NOTICE OF PROPOSED RULE MAKING

Medicare Access and CHIP Reauthorization Act of 2015

QUALITY PAYMENT PROGRAM

Executive Summary

On April 27, 2016, the Department of Health and Human Services issued a Notice of Proposed Rulemaking to implement key provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), bipartisan legislation that replaced the flawed Sustainable Growth Rate formula with a new approach to paying clinicians for the value and quality of care they provide.

The proposed rule would implement these changes through the unified framework called the "Quality Payment Program," which includes two paths:

The Merit-based Incentive Payment System (MIPS)

or

Advanced Alternative Payment Models (APMs)

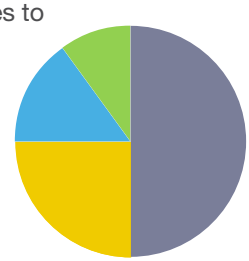
The Merit-based Incentive Payment System (MIPS)

Currently, Medicare measures the value and quality of care provided by doctors and other clinicians through a patchwork of programs, including the Physician Quality Reporting System, the Value Modifier Program, and the Medicare Electronic Health Record (EHR) Incentive Program. Through the law, Congress streamlined and improved these programs into one new Merit-based Incentive Payment System (MIPS). Most Medicare clinicians will initially participate in the Quality Payment Program through MIPS.

Consistent with the goals of the law, the proposed rule would improve the relevance and depth of Medicare's value and quality-based payments and increase clinician flexibility by allowing clinicians to choose measures and activities appropriate to the type of care they provide. MIPS allows Medicare clinicians to be paid for providing high quality, efficient care through success in four performance categories:

COST

(10 percent of total score in year 1; replaces the cost component of the Value Modifier Program, also known as Resource Use): The score would be based on Medicare claims, meaning no reporting requirements for clinicians. This category would use more than 40 episode-specific measures to account for differences among specialties.



QUALITY

(50 percent of total score in year 1; replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program): Clinicians would choose to report six measures versus the nine measures currently required under the Physician Quality Reporting System. This category gives clinicians reporting options to choose from to accommodate differences in specialty and practices.

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES

(15 percent of total score in year 1): Clinicians would be rewarded for clinical practice improvement activities such as activities focused on care coordination, beneficiary engagement, and patient safety. Clinicians may select activities that match their practices' goals from a list of more than 90 options. In addition, clinicians would receive credit in this category for participating in Alternative Payment Models and in Patient-Centered Medical Homes.

ADVANCING CARE INFORMATION

(25 percent of total score in year 1; replaces the Medicare EHR Incentive Program for physicians, also known as "Meaningful Use"): Clinicians would choose to report customizable measures that reflect how they use electronic health record (EHR) technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange. Unlike the existing Meaningful Use program, this category would not require all-or-nothing EHR measurement or quarterly reporting.

The proposed rule seeks to streamline and reduce reporting burden across all four categories, while adding flexibility and accountability for physician practices.

The law requires MIPS to be budget neutral. Therefore, clinicians' MIPS scores would be used to compute a positive, negative, or neutral adjustment to their Medicare payments. In the first year, depending on the variation of MIPS scores, adjustments are calculated so that negative adjustments can be no more than 4 percent, and positive adjustments are generally up to 4 percent, with additional bonuses for the highest performers.

The Center for Medicare & Medicaid Services (CMS) would begin measuring performance for doctors and other clinicians through MIPS in January 2017, with payments based on those measures beginning in 2019.

Advanced Alternative Payment Models (APMs)

Clinicians who take a further step towards care transformation—participating to a sufficient extent in Advanced Alternative Payment Models—would be exempt from MIPS payment adjustments and would qualify for a 5 percent Medicare Part B incentive payment.

To qualify for incentive payments, clinicians would have to receive enough of their payments or see enough of their patients through Advanced APMs. The participation requirements are specified in statute and increase over time.

Under the new law, Advanced APMs are the CMS Innovation Center models, Shared Savings Program tracks, or statutorily-required demonstrations where clinicians accept both risk and reward for providing coordinated, high-quality, and efficient care. These models must also meet criteria for payment based on quality measurement and for the use of EHRs. The proposed rule lays out specific criteria for determining what would qualify as an Advanced APM. These include criteria designed to ensure that primary care physicians have opportunities to participate in Advanced APMs through medical home models.

