The *Report and Order* directed that eligible space station operators that choose to clear on the accelerated timeframe in exchange for an accelerated relocation payment must do so via a written commitment by filing an Accelerated Relocation Election in GN Docket No. 18–122. Such elections are public and irrevocable. Pursuant to the *Report and Order,* WTB prescribes the following format for filing an Accelerated Relocation Election: The election must state that the eligible space station operator elects to perform an accelerated relocation, understands and accepts the commitments made when filing an Accelerated Relocation Election, and understands and accepts the reduction in payments for missing deadlines as outlined in the *Report and Order.* The election must be signed by a company officer of the eligible space station operator with authority to bind the company. The election must acknowledge the Commission's authority to adopt the accelerated relocation payment and the reduction in payments for missing deadlines. The election must acknowledge that sufficient eligible space station operators must elect accelerated relocation such that at least 80% of the total possible accelerated relocation payments are accepted for the Commission to accept elections and require overlay licensees to pay accelerated relocation payments.

The information collection requirements were approved by OMB on May 5, 2020 under OMB control number 3060–1272.

If an eligible space station operator elects not to make an Accelerated Relocation Election, that operator will forfeit its eligibility to receive accelerated relocation payments, even if it completes all tasks by the Accelerated Relocation Deadlines and files a Certification of Accelerated Relocation.

Federal Communications Commission.

**Katherine Harris,**

*Deputy Chief, Mobility Division, Wireless Telecommunications Bureau.*

[FR Doc. 2020–11004 Filed 5–20–20; 8:45 am]

**BILLING CODE 6712–01–P**

## FEDERAL RETIREMENT THRIFT INVESTMENT

### Board Member Meeting

**May 27, 2020—10:00 a.m., Telephonic**

*Open Session*

1. Approval of the Minutes of the April 27, 2020 Board Meeting
2. Monthly Reports
   (a) Participant Activity Report
   (b) Investment Performance
   (c) Legislative Report
3. Quarterly Reports
   (d) Metrics
4. Internal Audit Report

*Executive Session*

Information covered under 5 U.S.C. 552b(c)(7).

**CONTACT PERSON FOR MORE INFORMATION:** Kimberly Weaver, Director, Office of External Affairs, (202) 942–1640.

**SUPPLEMENTARY INFORMATION:**

Dial-in (listen only) information: Number: 1–877–446–3914, Code: 5962888.

Kimberly Weaver, Director, Office of External Affairs, (202) 942–1640.

Dated: May 18, 2020.

**Megan Grumbine,**

*General Counsel, Federal Retirement Thrift Investment Board.*

[FR Doc. 2020–11003 Filed 5–20–20; 8:45 am]

**BILLING CODE 6760–01–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

**[60Day-20–20NT; Docket No. CDC–2020–0054]**

### 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 effort to reduce public burden and maximize the utility of government information, invites the general public and other Federal agencies the opportunity to comment on a proposed and/or continuing information collection, as required by the Paperwork Reduction Act of 1995. This notice invites comment on a proposed information collection project titled *Using Real-time Prescription and Insurance Claims Data to Support the HIV Care Continuum* which will collect data to evaluate the efficacy of using administrative insurance and prescription claims (billing) data to identify and intervene upon persons with HIV who fail to fill antiretroviral (ARV) prescriptions.

**DATES:** CDC must receive written comments on or before July 20, 2020.

**ADDRESSES:** You may submit comments, identified by Docket No. CDC–2020–0054 by any of the following methods:

- *Federal eRulemaking Portal: Regulations.gov*. Follow the instructions for submitting comments.
- *Mail:* Jeffrey M. Zirger, 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. CDC will post, without change, all relevant comments to *Regulations.gov*.

**Please note:** *Submit all comments 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 Jeffrey M. Zirger, 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 the OMB for approval. To comply with this requirement, we are publishing this notice of a proposed data collection as described below.

The OMB is particularly interested in comments that will help:

1. Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

2. Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

3. Enhance the quality, utility, and clarity of the information to be collected; and

4. Minimize the burden of the collection of information on those who

are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submissions of responses.

