Boot camp Agenda

• 2:00 – 2:15 – Challenge Introduction – Mindy Hangsleben, CMS

• 2:15 – 2:45 - Overview of Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)/MIPS and Current State Education & Outreach Research Findings – Dr. Pierre Yong, Director Quality Measure Value-Based Incentive Group, CMS

• 2:45 – 3:15 - Customer Insight

• 3:15 – 5:00 – Q & A/Working Time with experts in the room
The Challenge

• CMS recently issued a proposed rule that will change the way Medicare physicians are paid for giving quality care through the Quality Payment Program (QPP)

• This challenge will focus on solving the problem that many of the 1.2 Million Clinicians and their staff will face – the ability to easily access information that is relevant to enable successful reporting in the new Merit Based Incentive Payment System (MIPS) program.
Why this Challenge?

- Many small practice and solo clinicians along with their staff may be unaware of the program, what it means for them, key dates, or how to successfully participate.
- Clinicians that are aware of the program still need to know and understand when things are changing.
- The Quality Payment Program offers many options that clinicians will need to successfully navigate.
- Different clinicians may have different needs and motivations for their involvement.
Our Goal

Engagement & Education

• To help clinicians and their support teams **understand** the Merit-Based Incentive Payment System (MIPS), the **benefits** of participation, and how they can **move their** practice toward quality based care.
What’s a Challenge?

- The solutions are up to you!
- Allows the government to collect great ideas and a wide variety of perspectives to solve a particular problem
- Submissions could be interesting suggestions, approaches, plans, proposals, designs, or other proposed solutions in written, graphic, or video form
Challenge Phases

**Ideation – Phase 1 Challenge**
- Wireframes
- Storyboards
- Mobile Screen Mock-ups
- Initial User Acceptance Testing
- 3-5 winning ideas: $10,000 Awards

**Creative Contest – Phase 2 Challenge**
- Test Basic Functionality with User types
- Create & Test Features that would enhance communication
- Launch – Beta
- 1 Grand Prize Winner: $25,000 Award

**Pick and Choose features from the challenge that best met user needs and integrate into the current Education and Outreach efforts**
Prizes

• Phase 1: Top 3-5 will receive $10,000/winning submission
• Phase 2: Winner will receive $25,000
Dates & Timing

• July 15: Deadline for Phase I Submissions
• July 30: HHS announces top three to five challenge applicants and launches Phase II
  – Applicants that did not win in Phase I will be permitted to compete for Phase II
• September 30: Deadline for Phase II Submissions
• October 15: HHS announces grand prize winner
Judging Criteria – Phase 1

• Ease with which a user can navigate Usability and Design
• Evidence of design incorporating User feedback
• Innovation in Design
• Look and Feel
Phase I Submission Requirements

Submissions could take many forms, including but not limited to:
• Mockups/Wireframes
• Storyboards
• Flowcharts
• Videos/animations
• User Feedback Incorporation
List of users and the lessons learned from co-design around the problem statement
Judging Criteria – Phase 2

- Are a majority of clinicians able to easily use the solution from start to finish?
- Do a majority of clinicians understand the requirements of MIPS after using the solution?
- Are a majority of clinicians able to identify if they are qualified to participate in MIPS after using the solution?
Phase II Submission Requirements

• Working prototype of the mobile solution
• Video demonstrating the use of the mobile solution (maximum of 5 minutes, on YouTube or Vimeo)
  - Provide clear sense of look, feel, and interactions
• Presentation describing solution
• User research summary
  – List of users
  – Lessons learned from usability testing and updates made to the solution
Eligibility & Registration

• Eligibility details can be found on the challenge.gov website
THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)
Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.
KEY TOPICS:

1) The Quality Payment Program and HHS Secretary’s Goals
2) What is the Quality Payment Program?
3) How do I submit comments on the proposed rule?
4) The Merit-based Incentive Payment System (MIPS)
5) What are the next steps?
In January 2015, the Department of Health and Human Services announced **new goals for value-based payments and APMs in Medicare**.
Medicare Payment Prior to MACRA

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

**The Sustainable Growth Rate (SGR)**

- Established in 1997 to control the cost of Medicare payments to physicians.

