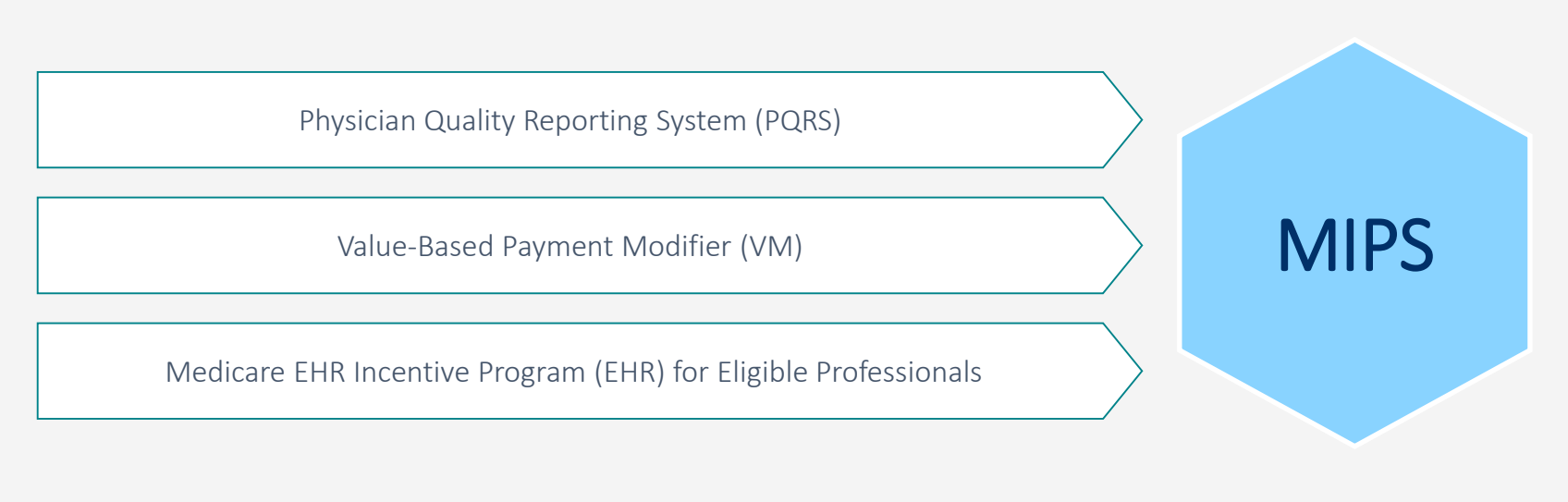
- TIN - Tax Identification Number
  - Used by the Internal Revenue Service to identify an entity, such as a group medical practice, that is subject to federal taxes
- NPI – National Provider Identifier
  - 10-digit numeric identifier for individual clinicians
- TIN/NPI
  - Identifies the individual clinician and the entity/group practice through which the clinician bills services to CMS

Year	Also Referred to as…	Corresponding Payment Year	Corresponding Adjustment
2017	2017 “Transition” Year	2019	Up to +4%
2018	2018 Performance Year	2020	Up to +5%
2019	2019 Performance Year	2021	Up to +7%

Merit-based Incentive Payment System (MIPS)

Quick Overview

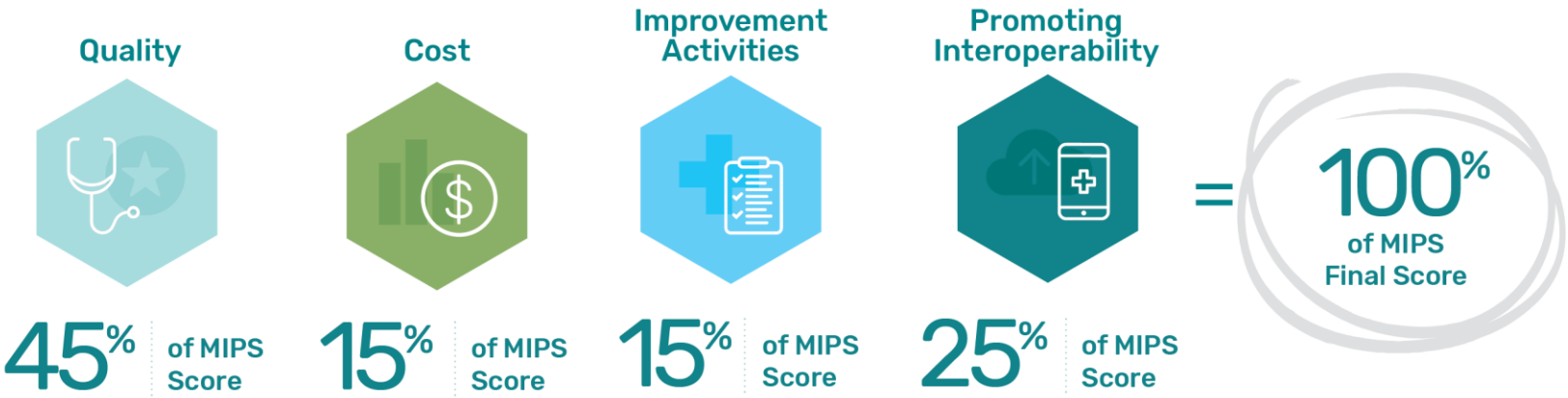
Combined legacy programs into a single, improved program.



Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS Performance Categories



- Comprised of **four** performance categories
- So What? *The points from each performance category are added together to give you a MIPS Final Score*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**

Merit-based Incentive Payment System (MIPS)

General Timeline

2019
Performance Year

- Performance period opens January 1, 2019
- Closes December 31, 2019
- Clinicians care for patients and record data during the year

March 31, 2020
Data Submission

- Deadline for submitting data is March 31, 2020
- Clinicians are encouraged to submit data early

Feedback

- CMS provides performance feedback after the data is submitted
- Clinicians will receive feedback before the start of the payment year

January 1, 2021
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2021

Merit-based Incentive Payment System (MIPS)

Key Resources

- Quality Payment Program website – qpp.cms.gov
- QPP Participation Status Look-up Tool
- MIPS Explore Measures Tool
- QPP Resource Library
- QPP Webinar Library
- QPP Help and Support Page
- QPP Listserv – available on the Quality Payment Program website

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Eligibility 101

Merit-based Incentive Payment System (MIPS)

Determining Eligibility

How does CMS Determine if I am Included in MIPS for the 2019 Performance Year?

- We start by identifying if you're a MIPS eligible clinician type
- We then look to see if you exceed **all three elements** of the low-volume threshold criteria during a specific determination period
- If you meet these elements, you're required to participate in MIPS

Merit-based Incentive Payment System (MIPS)

Determining Eligibility

Are There any Basic Exemptions?

If you are…

Newly-enrolled in Medicare

Below the low-volume threshold

Significantly participating in Advanced APMs

…then you are excluded from MIPS

Merit-based Incentive Payment System (MIPS)

MIPS Eligible Clinician Types

What is a MIPS Eligible Clinician?

- MIPS eligible clinicians are both physicians and non-physician clinicians who are eligible to participate in MIPS
- CMS, through rulemaking, defines the clinician types that are considered MIPS eligible clinicians for a specific performance year

So What?

- Being identified as a MIPS eligible clinician type is the first step in determining whether you're required to participate in MIPS
- Clinicians who are not considered MIPS eligible clinicians are **excluded** from MIPS

Merit-based Incentive Payment System (MIPS)

MIPS Eligible Clinician Types

For 2019, MIPS Eligible Clinicians Include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Speech Pathologists
- Audiologists
- Registered Dieticians or Nutrition Professionals
- Groups of such clinicians

Merit-based Incentive Payment System (MIPS)

Low-Volume Threshold

What is the Low-Volume Threshold?

- The low-volume threshold is the second step in determining whether you are included in MIPS for a specific performance period

- It helps CMS determine if you, as a MIPS eligible clinician, bill a sufficient amount of allowed charges under the Medicare Physician Fee Schedule (PFS), provide care for enough Medicare beneficiaries, and furnish an adequate amount of services to be included in MIPS

Merit-based Incentive Payment System (MIPS)

Low-Volume Threshold

How Does the Low-Volume Threshold Work?

- CMS conducts MIPS determination periods where we'll look to see if you as an individual MIPS eligible clinician exceed the following criterion:
    - Bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS)

    AND

    - Furnish covered professional services to more than 200 Medicare beneficiaries

    AND

    - Provide more than 200 covered professional services under the PFS

So What?

- If you exceed all three criterion, you are included in MIPS and required to participate by submitting performance data

- If you do not exceed all three criterion, you are excluded from MIPS

Merit-based Incentive Payment System (MIPS)

Low-Volume Threshold

What are the Determination Periods for the 2019 Performance Year?

