Trans No.	Acquiring	Acquired	Entities
20090177	TransDigm Group Incorporated	General Electric Company	Aircraft Parts Corporation.
20090183	Tenaska Energy, Inc	American International Group, Inc	TMV Holdings, LLC.
20090184	Tenaska Energy Holdings LLC	American International Group, Inc	TMV Holdings, LLC.
TRANSACTIONS GRANTED EARLY TERMINATION—12/08/2008			
20090115	Fairholme Funds, Inc	AmeriCredit Corp	AmeriCredit Corp.
20090145	Samsung SDI Co., Ltd	Samsung Mobile Display Co., Ltd	Samsung Mobile Display Co., Ltd.
TRANSACTIONS GRANTED EARLY TERMINATION—12/09/2008			
20081463	Verizon Communications Inc	Atlantis Holdings LLC	Alltel Corporation.
20090148	Clarian Health Partners, Inc	Cardinal Health System, Inc	Ball Memorial Hospital, Inc.
20090175	Partners Limited	Norbord Inc	Norbord Inc.
TRANSACTIONS GRANTED EARLY TERMINATION—12/10/2008			
20090180	Windjammer Senior Equity Fund III, L.P.	SPC Partners II, L.P	S.T. Specialty Foods, Inc.
20090187	Compass Group PLC	Kimco Facilities Services Corporation	Kimco Facilities Services Corporation.
TRANSACTIONS GRANTED EARLY TERMINATION—12/11/2008			
20090182	Prime Financial Credit Union	Guardian Credit Union	Guardian Credit Union.
TRANSACTIONS GRANTED EARLY TERMINATION—12/12/2008			
20090190	Nestucca Forests LLC	Stimson Lumber Company, Inc	Stimson Lumber Company, Inc.
20090192	Sierra Wireless, Inc	Wavecom S.A	Wavecom S.A.
20090196	New Mountain Partners III, L.P	Tygris Commercial Finance Group, Inc	Tygris Commercial Finance Group, Inc.
20090197	TPG Partners VI, L.P	Tygris Commercial Finance Group, Inc	Tygris Commercial Finance Group, Inc.
20090199	Platinum Equity Capital Partners II, L.P.	Stephen J. Williams	International Offshore Services, LLC.

FOR FURTHER INFORMATION CONTACT: Sandra M. Peay, Contact Representative or Renee Hallman, Contact Representative, Federal Trade Commission, Premerger Notification Office, Bureau of Competition, Room H–303, Washington, DC 20580, (202) 326–3100.

By Direction of the Commission.

Donald S. Clark,

Secretary.

[FR Doc. E8–30872 Filed 12–30–08; 8:45 am]

BILLING CODE 6750–01–M

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: ''The AHRQ Data Inventory.'' In accordance with the Paperwork Reduction Act of 1995, 44 U.S.C. 3506(c)(2)(A), AHRQ invites the public to comment on this proposed information collection.

This proposed information collection was previously published in the **Federal Register** on October 24th, 2008 and allowed 60 days for public comment. One comment was received. The purpose of this notice is to allow an additional 30 days for public comment.

DATES: Comments on this notice must be received by January 30, 2009.

ADDRESSES: Written comments should be submitted to: AHRQ's OMB Desk Officer by fax at (202) 395–6974 (Attention: AHRQs desk officer) or by e-mail at *OIRA_submission@omb.eop.gov* (attention: AHRQ's desk officer).

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 e-mail at *doris.lefkowitz@ahrq.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Proposed Project: ''The AHRQ Data Inventory''

The Agency for Healthcare Research and Quality (AHRQ) is interested in determining the availability of regularly collected administrative and other data collection initiatives about outpatient health service utilization. AHRQ seeks to better understand issues in developing data collection initiatives, redundancies in these initiatives, uses of available data, gaps in available information, similarities across data projects, and areas for possible collaboration and coordination. AHRQ's initial focus is on those data sets that would inform healthcare providers, policymakers, and consumers about outpatient health service utilization and episodes of care.

