consent order that requires them to make the deal along with a handful of other changes. But that is not our role. There is no legal authority for the proposition that the Commission can prophylactically impose remedies without an underlying violation of the antitrust laws. And there is no legal authority to support the view that the Commission can isolate selected components of a three-way transaction to find such a violation. In the absence of such authority, the appropriate course is to evaluate the three-way transaction presented to the agency as a whole. Because I conclude, as apparently does the Commission, that the three-way transaction does not substantially lessen competition, there is no competitive harm to correct and any remedy is unnecessary and unwarranted.[5] Entering into consents is appropriate only when the transaction at issue—in this case the three-way transaction—is likely to substantially lessen competition. This one does not.

[FR Doc. 2015–13861 Filed 6–5–15; 8:45 am]

BILLING CODE 6750–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–15–0856; Docket No. CDC–2015–0041]

Proposed Data Collection Submitted for Public Comment and Recommendations

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice with comment period.

SUMMARY: The Centers for Disease Control and Prevention (CDC), as part of its continuing efforts to reduce public burden and maximize the utility of government information, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995. This notice invites comment on the proposed revision of the National Quitline Data Warehouse (NQDW) information collection. The NQDW is a repository of information about callers who have received services from state quitlines and a quarterly summary of services provided by each quitline.

DATES: Written comments must be received on or before August 7, 2015.

ADDRESSES: You may submit comments, identified by Docket No. CDC–2015–0041 by any of the following methods:

Federal eRulemaking Portal: Regulation.gov. Follow the instructions for submitting comments.

Mail: Leroy A. Richardson, Information Collection Review Office, Centers for Disease Control and Prevention, 1600 Clifton Road NE., MS–D74, Atlanta, Georgia 30329.

Instructions: All submissions received must include the agency name and Docket Number. All relevant comments received will be posted without change to *Regulations.gov,* including any personal information provided. For access to the docket to read background documents or comments received, go to *Regulations.gov.*

Please note: All public comment should be submitted through the Federal eRulemaking portal (*Regulations.gov*) or by U.S. mail to the address listed above.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the information collection plan and instruments, contact the Information Collection Review Office, Centers for Disease Control and Prevention, 1600 Clifton Road NE., MS–D74, Atlanta, Georgia 30329; phone: 404–639–7570; Email: *omb@cdc.gov.*

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. In addition, the PRA also requires Federal agencies to provide a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each new proposed collection, each proposed extension of existing collection of information, and each reinstatement of previously approved information collection before submitting the collection to OMB for approval. To comply with this requirement, we are publishing this notice of a proposed data collection as described below.

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; (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; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information, to search data sources, to complete and review the collection of information; and to transmit or otherwise disclose the information.

Proposed Project

National Quitline Data Warehouse (NQDW) (OMB No. 0920–0856, exp. 10/31/2015)—Revision—National Center for Chronic Disease 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. Smoking results in approximately 480,000 deaths annually (USDHHS, 2014). This total includes approximately 41,000 annual deaths in nonsmoking U.S. adults caused by secondhand smoke exposure (USDHHS, 2014). Although the prevalence of current smoking among adults has been decreasing, substantial disparities in smoking prevalence continue to exist among individuals of low socioeconomic status, persons with mental health and substance abuse conditions, and certain racial/ethnic populations, among other groups.

Quitlines are telephone-based tobacco cessation services that help tobacco users quit through a variety of services,

[5] The Commission points to the HSR Act as providing the legal basis for the FTC to enter into consent orders ''to ensure that any competitive issues with a proposed transaction are addressed effectively.'' Statement of the Federal Trade Commission, *supra* note 1, at 4 n.7. When a proposed transaction or set of transactions would not substantially lessen competition, as is the case with the three way transaction originally proposed here, there are no competitive issues with the proposed transaction to be addressed, and the belief that a consent order may even further mitigate concerns regarding the transfer of assets is not material to our analysis under the Clayton Act. The HSR Act is not in conflict with the Clayton Act and does not change this result.

including counseling, medications, information and self-help materials (NAQC, 2009). Quitlines are effective, population-based interventions that increase successful quitting. Tobacco cessation quitlines overcome many of the barriers to in-person tobacco cessation individual and group counseling because they are free, available at the caller's convenience, and do not require transportation or child care. They are also efficient and cost-effective, in part because they offer multiple services centrally that often are unavailable locally. 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 to U.S. tobacco users. Also, as part of the Initiative, NCI established a toll-free national portal number at 1–800–QUIT–NOW. This portal number automatically transfers callers to their state quitline.

