determined and fixed by the Secretary of the Treasury after considering private consumer rates of interest on the date that the Department of Health and Human Services becomes entitled to recovery. The rate cannot be lower than the Department of Treasury's current value of funds rate or the applicable rate determined from the ''Schedule of Certified Interest Rates with Range of Maturities'' unless the Secretary waives interest in whole or part, or a different rate is prescribed by statute, contract, or repayment agreement. The Secretary of the Treasury may revise this rate quarterly. The Department of Health and Human Services publishes this rate in the **Federal Register**.

The current rate of 10⅞%, as fixed by the Secretary of the Treasury, is certified for the quarter ended September 30, 2011. This interest rate is effective until the Secretary of the Treasury notifies the Department of Health and Human Services of any change.

Dated: March 28, 2012.

Margie Yanchuk,

Director, Office of Financial Policy and Reporting.

[FR Doc. 2012–8072 Filed 4–3–12; 8:45 am]

BILLING CODE 4150–04–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60-Day–12–0856]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–7570 or send comments to Ron Otten, at 1600 Clifton Road, MS D–74, Atlanta, GA 30333 or send an email to *omb@cdc.gov*.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection 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 on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

National Quitline Data Warehouse (OMB No. 0920–0856, exp. 7/31/2012)—Extension—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Despite the high level of public knowledge about the adverse effects of smoking, tobacco use remains the leading preventable cause of disease and death in the United States. Tobacco use results in approximately 440,000 deaths annually, including approximately 38,000 deaths from secondhand smoke exposure. Adults who smoke contribute to $92 billion annually in lost worker productivity, and die an average of 14 years earlier than nonsmokers. Although the prevalence of current smoking among adults decreased significantly since its peak in the 1960s, overall smoking prevalence among U.S. adults has remained virtually unchanged during the past five years. Large disparities in smoking prevalence continue to exist among members of racial/ethnic minority groups and individuals of low socioeconomic status.

The National Tobacco Control Program (NTCP) was established by CDC to reduce tobacco use and tobacco-related disease, disability, and death. The NTCP's four goal areas are: (1) The prevention of initiation of tobacco use among young people, (2) the elimination of nonsmokers' exposure to secondhand smoke, (3) the promotion of quitting among adults and young people, and (4) the elimination of tobacco-related disparities. Essential elements of this approach include state, community, and health systems interventions and assessments of their impact; cessation services; media campaigns designed to educate the public about the harmful effects of tobacco; surveillance; and program evaluation. Many interventions are designed to serve individuals who are at highest risk for tobacco-related health problems due to disparities among demographic subgroups in the U.S. in their tobacco use.

Quitlines are effective, population-based interventions that increase successful quitting. Quitlines provide telephone-based tobacco cessation services that help tobacco users quit through individualized, tailored counseling and self-help materials. Quitline counseling that includes counselor-initiated calls or proactive counseling has been shown to increase the odds of tobacco abstinence by approximately 60%. Tobacco cessation quitlines overcome many of the barriers to tobacco cessation classes and traditional clinics because they are free and available at the caller's convenience. They are also cost-effective because they offer multiple services centrally that may be unavailable locally. The demand for quitline services has increased over time. Unfortunately, quitlines remain under-funded and services are not available to everyone who seeks to access them. CDC estimates that 6 to 8 percent of tobacco users could potentially be reached by quitlines, however—primarily due to lack of resources—only 1 to 2 percent of tobacco users are currently using quitlines.

CDC has directly supported state quitlines since 2004, when CDC and the National Cancer Institute (NCI) created the National Network of Tobacco Cessation Quitlines Initiative to provide greater access to counseling for tobacco cessation. As part of the Initiative, NCI established a toll-free national portal number, 1–800–QUIT–NOW, which automatically transfers callers to their state quitline. Quitlines now exist in all U.S. states, the District of Columbia, and five U.S. territories.

