

amendment corrects technical and typographic errors in the preamble and regulation text included in the 2015 EHR Incentive Programs final rule with comment period. The corrections contained in this document are consistent with, and do not make substantive changes to, the policies that were adopted subject to notice and comment procedures in the final rule with comment period. As a result, the corrections made through this correcting amendment are intended to ensure that the 2015 EHR Incentive Programs final rule with comment period accurately reflects the policies adopted in that rule. In addition, even if this were a rulemaking to which the notice and comment procedures and delayed effective date requirements applied, we find that there is good cause to waive such requirements. Undertaking further notice and comment procedures to incorporate the corrections in this document into the final rule with comment period or delaying the effective date would be contrary to the public interest because it is in the

public's interest for EPs, eligible hospitals, and critical access hospitals to be advised, in a timely manner, of the meaningful use criteria and EHR reporting periods that they must meet in order to qualify for Medicare and Medicaid electronic health record incentive payments and avoid payment reductions under Medicare, and to ensure that the final rule with comment period accurately reflects our policies as of the date they take effect and are applicable. Furthermore, such procedures would be unnecessary due to the changes in the law made by the MACRA, under which the meaningful use payment adjustment for EPs under section 1848(a)(7)(A) of the Act will sunset at the end of CY 2018. The statements identified above in the preamble and the regulations text concerning a payment adjustment in 2019 are moot as a result of those changes in the law. In addition, such procedures would be unnecessary, as we are not altering our policies; rather, we are simply implementing correctly the policies that we previously

proposed, received comment on, and subsequently finalized. This correcting document is intended solely to ensure that the 2015 EHR Incentive Programs final rule with comment period accurately reflects these policies. Therefore, we believe we have good cause to waive the notice and comment and effective date requirements.

**IV. Correction of Errors**

In FR Doc. 2015–25595 of October 16, 2015 (80 FR 62762), we are making the following corrections:

1. On page 62905, first column, first partial paragraph, lines 7 through 10, the phrase “the payment adjustment in 2019 for returning participants and for the payment adjustment in 2018 for new participants” is corrected to read “the payment adjustment in 2018 for new participants”.

2. On page 62906, in TABLE 18—EHR REPORTING PERIODS AND RELATED PAYMENT ADJUSTMENT YEARS FOR EPs, the entry for 2017 is corrected to read as follows:

2017

	EHR reporting period for a payment adjustment year	Applies to avoid a payment adjustment in CY 2018	Applies to avoid a payment adjustment in CY 2019
EP new participants (including those demonstrating Stage 3 under Medicare or Medicaid).	Any continuous 90-day period in CY 2017.	Yes, if EP successfully attests by October 1, 2017.	N/A.
EP returning participants .....	N/A .....	N/A .....	N/A.

3. On page 62920, TABLE 21—BURDEN ESTIMATES STAGE 3, third column, third full paragraph (Measure 2), lines 8 and 10, the phrase “an electronic summary of care document from a source other than the provider’s EHR system.” is corrected to read “an electronic summary of care document.”.

**List of Subjects in 42 CFR Part 495**

Administrative practice and procedure, Electronic health records, Health facilities, Health professions, Health maintenance organizations (HMO), Medicaid, Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.

As noted in section II.B. of this correcting amendment, the Centers for Medicare & Medicaid Services is making the following correcting amendments to 42 CFR part 495:

**PART 495—STANDARDS FOR THE ELECTRONIC HEALTH RECORD TECHNOLOGY INCENTIVE PROGRAM**

■ 1. The authority citation for part 495 continues to read as follows:

**Authority:** Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

**§ 495.4 [Amended]**

■ 2. In § 495.4, paragraph (1)(ii)(C)(2) of the definition of “EHR reporting period for a payment adjustment year” is removed and reserved.

**§ 495.24 [Amended]**

■ 3. In § 495.24, paragraph (d)(7)(ii)(B)(2) is amended by removing the phrase “an electronic summary of care document from a source other than the provider’s EHR system.” and adding in its place the phrase “an electronic summary of care document.”.

Dated: May 25, 2016.

**Madhura Valverde,**

*Executive Secretary to the Department, Department of Health and Human Services.*

[FR Doc. 2016–12853 Filed 5–31–16; 8:45 am]

**BILLING CODE 4120–01–P**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Part 414**

[CMS–1631–F3]

RIN 0938–AS40

**Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Corrections**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Final rule; correcting amendment.

**SUMMARY:** This document corrects technical and typographical errors that appeared in the final rule with comment period published in the November 16, 2015 **Federal Register** (80 FR 70886 through 71386) entitled “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and

Other Revisions to Part B for CY 2016.” The effective date for the rule was January 1, 2016.

#### DATES:

*Effective Date:* This correcting document is effective May 31, 2016.

