the Agencies and also Form 8–Ks with the SEC announcing they have entered into an agreement to merge. Subsequent findings in the course of due diligence cause A and B to terminate the merger agreement and A files an additional Form 8–K announcing the termination of an agreement. A states that it may seek to enter into a new or amended merger agreement with B. A's premerger notification filing is deemed to have been withdrawn on the date of the filing of the Form 8–K announcing the termination of the merger agreement. A can, however, refile within two business days on a new merger agreement, commencing a new waiting period, without paying an additional filing fee, if it meets the requirements of § 803.12(c).

6. A and B enter into a merger agreement and file premerger notification filings with the Agencies and Form 8–Ks with the SEC. Second requests are issued. A and B subsequently certify compliance with the second request, starting the extended waiting period. Prior to the expiration of the extended waiting period, the parties enter into an agreement with the agency conducting the investigation to delay closing of the transaction, allowing the consummation of the acquisition only after 30-days' notice (a ''timing agreement''), and the extended waiting period expires. During the pendency of the timing agreement, A and B terminate the merger agreement and A files a Form 8–K with the SEC announcing the termination of an agreement. A's premerger notification filing is deemed withdrawn on the date of the SEC filing as a result of that filing, even though the extended waiting period has expired and the parties are still within the one year period following that expiration under § 803.7(a). Note that had the extended waiting period expired and no timing agreement had been entered into, a filing with the SEC announcing the termination of the agreement would not result in the withdrawal of A's premerger notification filing.

7. A and B enter into a merger agreement and file premerger notification filings with the Agencies and Form 8–Ks with the SEC. The agencies complete their review and early termination of the initial 30-day waiting period is granted. Prior to the expiration of the one year period following the grant of early termination, A and B terminate the merger agreement and A files a Form 8–K with the SEC announcing the termination of an agreement. A's premerger notification filing is not deemed withdrawn as a result of the SEC filing because the initial 30-day premerger notification waiting period had been granted early termination. Therefore, the parties still have the full one year period prior to the expiration of the notification under § 803.7(a) to consummate the transaction should it be recommenced.

By direction of the Commission.

Donald S. Clark,

Secretary.

Note: The following appendix will not appear in the Code of Federal Regulations.

Concurring Statement of Commissioner Joshua D. Wright Regarding Proposed Amendments to Hart-Scott-Rodino Rules

FTC Matter No. P859910

February 1, 2013.

The Commission has voted today to publish a notice of proposed rulemaking seeking comment on amendments to the Hart-Scott-Rodino (HSR) rules. Under the proposed amendments, HSR filings would be automatically withdrawn upon the submission of an SEC filing that the notified transaction had been terminated.[1] I wish to thank staff in the Premerger Notification Office for their efforts in crafting this proposed rule and their diligent administration of the premerger notification program.

I concur in the Commission's decision because I believe the Commission would benefit from the public's input into this proposed rulemaking. Nevertheless, I am concerned that the proposed rules may impose costs in excess of any potential benefits.

The proposed rulemaking appears to be a solution in search of a problem. The **Federal Register** notice states that the proposed rules are necessary to prevent the FTC and DOJ from ''expend[ing] scarce resources on hypothetical transactions.'' Yet, I have not to date been presented with evidence that any of the over 68,000 transactions notified under the HSR rules have required Commission resources to be allocated to a truly hypothetical transaction. Indeed, it would be surprising to see firms incurring the costs and devoting the time and effort associated with antitrust review in the absence of a good faith intent to proceed with their transaction.

The proposed rules, if adopted, could increase the costs of corporate takeovers and thus distort the market for corporate control. Some companies that had complied with or were attempting to comply with a Second Request, for example, could be forced to restart their antitrust review, leading to significant delays and added expenses. The proposed rules could also create incentives for firms to structure their transactions less efficiently and discourage the use of tender offers. Finally, the proposed new rules will disproportionately burden U.S. public companies; the **Federal Register** notice acknowledges that the new rules will not apply to tender offers for many non-public and foreign companies.

Given these concerns, I hope that interested parties will avail themselves of the opportunity to submit public comments so that the Commission can make an informed decision at the conclusion of this process.