**IF**

- Overall physician costs > Target Medicare expenditures

**THEN**

Physician payments cut across the board

Each year, Congress passed temporary “doc fixes” to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments to clinicians).
Fee-for-service (FFS) payment system, where clinicians are paid based on volume of services, not value.

The Sustainable Growth Rate (SGR)

Each year, Congress passed temporary “doc fixes” to avert cuts (no fix in 2015 would have meant a 21% cut in Medicare payments to clinicians).

MACRA replaces the SGR with a more predictable payment method that incentivizes value.
INTRODUCING THE QUALITY PAYMENT PROGRAM
Quality Payment Program

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- **Provides incentive payments** for participation in Advanced Alternative Payment Models (APMs)

- First step to a fresh start
- We’re listening and help is available
- A better, smarter Medicare for healthier people
- Pay for what works to create a Medicare that is enduring
- Health information needs to be open, flexible, and user-centric
When and where do I submit comments?

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting refer to file code CMS-5517-P.

- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

- For additional information, please go to: http://go.cms.gov/QualityPaymentProgram
First step to a fresh start
We’re listening and help is available
A better, smarter Medicare for healthier people
Pay for what works to create a Medicare that is enduring
Health information needs to be open, flexible, and user-centric

The Merit-based Incentive Payment System (MIPS)

or

Advanced Alternative Payment Models (APMs)
Note: Most practitioners will be subject to MIPS.

Subject to MIPS

Not in APM

In non-Advanced APM

In Advanced APM, but not a QP

QP in Advanced APM

Some clinicians may be in Advanced APMs but not have enough payments or patients through the Advanced APM to be a QP.

Note: Figure not to scale.
MIPS
MIPS: First Step to a Fresh Start

✓ MIPS is a new program
  • Streamlines 3 currently independent programs to work as one and to ease clinician burden.
  • Adds a fourth component to promote ongoing improvement and innovation to clinical activities.

✓ MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.
Currently there are multiple quality and value reporting programs for Medicare clinicians:

- Physician Quality Reporting Program (PQRS)
- Value-Based Payment Modifier (VM)
- Medicare Electronic Health Records (EHR) Incentive Program
PROPOSED RULE
MIPS: Major Provisions

✓ Eligibility (participants and non-participants)
✓ Performance categories & scoring
✓ Data submission
✓ Performance period & payment adjustments
Who Will Participate in MIPS?

Affected clinicians are called “MIPS eligible clinicians” and will participate in MIPS. The types of Medicare Part B eligible clinicians affected by MIPS may expand in future years.

Years 1 and 2

Physicians (MD/DO and DMD/DDS), PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

Secretary may broaden Eligible Clinicians group to include others such as

Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals
Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:

1. **First year of Medicare Part B participation**
2. Below low patient volume threshold
3. Certain participants in ADVANCED Alternative Payment Models

Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Medicare patients in one year

Note: MIPS does not apply to hospitals or facilities
### PROPOSED RULE
#### MIPS Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>2017</td>
<td>Performance Period (Jan-Dec)</td>
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<tr>
<td></td>
<td>1st Feedback Report (July)</td>
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<tr>
<td>2018</td>
<td>Reporting and Data Collection</td>
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<tr>
<td></td>
<td>2nd Feedback Report (July)</td>
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<tr>
<td>July</td>
<td>Targeted Review Based on 2017 MIPS Performance</td>
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<tr>
<td>2019</td>
<td>MIPS Adjustments in Effect</td>
</tr>
<tr>
<td>2020</td>
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**Analysis and Scoring**
How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.

The potential maximum adjustment % will increase each year from 2019 to 2022.
Note: Most clinicians will be subject to MIPS.

Subject to MIPS

Not in APM

In non-Advanced APM

In Advanced APM, but not a QP

QP in Advanced APM

Some people may be in Advanced APMs but not have enough payments or patients through the Advanced APM to be a QP.