The proposed rule includes a list of models that would qualify under the terms of the proposed rule as Advanced APMs. These include:

- Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program—Track 2
- Medicare Shared Savings Program—Track 3
- Next Generation ACO Model
- Oncology Care Model Two-Sided Risk Arrangement (available in 2018)

Under the proposed rule, CMS would update this list annually to add new payment models that qualify to be an Advanced APM. CMS will continue to modify models in coming years to help them qualify as Advanced APMs. In addition, starting in performance year 2019, clinicians could qualify for incentive payments based, in part, on participation in Advanced APMs developed by non-Medicare payers, such as private insurers or state Medicaid programs. The proposed rule also establishes the Physician-Focused Payment Technical Advisory Committee to review and assess additional physician-focused payment models suggested by stakeholders.

Intermediate Options

In order to determine whether clinicians met the requirements for the Advanced APM track, all clinicians will report through MIPS in the first year.

The proposed rule provides flexibility for participating in MIPS and makes it easy for clinicians to move between the components of the Quality Payment Program—the MIPS track or the Advanced APM track

For example:

MIPS participants who participate in APMs would receive credit toward scores in the Clinical Practice Improvement Activities category.

Certain Advanced APMs participants, who fall short of the payment or patient participation requirements for the incentive payments, but meet a lower threshold of participation, would be able to choose whether they would like to receive the MIPS payment adjustment.

Wherever possible, the proposed rule aligns standards between the two parts of the Quality Payment Program in order to make it easy for clinicians to move between them.

We expect that the number of clinicians who qualify for the incentive payments from participating in Advanced APMs will grow as the program matures and as physicians take advantage of the intermediate tracks of the Quality Payment Program to experiment with participation in APMs.

Beginning a Dialogue

In implementing the new law, we were guided by the same principles underlying the bipartisan legislation itself: streamlining and strengthening value and quality-based payments for all physicians; rewarding participation in Advanced APMs that create the strongest incentives for high-quality, coordinated, and efficient care; and giving doctors and other clinicians flexibility regarding how they participate in the new payment system.

Today's rule incorporates input received to date, but it is only a first step in an iterative process for implementing the new law. We welcome additional feedback from patients, caregivers, clinicians, health care professionals, Congress and others on how to better achieve these goals. HHS looks forward to feedback on the proposal and will accept comments until June 26, 2016.

Comments may be submitted electronically through our e-Regulation website at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking

Summary of the Major Provisions

Provisions Related to the Merit-Based Incentive Payment System

Currently, Medicare measures doctors and other clinicians on how they provide patient quality and reduce costs through a patchwork of programs, with clinicians reporting through some combination of the Physician Quality Reporting System, the Value Modifier Program, and the Medicare Electronic Health Record (EHR) Incentive Program. Through the law, Congress streamlined and improved these programs into one new Merit-based Incentive Payment System (MIPS).

MIPS Score

Consistent with the goals of the law, the proposed rule would improve the relevancy of Medicare's value and quality-based payments and increase clinician flexibility by allowing clinicians to choose measures and activities appropriate to the type of care they provide. MIPS allows clinicians to be paid for providing high quality care through measured success in four performance categories.

Under MIPS, clinicians will have the option to be assessed as a group across all four MIPS performance categories. The MIPS score measures clinicians' overall care delivery. Therefore, clinicians do not need to limit their MIPS reporting to the care provided to Medicare beneficiaries.

Payment Adjustments

The law requires MIPS to be budget neutral. Therefore, clinicians' MIPS scores would be used to compute a positive, negative, or neutral adjustment to their Medicare Part B payments.

In the first year, depending on the variation of MIPS scores, adjustments are calculated so that negative adjustments can be no more than 4 percent, and positive adjustments are generally up to 4 percent. The positive adjustments will be scaled up or down to achieve budget neutrality, meaning that the maximum positive adjustment could be lower or higher than 4 percent.

Per the law, both positive and negative adjustments would increase over time. Additionally, in the first five payment years of the program, the law allows for $500 million in an additional performance bonus that is exempt from budget neutrality for exceptional performance. This exceptional performance bonus will provide high performers a gradually increasing adjustment based on their MIPS score that can be no higher than an additional 10 percent.