[1] The proposed rulemaking would also codify, with one modification, the existing procedure for pulling and refiling an HSR notification without payment of an additional filing fee. I have no objections to this proposal.

[FR Doc. 2013–02821 Filed 2–13–13; 8:45 am]

BILLING CODE 6750–01–P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[Docket ID DOD–2012–HA–0105]

RIN 0720–AB58

TRICARE Revision to CHAMPUS DRG-Based Payment System, Pricing of Hospital Claims

AGENCY: Office of the Secretary, Department of Defense.

ACTION: Proposed rule.

SUMMARY: This rule proposes to change TRICARE's current regulatory provision for hospital claims priced under the DRG-based payment system. Claims are currently priced by using the rates and weights that are in effect on a beneficiary's date of admission. This rule proposes to change that provision to price such claims by using the rates and weights that are in effect on a beneficiary's date of discharge.

DATES: Written comments received at the address indicated below by April 15, 2013 will be accepted.

ADDRESSES: You may submit comments, identified by docket number and or Regulatory Information Number (RIN) number and title, by either of the following methods:

- *Federal eRulemaking Portal: www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Federal Docket Management System Office, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350–3100.

Instructions: All submissions received must include the agency name and

docket number or RIN for this **Federal Register** document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the Internet at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

FOR FURTHER INFORMATION CONTACT: Ms. Amber Butterfield, TRICARE Management Activity, Medical Benefits and Reimbursement Systems, telephone (303) 676–3565.

SUPPLEMENTARY INFORMATION:

Executive Summary and Overview

I. Purpose of the Regulatory Action

This rule proposes to amend the TRICARE/CHAMPUS regulatory provision of pricing hospital claims that are reimbursed under the DRG-based payment system from the beneficiary's date of admission, to pricing such claims based on the beneficiary's date of discharge.

The TRICARE/CHAMPUS DRG-based payment system applies to hospitals, unless such hospital is exempt by regulation from the payment system. Under the TRICARE DRG-based payment system, payment for the operating costs of inpatient hospital services subject to the payment system are made on the basis of prospectively determined rates.

The TRICARE DRG-based payment system is modeled on the Medicare Inpatient Prospective Payment System (IPPS). Although many of the procedures in the TRICARE DRG-based payment system are similar or identical to the procedures in the Medicare IPPS, the actual payment amounts, DRG weights, and certain procedures are different. This is necessary because of the differences in the two programs, especially in the beneficiary population.

Since the inception of the DRG-based payment system in 1987, claims have been priced following the beneficiary's discharge by the hospital, but using the rules, weights, and rates that were in effect on the beneficiary's date of admission. That is, claims submitted for the beneficiary's inpatient stay are grouped to a specific DRG, and the pricing (*i.e.,* payment rate) is determined by using the rules, weights and rates that were in effect on the date of the beneficiary's admission to the hospital. The August 31, 1988, Final Rule (53 FR 33461) published in the **Federal Register** explains TRICARE's decision to utilize the date of admission to price claims. Using the date of admission to price claims allowed hospitals to be reimbursed for inpatient services under the same payment methodology they expected to be used when the patient was admitted. Prior to implementation of the DRG-based payment system, the hospital could expect to be reimbursed at the billed charge rate since that was the method TRICARE used to reimburse hospitals at that time. For patients admitted after implementation of the DRG-based payment system, the hospital could expect to be reimbursed using the DRG-based payment system. The Final Rule continues by stating that since certain services were previously excluded from the DRG-based system, but may have already involved an interim bill prior to the effective date of the Final Rule, it would be administratively difficult and fiscally unfair to hospitals, to attempt to reconcile the total payments with the DRG-based allowed amounts. As a result of the analysis at the time, the provision stated, ''except for interim claims submitted for qualifying outlier cases, all claims reimbursed under the CHAMPUS DRG-based payment system are to be priced as of the date of admission, regardless of when the claim is submitted.''

II. Summary of the Major Provisions of the Regulatory Action

The major provision of this proposed rule is to revise TRICARE's regulation on the pricing of claims paid under the DRG-based payment system. Claims are currently priced by using the rates and weights that are in effect on a beneficiary's date of admission. This rule proposes to change that provision to price such claims by using the rates and weights that are in effect on a beneficiary's date of discharge.