*Applicability Date:* The corrections indicated in this document are applicable beginning January 1, 2016.

**FOR FURTHER INFORMATION CONTACT:** Michelle Peterman (410) 786–2591.

#### SUPPLEMENTARY INFORMATION:

### I. Background

In FR Doc. 2015–28005 (80 FR 70886 through 71386), the final rule entitled “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016” (hereinafter referred to as the CY 2016 PFS final rule with comment period), there were a number of technical and typographical errors that are identified and corrected in section IV., the Correction of Errors. These corrections are applicable as of January 1, 2016.

### II. Summary of Errors

#### A. Summary of Errors in the Preamble

On page 71138, due to typographical errors, the QualityNet Help Desk email address, the qualified clinical data registry (QCDR) data validation execution report delivery date, and the email subject are incorrect.

On page 71139, due to typographical errors, the QualityNet Help Desk email address, the qualified registry data validation execution report delivery date, and the email subject are incorrect.

On pages 71141 and 71145, we incorrectly stated the Measure Application Validation (MAV) process utilized to determine the reporting of Physician Quality Reporting System (PQRS) cross-cutting resources.

On page 71147, we inadvertently omitted language restating the Consumer Assessment of Healthcare Providers and Systems (CAHPS) requirements that apply to groups of 100 or more eligible professionals (EPs) that register to participate in the Group Practice Reporting Option (GPRO) regardless of reporting mechanism.

On pages 71148 through 71150, we inadvertently omitted language restating the CAHPS requirement for the QCDR reporting option in Table 28—Summary of Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO.

#### B. Summary of Errors in Regulation Text

On page 71380 of the CY 2016 PFS final rule with comment period, we inadvertently omitted language in § 414.90(k)(5)(i). In this paragraph, we inadvertently omitted language restating the CAHPS requirements that apply to groups of 100 or more EPs that register to participate in the Group Practice Reporting Option (GPRO) regardless of reporting mechanism.

### III. Waiver of Proposed Rulemaking

Under 5 U.S.C. 553(b) of the Administrative Procedure Act (APA), the agency is required to publish a notice of the proposed rule in the **Federal Register** before the provisions of a rule take effect. Similarly, section 1871(b)(1) of the Act requires the Secretary to provide for notice of the proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment. In addition, section 553(d) of the APA, and section 1871(e)(1)(B)(i) of the Act mandate a 30-day delay in effective date after issuance or publication of a rule. Sections 553(b)(B) and 553(d)(3) of the APA provide for exceptions from the APA notice and comment, and delay in effective date requirements; similarly, sections 1871(b)(2)(C) and 1871(e)(1)(B)(ii) of the Act provide exceptions from the notice and comment, and delay in effective date requirements of the Act. Section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act authorize an agency to dispense with normal notice and comment rulemaking procedures for good cause if the agency makes a finding that the notice and comment process is impracticable, unnecessary, or contrary to the public interest; and includes a statement of the finding and the reasons for it in the notice. In addition, both section 553(d)(3) of the APA and section 1871(e)(1)(B)(ii) of the Act allow the agency to avoid the 30-day delay in effective date where such delay is contrary to the public interest and the agency includes in the rule a statement of the finding and the reasons for it.

In our view, this correcting document does not constitute a rulemaking that would be subject to these requirements. This document merely corrects typographical and technical errors in the CY 2016 PFS final rule with comment period. The corrections contained in this document are consistent with, and do not make substantive changes to, the policies and payment methodologies that were adopted subject to notice and comment procedures in the CY 2016 PFS final

rule with comment period. As a result, the corrections made through this correcting document are intended to ensure that the CY 2016 PFS final rule with comment period accurately reflects the policies adopted in that rule.

Even if this were a rulemaking to which the notice and comment and delayed effective date requirements applied, we find that there is good cause to waive such requirements.

Undertaking further notice and comment procedures to incorporate the corrections in this document into the CY 2016 PFS final rule with comment period or delaying the effective date of the corrections would be contrary to the public interest because it is in the public interest to ensure that the CY 2016 PFS final rule with comment period accurately reflects our final policies as soon as possible following the date they take effect. Further, such procedures would be unnecessary, because we are not altering the payment methodologies or policies, but rather, we are simply correcting the **Federal Register** document to reflect the policies that we previously proposed, received comment on, and subsequently finalized. This correcting document is intended solely to ensure that the CY 2016 PFS final rule with comment period accurately reflects these policies. For these reasons, we believe there is good cause to waive the requirements for notice and comment and delay in effective date.