Note: Figure not to scale.
Eligible Clinicians can participate in MIPS as an:

- **Individual**
- **Group**

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

Note: “Virtual groups” will not be implemented in Year 1 of MIPS.
PROPOSED RULE
MIPS: PERFORMANCE CATEGORIES & SCORING
A single MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:
Year 1 Performance Category Weights for MIPS

- QUALITY: 50%
- ADVANCING CARE INFORMATION: 25%
- CLINICAL PRACTICE IMPROVEMENT ACTIVITIES: 15%
- COST: 10%
The MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:

- Resource use
- Clinical practice improvement activities
- Advancing care information

*Proposed quality measures are available in the NPRM

*Clinicians will be able to choose the measures on which they’ll be evaluated
Summary:

✓ Selection of 6 measures
✓ 1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable
✓ Select from individual measures or a specialty measure set
✓ Population measures automatically calculated
✓ Key Changes from Current Program (PQRS):
  • Reduced from 9 measures to 6 measures with no domain requirement
  • Emphasis on outcome measurement
  • Year 1 Weight: 50%
The MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

*MIPS Composite Performance Score (CPS)*

*Will compare resources used to treat similar care episodes and clinical condition groups across practices*

*Can be risk-adjusted to reflect external factors*
Summary:

✓ Assessment under all available resource use measures, as applicable to the clinician

✓ CMS calculates based on claims so there are no reporting requirements for clinicians

✓ Key Changes from Current Program (Value Modifier):
  • Adding 40+ episode specific measures to address specialty concerns
  • Year 1 Weight: 10%
What will determine my MIPS score?

The MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

MIPS Composite Performance Score (CPS)

*Examples include care coordination, shared decision-making, safety checklists, expanding practice access
MIPS: Clinical Practice Improvement Activity Performance Category

Summary:

✓ Minimum selection of one CPIA activity (from 90+ proposed activities) with additional credit for more activities

✓ Full credit for patient-centered medical home

✓ Minimum of half credit for APM participation

✓ Key Changes from Current Program:
  • Not applicable (new category)
  • Year 1 Weight: 15%
What will determine my MIPS score?

The MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

* % weight of this may decrease as more users adopt EHR
PROPOSED RULE
MIPS: Advancing Care Information Performance Category

Who can participate?

All MIPS Eligible Clinicians

Participating as an...

Individual

or

Groups

Those Not Eligible

Include: NPs, PAs, Hospitals, Facilities & Medicaid
The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points.
To receive the base score, physicians and other clinicians must simply provide the numerator/denominator or yes/no for each objective and measure.
CMS proposes six objectives and their measures that would require reporting for the base score:

- **Protect Patient Health Information** (yes required)
- **Electronic Prescribing** (numerator/denominator)
- **Patient Electronic Access** (numerator/denominator)
- **Coordination of Care Through Patient Engagement** (numerator/denominator)
- **Health Information Exchange** (numerator/denominator)
- **Public Health and Clinical Data Registry Reporting** (yes required)
The Performance Score
The performance score accounts for up to 80 points towards the total Advancing Care Information category score.

- Patient Electronic Access
- Coordination of Care Through Patient Engagement
- Health Information Exchange

Physicians and other clinicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:
PROPOSED RULE
MIPS: Advancing Care Information Performance Category

Summary:

✓ Scoring based on key measures of health IT interoperability and information exchange.

✓ Flexible scoring for all measures to promote care coordination for better patient outcomes

✓ Key Changes from Current Program (EHR Incentive):
  • Dropped “all or nothing” threshold for measurement
  • Removed redundant measures to alleviate reporting burden
  • Eliminated Clinical Provider Order Entry and Clinical Decision Support objectives
  • Reduced the number of required public health registries to which clinicians must report
  • Year 1 Weight: 25%
### PROPOSED RULE