We look at your Medicare claims from two 12-month segments aligned to the fiscal year:

- October 1, 2017 – September 30, 2018 (historical period)
  - Determines your initial eligibility in MIPS
  - If you're excluded during this initial run, you will maintain this status for the entire performance period
- October 1, 2018 – September 30, 2019 (performance period)

Merit-based Incentive Payment System (MIPS)

Low-Volume Threshold

How Does the Low-Volume Threshold Apply to Groups?

- CMS will simultaneously conduct a similar look during a given determination period to see if your group contains at least one MIPS eligible clinician type and **collectively** exceeds the low-volume threshold

So What?

- If your group has at least one MIPS eligible clinician and exceeds all three criterion, your group is eligible to participate in MIPS
    - Please note that participating as a group is an option
    - If you are excluded from MIPS as an individual but eligible to participate as a part of a group, you are not required to do so
- If your group does not exceed all three criterion, your group is excluded from MIPS and does not need to submit any performance data

Merit-based Incentive Payment System (MIPS)

MIPS Eligibility Determinations

What Happens if I am Excluded, but Want to Participate in MIPS?

- You have two options:

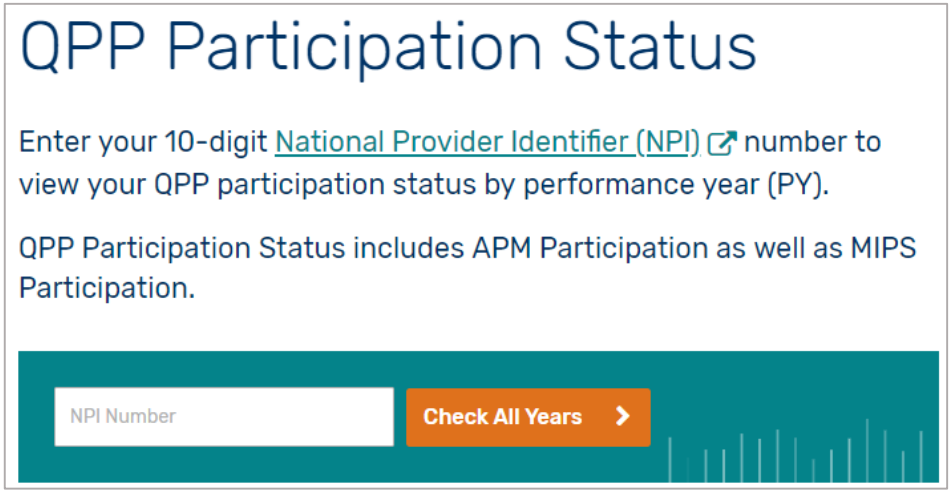
1. Voluntarily participate
    - You'll submit data to CMS and receive a performance feedback
    - You will not receive a MIPS payment adjustment
2. Opt-in
    - If you are a MIPS eligible clinician and meet or exceed at least one of the low-volume threshold criteria, you may opt-in to MIPS
    - If you opt-in, you'll be subject to the MIPS rules, special status, and MIPS payment adjustment

Merit-based Incentive Payment System (MIPS)

MIPS Eligibility Determinations

Is There Somewhere I can go to Check my MIPS Status?

- You can check your participation status using the National Provider Identifier (NPI) Look-up Tool on qpp.cms.gov



- We also encourage you to review the 2019 MIPS Participation and Eligibility fact sheet for additional information

Merit-based Incentive Payment System (MIPS)

MIPS Eligibility Determinations

What Happens if I am Associated with Multiple Practices in the Look-up Tool?

- If you're in multiple practices you are required to participate in MIPS for ***each associated practice*** (TIN/NPI) where you exceed the low volume threshold
- You will receive a payment adjustment based on the TIN/NPIs where the low volume threshold was exceeded
- Any associated practices (TIN/NPIs) where you did not exceed the low volume threshold (or was otherwise excluded from MIPS) would not receive a payment adjustment