5. Assess information collection costs.

**Proposed Project**

Using Real-time Prescription and Insurance Claims Data to Support the HIV Care Continuum—New—National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

**Background and Brief Description**

Use of HIV surveillance data to identify out-of-care persons is one strategy for identifying and re-engaging out-of-care persons and is called Data-to-Care or ''D2C.'' Data-to-Care uses laboratory reports (*i.e.,* CD4 and HIV viral load test results) received by a health department's HIV surveillance program as markers of HIV care. In the current D2C model, there is a delay in the identification of out-of-care persons due to the time interval between recommended monitoring tests (*i.e.,* every three to six months) and the subsequent reporting of these tests to surveillance.

Insurance and prescription administrative claims (billing) data can be used to identify persons who fail to fill antiretroviral (ARV) prescriptions and who are at risk for becoming out of care. Because most ARVs are prescribed as a 30-day supply of medication, prescription claims can be used to identify persons who are not filling ARV prescriptions on a monthly basis. Tracking ARV refill data can, therefore, be a more real-time indicator of poor adherence and can act as a harbinger of potential poor retention in care. Using real time insurance and prescription claims data to identify persons who fail to fill ARV prescriptions, and to intervene, could have a significant impact on ARV therapy adherence, viral suppression and potentially on retention in care.

The purpose of the *A*ntiretroviral *I*mprovement among *M*edicaid *E*nrollees (AIMS) study is to develop, implement and evaluate a D2C strategy that uses Medicaid insurance and prescription claims data to identify (1) persons with HIV who have never been prescribed ARV therapy and (2) persons with HIV who fail to pick up prescribed ARV medications in a timely manner and to target these individuals for adherence interventions.

A validated HIV case identification algorithm will be applied to the Virginia Medicaid database to identify persons with HIV who have either never filled an ARV prescription or have not filled an ARV prescription within >30 to <90 days of the expected fill date. Deterministic and probabilistic methods will be used to link this list to Virginia Department of Health's (VDH) Care Markers (an extract of the VDH HIV surveillance database) database. Individuals that are matched across the two databases (indicating that the persons are both enrolled in Medicaid and confirmed HIV positive) are eligible for study participation. Additional eligibility criteria include age 19–64 years and continuous enrollment in Virginia Medicaid for the preceding 12 months.

Once identified, individuals will be randomized to receive either an intervention or usual care. Participants in the intervention arm will be assigned to receive either a provider-level intervention or a patient-level intervention, depending on need; providers of study eligible participants who have never been prescribed ARV therapy (ART) will receive a provider-level intervention and participants who are >30 to <90 days late filling their ARV prescriptions will receive a patient-level intervention. Potential participants will be contacted by a VDH Linkage Coordinator or Study Coordinator to explain the study and obtain consent for participation.

The provider-level intervention will consist of a peer-to-peer clinician consultation delivered by members of Virginia Department of Health's AIDS Drug Assistance Program (ADAP) Advisory Committee. The peer-to-peer clinician consultations will involve introduction or reinforcement of HIV clinical guidelines for ART initiation, strategies to optimize ART adherence, and resources for supporting adherence for people with HIV. The consultation will be tailored to the needs of the provider.

The patient-level intervention has two phases. In Phase I, a Linkage Coordinator will contact participants to discuss the participants' adherence barriers. Once the participant's adherence barriers are identified, the participant will be referred to appropriate resources to assist them in overcoming their adherence barrier(s). Phase II is intended for patients who were enrolled in Phase I but who failed to fill their ARV prescriptions in the subsequent 30 days of the Phase I consultation, and for participants who are >60 to <90 days late at the time the participant was determined to be study eligible. In Phase II, the Linkage Coordinator will lead a similar consultation as in Phase I but will probe for more complex adherence barriers (*e.g.,* mental health concerns) and referrals will be made accordingly. The participant will also be offered PositiveLinks, an evidence-informed mobile application (''app'') which is designed to support ART adherence and retention in care. PositiveLinks provides daily queries of stress, mood, and medication adherence; weekly quizzes on general and HIV-specific understanding; appointment and medication reminders, curated resources, a community message board, direct messaging with the Linkage Coordinator, and contact information for participants' providers.

All analyses will be conducted at the patient level. Persons within the intervention and control arms will be followed for 12 months to compare the primary study outcome of HIV viral suppression (HIV RNA < 200 copies/mL).