As specified under the statute, negative adjustments would increase over time, and positive adjustments would correspond. The maximum negative adjustments for each year are:

2019	2020	2021	2022 and after
4%	5%	7%	9%

Participants

MIPS applies to Medicare Part B clinicians, including physicians, physician assistants, nurse practitioners, clinical nurse specialist, and certified registered nurse anesthetists. All Medicare Part B clinicians will report through MIPS during the first performance year, which begins January 2017. Medicare Part B clinicians may be exempted from the payment adjustment under MIPS if they:

Are newly enrolled in Medicare;

Have less than or equal to $10,000 in Medicare charges and less than or equal to 100 Medicare patients; or

Are significantly participating in an Advanced Alternative Payment Model (APM).

Physicians who meet the criteria for Advanced APM incentive payments do not receive a payment adjustment under MIPS and instead receive a 5 percent Medicare Part B incentive payment. Clinicians who significantly participate in an Advanced APM, but do not qualify for incentive payments can choose whether to receive a payment adjustment under MIPS.

Performance Period

The first performance period for MIPS would be from January 1, 2017 through December 31, 2017. MIPS combines the requirements of the Physician Quality Reporting System, the Value Modifier Program, and the Medicare EHR Incentive Program into a single, improved reporting program. Therefore, the last performance period for these separate reporting programs would be January 1, 2016 through December 31, 2016.

The first payment year for MIPS will be 2019, based on the first performance period of 2017.

Quality

(50 percent of total score in year 1; replaces the Physician Quality Reporting System)

The quality category accounts for 50 percent of the MIPS score in the first year. For this category, clinicians would choose six measures to report (versus the nine measures currently required under Physician Quality Reporting System). In addition, for individual clinicians and small groups (2-9 clinicians), MIPS calculates two population measures based on claims data, meaning there are no additional reporting requirements for clinicians for population measures. For groups with 10 clinicians or more, MIPS calculates three population measures. The measures would be each worth up to ten points for a total of 80 to 90 possible points depending on group size.

The proposal strives to align with the private sector and reduce the reporting burden by including the core quality measures that private payers already use for their clinicians. When choosing the six quality measures, clinicians would choose one crosscutting measure and one outcome measure (if available) or another high quality measure. High quality measures are measures related to patient outcomes, appropriate use, patient safety, efficiency, patient experience, or care coordination. There will be more than 200 measures to pick from and more than 80 percent of the quality measures proposed are tailored for specialists. Clinicians may

also choose to report a specialty measure set—which are specifically designed around certain conditions and specialty-types—instead of the six measures described above.

Advancing Care Information Category

The Advancing Care Information category (formerly Meaningful Use) would account for 25 percent of the MIPS score in the first year. For this category, clinicians must use certified EHR technology and would choose to report a customizable set of measures that reflects how they use EHR technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange. This category would no longer require all-or-nothing EHR measurement or quality reporting. The measures align with the Office of the National Coordinator for Health Information Technology's 2015 Edition Health IT Certification Criteria.

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. There are multiple paths to achieve the maximum score in this category.

Base Score: The base score accounts for 50 points of the total Advancing Care Information category score. To receive the base score, clinicians must 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/no)

Patient Electronic Access (numerator/denominator)

Coordination of Care Through Patient Engagement (numerator/denominator)

Electronic Prescribing (numerator/denominator)

Health Information Exchange (numerator/denominator)

Public Health and Clinical Data Registry Reporting (yes/no)

Because of the importance of protecting patient privacy and security, clinicians must achieve the Protect Patient Health Information objective to receive any score in the Advance Care Information performance category.

This proposal would no longer require reporting on the Clinical Decision Support and the Computerized Provider Order Entry objectives for the base score.

Performance Score: The performance score accounts for up to 80 points towards the total Advancing Care Information category score (note that the score can exceed 100 points, but anyone who score 100 points or above will receive the maximum 25 points towards the MIPS score). Clinicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:

