

Commercial Issues Amendment,
Comment Period Ends: 10/12/2018,
Contact: Emily Gilbert 978-491-8024
*EIS No. 20180182, Draft, USFS, NV, Lee
Canyon EIS, Comment Period Ends:
10/01/2018, Contact: Jonathan Stein
702-515-5418*

*EIS No. 20180183, Draft, TVA, TN,
Transmission System Vegetation
Management Programmatic EIS,
Comment Period Ends: 10/01/2018,
Contact: Anita E. Masters 423-751-
8697*

*EIS No. 20180184, Draft, BLM, UT, Draft
Bears Ears National Monument Indian
Creek and Shash Jaa Units Monument
Management Plans and Associated
Environmental Impact Statement,
Comment Period Ends: 11/15/2018,
Contact: Lance Porter 435-259-2100*

*EIS No. 20180185, Draft, BLM, UT,
Grand Staircase-Escalante National
Monument-Grand Staircase,
Kaiparowits, and Escalante Canyon
Units and Federal Lands Previously
Included in the Monument That Are
Excluded From the Boundaries Draft
Resource Management Plans and
Associated Environmental Impact
Statement, Comment Period Ends: 11/
15/2018, Contact: Matt Betenson 435-
644-1200*

*EIS No. 20180186, Final, USFS, OR,
East Hills Project, Review Period
Ends: 09/17/2018, Contact: Jody
Perozzi 541-353-2723*

Amended Notice

Revision to the **Federal Register**
Notice published 07/06/2018, extend
comment period from 08/20/2018 to 09/
04/2018.

*EIS No. 20180149, Draft, FHWA, ND,
Little Missouri Crossing, Contact:
Gary Goff 701-221-9466*

Dated: August 14, 2018.

Robert Tomiak,

Director, Office of Federal Activities.

[FR Doc. 2018-17747 Filed 8-16-18; 8:45 am]

BILLING CODE 6560-50-P

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

Sunshine Act Meetings

TIME AND DATE: Friday, August 24, 2018,
9:00 a.m. Eastern Time.

PLACE: Jacqueline A. Berrien Training
Center on the First Floor of the EEOC
Office Building, 131 "M" Street NE,
Washington, DC 20507.

STATUS: The meeting will be closed to
the public.

MATTERS TO BE CONSIDERED:

Closed Session

The Associate Legal Counsel has
certified that, in her opinion, exemption
10 of the Sunshine Act, 5 U.S.C.
552b(c)(10) and 29 CFR 1612.4(j),
permits consideration of the scheduled
matters at the closed meeting.

Agency Adjudication and
Determination on Federal Agency
Discrimination Complaint Appeals:

The Commission will be considering
four (4) cases.

Note: Any matter not discussed or
concluded may be carried over to a later
meeting. (In addition to publishing
notices on EEOC Commission meetings
in the **Federal Register**, the Commission
also provides information about
Commission meetings on its website,
www.eeoc.gov., and provides a recorded
announcement a week in advance on
future Commission sessions.)

Please telephone (202) 663-7100
(voice) and (202) 663-4074 (TTY) at any
time for information on these meetings.
The EEOC provides sign language
interpretation and Communication
Access Realtime Translation (CART)
services at Commission meetings for the
hearing impaired. Requests for other
reasonable accommodations may be
made by using the voice and TTY
numbers listed above.

**CONTACT PERSON FOR FURTHER
INFORMATION:** Bernadette B. Wilson,
Executive Officer on (202) 663-4077.

Dated: August 15, 2018.

Bernadette B. Wilson,

Executive Officer, Executive Secretariat.

[FR Doc. 2018-17922 Filed 8-15-18; 4:15 pm]

BILLING CODE 6570-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-3357-FN]

Medicare and Medicaid Program; Application From DNV GL—Healthcare (DNV GL) for Continued Approval of Its Hospital Accreditation Program

AGENCY: Centers for Medicare &
Medicaid Services (CMS), HHS.

ACTION: Final notice.

SUMMARY: This final notice announces
our decision to approve the DNV GL—
Healthcare for continued recognition as
a national accrediting organization for
hospitals that wish to participate in the
Medicare or Medicaid programs.

DATES: This decision is effective August
17, 2018 through September 26, 2022.