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

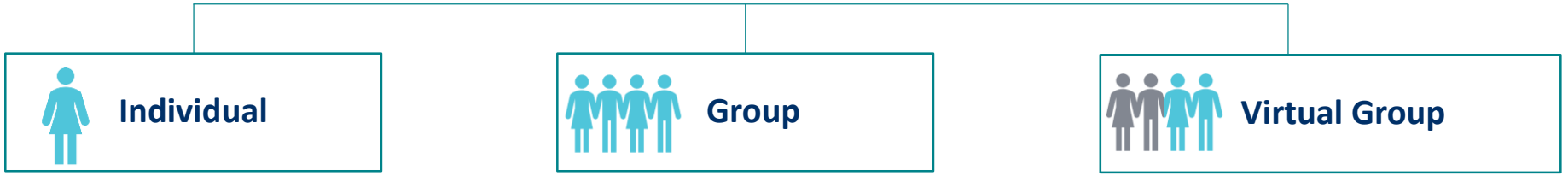
Reporting Options

Merit-based Incentive Payment System (MIPS)

Reporting Options

What are my Reporting Options if I am Required to Participate in MIPS?

MIPS eligible clinicians can report as an/part of a:



1. As an Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

2. As a Group

a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*

b) As an APM Entity

3. As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together "virtually" (no matter what specialty or location) to participate in MIPS for a performance period for a year

Merit-based Incentive Payment System (MIPS)

Submitting Data - Collection, Submission, and Submitter Types

Key Terms to Know…

- **Collection type –** a set of quality measures with comparable specifications and data completeness criteria including, as applicable, including, but not limited to: electronic clinical quality measures (eCQMs); MIPS Clinical Quality Measures* (MIPS CQMs); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey; and administrative claims measures

- **Submitter type –** the MIPS eligible clinician, group, virtual group, or third party intermediary acting on behalf of a MIPS eligible clinician, group, or virtual group, as applicable, that submits data on measures and activities.

- **Submission type –** the mechanism by which a submitter type submits data to CMS, including: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface.
    - The Medicare Part B claims submission type is for clinicians or groups in small practices only to continue providing reporting flexibility

*The term MIPS CQMs replaces what was formerly referred to as “registry measures” since clinicians that don’t use a registry may submit data on these measures.

Merit-based Incentive Payment System (MIPS)

Collection, Submission, and Submitter Types - Example

Data Submission for MIPS Eligible Clinicians Reporting as Individuals

Performance Category	Submission Type	Submitter Type	Collection Type
 Quality	• Direct • Log-in and Upload • Medicare Part B Claims (small practices only)	• Individual • Third Party Intermediary	• eCQMs • MIPS CQMs • QCDR Measures • Medicare Part B Claims Measures (small practices only)
 Cost	• No data submission required	• Individual	-
 **Improvement** Activities	• Direct • Log-in and Upload • Log-in and Attest	• Individual • Third Party Intermediary	-
 **Promoting** Interoperability	• Direct • Log-in and Upload • Log-in and Attest	• Individual • Third Party Intermediary	-

Merit-based Incentive Payment System (MIPS)

Collection, Submission, and Submitter Types - Example

Data Submission for MIPS Eligible Clinicians Reporting as Groups

Performance Category	Submission Type	Submitter Type	Collection Type
 Quality	• Direct • Log-in and Upload • CMS Web Interface (groups of 25 or more eligible clinicians) • Medicare Part B Claims (small practices only)	• Group • Third Party Intermediary	• eCQMs • MIPS CQMs • QCDR Measures • CMS Web Interface Measures • CMS Approved Survey Vendor Measure • Administrative Claims Measures • Medicare Part B Claims (small practices only)
 Cost	• No data submission required	• Group	-
 Improvement Activities	• Direct • Log-in and Upload • Log-in and Attest	• Group • Third Party Intermediary	-
 Promoting Interoperability	• Direct • Log-in and Upload • Log-in and Attest	• Group • Third Party Intermediary	-

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Performance Requirements – What Exactly do I Need to do?

Merit-based Incentive Payment System (MIPS)

Performance Periods

What is a Performance Period under MIPS?

- A performance period is the length of time that you or your group are required to report data for a specific MIPS performance category
- In order to receive the highest possible MIPS final score, you should report data for the minimum performance period under each performance category

Performance Category	Performance Periods for 2019
 Quality	12-months
 Cost	12-months
 Improvement Activities	90-days
 Promoting Interoperability	90-days

Merit-based Incentive Payment System (MIPS)

Performance Category Weights

What is a Performance Category Weight?

- A "weight" is the overall value assigned to each performance category

Did you Know?

