telehealth service includes the cost of medical consultations or appointments, lab work, or a drug, supplement, or other medical treatment; (b) that a product or service is free or without cost or obligation; (c) about the cost or price of a product or service, the total cost to obtain it, or the amount that a consumer will be charged; (d) that a consumer will not be charged for a product or service; (e) about the timing or manner of any charge or bill; (f) that a consumer purchased or agreed to purchase a product or service, or that a transaction has been authorized by a consumer, or that a customer is obligated to pay any charge for which the customer has not given express informed consent; (g) about the existence of a negative option feature or its terms; or (h) about any other fact material to consumers concerning the nature or terms of a refund, cancellation, exchange, or repurchase policy of a product or service, or about the performance, efficacy, nature, or central characteristics of a product or service.

Provision II prohibits any representation about the average or typical results or benefits achieved by users of a product or service, unless it is non-misleading and supported by competent and reliable evidence. Provision III prohibits any misrepresentation: (a) that an endorsement or review of a product or service is truthful or by an actual user, or (b) about the status of any endorser or person providing a review.

Provision IV prohibits charging a consumer without first obtaining the consumer's unambiguously affirmative consent to be charged. In doing so, respondents must disclose clearly and conspicuously, and in close proximity to any request for billing information, certain information, including the name of the seller, a description of the product or service, the length of any contract, the amount and timing of every charge, and all material limitations or conditions applicable to the purchase, receipt, or use of the product or service. Respondents also must maintain records of verification of consumers' consent for at least three years.

Provision V requires the clear and conspicuous disclosure of all material terms and conditions of any cancellation or refund policy before asking consumers to pay money or provide their billing information. It also requires providing a simple mechanism by which consumers can request a cancellation or refund. The provision prohibits denying a cancellation or refund request based on a minimum contract length or imposing an early termination fee unless those requirements were disclosed clearly and conspicuously prior to purchase. It also prohibits failing to promptly honor any consumer's cancellation or refund request that complies with policies in effect at the time of purchase, or if a product or service was not timely provided.

Provision VI prohibits making any misrepresentation about any endorser or reviewer of a product or service without disclosing, clearly and conspicuously, and in close proximity to that representation, any unexpected material connection between such endorser or reviewer and any Respondent or other individual or entity affiliated with the product or service. Provision VII prohibits Respondents from manipulating consumer reviews to distort or misrepresent what consumers think of a product or service, including by: selectively soliciting reviews from individuals more likely to give positive reviews; offering payments, refunds, or other incentives conditioned on removing or changing negative or critical reviews or posting positive or favorable reviews; or reporting, disputing, or selectively reporting negative or critical reviews as false, suspicious, or violative of policies without a reasonable basis for doing so.

Provision VIII requires Respondents to obtain consumers' authorization before initiating electronic fund transfers and provide consumers with advance notice of electronic fund transfers. Provision IX requires Respondents to pay the Commission $150,000 within eight days of the effective date of the order. Provision X sets out additional requirements related to the monetary relief. Provision XI requires the respondents to provide customer information to facilitate consumer redress. Provision XII requires Respondents to send letters to current members of their weight-loss programs notifying them of the Commission's action and telling the consumers how they can cancel their memberships.

Provisions XIII through XVI of the proposed order contain reporting and compliance provisions. Provision XIII mandates that Respondents acknowledge receipt of the order, distribute the order to principals, officers, and certain employees and agents, and obtain signed acknowledgments from them. Provision XIV requires them to submit compliance reports to the Commission one year after the order's issuance and submit notifications when certain events occur. Under Provision XV, Respondents must create certain records for fifteen years and retain them for five years. Provision XVI provides for the Commission's continued compliance monitoring of the respondents' activity during the order's effective dates. Finally, Provision XVII provides the effective dates of the order, including that, with exceptions, the order will terminate in 20 years.

The purpose of this analysis is to facilitate public comment on the proposed order. It is not intended to constitute an official interpretation of the complaint or proposed order, or to modify in any way the proposed order's terms.

By direction of the Commission.

April J. Tabor,

Secretary.

[FR Doc. 2025–13407 Filed 7–16–25; 8:45 am]

BILLING CODE 6750–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1842–N]

Medicare Program; Announcement of the Advisory Panel on Hospital Outpatient Payment Meeting—August 25, 2025

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

ACTION: Notice of meeting.

SUMMARY: This meeting notice announces the virtual meeting of the Advisory Panel on Hospital Outpatient Payment (the Panel) on Monday, August 25, 2025. The purpose of the Panel is to advise the Secretary on the clinical integrity of the Ambulatory Payment Classification groups and their associated weights, which are major elements of the Medicare Hospital Outpatient Prospective Payment System and the Ambulatory Surgical Center payment system, and supervision of hospital outpatient therapeutic services.