The primary purpose of this information collection is to comprehensively document outpatient health care data collection initiatives in the 50 states, the District of Columbia, and other geographic units. Information being collected about the data sets is not readily available to the public. In-depth information about the data sets will provide guidance to AHRQ on the potential synergy across such initiatives and suggest how the information can inform Federal, State, and local health care policymakers, clinicians, and consumers. Information collected during the interviews will comprehensively document outpatient health care data collection initiatives.

This project is important for several reasons. First, many data collection initiatives exist or are in the planning stages, but there is limited collaboration and synthesis among initiatives. With limited resources and common goals, it is imperative to understand the issues in developing data collection initiatives, redundancies in such initiatives, and gaps in available information. Second, with the increasing costs of health care, it has become more important than ever to use health services efficiently, yet care and information about care is often collected and delivered in isolation without coordination across sites or providers of care. The results of this project will provide AHRQ and other policymakers with the information they need to serve as a catalyst to promote coordinated standardization, reduce redundancies, identify gaps in information, and assist in further development of needed data efforts.

This project is being conducted pursuant to AHRQ's statutory mandates to (1) promote health care quality improvement by conducting and supporting research that develops and presents scientific evidence regarding all aspects of health care, including the costs and utilization of, and access to, health care and the ways in which health care services are organized, delivered, and financed (42 U.S.C. 299(b)(l)(D) and (E)); (2) conduct and support research on health care and on systems for the delivery of such care (42 U.S.C. 299a(a)); and (3) conduct and support research to advance the creation of effective linkages between various sources of health information (42 U.S.C. 299b–3(a)(3)).

Method of Collection

The survey will be initiated with an e-mail message from AHRQ to managers/administrators of each data set selected for inclusion in the Inventory. Data sets listed in the inventory were identified from a search of Web-based information about outpatient and ambulatory patient care data sets. The initial contact will be followed by an e-mail distribution of a cover letter and the questionnaire. The cover letter will include information about the purpose of the study, reason respondents are being contacted, information about the nondisclosure of their responses, and a request to have respondents review information captured from the Internet about their data sets. In addition, respondents will be informed that they have the option to complete and return the questionnaire electronically or participate in a telephone interview. Respondents who do not return their questionnaires by the requested time will get an e-mail reminder. The e-mail reminder will be followed by a telephone reminder.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annual burden hours for the respondent's time to participate in this project. A maximum of 80 respondents will complete the survey questionnaire which will require about 45 minutes to complete. The total estimated burden hours for this information collection is 60 hours.

Exhibit 2 show the estimated cost burden based on the respondent's time to participate in this project. The total cost burden is approximately $2,993.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Inventory Survey	80	1	45/60	60
Total	80	1	na	60

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate *	Total costs burden
Inventory Survey	80	60	$49.89	$2,993
Total	80	60	na	2,993

* Based upon the mean of general and operations managers (11–102 1), National Compensation Survey: Occupational Wages in the United States 2007, U.S. Department of Labor, Bureau of Labor Statistics.

Estimated Annual Costs to the Federal Government

This one-year project is estimated to cost the government $136,000. Exhibit 3 details the costs associated with this project, which include $11,000 for project development, $72,500 for data collection and analysis, $12,000 for preparing reports, $20,000 for project management and $21,000 for overhead.

EXHIBIT 3—PROJECT COSTS

Cost component	Total cost
Project Development	$11,000.00
Data Collection and Analysis	72,500.00
Preparation of Reports	12,000.00
Project Management	20,000.00
Overhead	21,000.00
Total	136,500.00

Request for Comments

In accordance with the above-cited Paperwork Reduction Act legislation, 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.

Dated: December 17, 2008.

Carolyn M. Clancy,

Director.

[FR Doc. E8–30762 Filed 12–30–08; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Board of Scientific Counselors, National Center for Injury Prevention and Control: Notice of Charter Amendment

This gives notice under the Federal Advisory Committee Act (Pub. L. 92–463) of October 6, 1972, that the statutory requirements of the Advisory Committee for Injury Prevention and Control (ACIPC) have been transferred to the Board of Scientific Counselors, National Center for Injury Prevention and Control (BSC, NCIPC).