Patient Electronic Access

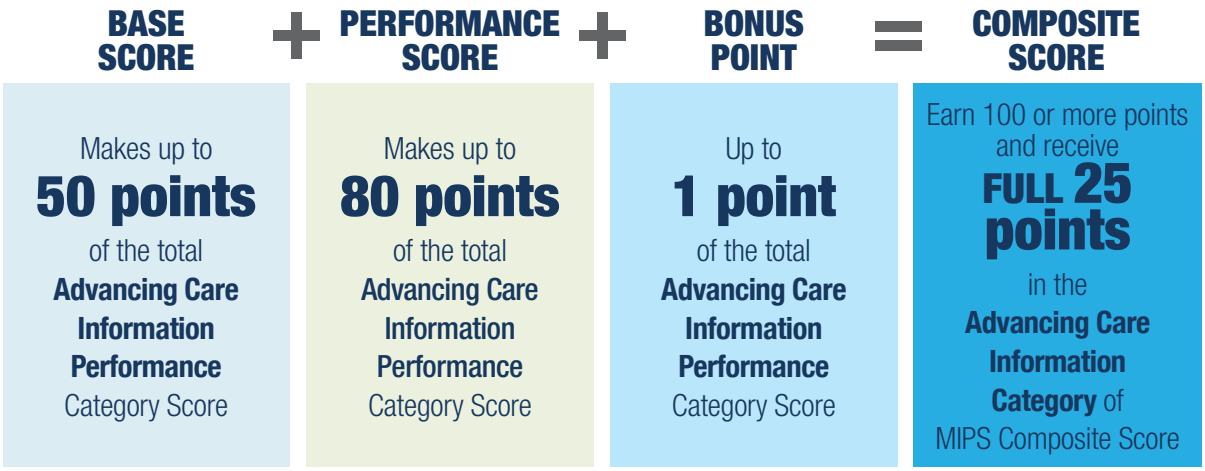
Coordination of Care Through Patient Engagement

Health Information Exchange

Public Health Registry Bonus Point: Immunization registry reporting is required. In addition, clinicians may choose to report on more than one public health registry, and will receive one additional point for reporting beyond the immunization category.

The clinicians' base score, performance score, and bonus point (if applicable) are added together for a total of up to 131 points. If clinicians earn 100 points or more then they receive the full 25 points in the Advancing Care Information category. If clinicians earn less than 100 points, their overall score in MIPS declines proportionately—scoring is not all-or-nothing.

For clinicians for whom the objectives and measures are not applicable (for example, a hospital-based clinician), CMS proposes to reweight the Advancing Care Information performance category to zero, and adjust the other MIPS performance category scores to make up the difference in the MIPS score.



Clinical Practice Improvement Activities Category

(15 percent of total score in year 1)

The clinical practice improvement activities category accounts for 15 percent of the MIPS score in the first year. For this category, MIPS would reward clinical practice improvement activities such as activities focused on care coordination, beneficiary engagement, and patient safety, which clinicians would select from a list of more than 90 options. In addition, clinicians would receive credit toward scores in this category for participating in Alternative Payment Models and Patient-Centered Medical Homes.

Based on the law and the feedback received in the 2015 Request for Information, CMS proposes more than 90 activities (which will be updated annually) that clinicians may choose from in the following categories:

Expanded Practice Access	Beneficiary Engagement	Achieving Health Equity
Population Management	Patient Safety and Practice Assessment	Emergency Preparedness and Response
Care Coordination	Participation in an APM, including a medical home model	Integrated Behavioral and Mental Health

The maximum total points in this category would be 60 points. CMS proposes to determine a clinicians' score by weighting the activities on which they report. Highly weighted activities would be worth 20 points, and other activities would be worth 10 points. CMS proposes that activities that would be highly weighted would be those activities that support the patient-centered medical home, as well as activities that support the transformation of clinical practice or a public health priority. Some examples of highly weighted activities are the collection and follow-up on patient experience or seeing Medicaid patients in a timely manner. Clinicians who are not patient-facing (for example, pathologists or radiologists) will only need to report on one activity.

Cost Category

(10 percent of total score in year 1; replaces the Value Modifier Program, also known as Resource Use)

The cost category accounts for 10 percent of the MIPS score in the first year. For this category, MIPS calculates scores based on Medicare claims, meaning there are no additional reporting requirements for clinicians under the cost category. This category uses over 40 episode-specific measures to account for differences among specialties. For cost measures, clinicians that deliver more efficient, high quality care achieve better performance, so clinicians scoring the highest points would have the most efficient resource use.

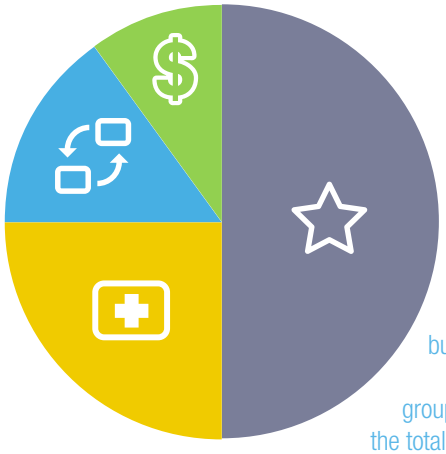
Each cost measure would be worth up to 10 points. Clinicians must see a sufficient number of patients in each cost measure to be scored, which is generally a minimum of a 20-patient sample. The clinician's cost score would be calculated based on the average score of all the cost measures that can be attributed to the clinician. For example, if a clinician only has two cost measures with sufficient patient volume to be scored, then the total number of points they could earn is 20 points. Their score will be the number of points they earned divided by the 20 possible points.