DATES:

Virtual Meeting Dates: Monday, August 25, 2025, from 9:30 a.m. to 5:00 p.m. Eastern Daylight Time (EDT). The time listed in this notice is approximate. Consequently, the meeting may be longer or shorter than the times listed in this notice but will not begin before the posted time.

Deadline for presentations and comments: Presentations or comment letters must be received by 5:00 p.m. EDT on Friday, August 01, 2025. Presentations or comment letters must be submitted through the ''Hospital Outpatient Payment (HOP) Panel Meeting Presentation & Comment

Letters'' module. To access the module, go to *https://mearis.cms.gov* to register, log in, and submit your presentation or comment letter. CMS can only accept HOP Panel Meeting presentations and comment letters that are submitted via MEARIS™. Please note that with the submissions in MEARIS™, CMS no longer requires the completion or submission of form CMS–20017 as part of the presentation or comment letter package. Therefore, submitters do not need to complete this form.

Presentations and comment letters that are not received by the due date and time will be considered late or incomplete and will not be included in the agenda. Presentations and comment letters may not be revised once they are submitted. If a presentation or comment letter requires changes, a new submittal must be submitted by August 01, 2025.

Please see additional information regarding the submission of section 508 compliant presentation and comment letter materials in section ''III. Presentations and Comment Letters'' of this notice.

ADDRESSES:

Virtual meeting location and webinar: The August 25, 2025, meeting will be held virtually via Zoom only. Closed captioning will be available on the webinar. Webinar information will appear on the final meeting agenda, which will be posted on our website when available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.*

Websites: For additional information on the Panel, including the Panel charter, and updates to the Panel's activities, we refer readers to view our website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.* Information about the Panel and its membership in the Federal Advisory Committee Act database is located at *https://www.facadatabase.gov.*

Virtual meeting registration: While there is no meeting registration, presenters must be identified and included as part of the MEARIS™ presentation submission process by the presentation and comment letter deadline specified in the **DATES** section of this notice. We note that no advanced registration is required for participants who plan to view the Panel meeting via Zoom webinar or may wish to make a public comment during the meeting.

FOR FURTHER INFORMATION CONTACT:

Abigail Cesnik, Designated Federal Official by email at *APCPanel@cms.hhs.gov.* Press inquiries are handled through the CMS Press Office at (202) 690–6145.

SUPPLEMENTARY INFORMATION:

I. Background

The Secretary of the Department of Health and Human Services (the Secretary) is required by section 1833(t)(9)(A) of the Social Security Act (the Act) and is allowed by section 222 of the Public Health Service Act to consult with an expert outside panel, such as the Advisory Panel on Hospital Outpatient Payment (the Panel), regarding the clinical integrity of the Ambulatory Payment Classification (APC) groups and relative payment weights. The Panel is governed by the provisions of the Federal Advisory Committee Act (Pub. L. 92–463), as amended (5 U.S.C. Appendix 2), to set forth standards for the formation and use of advisory panels. We consider the technical advice provided by the Panel as we prepare the final rule and the following calendar year's proposed rule to update the Hospital Outpatient Prospective Payment System (OPPS).

II. Virtual Meeting Agenda

The agenda for the August 25, 2025 virtual Panel meeting will provide for discussion and comment on the following topics as designated in the Panel's Charter:

- Addressing whether procedures within an APC group are similar both clinically and in terms of resource use.
- Reconfiguring APCs.
- Evaluating APC group weights.
- Review packaging costs of items and services, including drugs and devices, into procedures and services, including the methodology for packaging and the impact of packaging the cost of those items and services on APC group structure and payment.
- Removing procedures from the inpatient only list for payment under the OPPS.
- Using claims and cost report data for the Centers for Medicare & Medicaid Services' (CMS) determination of APC group costs.
- Addressing other technical issues concerning APC group structure.
- Evaluating the required level of supervision for hospital outpatient services.
- OPPS APC rates for covered Ambulatory Surgical Center (ASC) procedures.

The agenda will be posted on our website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups* approximately 1 week before the meeting.

Virtual Meeting Information Updates: The actual meeting hours and days will be posted in the agenda. As information and updates regarding this webinar and listen-only teleconference, including the agenda, become available, they will be posted to our website at *https://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.*

III. Presentations and Comment Letters

The subject matter of any presentation and comment letter must be within the scope of the Panel as designated in the Charter. Any presentations or comments outside of the scope of the Panel will be returned or requested for amendment. Unrelated topics include, but are not limited to: the conversion factor; charge compression; revisions to the cost report; pass-through payments; correct coding; new technology applications (including supporting information/documentation); provider payment adjustments; supervision of hospital outpatient diagnostic services; and the types of practitioners that are permitted to supervise hospital outpatient services. The Panel may not recommend that services be designated as nonsurgical extended duration therapeutic services. Presentations or comment letters that address OPPS APC rates as they relate to covered ASC procedures are within the scope of the Panel; however, ASC payment rates, ASC payment indicators, the ASC covered procedures list, or other ASC payment system matters will be considered out of scope. The Panel may use data collected or developed by entities and organizations other than the Department of Health and Human Services or CMS in conducting its review. We recommend organizations submit data for CMS staff and the Panel's review. All presentations are limited to 5 minutes, regardless of the number of individuals or organizations represented by a single presentation. Presenters may use their 5 minutes to represent either one or more agenda items.