The ACIPC was established on October 18, 1988, in accordance with Public Law 92–463, as amended (5 U.S.C. App. 2). Section 394(a) of the Public Health Service Act, (42 U.S.C. 280b–2(a)), as amended, directed the Secretary, Department of Health and Human Services, acting through the Director, CDC, to establish an advisory committee to provide advice with respect to the prevention and control of injuries. On October 28, 1994, ACIPC was reestablished under statute.

The responsibilities of ACIPC have been assumed by the BSC, NCIPC. By assuming the statutorily mandated responsibilities of ACIPC, the BSC, NCIPC will thereby become a statutorily mandated committee, continuing to serve the purposes set forth by Section 394(a) of the Public Health Service Act.

For information, contact Gwendolyn Cattledge, Ph.D., Executive Secretary, Board of Scientific Counselors, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Department of Health and Human Services, 4770 Buford Highway, Mailstop K02, Atlanta, Georgia 30341, telephone (770) 488–4655 or fax (770) 488–4422.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Dated: December 17, 2008.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. E8–31111 Filed 12–30–08; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Privacy Act of 1974; Notice of Modified System of Records

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

ACTION: Notice of a Modified System of Records.

SUMMARY: In accordance with the requirements of the Privacy Act of 1974, CMS is proposing to make minor amendments to an existing system of records (SOR) titled, ‘‘Performance Measurement and Reporting System (PMRS),’’ System No. 09–70–0584, published at 72 FR 52133 (September 12, 2007). PMRS serves as a master system of records to assist in projects that provide transparency in health care on a broad scale enabling consumers to compare the quality and price of health care services so that they can make informed choices among individual physicians, practitioners, and other providers of services. We are making minor amendments to PMRS to include two additional legal authorities: The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (Pub. L. 110–173) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275). Section 101(b) of the MMSEA amended section 1848(k)(2)(B) of the Social Security Act (the Act) (42 U.S.C. 1395w–4) and section 101(c) of division B of the Tax Relief and Health Care Act of 2006 to extend the Physician Quality Reporting Initiative (PQRI). MIPPA, effective July 15, 2008, extended the PQRI for 2010 and subsequent years and authorized a new incentive program for successful electronic prescribers under section 1848(m)(2) of the Act. In addition, the MIPPA requires the Secretary to post on the CMS Web site the names of eligible professionals or group practices who satisfactorily submit data on quality measures through PQRI and the names of those eligible professionals or group practices who are successful electronic prescribers. This requirement is codified at section 1848(m)(5)(G) of the Act. Accordingly, CMS is adding §§ 131 and 132 of MIPPA, § 101 of MMSEA, § 1848(k) of the Act, and § 1848(m) of the Act to the PMRS’ legal authority section.

In addition, we are clarifying in this notice that the term, ‘‘performance measurement results’’ used in the PMRS includes, but is not limited to, submission of data on measures, e-prescribing usage, frequency of reporting or performance, as well as rates or scores based on application of specific measures. We consider all of these types of information to be valid indicators of a physician’s, practitioner’s, or other provider’s commitment to and delivery of high quality, high value health care.

The primary purpose of this system is to support the collection, maintenance, and processing of information to promote the delivery of high quality, efficient, effective, and economical health care services, and promoting the quality and efficiency of services of the type for which payment may be made under title XVIII by allowing for the establishment and implementation of performance measures, the provision of feedback to physicians, and public reporting of performance information. Information in this system will also be disclosed to: (1) Support regulatory, reimbursement, and policy functions performed for the Agency or by a contractor, consultant, or a CMS grantee; (2) assist another Federal and/or state agency, agency of a state government, or an agency established by state law; (3) promote more informed choices by Medicare beneficiaries among their Medicare group options by making physician performance measurement information available to Medicare beneficiaries through a Web site and other forms of data dissemination; (4) provide CVEs and data aggregators with information that will assist in generating single or multi-payer performance measurement results to promote transparency in health care to members of their community; (5) assist individual physicians, practitioners, providers of services, suppliers, laboratories, and other health care professionals who are participating in health care transparency projects; (6) assist individuals or organizations with projects that provide transparency in health care on a broad scale enabling consumers to compare the quality and price of health care services; or for research, evaluation, and epidemiological projects related to the prevention of disease or disability;