Antitrust Improvements Act of 1976, Public Law 94–435, 90 Stat. 1390 ("the Act"), requires all persons contemplating certain mergers or acquisitions, which meet or exceed the jurisdictional thresholds in the Act, to file notification with the Commission and the Assistant Attorney General and to wait a designated period of time before consummating such transactions. Section 7A(a)(2) requires the Federal Trade Commission to revise those thresholds annually, based on the change in gross national product, in accordance with Section 8(a)(5). The new thresholds, which take effect 30 days after publication in the **Federal Register**, are as follows:

Subsection of 7A	Original threshold	Adjusted threshold
7A(a)(2)(A)	$200 million	$263.8 million.
7A(a)(2)(B)(i)	$50 million	$66.0 million.
7A(a)(2)(B)(i)	$200 million	$263.8 million.
7A(a)(2)(B)(ii)(i)	$10 million	$13.2 million.
7A(a)(2)(B)(ii)(i)	$100 million	$131.9 million.
7A(a)(2)(B)(ii)(II)	$10 million	$13.2 million.
7A(a)(2)(B)(ii)(II)	$100 million	$131.9 million.
7A(a)(2)(B)(ii)(III)	$100 million	$131.9 million.
7A(a)(2)(B)(ii)(III)	$10 million	$13.2 million.
Section 7A note: Assessment and Collection of Filing Fees [1] (3)(b)(1)	$100 million	$131.9 million.
Section 7A note: Assessment and Collection of Filing Fees (3)(b)(2)	$100 million	$131.9 million.
Section 7A note: Assessment and Collection of Filing Fees (3)(b)(2)	$500 million	$659.5 million.
Section 7A note: Assessment and Collection of Filing Fees (3)(b)(3)	$500 million	$659.5 million.

[1] Public Law 106–553, Sec. 630(b) amended Sec. 18a note.

Any reference to these thresholds and related thresholds and limitation values in the HSR rules (16 CFR Parts 801–803) and the Antitrust Improvements Act Notification and Report Form and its Instructions will also be adjusted, where indicated by the term "(as adjusted)," as follows:

Original threshold	Adjusted threshold
$10 million	$13.2 million
$50 million	$66.0 million
$100 million	$131.9 million
$110 million	$145.1 million
$200 million	$263.8 million
$500 million	$659.5 million
$1 billion	$1,319.0 million

DATES: *Effective Date:* February 24, 2011.

FOR FURTHER INFORMATION CONTACT: B. Michael Verne, Bureau of Competition, Premerger Notification Office, (202) 326–3100.

Authority: 16 U.S.C. 7A.

By direction of the Commission.

Donald S. Clark,

Secretary.

[FR Doc. 2011–1501 Filed 1–24–11; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Information Technology Extension Program

ACTION: Public Notice.

SUMMARY: This notice announces changes to the Health Information Technology Extension Program, which assists providers seeking to adopt and become meaningful users of health information technology, as authorized under section 3012(c) of the Public Health Service Act, as added by the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) (ARRA).

FOR FURTHER INFORMATION CONTACT: The Office of the National Coordinator for Health Information Technology, 200 Independence Ave, SW., Suite 729D, Washington, DC 20201, Phone 202–690–7151, E-mail: *onc.request@hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

On February 17, 2009, the President signed the American Recovery and Reinvestment Act of 2009 (ARRA). Title XIII of Division A and Title IV of Division B of ARRA, together cited as the Health Information Technology for Economic and Clinical Health Act (HITECH Act), include provisions to promote meaningful use of health information technology to improve the quality and value of American health care. The HITECH Act also established the Office of the National Coordinator for Health Information Technology (ONC) within the U.S. Department of Health and Human Services (HHS) as the principal Federal entity responsible for coordinating the effort to implement a nationwide health information technology (health IT) infrastructure that allows for the use and exchange of electronic health information in electronic format.

Subtitles A and B of Title IV in Division B of ARRA authorize incentive payments for eligible Medicare and Medicaid providers' adoption and meaningful use of certified electronic health record (EHR) technology. In 2015, Medicare eligible providers are expected to have adopted and be actively utilizing certified EHR technology in compliance with the "meaningful use" definition or they will be subject to payment adjustments under Medicare (per sections 4101(b) and 4102(b) of ARRA). The detailed criteria to qualify for meaningful use incentive payments were established by the Secretary of HHS (hereafter referred to as the Secretary) through the formal notice-and-comment rulemaking process. For access to the most current publicly available information about meaningful use, please visit the Meaningful Use section of the ONC programmatic Web site (*http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__meaningful_use_announcement/2996*) and *http://www.cms.gov/EHRIncentivePrograms/.*

Providers seeking to meaningfully use certified EHR technology face a variety of challenging tasks. Those tasks include assessing needs, selecting and negotiating with a system vendor or reseller, implementing project management, and instituting workflow changes to improve clinical performance and ultimately, outcomes. Past experience has shown that robust local technical assistance can result in effective implementation of EHRs and quality improvement throughout a defined geographic area.

Section 3012 of the Public Health Service Act (PHSA), as added by ARRA (*see* Appendix A), authorized the establishment of the Health Information Technology Extension Program (Extension Program). By statute, the Extension Program is to include a national Health Information Technology

Research Center (HITRC), and grant funding toward the creation and operation of Regional Extension Centers (Regional Centers).

