assess the sufficiency of any safeguards in place to control these risks;

• Design and implement reasonable safeguards to control the risks identified through risk assessment, and regularly test or monitor the effectiveness of the safeguards' key controls, systems, and procedures;

• Develop and use reasonable steps to select and retain service providers capable of appropriately safeguarding personal information they receive from Cbr, and require service providers by contract to implement and maintain appropriate safeguards; and

• Evaluate and adjust its information security program in light of the results of testing and monitoring, any material changes to operations or business arrangement, or any other circumstances that it knows or has reason to know may have a material impact on its information security program.

Part III of the proposed order requires Cbr to obtain within the first one hundred eighty (180) days after service of the order, and on a biennial basis thereafter for a period of twenty (20) years, an assessment and report from a qualified, objective, independent third-party professional, certifying, among other things, that: (1) It has in place a security program that provides protections that meet or exceed the protections required by Part II of the proposed order; and (2) its security program is operating with sufficient effectiveness to provide reasonable assurance that the security, confidentiality, and integrity of sensitive consumer, employee, and job applicant information has been protected.

Parts IV through VIII of the proposed order are reporting and compliance provisions. Part IV requires Cbr to retain documents relating to its compliance with the order. For most records, the order requires that the documents be retained for a five-year period. For the third-party assessments and supporting documents, Cbr must retain the documents for a period of three years after the date that each assessment is prepared. Part V requires dissemination of the order now and in the future to all current and future principals, officers, directors, and managers, and to persons with responsibilities relating to the subject matter of the order. Part VI ensures notification to the FTC of changes in corporate status. Part VII mandates that Cbr submit a compliance report to the FTC within 60 days, and periodically thereafter as requested. Part VIII is a provision ''sunsetting'' the order after twenty (20) years, with certain exceptions.

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 proposed complaint or order or to modify the order's terms in any way.

By direction of the Commission.

Donald S. Clark,

Secretary.

[FR Doc. 2013–02143 Filed 1–31–13; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifiers CMS–10409 and CMS–10461]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS) is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Long Term Care Hospital (LCTH) Continuity Assessment Record and Evaluation (CARE) Data Set; *Use:* Section 3004 of the Affordable Care Act authorizes the establishment of a new quality reporting program for LTCH. LTCHs that fail to submit quality measure data may be subject to a 2 percentage point reduction in their annual update to the standard Federal rate for discharges occurring during a rate year. In the FY 2013 IPPS/LTCH PPS final rule (76 FR 51743 through 51756), CMS retained three measures (NQF #0678, NQF #0138 and NQF #0139) and adopted two new measure (NQF #0680 and NQF#0431) for the FY 2016 payment determination. NQF #0680 is the percent of residents or patients who were assessed and appropriately given the seasonal influenza vaccine (short-stay). NQF #0431 is influenza vaccination coverage among healthcare personnel. The data collection for these two NQF endorsed measures will start January 1, 2014.

LTCH CARE Data Set was developed specifically for use in LTCHs for data collection of NQF #0678 Pressure Ulcer measures beginning October 1, 2012, with the understanding that the data set would expand in future rulemaking years with the adoption of additional quality measures. Relevant data elements contained in other well-known and clinically established data sets, including but not limited to the Minimum Data Set 3.0 (MDS 3.0) and CARE, were incorporated into the LTCH CARE Data Set V1.01. *Form Number:* CMS–10409 (OCN: 0938–1163); *Frequency:* Occasionally; *Affected Public:* Private Sector: Business or other for-profit and not-for-profit institutions; *Number of Respondents:* 442; *Total Annual Responses:* 403,988; *Total Annual Hours:* 212,160. (For policy questions regarding this collection contact Charles Padgett at 410–786–2811. For all other issues call 410–786–1326.)

2. *Type of Information Collection Request:* New collection (request for a new OMB control number). *Title of Information Collection:* Emergency Department Patient Experience of Care Survey. *Use:* This survey supports the six national priorities for improving care from the National Quality Strategy developed by the U.S. Department of Health and Human Services (HHS) that was called for under the Affordable Care Act to create national aims and priorities to guide local, state, and national efforts to improve the quality of health care. This strategy has established six priorities that support a three-part aim focusing on better care, better health, and lower costs through improvement. The six priorities include: making care safer by reducing harm caused by the delivery of care; ensuring that each person and family are engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and

governments by developing and spreading new health care delivery models. This survey will provide patient experiences with care data that enables making comparisons of emergency departments across the nation and promoting effective communication and coordination. *Form Number:* CMS–10461 (OCN 0938-New). *Frequency:* Once. *Affected Public:* Individuals and households. *Number of Respondents: Total Annual Responses:* 3,360. *Total Annual Hours:* 799. (For policy questions regarding this collection contact Sai Ma at 410–786–1479. For all other issues call 410–786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* or Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by April 2, 2013:

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number _____, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: January 29, 2013.