In the early stages of the DRG-based payment system, the approach of pricing claims based on the date of the beneficiary's admission to the hospital was an effective operational policy for TRICARE. It is now time, however, to revise this policy to be consistent with industry standards. Medicare and other payers have an operational policy of pricing all claims, to include interim claims, based on the date of discharge. While pricing using the date of discharge applies to all claims, it becomes an issue only for those relatively few claims that span Fiscal Years (FY). That is, if an admission occurs on September 29, 2013, (FY 2013) and the discharge occurs on October 2, 2013, (FY2014) the payment rate is currently based upon the DRG rates and weights in effect on September 29, 2013, (FY2013) rather than on October 2, 2013, (FY2014). Using this same example, if the provisions of this proposed rule are made final and the date of discharge is used to price the claim, the claim will be priced using the rates and weights in place on October 2, 2013, (FY2014). The rates and weights for the DRG-based payment system are updated every FY, and are based on the previous year's TRICARE claims data.

III. Costs and Benefits

The benefits of this change include, aligning TRICARE pricing of hospital claims practices with industry standards and enhancing provider satisfaction because we are following Medicare and industry standards.

There are known cost impacts associated with this change:

1. One-time information technology costs associated with changes to Managed Care Support Contractors' claims processing systems and one time administrative costs associated with the review change order and the assessment of the impact on Claims Operations, Customer Service, Provider Administration and Contracts Maintenance. The total one time information technology and administrative costs is estimated at $88,208.

2. An annual cost of reprocessing interim claims of $2,500.

3. An increase in health care costs to account for using the weights and rates in place on the date of discharge. Using 2009 claims data, it is estimated about 1,200 inpatient claims will span FYs. Consequently, reimbursing using the updated weights and rates in place for the new FYs date of discharge is expected to increase the payment for approximately 1,200 claims with estimated additional cost of $500,000 annually.

4. Total costs for this change equal approximately $600,000.

IV. Regulatory Procedures

Executive Order 12866, ''Regulatory Planning and Review'' and Executive Order 13563, ''Improving Regulation and Regulatory Review''

Section 801 of title 5, United States Code, and Executive Orders 12866 and 13563 require certain regulatory assessments and procedures for any major rule or significant regulatory action, defined as one that would result in an annual effect of $100 million or more on the national economy or which would have other substantial impacts. It has been certified that this rule is not economically significant, and has been reviewed by the Office of Management and Budget as required under the provisions of E.O. 12866.

Public Law 104–4, Section 202, ''Unfunded Mandates Reform Act''

Section 202 of Public Law 104–4, ''Unfunded Mandates Reform Act,'' requires that an analysis be performed to determine whether any federal mandate may result in the expenditure by State, local and tribal governments, in the aggregate, or by the private sector of $100 million in any one year. It has been certified that this proposed rule does not contain a Federal mandate that may result in the expenditure by State, local and tribal governments, in aggregate, or by the private sector, of $100 million or more in any one year, and thus this proposed rule is not subject to this requirement.

Public Law 96–354, ''Regulatory Flexibility Act'' (RFA) (5 U.S.C. 601)

Public Law 96–354, ''Regulatory Flexibility Act'' (RFA) (5 U.S.C. 601), requires that each Federal agency prepare a regulatory flexibility analysis when the agency issues a regulation which would have a significant impact on a substantial number of small entities. This proposed rule is not an economically significant regulatory action, and it has been certified that it will not have a significant impact on a substantial number of small entities. Therefore, this proposed rule is not subject to the requirements of the RFA.

Public Law 96–511, ''Paperwork Reduction Act'' (44 U.S.C. Chapter 35)

This rule does not contain a ''collection of information'' requirement, and will not impose additional information collection requirements on the public under Public Law 96–511, ''Paperwork Reduction Act'' (44 U.S.C. Chapter 35).

Executive Order 13132, ''Federalism''

E.O. 13132, ''Federalism,'' requires that an impact analysis be performed to determine whether the rule has federalism implications that would have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. It has been certified that this proposed rule does not have federalism implications, as set forth in E.O. 13132.