### IV. Correction of Errors

In FR Doc. 2015–28005 of November 16, 2015 (80 FR 70886), make the following corrections:

#### A. Correction of Errors in the Preamble

1. On page 71138, second column, second paragraph, lines 8 through 12, the phrase and sentence “Desk at *Qnetsupport@sdps.org* by 5:00 p.m. e.s.t. on June 30, 2016. The email subject should be “PY2015 Qualified Registry Data Validation Execution Report.”” are corrected to read “Desk at *Qnetsupport@hcqis.org* by 5:00 p.m. e.s.t. on June 30, 2017. The email subject should be “PY2016 Qualified Registry Data Validation Execution Report.””.

2. On page 71139, third column, fifth full paragraph, lines 8 through 14, the phrase and sentence “Desk at *Qnetsupport@sdps.org* by 5:00 p.m. ET on June 30 of the year in which the reporting period occurs (that is, June 30, 2016 for reporting periods occurring in 2016). The email subject should be “PY2015 Qualified Registry Data Validation Execution Report.”” are corrected to read “Desk at *Qnetsupport@*

hcqis.org by 5:00 p.m. ET on June 30 following the year in which the reporting period occurs (that is, June 30, 2017 for the reporting periods occurring in 2016). The email subject should be “PY2016 Qualified Registry Data Validation Execution Report.””.

3. On page 71141, first column, first partial paragraph, lines 5 through 9, the sentence “In addition, the MAV process will also allow us to determine whether an EP should have reported on any of the PQRS cross-cutting measures.” is corrected to read “Please note, the MAV process is not utilized to determine whether an EP should have reported on any of the PQRS cross-cutting measures. This analysis occurs prior to the EP being subject to MAV.”.

4. On page 71145, third column, first partial paragraph, lines 4 through 8, the sentence “However, please note that the MAV process for the 2018 PQRS

payment adjustment will now allow us to determine whether a group practice should have reported on at least 1 cross-cutting measure.” is corrected to read “Please note, the MAV process is not utilized to determine whether an EP should have reported on any of the PQRS cross-cutting measures. This analysis occurs prior to the EP being subject to MAV.”.

5. On page 71147, the third column is corrected by adding the following paragraph after the first partial paragraph:

“For group practices of 100 or more EPs registered to participate in the GPRO via QCDR for the 2018 PQRS payment adjustment: The administration of the CAHPS for PQRS survey is REQUIRED. Therefore, if reporting via QCDR, these group practices must meet the following criterion for satisfactory reporting for the 2018 PQRS payment adjustment: For the 12-month

reporting period for the 2018 PQRS payment adjustment, report all CAHPS for PQRS survey measures via a certified survey vendor, and report at least 6 measures available for reporting under a QCDR covering at least 2 of the NQS domains, AND report each measure for at least 50 percent of the group practice’s patients. Of the non-CAHPS for PQRS measures, the group practice would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures—resource use, patient experience of care, efficiency/appropriate use, or patient safety.”

6. On page 71148 through 71150, Table 28—Summary of Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO is corrected to read as follows:

Reporting period	Group practice size	Measure type	Reporting mechanism	Satisfactory reporting criteria
12-month (Jan 1–Dec 31, 2016).	25–99 EPs; 100+ EPs (if CAHPS for PQRS does not apply).	Individual GPRO Measures in the Web Interface.	Web Interface .....	Report on all measures included in the web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group’s sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 percent of assigned beneficiaries. In other words, we understand that, in some instances, the sampling methodology we provide will not be able to assign at least 248 patients on which a group practice may report, particularly those group practices on the smaller end of the range of 25–99 EPs. If the group practice is assigned less than 248 Medicare beneficiaries, then the group practice must report on 100 percent of its assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31, 2016).	25–99 EPs that elect CAHPS for PQRS;. 100+ EPs (if CAHPS for PQRS applies).	Individual GPRO Measures in the Web Interface + CAHPS for PQRS.	Web Interface + CMS-Certified Survey Vendor.	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. In addition, the group practice must report on all measures included in the Web Interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group’s sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 percent of assigned beneficiaries. A group practice will be required to report on at least 1 measure for which there is Medicare patient data. Please note that, if the CAHPS for PQRS survey is applicable to a group practice who reports quality measures via the Web Interface, the group practice must administer the CAHPS for PQRS survey in addition to reporting the Web Interface measures.