Quitlines now exist in all U.S. states, the District of Columbia, Guam, and Puerto Rico. CDC currently supports the maintenance and enhancement of state quitlines as part of the National Tobacco Control Program, a cooperative agreement program with the states, and additional funding designated for ensuring quitline capacity. One of CDC's current goals is to expand quitline capacity so that all callers to the quitline during a federal media campaign are offered at least one coaching call, either immediately upon calling or by being re-contacted within two to three days. A secondary purpose is to continue to expand the capacity of state tobacco control programs to implement evidence-based cessation interventions and to provide interventions that are culturally and linguistically appropriate for populations that experience disparities.

In 2010, with funding provided by the American Reinvestment and Recovery Act (ARRA) of 2009, CDC's Office on Smoking and Health (OSH) obtained approval to collect information through the National Quitline Data Warehouse (NQDW; OMB No. 0920–0856). The NQDW information collection continued from 2012–2014 using funds from the Patient Protection and Affordable Care Act (ACA) and CDC's Prevention and Public Health Fund (PPHF). During its five years in existence, the NQDW has collected a quarterly services summary report from 50 states, the District of Columbia, Guam and Puerto Rico. NQDW has also collected de-identified, individual-level data about tobacco users who have received services from state quitlines including caller demographics, tobacco use behaviors of callers, reasons for calling the quitline, how callers reported hearing about the quitline, what services callers have received from the quitline, and whether or not callers were able to make successful quit attempts after using state quitline programs.

Information collected by the NQDW has demonstrated an increase in the demand for quitline services over time. Unfortunately, quitlines remain under-funded and under-promoted. According to CDC's *Best Practices for Comprehensive Tobacco Control Programs,* currently about 1 percent of tobacco users receive services from state quitlines each year, however approximately 6 to 8 percent of tobacco users could potentially be reached by state quitlines if quitlines were sufficiently funded and promoted.

CDC uses the information collected by the NQDW for ongoing monitoring and evaluation related to state quitlines. The NQDW collects important information used to monitor and evaluate the impact of funding for tobacco control programs and state quitlines as well as other tobacco programs, policies and interventions. In addition, data collected by the NQDW serves an important role in helping CDC assess the effectiveness of the *Tips From Former Smokers* media campaign. The ''*Tips*'' campaign was initiated in 2012 to increase public awareness of the immediate health damage caused by smoking and to encourage adult smokers to quit (*www.cdc.gov/tips*).

CDC plans to request OMB approval to continue the NQDW information collection for three years. All 50 states, the District of Columbia, Guam, and Puerto Rico will continue to participate. Changes to be implemented include:

(1) The Asian Smokers' Quitline (ASQ) will participate in the NQDW. The ASQ will be administered and operated by a single, national quitline service provider. This change will allow CDC to assess state quitline efforts to expand quitline capacity and service provision to the tobacco users who speak Asian languages. The total number of programs reporting through the NQDW will increase from 53 to 54.

(2) Five questions will be added to the NQDW Intake Questionnaire concerning pregnancy, insurance status, type of health insurance, mental health, and language of service. This information will help CDC and the states tailor quitline services to the needs of callers. In 2014, CDC inquired with states as to whether their state quitlines are already collecting information on pregnancy status, insurance status, and mental health status and learned that most state quitlines already collect this information. However, these questions are not included in the current NQDW Intake Questionnaire. Adding these items to the NQDW Intake Questionnaire will impose minimal additional burden on states but will substantially improve the utility of the NQDW data to identify use of state quitlines by key tobacco use populations. Finally, CDC proposes to add a question about the language in which quitline services are provided. This question would not be a question posed to callers, but would be recorded by the quitline service provider.

(3) In 2012, CDC discontinued data collection for the NQDW Seven-Month Follow-up Survey. During the three year period of this Revision request, the NQDW Seven-Month Follow-up Questionnaire will be collected, but only for callers who receive services through the Asian Smokers' Quitline. Should the need arise in the future to resume collecting seven-month follow-up data from all callers, an additional Revision request will be submitted to OMB.

Participation in the caller intake and follow-up interviews is voluntary for quitline callers. The estimated burden is 10 minutes for a complete intake call conducted with an individual who calls on their own behalf. The estimated burden is one minute for a caller who requests information for someone else, as these callers complete only a subset of questions on the intake questionnaire. The estimated burden per response for the Seven-Month Follow-Up Questionnaire is seven minutes.

As a condition of funding, the 54 cooperative agreement awardees are required to submit a quarterly services survey. CDC recognizes that awardees incur additional burden for preparing and transmitting summary files with their de-identified caller intake and follow-up data. This burden is acknowledged in the instructions for transmitting the electronic data files. There is a net decrease in burden, primarily due to discontinuation of the Seven-Month Follow-Up Questionnaire for the majority of callers.