Section 508 Compliance

For this meeting, we are aiming to have all presentations and comment letters available on our website. Materials on our website must be section 508 compliant to ensure access to Federal employees and members of the public with and without disabilities. Presenters and commenters should reference the guidance on making documents section 508 compliant as they draft their submissions, and, whenever possible, submit their

presentations and comment letters in a 508 compliant form. The section 508 guidance is available at *https://www.cms.gov/research-statistics-data-and-systems/cms-information-technology/section508.* Presentations and comment letters should limit the use of graphs or pictures. Any use of these visual depictions must include alternate text that verbally describes what these visuals convey.

We will review presentations and comment letters for section 508 compliance and place compliant materials on our website. As resources permit, we will also convert non-compliant submissions to section 508-compliant forms and offer assistance to submitters who are making their submissions section 508-compliant. All section 508-compliant presentations and comment letters will be made available on the CMS website. If difficulties are encountered accessing the materials, please contact the Designated Federal Official in the **FOR FURTHER INFORMATION CONTACT** section of this notice.

IV. Virtual Formal Presentations

In addition to formal presentations (limited to 5 minutes total per presentation), there will be an opportunity during the meeting for public comments as time permits (limited to 1 minute for each individual and a total of 3 minutes per organization).

V. Panel Recommendations and Discussions

The Panel's recommendations at any Panel meeting generally are not final until they have been reviewed and approved by the Panel prior to the final adjournment. These recommendations will be posted to our website after the meeting.

VI. Membership Appointments to the Advisory Panel on Hospital Outpatient Payment

The Panel Charter provides that the Panel shall meet up to 3 times annually. We consider the technical advice provided by the Panel as we prepare the OPPS proposed and final rules to update the OPPS for the following calendar year. The Panel shall consist of a chair and up to 15 members who are full-time employees of hospitals, hospital systems, or other Medicare providers that are subject to the OPPS. The Panel may also include a representative of a provider with ASC expertise, who advises CMS only on OPPS APC rates, as appropriate, impacting ASC covered procedures within the context and purview of the Panel's scope. The Secretary or a designee selects the Panel membership based upon either self-nominations or nominations submitted by Medicare providers and other interested organizations of candidates determined to have the required expertise. For supervision deliberations, the Panel may include members that represent the interests of critical access hospitals, who advise CMS only regarding the level of supervision for hospital outpatient therapeutic services. New appointments are made in a manner that ensures a balanced membership under the Federal Advisory Committee Act guidelines. The Secretary rechartered the Panel in 2024 for a 2-year period effective through November 20, 2026. The current charter is available on the CMS website at *https://www.cms.gov/files/document/2024-hop-panel-charter.pdf.*

VII. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Dr. Mehmet Oz, having reviewed and approved this document, authorizes Vanessa Garcia, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Vanessa Garcia,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2025–13428 Filed 7–16–25; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

[Office of Management and Budget #: 0970–0174]

Submission for Office of Management and Budget Review; Native Employment Works (NEW) Plan Guidance and NEW Program Report

AGENCY: Division of Tribal Temporary Assistance for Needy Families Management, Office of Family Assistance, Administration for Children and Families, U.S. Department of Health and Human Services.

ACTION: Request for Public Comment.

SUMMARY: The Administration for Children and Families (ACF) is requesting a 3-year extension of the Native Employment Works (NEW) Plan Guidance and NEW Program Report (Office of Management and Budget (OMB) #0970–0174, expiration August 31, 2025). There are minor changes requested to the NEW Plan Guidance.

DATES: *Comments due August 18, 2025.* OMB must make a decision about the collection of information between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function. You can also obtain copies of the proposed collection of information by emailing *infocollection@acf.hhs.gov.* Identify all emailed requests by the title of the information collection.

SUPPLEMENTARY INFORMATION:

Description: The NEW Program Plan Guidance documents specify the information needed to complete a NEW program plan and explains the process for plan submission every third year and to complete the annual program report. The program plan is the application for NEW program funding and documents how the grantee will carry out its NEW program.

The only proposed changes are the date of submission and the requirement that the plan be submitted electronically via the Online Data Collection system. The program report provides the U.S. Department of Health and Human Services, Congress, and grantees information to document and assess the activities and accomplishments of the NEW program. ACF proposes to extend the program report without changes.

Respondents: Indian tribes and tribal coalitions that operate NEW programs.