List of Subjects in 32 CFR part 199

Claims, Dental health, Health care, Health insurance, Individuals with disabilities, Military personnel.

Accordingly, 32 CFR Part 199 is amended as follows:

PART 199—[AMENDED]

■ 1. The authority citation for Part 199 continues to read as follows:

Authority: 5 U.S.C. 301; 10 U.S.C. chapter 55.

■ 2. Section 199.14 is amended by revising paragraph (a)(1)(i)(C)(*3*) to read as follows:

§ 199.14 Provider Reimbursement Methods

(a) * * *
(1) * * *
(i) * * *
(C) * * *

(*3*) *Pricing of claims.* All claims reimbursed under the CHAMPUS DRG-based payment system are to be priced as of the date of discharge, regardless of when the claim is submitted.

* * * * *

Dated: February 1, 2013.

Patricia L. Toppings,

OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2013–03419 Filed 2–13–13; 8:45 am]

BILLING CODE 5001–06–P

ARCHITECTURAL AND TRANSPORTATION BARRIERS COMPLIANCE BOARD

36 CFR Part 1192

RIN 3014–AA42

Rail Vehicles Access Advisory Committee

AGENCY: Architectural and Transportation Barriers Compliance Board.

ACTION: Notice of intent to establish advisory committee.

SUMMARY: We, the Architectural and Transportation Barriers Compliance Board (Access Board), plan to revise and update our accessibility guidelines issued pursuant to the Americans with Disabilities Act for transportation vehicles that operate on fixed guideway systems (e.g., rapid rail, light rail, commuter rail, and intercity rail). We are establishing a Rail Vehicles Access Advisory Committee (Committee) to make recommendations for revisions and updates to the accessibility guidelines. We request applications from interested organizations for representatives to serve on the Committee.

DATES: Submit applications by April 1, 2013.

ADDRESSES: Submit applications by any of the following methods:

- *Mail or Hand Delivery/Courier:* Paul Beatty, Access Board, 1331 F Street NW., Suite 1000, Washington, DC 20004–1111.
- *Fax:* 202–272–0081.
- *Email: rvaac@access-board.gov.*

FOR FURTHER INFORMATION CONTACT: Paul Beatty, Access Board, 1331 F Street NW., Suite 1000, Washington, DC 20004–1111. Telephone: (202) 272–0012 (Voice) or (202) 272–0072 (TTY). Email address: *rvaac@access-board.gov.*

SUPPLEMENTARY INFORMATION: In this notice, ''we,'' ''us'' and ''our'' refer to the Architectural and Transportation Barriers Compliance Board (Access Board).

The Americans with Disabilities Act requires us to issue guidelines to ensure that transportation vehicles covered by the statute are accessible to individuals with disabilities. 42 U.S.C. 12204. Our accessibility guidelines for transportation vehicles form the basis for legally enforceable accessibility standards issued by the U.S. Department of Transportation (DOT). Our accessibility guidelines for transportation vehicles are codified at 36 CFR part 1192; the DOT accessibility standards for transportation vehicles are codified at 49 CFR part 38.

We issued a notice of proposed rulemaking (NPRM) in 2010 to revise and update our accessibility guidelines for buses, over-the-road buses, and vans. 75 FR 43748 (July 26, 2010). The NPRM noted that we would revise and update our accessibility guidelines for transportation vehicles that operate on fixed guideway systems (e.g., rapid rail, light rail, commuter rail, and intercity rail) at a future date. To begin the process of revising and updating our accessibility guidelines for transportation vehicles that operate on fixed guideway systems, we are establishing a Rail Vehicles Access Advisory Committee (Committee) to make recommendations for revisions and updates to the guidelines. We request applications from representatives of the following interests for membership on the Committee:

- Manufacturers of transportation vehicles that operate on fixed guideway systems;
- Transportation providers that operate fixed guideway systems;
- Organizations representing individuals with disabilities; and
- Other entities whose interests may be affected by the accessibility guidelines.

Federal agencies may serve as ex-officio members on the advisory committee.

The number of Committee members will be limited so that the Committee's