Martique Jones,

Deputy Director, Regulations Development Group, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2013–02155 Filed 1–31–13; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1602–N]

Medicare Program: Notice of Two Membership Appointments to the Advisory Panel on Hospital Outpatient Payment

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This notice announces two new membership appointments to the Advisory Panel on Hospital Outpatient Payment (HOP, the Panel). The two new appointments to the Panel will each serve a 4-year period. The new members will have terms that begin on February 1, 2013 and continue through January 31, 2017. The purpose of the Panel is to advise the Secretary of the Department of Health and Human Services and the Administrator of the Centers for Medicare & Medicaid Services concerning the clinical integrity of the Ambulatory Payment Classification groups and their relative payment weights. The Panel also addresses and makes recommendations regarding supervision of outpatient services. The advice provided by the Panel will be considered as we prepare the annual updates for the hospital outpatient prospective payment system.

FOR FURTHER INFORMATION CONTACT: For additional information on the Panel meeting dates, agenda topics, copy of the charter, as well as updates to the Panel's activities, search our Internet Web site: *https://www.cms.gov/Regulations-and Guidance/Guidance/FACA/AdvisoryPanelonAmbulatoryPaymentClassificationGroups.html* For other information regarding the Panel, contact Chuck Braver, the Designated Federal Officer at CMS, Center for Medicare, Hospital and Ambulatory Policy Group, Division of Outpatient Care, 7500 Security Boulevard, Mail Stop C4–05–17, Baltimore, MD 21244–1850, phone (410) 786–3985.

SUPPLEMENTARY INFORMATION:

I. Background

The Department of Health and Human Services (the Secretary) is required by section 1833(t)(9)(A) of the Social Security Act (the Act) (42 U.S.C. 1395l(t)(9)(A)) and section 222 of the Public Health Service Act (PHS Act) (42 U.S.C. 217a) to consult with an expert outside advisory panel on the clinical integrity of the Ambulatory Payment Classification groups and weights. The Advisory Panel on Hospital Outpatient Payment (HOP, the Panel) is governed by the provisions of the Federal Advisory Committee Act (FACA) (Pub. L. 92–463), as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory panels. 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 proposed and final rules to update the outpatient prospective payment system for the following calendar year.

The Panel shall consist of a Chair and up to 19 members who are full-time employees of hospitals, hospital systems, or other Medicare providers. The Secretary or a designee selects the Panel membership based upon either self-nominations or nominations submitted by Medicare providers and other interested organizations. New appointments are made in a manner that ensures a balanced membership under the FACA guidelines.

The Panel presently consists of the following members and a Chair.

- Edith Hambrick, M.D., J.D., Chair, CMS Medical Officer.
- Karen Borman, M.D., FACS.
- Ruth L. Bush, M.D., M.P.H.
- Lanny Copeland, M.D., AAFP.
- Kari S. Cornicelli, C.P.A., FHFMA.
- Dawn L. Francis, M.D., M.H.S.
- David A. Halsey, M.D.
- Brian D. Kavanagh, M.D., MPH.
- Scott Manaker, M.D., Ph.D.
- John Marshall, CRA, RCC, CIRCC, RT(R), FAHRA.
- Jim Nelson, M.B.A., C.P.A., FHFMA.
- Leah Osbahr, M.A., MPH.
- Jacqueline Phillips.
- Daniel J. Pothen, M.S., RHIA, CHPS.
- Gregory Przybylski, M.D.
- Traci Rabine.
- Marianna V. Spanaki-Varela, MD, Ph.D., M.B.A.
- Gale Walker.

II. Provisions of the Notice

We published a notice in the **Federal Register** on August 24, 2012, entitled '' Medicare Program; Solicitation of Two Nominations to the Advisory Panel on Hospital Outpatient Payment'' (77 FR 51542). The notice solicited nominations for two new members to the Advisory Panel on Hospital Outpatient Payment (HOP, the Panel) to fill two vacancies on the panel beginning September 30, 2012. As a result of that notice, we are announcing two new members to the Panel. Their appointments are for 4-year terms beginning on February 1, 2013.