**MIPS: Performance Category Scoring**

<table>
<thead>
<tr>
<th>Summary of MIPS Performance Categories</th>
<th>Maximum Possible Points per Performance Category</th>
<th>Percentage of Overall MIPS Score (Performance Year 1 - 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality:</strong> Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.</td>
<td>80 to 90 points depending on group size</td>
<td>50 percent</td>
</tr>
<tr>
<td><strong>Advancing Care Information:</strong> Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</td>
<td>100 points</td>
<td>25 percent</td>
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<tr>
<td><strong>Clinical Practice Improvement Activities:</strong> Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn “full credit” in this category, and those participating in Advanced APMs will earn at least half credit.</td>
<td>60 points</td>
<td>15 percent</td>
</tr>
<tr>
<td><strong>Cost:</strong> CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</td>
<td>Average score of all cost measures that can be attributed</td>
<td>10 percent</td>
</tr>
</tbody>
</table>
A single MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

The CPS will be compared to the MIPS performance threshold to determine the adjustment percentage the eligible clinician will receive.
MIPS composite performance scoring method that accounts for:

- Weights of each performance category
- Exceptional performance factors
- Availability and applicability of measures for different categories of clinicians
- Group performance
- The special circumstances of small practices, practices located in rural areas, and non-patient-facing MIPS eligible clinicians
Calculating the Composite Performance Score (CPS) for MIPS

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
<th>Scoring</th>
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</table>
| Quality                         | 50%    | • Each measure 1-10 points compared to historical benchmark (if avail.)  
• 0 points for a measure that is not reported  
• Bonus for reporting outcomes, patient experience, appropriate use, patient safety and EHR reporting  
• Measures are averaged to get a score for the category |
| Advancing care information      | 25%    | • Base score of 60 points is achieved by reporting at least one use case for each available measure  
• Up to 10 additional performance points available per measure  
• Total cap of 100 percentage points available |
| CPIA                            | 15%    | • Each activity worth 10 points; double weight for “high” value activities; sum of activity points compared to a target |
| Resource Use                    | 10%    | • Similar to quality |

Unified scoring system:  
1. Converts measures/activities to points  
2. Eligible Clinicians will know in advance what they need to do to achieve top performance  
3. Partial credit available
HOW DO I GET MY DATA TO CMS?
DATA SUBMISSION FOR MIPS
## PROPOSED RULE
### MIPS Data Submission Options
#### Quality and Resource Use

<table>
<thead>
<tr>
<th>Individual Reporting</th>
<th>Group Reporting</th>
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<tbody>
<tr>
<td>✓ QCDR</td>
<td>✓ QCDR</td>
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<tr>
<td>✓ Qualified Registry</td>
<td>✓ Qualified Registry</td>
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<tr>
<td>✓ EHR Vendors</td>
<td>✓ EHR Vendors</td>
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<tr>
<td>✓ Administrative Claims (No submission required)</td>
<td>✓ Administrative Claims (No submission required)</td>
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<tr>
<td>✓ Claims</td>
<td>✓ CMS Web Interface (groups of 25 or more)</td>
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<tr>
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<td>✓ CAHPS for MIPS Survey</td>
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<tr>
<td>✓ Administrative Claims (No submission required)</td>
<td>✓ Administrative Claims (No submission required)</td>
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</tbody>
</table>

**Quality**

- QCDR
- Qualified Registry
- EHR Vendors
- Administrative Claims (No submission required)
- Claims

**Resource use**

- Administrative Claims (No submission required)
PROPOSED RULE
MIPS Data Submission Options
Advancing Care Information and CPIA

Individual Reporting
- Attestation
- QCDR
- Qualified Registry
- EHR Vendor

Group Reporting
- Attestation
- QCDR
- Qualified Registry
- EHR Vendor
- CMS Web Interface (groups of 25 or more)

Advancing care information
CPIA
PROPOSED RULE
MIPS PERFORMANCE
PERIOD & PAYMENT
ADJUSTMENT
PROPOSED RULE
MIPS Performance Period

- All MIPS performance categories are aligned to a performance period of one full calendar year.
- Goes into effect in first year (2017 performance period, 2019 payment year).

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<td>2019</td>
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<td>Performance Period</td>
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<td>Payment Year</td>
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A MIPS eligible clinician’s payment adjustment percentage is based on the relationship between their CPS and the MIPS performance threshold.

