must propose first or second aural reception service or first local commercial Tribal-owned transmission service to the proposed community of license, which must be located on Tribal lands. Applicants claiming Section 307(b) preferences using these factors will submit information to substantiate their claims.

On March 3, 2011, the Commission adopted a Second Report and Order (''Second R&O''), First Order on Reconsideration, and Second Further Notice of Proposed Rule Making in MB Docket No. 09–52, FCC 11–28. The First Order on Reconsideration modified the initially adopted Tribal Priority coverage requirement, by creating an alternate coverage standard under criterion (2), enabling Tribes to qualify for the Tribal Priority even when their Tribal lands are too small or irregularly shaped to comprise 50 percent of a station's signal. In such circumstances, Tribes may claim the priority (i) if the proposed principal community contour encompasses 50 percent or more of that Tribe's Tribal lands, but does not cover more than 50 percent of the Tribal lands of a non-applicant Tribe; (ii) serves at least 2,000 people living on Tribal lands, and (iii) the total population on Tribal lands residing within the station's service contour constitutes at least 50 percent of the total covered population, with provision for waivers as necessary to effectuate the goals of the Tribal Priority. This modification will now enable Tribes with small or irregularly shaped lands to qualify for the Tribal Priority.

The modifications to the Commission's allotment and assignment policies adopted in the Second R&O included a rebuttable ''Urbanized Area service presumption'' under Priority (3), whereby an application to locate or relocate a station as the first local transmission service at a community located within an Urbanized Area, that would place a daytime principal community signal over 50 percent or more of an Urbanized Area, or that could be modified to provide such coverage, will be presumed to be a proposal to serve the Urbanized Area rather than the proposed community. In the case of an AM station, the determination of whether a proposed facility ''could be modified'' to cover 50 percent or more of an Urbanized Area will be made based on the applicant's certification in the Section 307(b) showing that there could be no rule-compliant minor modifications to the proposal, based on the antenna configuration or site, and spectrum availability as of the filing date, that could cause the station to place a principal community contour over 50 percent or more of an Urbanized Area. To the extent the applicant wishes to rebut the Urbanized Area service presumption, the Section 307(b) showing must include a compelling showing (a) that the proposed community is truly independent from the Urbanized Area; (b) of the community's specific need for an outlet of local expression separate from the Urbanized Area; and (c) the ability of the proposed station to provide that outlet.

In the case of applicants for new AM stations making a showing under Priority (4), other public interest matters, an applicant that can demonstrate that its proposed station would provide third, fourth, or fifth reception service to at least 25 percent of the population in the proposed primary service area, where the proposed community of license has two or fewer transmission services, may receive a dispositive Section 307(b) preference under Priority (4). An applicant for a new AM station that cannot demonstrate that it would provide the third, fourth, or fifth reception service to the required population at a community with two or fewer transmission services may also, under Priority (4), calculate a ''service value index'' as set forth in the case of Greenup, Kentucky and Athens, Ohio, Report and Order, 2 FCC Rcd 4319 (MMB 1987). If the applicant can demonstrate a 30 percent or greater difference in service value index between its proposal and the next highest ranking proposal, it can receive a dispositive Section 307(b) preference under Priority (4). Except under these circumstances, dispositive Section 307(b) preferences will not be granted under Priority (4) to applicants for new AM stations. The Commission specifically stated that these modified allotment and assignment procedures will not apply to pending applications for new AM stations and major modifications to AM facilities filed during the 2004 AM Auction 84 filing window.

Federal Communications Commission.

Gloria J. Miles,

Federal Register Liaison, Office of the Secretary, Office of Managing Director.

[FR Doc. 2014–05747 Filed 3–14–14; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60-Day–14–0212]

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 Leroy Richardson, 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

The National Hospital Care Survey (NHCS) (OMB No. 0920–0212, Expires 04–30–2016)—Revision—National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Section 306 of the Public Health Service (PHS) Act (42 U.S.C. 242k), as amended, authorizes that the Secretary of Health and Human Services (DHHS), acting through NCHS, shall collect statistics on the extent and nature of illness and disability of the population of the United States. This three-year clearance request for NHCS includes the collection of all impatient and ambulatory Uniform Bill–04 (UB–04) claims data or electronic health record (EHR) data from a sample of 581 hospitals as well as the collection of additional clinical data from a sample of

emergency department (ED) and outpatient department (OPD) visits (including ambulatory surgeries) through the abstraction of medical records.