If a clinician does not have enough patient volume for any cost measures, then a cost score would not be calculated. CMS would reweight the cost category to zero, and adjust the other MIPS performance category scores to make up the difference in the MIPS score.

Table 1 below summarizes the categories of MIPS as proposed.

Table 1: Summary of MIPS Performance Categories

Performance Category	Points Need to Get a Full Score per Performance Category[1]	Maximum Possible Points per Performance Category
Quality: 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 quality measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 percent
Advancing Care Information: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
Clinical Practice Improvement Activities: 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.	60 points	15 percent
Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all resource measures that can be attributed.	10 percent



[1]These total points generally apply, but possible exemptions or adjustments may apply depending on a clinician or groups' circumstances which would cause the total score for the category to be different.

Reporting

The rule proposes to allow third parties, including registries, Qualified Clinical Data Registries, health information technology developers, and certified survey vendors to act as intermediaries on behalf of clinicians and submit data for the performance categories as applicable.

Provisions Related to Advanced Alternative Payment Models

For clinicians who take a further step towards care transformation, the law creates another path. Clinicians who participate to a sufficient extent in Advanced APMs would qualify for incentive payments.

Importantly, the law does not change how any particular APM rewards value. Instead, it creates extra incentives for participation in Advanced APMs. For years 2019 through 2024, a clinician who meets the law's standards for Advanced APM participation is excluded from MIPS adjustments and receives a 5 percent Medicare Part B incentive payment. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and receives a higher fee schedule update than those clinicians who do not significantly participate in an Advanced APM.

Standards for Advanced Alternative Payment Models (APMs)

Under the law, Advanced APMs are those in which clinicians accept risk for providing coordinated, high-quality care. As proposed, to be an Advanced APM, models must be a CMS Innovation Center model or a statutorily required demonstration and must generally:

1. **Require participants to bear a certain amount of financial risk.** Under our proposal, an Advanced APM would meet the financial risk requirement if CMS would withhold payment, reduce rates, or require the entity to make payments to CMS if its actual expenditures exceed expected expenditures. We propose that the amount of risk must meet the following standards:
    - Total risk (maximum amount of losses possible under the Advanced APM) must be at least 4 percent of the APM spending target.
    - Marginal risk (the percent of spending above the APM benchmark (or target price for bundles) for which the Advanced APM Entity is responsible (i.e., sharing rate) must be at least 30 percent.
    - Minimum loss rate (the amount by which spending can exceed the APM benchmark (or bundle target price) before the Advanced APM Entity has responsibility for losses) must be no greater than 4 percent.
2. **Base payments on quality measures comparable to those used in the MIPS quality performance category.** To meet this requirement, we propose that an Advanced APM must base payment on quality measures that are evidence-based, reliable, and valid. In addition, at least one such measure must be an outcome measure if an outcome measure appropriate to the Advanced APM is available on the MIPS measure list.
3. **Require participants to use certified EHR technology.** To meet this requirement, we propose that an Advanced APM must require that at least 50 percent of the clinicians use certified EHR technology to document and communicate clinical care information in the first performance year. This requirement increases to 75 percent in the second performance year.

Special Rules for Medical Home Models

Under the statute, medical home models that have been expanded under the Innovation Center authority qualify as Advanced APMs regardless of whether they meet the financial risk criteria. While medical home models have not yet been expanded, the proposed rule lays out criteria for medical home models to ensure that primary care physicians have opportunities to participate in Advanced APMs.

The rule proposes a definition of medical home models, which focus on primary care and accountability for empaneled patients across the continuum of care. Because medical homes tend to have both less experience with financial risk than larger organizations and limited capability to sustain substantial losses, we propose unique Advanced APM financial risk standards, consistent with the statute, to accommodate medical homes that are part of organizations with 50 or fewer clinicians.