A CPS below the performance threshold will yield a negative payment adjustment; a CPS above the performance threshold will yield a neutral or positive payment adjustment.

A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.
A CPS that falls at or above the threshold will yield payment adjustment of 0 to +12%, based on the degree to which the CPS exceeds the threshold and the overall CPS distribution.

An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians with exceptional performance where CPS is equal to or greater than an “additional performance threshold,” defined as the 25th percentile of possible values above the CPS performance threshold.
How much can MIPS adjust payments?

Note: MIPS will be a budget-neutral program. Total upward and downward adjustments will be balanced so that the average change is 0%.

*Potential for 3X adjustment
Dr. Joy Smith, who receives the +4% adjustment for MIPS, could receive up to +12% in 2019. For exceptional performance she could earn an additional adjustment factor of up to +10%.

**Note:** This scaling process will only apply to positive adjustments, not negative ones.
MIPS Incentive Payment Formula

Exceptional performers receive additional positive adjustment factor – up to $500M available each year from 2019 to 2024

Exceptional Performance

EPs above performance threshold = positive payment adjustment

Lowest 25% = maximum reduction

2019 2020 2021 2022 and onward

*MACRA allows potential 3x upward adjustment BUT unlikely
When will these Quality Payment Program provisions take effect?
Putting it all together:

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule</th>
<th>MIPS</th>
<th>QP in Advanced APM</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>+0.5% each year</td>
<td>4</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
<tr>
<td>2017</td>
<td>+0.5% each year</td>
<td>5</td>
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<tr>
<td>2018</td>
<td>+0.5% each year</td>
<td>7</td>
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<tr>
<td>2019</td>
<td>+0.5% each year</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>No change</td>
<td>9</td>
<td></td>
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<tr>
<td>2021</td>
<td>No change</td>
<td>9</td>
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<td>2022</td>
<td>No change</td>
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<td>2024</td>
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<td>2025</td>
<td>No change</td>
<td>9</td>
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<tr>
<td>2026 &amp; on</td>
<td>+0.25% or 0.75%</td>
<td>Max Adjustment (+/-)</td>
<td>+5% bonus (excluded from MIPS)</td>
</tr>
</tbody>
</table>
TAKE-AWAY POINTS

1) The Quality Payment Program changes the way Medicare pays clinicians and offers financial incentives for providing high value care.

2) Medicare Part B clinicians will participate in the MIPS, unless they are in their 1st year of Part B participation, become QPs through participation in Advanced APMs, or have a low volume of patients.

3) Payment adjustments and bonuses will begin in 2019.
Current State of Education & Outreach

- Users are unaware of key dates or opportunities to learn more about the program until it’s too late
  - Ex. A practice found out that in order to qualify for an incentive payment for the current year they would have had to submit data one year beforehand, therefore missing out on incentive for the year
- Hard to navigate cms.gov
- Many sources of information that don’t align which is problematic since CMS is a trusted source by users
  - Current sources being used, CMS.gov, listservs, Quality Improvement Organizations (QIOs), Quality Improvement Networks (QINs), Regional Extension Centers (RECs), Consultant websites, specialty societies, Electronic Health Record Vendors (EHR), Data Registries, Qualified Clinical Data Registries (QCDRs), etc.
Current State of Education & Outreach

- Complex program creating lots of time wasted trying to find out who has the right answer
- Multiple users with very different needs
- Large volume of communication hinders keeping track of what to pay attention and what is relevant to the user
Imagine CMS was a grocery store. Can you describe what it’s like to shop there?
Potential Types of Users/Customers

• Physicians, Nurse Practitioners, Physician Assistants
  – Broad and diverse practice setting and specialty focus
• APM Entities
• Non-clinical staff (e.g. Office Managers/Practice Managers/Administrators)
• Registries
• EHR Vendors
• Quality Analysts
“If I have to choose between what’s best for the patient or the checkbox, I will choose the patient every time”.

“Our savviest policy physicians were overwhelmed after 15 minutes of a MACRA overview”

“Give me information specific to a Radiologist”
Co-design Time