In 2009, CDC used one-time American Recovery and Reinvestment Act (ARRA) funding to support expansion of quitline services and standardization of the client-level information collected in conjunction with those services. In 2010, CDC established the National Quitline Data Warehouse (NQDW) to compile national information about quitline services based on uniform caller intake and follow-up protocols (OMB No. 0920–0856, exp. 7/31/2012). The Minimum Data Set for this information collection was developed in collaboration with a number of stakeholders and tobacco control organizations, including the North American Quitline Consortium (NAQC). Information collected through the NQDW is being used to quantify and improve quitline services and to plan and assess the effectiveness of tobacco control programs, including the NTCP. This information collection is authorized by the Public Health Service Act.

CDC requests OMB approval to continue information collection for

three years. During this period, a number of critical tobacco control activities will be implemented, such as the Department of Health and Human Service's first National Tobacco Education Campaign and a variety of state-based activities made possible by the Affordable Care Act (ACA) funds, including further quitline enhancements. The NQDW will provide essential information for monitoring and evaluating these efforts; improving understanding of quitline promotions and caller usage patterns; developing service benchmarks; increasing the number of tobacco users who quit each year; and aiding efforts to reduce mortality, morbidity, and health care costs related to tobacco use.

The Intake Questionnaire will be administered to an estimated 730,000 callers per year across all states, the District of Columbia, and participating U.S. territories. The estimated burden for completing the Intake Questionnaire interview is ten minutes for callers who seek personal counseling or services, and one minute for callers who seek information on behalf of someone else. A seven-month Follow-up Questionnaire will be administered to an average of 28,900 callers per year. The estimated burden per response is seven minutes.

In addition, the Tobacco Control Manager for each state, district, or territory will be asked to complete a quarterly, web-based Quitline Services Questionnaire describing the services provided through their quitline. The estimated burden per response is seven minutes.

All information will be collected electronically. There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Caller who contacts the Quitline on behalf of someone else.	Intake Questionnaire	230,000	1	1/60	3,833
Caller who contacts the Quitline for personal use.		500,000	1	10/60	83,333
Quitline caller who received a Quitline service.	Follow-up Questionnaire	28,900	1	7/60	3,372
Tobacco Control Manager	Quitline Services Questionnaire	52	4	7/60	24
Total					90,562

Dated: March 29, 2012.

Ron A. Otten,

Director, Office of Scientific Integrity, Office of the Associate Director for Science (OADS), Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2012–8089 Filed 4–3–12; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60-Day–12–0556]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–639–7570 and send comments to Ron Otten, at 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email to *omb@cdc.gov.*

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection 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 on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Assisted Reproductive Technology (ART) Program Reporting System exp. 9/30/2012—Revision—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Section 2(a) of Public Law 102–493 (known as the Fertility Clinic Success Rate and Certification Act of 1992 (FCSRCA), 42 U.S.C. 263a–1(a)) requires that each assisted reproductive technology (ART) program shall annually report to the Secretary through the Centers for Disease Control and Prevention: (1) Pregnancy success rates achieved by such ART program, and (2) the identity of each embryo laboratory used by such ART program and whether the laboratory is certified or has applied for such certification under the Act. The required information is currently reported by ART programs to CDC as specified in the Assisted Reproductive Technology (ART) Program Reporting System (OMB no. 0920–0556, exp. 9/30/2012). CDC seeks to extend OMB approval for a period of three years and to implement a brief, one-time optional feedback survey to clinics for each reporting year. The revised total burden estimate includes an anticipated increase in the number of participating clinics from 430 to 440 and an increase in the average number of responses per respondent from 321 to 339. There is a 2-minute increase to the estimated burden per response.

The currently approved program reporting system, also known as the National ART Surveillance System (NASS), includes information about all ART cycles initiated by any of the ART programs in the United States. An ART cycle is considered to begin when a woman begins taking ovarian stimulatory drugs or starts ovarian monitoring with the intent of having embryos transferred. The system also collects information about the pregnancy outcome of each cycle, as well as a number of data items deemed