effects arising from the Transaction. Significant entry barriers include the availability of attractive real estate, the time and cost associated with constructing a new retail fuel outlet, and the time associated with obtaining necessary permits and approvals.

V. The Proposed Consent Agreement

The proposed Consent Agreement remedies the Transaction's anticompetitive effects by requiring 7-Eleven to sell retail fuel outlets in some local markets to Sunoco and reject Sunoco retail fuel outlets in other local markets pursuant to the Respondents' asset purchase agreement (thereby allowing Sunoco to retain these assets). Sunoco intends to convert the acquired or retained stations from company-operated sites to commission agent sites. This remedy would preserve competition as it is today, ensure that the divestiture assets go to a viable, large-scale competitor, and reduce the risks and costs associated with asset integration.

The Commission is satisfied that allowing Sunoco to acquire or retain retail fuel stations and transition them to commission agent sites is an appropriate remedy. Most importantly, the proposed remedy preserves competition in each local market. Indeed, as Sunoco controls retail fuel pricing at both its company-operated stations and its commission agent stations, Sunoco and 7-Eleven would continue as independent retail fuel competitors in each local market. Moreover, Sunoco is a large, viable competitor capable of maintaining the competitive landscape in each local market. Finally, the proposed Consent Agreement reduces the uncertainty and costs relating to integration since Sunoco already is familiar with the majority of the stations at issue.

The proposed Consent Agreement also requires that for up to six months following the divestiture, with up to an additional twelve months at the buyer's option, 7-Eleven make available transitional services, as needed, to assist the buyer of each divestiture asset. The buyer may extend the period for an additional twelve months, but only with Commission approval.

In addition to requiring outlet divestitures, the proposed Consent Agreement also requires 7-Eleven to provide the Commission (and Florida, Texas, or Virginia, where applicable) notice before acquiring designated outlets in the 76 local areas for ten years. The prior notice provision is necessary because acquisitions of the designated outlets likely would raise competitive concerns and may fall below the HSR Act premerger notification thresholds.

The proposed Consent Agreement contains additional provisions designed to ensure the effectiveness of the proposed relief. For example, Respondents have agreed to an Order to Maintain Assets that will issue at the time the proposed Consent Agreement is accepted for public comment. The Order to Maintain Assets requires Respondents to operate and maintain each divestiture outlet in the normal course of business through the date the Respondents' complete divestiture of the outlet, thereby maintaining the economic viability, marketability, and competitiveness of each divestiture asset. During this period, and until such time as the buyer (or buyers) no longer requires transitional assistance, the Order to Maintain Assets authorizes the Commission to appoint an independent third party as a monitor to oversee the Respondents' compliance with the requirements of the proposed Consent Agreement.

The proposed Consent Agreement also requires Sunoco to take steps to ensure that its employees in charge of setting retail fuel prices at the acquired or retained retail fuel outlets do not have access to confidential information about Sunoco's post-Transaction wholesale supply of 7-Eleven's retail fuel stations. To ensure appropriate firewalls remain in place for the duration of the Respondents' fuel supply agreement, the proposed Consent Agreement has a term of fifteen years.

The purpose of this analysis is to facilitate public comment on the proposed Consent agreement, and the Commission does not intend this analysis to constitute an official interpretation of the proposed Consent Agreement or to modify its terms in any way.

By direction of the Commission.

Donald S. Clark,

Secretary.

[FR Doc. 2018–01547 Filed 1–26–18; 8:45 am]

BILLING CODE 6750–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Agency for Healthcare Research and Quality, HHS.

ACTION: Notice.

SUMMARY: This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed information collection project ''Outcome Measure Repository (OMR).''

DATES: Comments on this notice must be received by March 30, 2018.

ADDRESSES: Written comments should be submitted to: Doris Lefkowitz, Reports Clearance Officer, AHRQ, by email at *doris.lefkowitz@AHRQ.hhs.gov*.

Copies of the proposed collection plans, data collection instruments, and specific details on the estimated burden can be obtained from the AHRQ Reports Clearance Officer.

FOR FURTHER INFORMATION CONTACT: Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427–1477, or by emails at *doris.lefkowitz@AHRQ.hhs.gov*.

SUPPLEMENTARY INFORMATION:

Proposed Project

Outcome Measure Repository

In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3521, AHRQ invites public comment on this proposed information collection. In accordance with the agency's mission, AHRQ developed the Outcome Measure Repository (OMR), a web-based database with the purpose of providing a readily available public resource that includes definitions of outcome measures associated with patient registries. The information being collected in each OMR record will be visible to the public and readily available for public use.