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

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hrs.)	Total burden (in hrs.)
Quitline callers who contact the quitline for help themselves.	NQDW Intake Questionnaire (complete)	509,742	1	10/60	84,957
Caller who contacts the quitline on behalf of someone else.	NQDW Intake Questionnaire (subset)	26,902	1	1/60	448
Quitline caller who received a quitline service from the Asian Smokers' quitline.	NQDW 7-Month Follow-Up Questionnaire	659	1	7/60	77
Tobacco Control Manager or Their Designee.	Instructions for Submitting NQDW Intake Questionnaire Electronic Data File to CDC.	54	4	1	216
	Instructions for Submitting NQDW 7-Month Follow-up Electronic Data File to CDC.	1	1	1	1
	NQDW Quitline Services Survey	54	4	20/60	72
Total					85,771

Leroy A. Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

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BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Initial Review

In accordance with Section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces a meeting for the initial review of applications in response to Funding Opportunity Announcement (FOA), CK15–004, Epicenters for the Prevention of Healthcare Associated Infections (HAIs)—Cycle II.

Time and Date: 10:00 a.m.–4:00 p.m., EDT, July 9, 2015 (Closed).

Place: Teleconference.

Status: The meeting will be closed to the public in accordance with provisions set forth in Section 552b(c)(4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

Matters for Discussion: The meeting will include the initial review, discussion, and evaluation of applications received in response to ''Epicenters for the Prevention of Healthcare Associated Infections (HAIs)—Cycle II'', FOA CK15–004.

Contact Person for More Information: Gregory Anderson, M.S., M.P.H., Scientific Review Officer, CDC, 1600 Clifton Road NE., Mailstop E60, Atlanta, Georgia 30329–4027, Telephone: (404) 718–8833.

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.

Elaine L. Baker,

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

[FR Doc. 2015–13924 Filed 6–5–15; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Office for State, Tribal, Local and Territorial Support

In accordance with Presidential Executive Order No. 13175, November 6, 2000, and the Presidential Memorandum of November 5, 2009, and September 23, 2004, Consultation and Coordination with Indian Tribal Governments, CDC/Agency for Toxic Substances and Disease Registry (ATSDR), announces the following meeting and Tribal Consultation Session:

Name: Tribal Advisory Committee (TAC) Meeting and 13th Biannual Tribal Consultation Session.

Times and Dates: 8:00 a.m.–5:00 p.m., August 4, 2015 (TAC Meeting); 8:00 a.m.–5:00 p.m., August 5, 2015 (13th Biannual Tribal Consultation Session).

Place: The TAC Meeting and Tribal Consultation Session will be held at the Northern Quest, 100 North Hayford Road, Airway Heights, Washington 99001.

Status: The meetings are being hosted by CDC/ATSDR in-person only and are open to the public. Attendees must pre-register for the event by Friday, July 3, 2015, at the following link: *http://www.cdc.gov/tribal/meetings.html.*

Purpose: The purpose of these recurring meetings is to advance CDC/ATSDR support for and collaboration with tribes, and to improve the health of tribes through, including but not limited to, assisting in eliminating the health disparities faced by Indian tribes, ensuring that access to critical health and human services and public health services is maximized to advance or enhance the social, physical, and economic status of American Indian/Alaska Native (AI/AN) people; and promoting health equity for all AI/AN people and communities. To advance these goals, CDC/ATSDR conducts government-to-government consultations with elected tribal officials or their authorized representatives. Consultation is an enhanced form of communication that emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties that leads to mutual understanding and comprehension.

Matters for Discussion: The TAC and CDC leaders will discuss the following public health topics: Chronic disease prevention and health promotion in Indian Country, CDC's budget, and CDC's communication and engagement with tribes; however, discussion is not limited to these topics.

During the 13th Biannual Tribal Consultation Session, tribes and CDC leaders will engage in a listening session with CDC's director and have roundtable discussions with CDC senior leaders. Tribes will also have an opportunity to present testimony on tribal health issues.

Tribal leaders are encouraged to submit written testimony by July 17, 2015, by mail to Annabelle Allison, Deputy Associate Director, Tribal Support Unit, Office for State, Tribal, Local and Territorial Support (OSTLTS), Centers for Disease Control and Prevention, 4770 Buford Highway NE., MS E–70, Atlanta, Georgia 30341, or by email to *TribalSupport@cdc.gov.*

Depending on the time available, it might be necessary to limit each presenter's time.

The agenda is subject to change as priorities dictate.