The purpose of the Regional Centers is to furnish assistance (defined as education, outreach, and technical assistance) to help providers in their geographic service areas select, successfully implement, and meaningfully use certified EHR technology to improve the quality and value of health care. Regional Centers will also help providers achieve, through appropriate available infrastructures, exchange of health information in compliance with applicable statutory and regulatory requirements, and patient preferences. In doing this work, Regional Centers will also seek to ensure consistency with any applicable State HIE plan(s) that are developed under the cooperative agreements issued by ONC pursuant to section 3013 of the PHSA.

Pursuant to requirements of section 3012(c)(5) of the PHSA, Regional Centers must give priority to providers that are primary-care providers (physicians and/or other health care professionals with prescriptive privileges, such as physician assistants and nurse practitioners) in any of the following settings:

- Individual and small group practices (ten or fewer professionals with prescriptive privileges) primarily focused on primary care;
- Public and Critical Access Hospitals;
- Community Health Centers and Rural Health Clinics; and
- Other settings that predominantly serve uninsured, underinsured, and medically underserved populations.

A practice otherwise meeting the definition of individual or small-group physician practice, above, may participate in shared-services and/or group purchasing agreements, and/or reciprocal agreements for patient coverage, with other physician practices without affecting its status as individual or small-group practice for purposes of the Regional Centers.

In any given Regional Center's service area, some priority primary-care providers (as described above) may have already acquired and/or implemented EHR technology. Such providers remain priority providers, though the technical assistance required is anticipated to be focused on movement from having an EHR to achieving all aspects of meaningful use of EHR technology, including but not necessarily limited to electronic exchange of health information and reporting of quality measures using the EHR.

The ultimate measure of a Regional Center's effectiveness will be whether it has assisted providers in becoming meaningful users of certified EHR technology.

Cooperative agreement awards were made pursuant to an open competition to establish 62 Regional Centers. The awards were made on a rolling basis. The first set of 32 Regional Center awards was made in February 2010, the second set of 28 awards was made in April 2010, and the final 2 awards were made in September 2010.

While section 3012(c)(5) of the PHSA generally limited Federal funding for Regional Centers to 50% of their capital and annual operating and maintenance funds, it included a provision allowing for different cost sharing in instances in which the prescribed cost sharing ceiling would "render this cost-sharing requirement detrimental to the program." The Secretary made this finding, and, as a result, the original cooperative agreement award was comprised of a four-year project period, consisting of two two-year budget periods. The first budget period (years 1 and 2) had a 90/10 cost share requirement and the second budget period (years 3 and 4) had a 10/90 cost share requirement. For the first budget period the grantee was responsible for contributing 1 dollar for every 9 Federal dollars. For the second budget period, the grantee was responsible for contributing 9 dollars for every 1 dollar of Federal funds.

II. Description of Changes

In overseeing the ongoing Extension Program, the Secretary found that the established cost sharing requirements (90/10 in years one and two, and 10/90 in years three and four) are continuing to "render [the] cost-sharing requirement detrimental to the program" due to national economic conditions To alleviate these concerns, the Secretary will be seeking bi-lateral modifications to the grants to alter the initial timeline and cost-sharing requirements in the Regional Center grants. Through these modifications, the timeline would be lengthened in the first budget period from two years to four years, and the cost-sharing requirement would reflect a 90/10 Federal/grantee cost share for all four years. Modifications will be effectuated through the execution of revised Notice of Grant Awards (NGA).

If modified, the cost share requirements for the cooperative agreement will be as follows:

Year	Federal amount of costs (percent)	Recipient amount of costs (percent)
1	90	10
2	90	10
3	90	10
4	90	10

It is expected that the Regional Centers will generate resources to support cost sharing in ways that demonstrate hospital, provider, and community commitment to the project and its goals of supporting adoption and meaningful use of health IT. Such sources of funding to support the project's cost share obligation under the cooperative agreement could include per-provider participation fees. This statement does not preclude recipients using other legal sources of cost sharing contributions as governed by 45 CFR part 74. All of the funds for cooperative agreement should be spent during the base award's budget period (Years 1, 2, 3, and 4), including the cost sharing requirement described above.

Fees and other funds generated by the project are considered program income under 45 CFR Part 74. Program income generated by the recipient must be retained by the recipient and first used to finance the non-Federal share of the project. To support sustainability, ONC places no limits on the accrual of program income. After the Federal cost sharing requirement is met, program income generated using Federal funds, including fees for services, must be added to funds committed to the project by the Federal government and used to further eligible project or program objectives.

As stated in the original Funding Opportunity Announcement (FOA), a positive biennial evaluation will be required for grantees to continue work in years 3 and 4 of the grant; this requirement is unchanged by the December 2010 waiver. The anticipated bi-lateral modifications to the original grants will include achievement of a positive biennial evaluation as a term and condition of the grant. The previously approved goals, objectives, activities and timelines of the Regional Center program remain unchanged.

David Blumenthal,

National Coordinator for Health Information Technology.

[FR Doc. 2011–1447 Filed 1–24–11; 8:45 am]

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