This effort is in alignment the AHRQ Registry of Patient Registries (RoPR), which provides a centralized point of collection for information about all patient registries in the United States. The RoPR furthers AHRQ's goals to enhance the description of the quality, appropriateness, and effectiveness of health services, and patient registries in particular, in a more readily available, central location by enhancing patient registry information, extracted from ClinicalTrials.gov or modeled based on the ClinicalTrials.gov data elements.

The development of the OMR continues these efforts, and aims to achieve the following objectives:

(1) Provide a searchable database of outcome measures used in patient registries in the United States to promote collaboration, reduce redundancy, and improve transparency;

(2) Facilitate the use of standardized data elements and outcome measures; and

(3) Facilitate the identification of potential areas of harmonization.

The OMR system will be linked to RoPR in two key ways. First, users entering registry information in the RoPR system will be able to associate OMR measure records with the RoPR registry records. Second, measure stewards listing a measure record in the OMR system will be able to associate the measure with an existing patient registry in RoPR. Users will be able to access both databases with a single account (*i.e.,* users with a RoPR account will be able to log in/access the OMR using that account, and vice versa).

This study is being conducted by AHRQ through its contractor, L&M Policy Research and subcontractors Truven Health Analytics, an IBM Company, and OM1, pursuant to AHRQ's statutory authority to conduct and support research on health care and on systems for the delivery of such care, including activities with respect to the outcomes, cost, cost-effectiveness, and use of health care services and access to such services, and with respect to health statistics and database development. 42 U.S.C. 299a(a)(3) and (8).

Method of Collection

To achieve the three objectives of this project, information on outcome measures and related sub-elements from measure stewards who populate the OMR database system will be collected. Users of the OMR will primarily fall into two types: those stewarding a registry who will provide information on the data they collect in their registry, and those who will search for information about how a particular type of outcome measure is collected within patient registries. For the OMR to succeed, the first group of users—registry stewards—must be able to enter information into the system easily and efficiently. The second group of users—parties interested in seeking information on outcome measures—must be able to find sufficient information efficiently on outcome measures to identify items for use in their own registry or research. Meeting the needs of both sets of users is an important consideration in the design of the OMR.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours for the respondent's time to contribute to the OMR.

Based on the number of respondents submitting RoPR records in 2016 (65 respondents), it is expected that a similar number of stakeholders (approximately 70 respondents) will provide measure information in the OMR on an annual basis.

All users will complete required fields on the ''Measure Profile'' form. Some users may also choose to complete the ''Sub-Element Profile'' form for one or more sub-elements associated with a given measure although this is not required. The number of sub-elements for a given measure is expected to vary widely. Many users may not provide sub-element information, while others may include five or more. It is expected that on average, measure stewards will enter information for two sub-elements.

In September 2017, Truven Health Analytics consulted with several stakeholders and used a sample of existing measure definitions to estimate the time required to enter all OMR fields. The sample included measures representing a range of depth and complexity. For example, one measure record contained no sub-element information, only required fields, and short responses to open text fields (*e.g.,* title and description). Another record contained two sub-elements, all optional fields, and longer responses to open text fields.

As a result of the knowledge gained during these processes, it is estimated that it will take users 16 minutes, on average, to enter manually the additional fields added through the self-registration process (an average of 12 minutes to complete the Measure Profile form and 4 minutes to complete two Sub-Element Profile sub-forms). If 70 respondents complete the Measure Profile form and two Sub-Element Profile sub-forms, the estimated annualized burden would be 18.7 hours total.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses er respondent	Minutes per response	Total burden hours
OMR Measure Profile/Sub-Element Profile	70	1	16/60	18.7
Total	70	1	16/60	18.7

Exhibit 2 shows the estimated cost burden associated with the respondent's time to participate in the OMR. The total cost burden to respondents is estimated at an average of $711.72 annually.

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate †	Total cost burden
OMR Measure Profile/Sub-Element Profile	70	18.7	$38.06	$711.72
Total	70	18.7	38.06	711.72

* Based on the mean wages for Healthcare Practitioners and Technical Occupations, 29–0000.
National Compensation Survey: Occupational Wages in the United States May 2016, ''U.S. Department of Labor, Bureau of Labor Statistics.'' Available at: *https://www.bls.gov/oes/current/oes290000.htm.*

Request for Comments

In accordance with the Paperwork Reduction Act, comments on AHRQ's information collection are requested with regard to any of the following: (a) Whether the proposed collection of information is necessary for the proper performance of AHRQ health care research and health care information

dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ's estimate of burden (including hours and costs) of the proposed collection(s) of information; (c) ways to enhance the quality, utility and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information upon the respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Sharon B. Arnold,

Deputy Director.