Reporting period	Group practice size	Measure type	Reporting mechanism	Satisfactory reporting criteria
12-month (Jan 1–Dec 31, 2016).	2–99 EPs; 100+ EPs (if CAHPS for PQRS does not apply).	Individual Measures ...	Qualified Registry .....	Report at least 9 measures, covering at least 3 of the NQS domains. Of these measures, if a group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice would report on at least 1 measure in the PQRS cross-cutting measure set. If less than 9 measures covering at least 3 NQS domains apply to the group practice, the group practice would report on each measure that is applicable to the group practice, AND report each measure for at least 50 percent of the group's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.
12-month (Jan 1–Dec 31, 2016).	2–99 EPs that elect CAHPS for PQRS; 100+ EPs (if CAHPS for PQRS applies).	Individual Measures + CAHPS for PQRS.	Qualified Registry + CMS-Certified Survey Vendor.	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of the CAHPS for PQRS survey, covering at least 2 of the NQS domains using the qualified registry. If less than 6 measures apply to the group practice, the group practice must report on each measure that is applicable to the group practice. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice must report on at least 1 measure in the PQRS cross-cutting measure set.
12-month (Jan 1–Dec 31, 2016).	2–99 EPs; 100+ EPs (if CAHPS for PQRS does not apply).	Individual Measures ...	Direct EHR Product or EHR Data Submission Vendor Product.	Report 9 measures covering at least 3 domains. If the group practice's direct EHR product or EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report all of the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31, 2016).	2–99 EPs that elect CAHPS for PQRS; 100+ EPs (if CAHPS for PQRS applies).	Individual Measures + CAHPS for PQRS.	Direct EHR Product or EHR Data Submission Vendor Product + CMS-Certified Survey Vendor.	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the direct EHR product or EHR data submission vendor product. If less than 6 measures apply to the group practice, the group practice must report all of the measures for which there is Medicare patient data. Of the additional 6 measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, a group practice would be required to report on at least 1 measure for which there is Medicare patient data.

Reporting period	Group practice size	Measure type	Reporting mechanism	Satisfactory reporting criteria
12-month (Jan 1–Dec 31, 2016).	2–99 EPs; 100+ EPs (if CAHPS for PQRS does not apply).	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR.	Qualified Clinical Data Registry (QCDR).	Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50 percent of the group practice’s patients. Of these measures, the group practice would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures—resource use, patient experience of care, efficiency/appropriate use, or patient safety.
12-month (Jan 1–Dec 31, 2016).	2–99 EPs that elect CAHPS for PQRS; 100+ EPs (if CAHPS for PQRS applies).	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR + CAHPS for PQRS.	Qualified Clinical Data Registry (QCDR) + CMS-Certified Survey Vendor.	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of the CAHPS for PQRS survey, covering at least 2 of the NQS domains using the QCDR AND report each measure for at least 50 percent of the group practice’s patients. Of these non-CAHPS measures, the group practice would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures—resource use, patient experience of care, efficiency/appropriate use, or patient safety.

**List of Subjects in 42 CFR Part 414**

Administrative practices and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

Accordingly, 42 CFR chapter IV is corrected by making the following correcting amendments to part 414:

**PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES**

■ 1. The authority citation for part 414 continues to read as follows:

**Authority:** Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

■ 2. Section 414.90 is amended by revising paragraph (k)(5)(i) to read as follows:

**§ 414.90 Physician Quality Reporting System (PQRS).**

\* \* \* \* \*

(k) \* \* \*  
(5) \* \* \*

(i) If a group practice does not report the CAHPS for PQRS survey measures, report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, and report each measure for at least 50 percent of the eligible professional’s patients. Of these measures, report on at least 3

outcome measures, or, if 3 outcomes measures are not available, report on at least 2 outcome measures and at least 1 of the following types of measures—resource use, patient experience of care, efficiency/appropriate use, or patient safety. If a group practice reports the CAHPS for PQRS survey measures, apply reduced criteria as follows: 6 QCDR measures covering 2 NQS domains; and, of the non-CAHPS for PQRS measures, 2 outcome measures or 1 outcome and 1 other specified type of measure, as applicable.

\* \* \* \* \*

Dated: May 25, 2016.

**Madhura Valverde,**

*Executive Secretary to the Department.*

[FR Doc. 2016–12841 Filed 5–31–16; 8:45 am]

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**DEPARTMENT OF COMMERCE**

**National Telecommunications and Information Administration**

**47 CFR Part 300**

[Docket Number: 160523450–6450–01]

**RIN 0660–AA32**

**Revision to the Manual of Regulations and Procedures for Federal Radio Frequency Management**

**AGENCY:** National Telecommunications and Information Administration, U.S. Department of Commerce.

**ACTION:** Final rule.

**SUMMARY:** The National Telecommunications and Information Administration (NTIA) is making certain changes to its regulations relating to the public availability of the Manual of Regulations and Procedures for Federal Radio Frequency Management (NTIA Manual). Specifically, NTIA is releasing an update to the current edition of the NTIA Manual, with which federal agencies must comply when requesting use of radio frequency spectrum. NTIA is also making changes to the regulatory text to comply with the Incorporation by Reference formatting structure.

**DATES:** This regulation is effective on June 1, 2016. The incorporation by