- The performance category weights have gradually increased over the last three performance years
- For the 2022 performance year, when the program is fully implemented, both Quality and Cost will be weighted at 30%

Performance Category	Performance Category Weights for 2019
 Quality	45%
 Cost	15%
 Improvement Activities	15%
 Promoting Interoperability	25%

Merit-based Incentive Payment System (MIPS)

Quality Performance Category

Basics for 2019

- 45% of your MIPS Final Score
- Total of 257 quality measures
- You select 6 individual measures
  - 1 must be an outcome measure OR a high-priority measure (if an outcome is not available)
    - High-priority measures fall within these categories: Outcome, Patient Experience, Patient Safety, Efficiency, Appropriate Use, Care Coordination, and Opioid-Related
  - If less than 6 measures apply, you should report on each applicable measure
  - May also select a specialty-specific set of measures

Resources to get you Started:

- Quality Performance Category Fact Sheet
- 2019 Quality Measure Benchmarks

Merit-based Incentive Payment System (MIPS)

Quality Performance Category

Basics for 2019

- Bonus points are available
  - 2 points for outcome or patient experience (after the first required outcome measure is submitted)
  - 1 point for other high-priority measures (after the first required measure is submitted)
  - 1 point for each measure submitted using electronic end-to-end reporting
  - Small practice bonus of 6 points

- Data completeness
  - *What does this mean?*
    - We check to see if you or your group have submitted data on a minimum percentage of your patients that meet a quality measure's denominator criteria
  - In 2019, the thresholds are:
    - 60% for data submitted on QCDR measures, CQMs, and eCQMS (all-payer data)
    - 60% for data submitted on Medicare Part B claims measures (Part B data)
  - Measures that do not meet the data completeness criteria earn 1 point
    - Small practices receive 3 points for measures that do not meet data completeness

Merit-based Incentive Payment System (MIPS)

Cost Performance Category

Basics for 2019

- 15% of your MIPS Final Score
- No reporting requirement – data is pulled from administrative claims
- We will measure you on:
  - Medicare Spending Per Beneficiary (MSPB) measure
  - Total Per Capita Cost measure
  - 8 episode-based measures (next slide)
- In order to be scored on a cost measure, you or your group must have enough attributed cases to meet or exceed the case minimum for that cost measure

Resources to get you Started:

- Cost Performance Category Fact Sheet

Merit-based Incentive Payment System (MIPS)

Cost Performance Category

Episode-based Measures:

- Elective Outpatient Percutaneous Coronary Intervention (PCI)
- Knee Arthroplasty
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia
- Routine Cataract Removal with Intraocular Lens (IOL) Implantation
- Screening/Surveillance Colonoscopy
- Intracranial Hemorrhage or Cerebral Infarction
- Simple Pneumonia with Hospitalization
- ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)

Merit-based Incentive Payment System (MIPS)

Improvement Activities Performance Category

Basics for 2019

- 15% of your MIPS Final Score
- Total of 118 Improvement Activities for 2019
- Each activity contains a weight:
  - Medium – worth 10 points
  - High – worth 20 points
- Select an activity and attest “yes” to completing
- You must earn 40 points to receive the full Improvement Activities category score
  - Small practices, non-patient facing clinicians, and/or clinicians located in rural or health professional shortage areas (HPSAs) receive double-weighting and report on no more than 2 activities to receive the highest score

Merit-based Incentive Payment System (MIPS)

Promoting Interoperability Performance Category

Basics for 2019

- 25% of your MIPS Final Score
- Must use 2015 Edition Certified EHR Technology (CEHRT)
- Performance-based scoring at the individual measure level
- Four Objectives:
  - e-Prescribing
  - Health Information Exchange
  - Provider to Patient Exchange
  - Public Health and Clinical Data Exchange

Resources to get you Started:

- 2019 Promoting Interoperability Measure Specifications

Merit-based Incentive Payment System (MIPS)

Promoting Interoperability Performance Category

Objectives	Measures	Maximum Points
e-Prescribing	• e-Prescribing	• 10 points
	• Query of Prescription Drug Monitoring Program (PDMP) (new)	• 5 bonus points
	• Verify Opioid Treatment Agreement (new)	• 5 bonus points
Health Information Exchange	• Support Electronic Referral Loops by Sending Health Information (formerly Send a Summary of Care)	• 20 points
	• Support Electronic Referral Loops by Receiving and Incorporating Health Information (new)	• 20 points
Provider to Patient Exchange	• Provide Patients Electronic Access to their Health Information (formerly Provide Patient Access)	• 40 points
Public Health and Clinical Data Exchange	• Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	• 10 points