[FR Doc. 2018–01515 Filed 1–26–18; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–18–1122]

Agency Forms Undergoing Paperwork Reduction Act Review

In accordance with the Paperwork Reduction Act of 1995, the Centers for Disease Control and Prevention (CDC) has submitted the information collection request titled Congenital Heart Survey To Recognize Outcomes, Needs, and well-being (CH STRONG) to the Office of Management and Budget (OMB) for review and approval. CDC previously published a ''Proposed Data Collection Submitted for Public Comment and Recommendations'' notice on 09/20/2017 to obtain comments from the public and affected agencies. CDC did not receive comments related to the previous notice. This notice serves to allow an additional 30 days for public and affected agency comments.

CDC will accept all comments for this proposed information collection project. The Office of Management and Budget is particularly interested in comments that:

(a) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(b) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(c) Enhance the quality, utility, and clarity of the information to be collected;

(d) Minimize the burden of the collection of information on those who are to respond, including, through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses; and

(e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639–7570 or send an email to *omb@cdc.gov.* Direct written comments and/or suggestions regarding the items contained in this notice to the Attention: CDC Desk Officer, Office of Management and Budget, 725 17th Street NW, Washington, DC 20503 or by fax to (202) 395–5806. Provide written comments within 30 days of notice publication.

Proposed Project

Congenital Heart Surveillance To Recognize Outcomes, Needs, and Well-being (CHSTRONG) (OMB Control Number 0920–1122,Expiration 07/31/2017)—Reinstatement with Change—National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Congenital heart defects (CHDs) are the most common type of structural birth defects, affecting approximately 1 in 110 live-born children. In prior decades, many CHDs were considered fatal during infancy or childhood, but with tremendous advances in pediatric cardiology and cardiac surgery, at least 85% of patients now survive to adulthood and there are approximately 1.5 million adults with CHD living in the United States.

With vast declines in mortality from pediatric heart disease over the past 30 years, it is vital to evaluate long-term outcomes and quality of life issues for adults with CHD. However, U.S. data on long-term outcomes, quality of life issues, and comorbidities of adults born with CHD are lacking. U.S. data is needed to provide insight into the public health questions that remain for this population and to develop services and allocate resources to improve long-term health and wellbeing.

The initial request for this project was one year, but there were delays in recruitment due to challenges with tracking and tracing individuals for correct addresses. The three sites, Metro-Atlanta Congenital Defect Program (MACDP), University of Arizona, and University of Arkansas, decided to conduct more intensive and time-consuming tracking and tracing to identify more accurate contact information for all eligible individuals and for those individuals whose materials were returned as undeliverable. At MACDP, this required modifying a contract to include the task of tracking and tracing 2,313 individuals. While the large majority of tracking and tracing at all three sites took place in the first year of the project, including that for the 2,313 individuals above, an additional 1,115 mothers of eligible individuals need to be sent a contact information form to assist to locating their child. Due to these delays and changes in the recruitment process, CH STRONG data collection is expected to last an additional 24 months and conclude two years after receiving OMB approval.

Since July 2016, the three CH STRONG sites identified 9,228 individuals with CHD through their respective birth defects registries. The CH STRONG project has successfully tracked and traced 6,417 individuals for current contact information. To date, the three sites have sent recruitment materials to 3,651 individuals (40% of all individuals).

The purpose of this survey is to collect information on barriers to health care, quality of life, social and educational outcomes, and transition of care from childhood to adulthood among adults born with CHD. Currently, Congress has appropriated approximately $4 million per year to CDC to conduct surveillance among adults with CHD.

CH STRONG will survey adults aged 18 to 45 years of age and born with a CHD as identified through the birth defects surveillance system in three participating sites in the United States. The information collected from this cohort will be used to identify the healthcare, educational, and social service needs of adults with CHDs. Findings will be reported through peer-reviewed publications, presentations at state and national conferences, and webinars and reports to partners who work on CHD. The findings will be used by national, state and local organizations to allocate resources and develop services and programs for adults with CHD.

With the information collected in this survey, the CDC, along with its partners, will have information on healthcare