CDC requests OMB approval to collect standardized information, from 500 AIMS study participants (including 460 patients and 40 providers) and 500 controls over the three year project period. Secondary data will be abstracted from the Virginia Medicaid and Virginia Department of Health Care Marker databases to determine study eligibility, to conduct the patient- and provider-level interventions, and to determine study outcomes. During the patient-level intervention data will be collected on participants' adherence barriers; this information will be used to refer participants to appropriate resources to assist their adherence to ART. During the provider-level intervention data will be collected to inform the peer-to-peer clinician consultation.

ESTIMATED ANNUALIZED BURDEN HOURS

| Respondents | Form name | Number of respondents | Number of responses per respondent | Average burden per response (in hours) | Total burden hours |
|---|---|---|---|---|---|
| Linkage Coordinator | Verbal consent (patient) | 460 | 1 | 15/60 | 115 |
| Study Coordinator | Verbal consent (provider) | 40 | 1 | 15/60 | 10 |
| Linkage Coordinator | PositiveLinks Program and Services Agreement. | 100 | 1 | 60/60 | 100 |
| VCU Data Manager | Medicaid data abstraction | 1 | 12 | 60/60 | 12 |
| VDH Surveillance Epidemiologist | Care Marker data abstraction | 1 | 12 | 60/60 | 12 |
| Linkage Coordinator | Phase I interview and Phase I data elements. | 460 | 1 | 30/60 | 230 |
| Linkage Coordinator | Phase II interview and Phase II data elements. | 100 | 1 | 30/60 | 50 |
| Linkage Coordinator | PositiveLinks data abstraction | 1 | 4 | 15/60 | 1 |
| ADAP Advisory Committee member | Clinician consultation and Clinician consultation data elements. | 40 | 1 | 30/60 | 20 |
| Total | | | | | 550 |

**Jeffrey M. Zirger,**

*Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.*

[FR Doc. 2020–10999 Filed 5–20–20; 8:45 am]

**BILLING CODE 4163–18–P**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

**[30Day–20–20DV]**

### Agency Forms Undergoing Paperwork Reduction Act Review

In accordance with the Paperwork Reduction Act of 1995, the Centers for Disease Control and Prevention (CDC) has submitted the information collection request titled ''Chronic Q Fever in the United States: Enhanced Clinical Surveillance'' to the Office of Management and Budget (OMB) for review and approval. CDC previously published a ''Proposed Data Collection Submitted for Public Comment and Recommendations'' notice on December 23, 2019 to obtain comments from the public and affected agencies. CDC received one comment related to the previous notice. This notice serves to allow an additional 30 days for public and affected agency comments.

CDC will accept all comments for this proposed information collection project. The Office of Management and Budget is particularly interested in comments that:

(a) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(b) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(c) Enhance the quality, utility, and clarity of the information to be collected;

(d) Minimize the burden of the collection of information on those who are to respond, including, through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses; and

(e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639–7570. Comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function. Direct written comments and/or suggestions regarding the items contained in this notice to the Attention: CDC Desk Officer, Office of Management and Budget, 725 17th Street NW, Washington, DC 20503 or by fax to (202) 395–5806. Provide written comments within 30 days of notice publication.

**Proposed Project**

Chronic Q Fever in the United States: Enhanced Clinical Surveillance – New – National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Centers for Disease Control and Prevention (CDC).

*Background and Brief Description*

Q fever is a worldwide zoonosis caused by *Coxiella burnetii* with acute and chronic disease presentations. Chronic Q fever can manifest months to years after the primary infection and is rare, occurring in <5% of persons with an acute infection. Chronic Q fever can take on several clinical forms, including endocarditis, chronic hepatitis, chronic vascular infections, osteomyelitis, and osteoarthritis. In the United States, Q fever cases are reported via the National Notifiable Disease Surveillance System; however, limited information is collected the various clinical manifestation of chronic Q fever or patients pre-existing risk factors. Data on outcomes other than death or hospitalizations are not collected by the current surveillance. Because of this lack of data, the true burden and proportion of cases exhibiting endocarditis and other forms of chronic Q fever in the United States is unknown. We plan to establish an enhanced medical surveillance for chronic Q fever by working with consulting clinicians to gather additional and more specific clinical data not otherwise collected during the course of routine public health surveillance for chronic Q fever. This information will allow for better characterization of the clinical presentation and risk factors of chronic Q fever in the United States. The results will help characterize an under-recognized disease and provide valuable data to educate physicians on identifying and diagnosing these cases.

The survey will take approximately 20 minutes per individual. CDC requests