Advanced Alternative Payment Models

The proposed rule includes a list of models that qualify as Advanced APMs under the terms of the proposed rule for the first performance year. These are:

Comprehensive End Stage Renal Disease Care Model (Large Dialysis Organization arrangement)	Comprehensive Primary Care Plus	Medicare Shared Savings Program—Track 2
Medicare Shared Savings Program—Track 3	Next Generation ACO Model	Oncology Care Model Two-Sided Risk Arrangement (available in 2018)

Under the proposed rule, CMS would update this list annually to add new payment models that qualify. CMS will continue to modify models in coming years to help them qualify as Advanced APMs.

Qualifying for Incentive Payments by Significantly Participating in Advanced APMs

To qualify for incentive payments, clinicians would have to receive enough of their payments or see enough of their patients through Advanced APMs. Clinicians will have the option to be assessed as a group to qualify for incentive payments. In 2019 and 2020, the participation requirements for Advanced APMs are only for Medicare payments or patients. Starting in 2021, the participation requirements for Advanced APMs may include non-Medicare payers and patients. CMS estimates that as many as 90,000 clinicians could receive the bonus for substantially participating in Advanced APMs in the first payment year.

As shown in Table 2 below, over time, the requirements would increase to require greater commitment to Advanced APM participation.

Table 2:
Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)

Payment Year	2019	2020	2021	2022	2023	2024 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Physician-focused Payment Technical Advisory Committee Will Identify Future Opportunities for APM Participation

The law established the Physician-focused Payment Technical Advisory Committee (PTAC) to review and assess additional Physician-Focused Payment Models based on proposals submitted by stakeholders to the Committee. The eleven members of the Committee were appointed in October 2015 by the US Comptroller General based on their expertise in physician-focused payment models and related delivery of care. The Committee will meet on a quarterly basis, and may meet more frequently as it starts to receive payment model proposals. The rule proposes criteria for the Committee to use in making comments and recommendations on proposed Physician-focused Payment Models. The criteria require that proposed Physician-Focused Payment Models further the goals outlined by the law, as well as reduce cost, improve care or both. The law, through this committee, provides a unique opportunity for stakeholders to have a key role in the development of new models and to help determine priorities for the physician community. For more information, go to https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee.

All-Payer Combination Option

Starting in performance year 2019, clinicians could qualify for incentive payments based in part on participation in Advanced APMs developed by non-Medicare payers, such as private insurers or state Medicaid programs.

If clinicians do not meet the required percentage of payments provided or patients cared for through an Advanced APM through Medicare alone, then payments and patients under payers beside Medicare called “Other Payer Advanced APMs” will also be able to count towards their participation status. In this rule, we propose criteria for Other Payer Advanced APMs that are similar to those proposed for Advanced APMs and specify standards for Medicaid medical home models.

Intermediate Options

For clinicians that participate to some extent in APMs, but may not meet the law's criteria for sufficient participation in the most advanced models. The proposed rule provides financial rewards within MIPS, and makes it easy for clinicians to move between the components of the Quality Payment Program. In order to determine whether clinicians met the requirements for the Advanced APM track, all clinicians will report through MIPS in the first year. For example:

MIPS participants who participate in APMs would receive credit in the Clinical Practice Improvement Activities category.

Wherever possible, the proposed rule aligns standards between the two parts of the Quality Payment Program (MIPS and the Advanced APM track) in order to make it easy for clinicians to move between them.

Advanced APMs participants who fall short of the requirements for the incentive payments would be able to choose whether they would like to receive a payment adjustment through MIPS. In order to opt out of the MIPS payment adjustment for 2019 and 2020, the clinician must receive 20 percent of their Medicare payments through an Advanced APM or must see 10 percent of their Medicare patients through an Advanced APM.

We expect that the number of clinicians who qualify as participating in Advanced APMs will grow as the program matures and as physicians take advantage of the intermediate tracks of the Quality Payment Program to experiment with participation in APMs.

Provisions Related to Public Reporting and Transparency

Per the law and as part of our commitment to transparent information and patient-centered care, we propose to make publically available the results of the Quality Payment Program on the Physician Compare website to help patients make informed choices. The law requires public reporting of the following information:

Names of clinicians in Advanced APMs

As feasible, the names and performance of Advanced APMs

MIPS scores for clinicians, including aggregate and individual scores for each performance category.

Consistent with current Physician Compare policies for the Physician Quality Reporting System and the Medicare EHR Incentive program, we propose a 30-day preview period in advance of the publication of any data on Physician Compare. Clinicians will be able to review and submit corrections prior to any information being made public.