Merit-based Incentive Payment System (MIPS)

Promoting Interoperability Performance Category

- To earn a score for the Promoting Interoperability performance category, you must:
  - Use CEHRT for the performance period (90-days or greater)
  - Submit a “yes” to the Prevention of Information Blocking Attestation
  - Submit a “yes” to the ONC Direct Review Attestation
  - Submit a “yes” for the security risk analysis measure
  - Report the required measures under each Objective or claim any applicable exclusions

- Each measure is scored on performance based on the submission of a numerator and denominator or a “yes or no”
  - Must submit a numerator of at least 1 or a “yes” to fulfill the required measures

- The scores for each of the individual measures are added together to calculate a final score

- If exclusions are claimed, the points will be allocated to other measures

Merit-based Incentive Payment System (MIPS)

Promoting Interoperability Performance Category

- Reweighting of the Promoting Interoperability performance category is available
- Clinicians who qualify for reweighting will have the 25% weight reallocated to the Quality performance category (i.e. Quality would be worth 70%; Promoting Interoperability 0%)

Automatic Reweighting	Application-based Reweighting
Non-patient Facing clinicians	Insufficient internet connectivity
Hospital-based clinicians	Extreme and uncontrollable circumstances
Ambulatory Surgical Center-based clinicians	Lack of control over the availability of CEHRT
PAs, NPs, Clinical Nurse Specialists, CRNAs, Physical Therapists, Occupational Therapists, Clinical Psychologists, Speech-Language Pathologists, Audiologists, Registered Dieticians, and Nutrition Professionals	Clinicians in small practices
	Clinicians using decertified EHR technology

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

How do you determine my payment adjustment?

Merit-based Incentive Payment System (MIPS)

Performance Thresholds and Payment Adjustments

Basics for 2019

- 30 point performance threshold
  - So What? – This is the minimum number of points needed to avoid a negative payment adjustment and earn a neutral payment adjustment
- Additional performance threshold for exceptional performance set at 75 points
- We'll compare your final score to the performance threshold (and exceptional performance threshold) to determine your payment adjustment
- Payment adjustment *could be* up to +7% or as low as -7%
  - Please note that this is a budget neutral program
  - To ensure budget neutrality, positive MIPS payment adjustment factors are likely to be increased or decreased by an amount called a "scaling factor"
  - The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians

Merit-based Incentive Payment System (MIPS)

Performance Thresholds and Payment Adjustments

Point Breakdown and Payment Adjustment

Final Score 2019	Payment Adjustment 2021
≥75 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance —minimum of additional 0.5%
30.01-74.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
30 points	• Neutral payment adjustment
7.51-29.99	• Negative payment adjustment greater than -7% and less than 0%
0-7.5 points	• Negative payment adjustment of -7%

Did you Know?

- The performance threshold has incrementally increased since 2017
- For the 2022 performance year, the performance threshold (the number in the green box) will be based on the mean or median of the final scores for all MIPS eligible clinicians

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Getting Started and Available Resources

Merit-based Incentive Payment System (MIPS)

Getting Started Checklist

Action Items to Consider:

- ❑ Familiarize yourself with contents and tools on the Quality Payment Program website – qpp.cms.gov
- ❑ Check your participation status using the QPP Participation Status Look-up Tool
- ❑ If you're included OR intend to opt-in to MIPS:
  - ❑ Determine whether you want to participate as an individual or as a part of a group
  - ❑ Identify the measures and activities on which you or your group will report
  - ❑ Begin capturing quality measure data – remember, you must collect data for 12 months for the Quality performance category (this is important if you're planning to opt-in)
- ❑ Reach out to the various forms of **FREE** support (next slide)
  - ❑ Quality Payment Program Service Center
  - ❑ Quality Payment Program Technical Assistance

Technical Assistance

Available Resources

CMS has no cost resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

LARGE PRACTICES

Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Learn more about technical assistance: https://qpp.cms.gov/about/help-and-support#technical-assistance

Q&A

Q&A Session

To ask a question, please dial:

1-866-452-7887

If prompted, use passcode: 5782298

Press ***1** to be added to the question queue.

You may also submit questions via the chat box.

Speakers will answer as many questions as time allows.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