NHCS integrates the former National Hospital Discharge Survey (OMB No. 0920–0212), the National Hospital Ambulatory Medical Care Survey (NHAMCS) (OMB No. 0920–0278) and the Drug-Abuse Warning Network (DAWN) (OMB No. 0930–0078, expired 12/31/2011) previously conducted by the Substance Abuse and Mental Health Services Administration's (SAMHSA). Integration of NHAMCS and DAWN into the NHCS is part of a broader strategy to improve efficiency by minimizing redundancy in data collection; broadening our capability to collect more relevant data on transitions of care; and identifying opportunities to exploit electronic and administrative clinical data systems to augment primary data collection.

NHCS consists of a nationally representative sample of 581 hospitals. These hospitals are currently being recruited, and participating hospitals are submitting all of their inpatient and ambulatory care patient data in the form of electronic UB–04 administrative claims or EHR data. Currently, hospital-level data are collected through a paper questionnaire and additional clinical data are being abstracted from a sample of visits to EDs and OPDs. This activity continues in 2014, and as more hospitals choose to send EHR data that includes clinical information, the need to conduct abstraction will be reduced.

This revision seeks approval to continue voluntary recruitment and data collection for NHCS, including inpatient, outpatient and emergency care; to revise the hospital-level questionnaire with additional items needed to improve weighting procedures; to combine the OPD and ambulatory surgery location patient record forms to more effectively capture ambulatory procedures in these settings; to continue collection of substance-involved ED visit data previously collected by DAWN; and to eliminate data collection from freestanding ambulatory surgery centers in order to concentrate efforts on hospital-based settings of care.

NHCS collects data items at the hospital, patient, inpatient discharge, and visit levels. Hospital-level data items include ownership, number of staffed beds, hospital service type, and EHR adoption. Patient-level data items are collected from both electronic data and abstraction components and include basic demographic information, personal identifiers, name, address, social security number (if available), and medical record number (if available). Discharge-level data are collected through the UB–04 claims or EHR data and include admission and discharge dates, diagnoses, diagnostic services, and surgical and non-surgical procedures. Visit-level data are collected through either EHR data, or for those hospitals submitting UB–04 claims, through the claims as well as through abstraction of medical records for a sample of visits. These visit-level data include reason for visit, diagnosis, procedures, medications, substances involved, and patient disposition.

NHCS users include, but are not limited to, CDC, Congressional Research Office, Office of the Assistant Secretary for Planning and Evaluation (ASPE), National Institutes of Health, American Health Care Association, Centers for Medicare & Medicaid Services (CMS), SAMHSA, Bureau of the Census, Office of National Drug Control Policy, state and local governments, and nonprofit organizations. Other users of these data include universities, research organizations, many in the private sector, foundations, and a variety of users in the media.

Data collected through NHCS are essential for evaluating health status of the population, for the planning of programs and policy to improve health care delivery systems of the Nation, for studying morbidity trends, and for research activities in the health field. Historically, data have been used extensively in the development and monitoring of goals for the Year 2000, 2010, and 2020 Healthy People Objectives.

There is no cost to respondents other than their time to participate.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden hours
Hospital DHIM or DHIT	Initial Hospital Intake Questionnaire	160	1	1	160
Hospital CEO/CFO	Recruitment Survey Presentation	160	1	1	160
Hospital CEO/CFO	Annual Hospital Interview	581	1	2	1,162
Hospital CEO/CFO	Annual Ambulatory Hospital Interview.	465	1	1.5	698
Hospital DHIM or DHIT	Prepare and transmit UB–04 for Inpatient and Ambulatory data.	481	12	1	5,772
Hospital DHIM or DHIT	Prepare and transmit EHR for Inpatient and Ambulatory data.	100	4	1	400
Total					8,352

LeRoy 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.

[FR Doc. 2014–05801 Filed 3–14–14; 8:45 am]

BILLING CODE 4163–18–P