FOR FURTHER INFORMATION CONTACT:

Karena Meushaw (410) 786-6609, or
Monda Shaver (410) 786-3410.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible
beneficiaries may receive covered
services from a hospital, provided that
certain requirements are met. Section
1861(e) of the Social Security Act (the
Act), establishes distinct criteria for
facilities seeking designation as a
hospital. Regulations concerning
provider agreements are at 42 CFR part
489 and those pertaining to activities
relating to the survey and certification
of facilities are at 42 CFR part 488. The
regulations at 42 CFR part 482 specify
the minimum conditions that a hospital
must meet to participate in the Medicare
program.

Generally, to enter into an agreement,
a hospital must first be certified by a
State survey agency as complying with
the conditions or requirements set forth
in part 482 of our regulations.
Thereafter, the hospital is subject to
regular surveys by a State survey agency
to determine whether it continues to
meet these requirements. There is an
alternative, however, to surveys by State
agencies.

Section 1865(a)(1) of the Act provides
that, if a provider entity demonstrates
through accreditation by an approved
national accrediting organization that all
applicable Medicare conditions are met
or exceeded, we may deem those
provider entities as having met the
requirements. Accreditation by an
accrediting organization is voluntary
and is not required for Medicare
participation.

If an accrediting organization is
recognized by the Secretary of the
Department of Health and Human
Services as having standards for
accreditation that meet or exceed
Medicare requirements, any provider
entity accredited by the national
accrediting body's approved program
may be deemed to meet the Medicare
conditions. A national accrediting
organization applying for approval of its
accreditation program under part 488,
subpart A, must provide the Centers for
Medicare and Medicaid Services (CMS)
with reasonable assurance that the
accrediting organization requires the
accredited provider entities to meet
requirements that are at least as
stringent as the Medicare conditions.
Our regulations concerning the approval
of accrediting organizations are set forth
at § 488.5. The regulations at
§ 488.5(e)(2)(i) require accrediting
organizations to reapply for continued
approval of its accreditation program

every 6 years or sooner as determined by CMS. DNV GL's current term of approval for their hospital accreditation program expires September 26, 2018.

II. Application Approval Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of applications for CMS approval of an accreditation program is conducted in a timely manner. The Act provides us 210 days after the date of receipt of a complete application, with any documentation necessary to make the determination, to complete our survey activities and application process. Within 60 days after receiving a complete application, we must publish a notice in the **Federal Register** that identifies the national accrediting body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish a notice in the **Federal Register** approving or denying the application.

III. Provisions of the Proposed Notice

In the April 17, 2018 **Federal Register** (83 FR 16862), we published a proposed notice announcing DNV GL's request for continued approval of its Medicare hospital accreditation program. In the proposed notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and in our regulations at § 488.5, we conducted a review of DNV GL's Medicare hospital accreditation renewal application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- An onsite administrative review of DNV GL's: (1) Corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its hospital surveyors; (4) ability to investigate and respond appropriately to complaints against accredited hospitals; and, (5) survey review and decision-making process for accreditation.

- The comparison of DNV GL's Medicare hospital accreditation program standards to our current Medicare hospitals Conditions of Participation (CoPs).

- A documentation review of hospital's survey process to:

- ++ Determine the composition of the survey team, surveyor qualifications, and DNV GL's ability to provide continuing surveyor training.

- ++ Compare DNV GL's processes to those we require of state survey agencies, including periodic resurvey and the ability to investigate and

respond appropriately to complaints against accredited hospitals.

- ++ Evaluate DNV GL's procedures for monitoring hospitals it has found to be out of compliance with DNV GL's program requirements. (This pertains only to monitoring procedures when DNV GL identifies non-compliance. If noncompliance is identified by a state survey agency through a validation survey, the state survey agency monitors corrections as specified at § 488.9(c)).

- ++ Assess DNV GL's ability to report deficiencies to the surveyed hospital and respond to the hospital's plan of correction in a timely manner.

- ++ Establish DNV GL's ability to provide us with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

- ++ Determine the adequacy of DNV GL's staff and other resources.

- ++ Confirm DNV GL's ability to provide adequate funding for performing required surveys.

- ++ Confirm DNV GL's policies with respect to surveys being unannounced.

- ++ Obtain DNV GL's agreement to provide us with a copy of the most current accreditation survey together with any other information related to the survey as we may require, including corrective action plans.

In accordance with section 1865(a)(3)(A) of the Act, the April 17, 2018 proposed notice also solicited public comments regarding whether DNV GL's requirements met or exceeded the Medicare CoPs for hospitals. We received two comments in response to our proposed notice. All of the comments received expressed unanimous support for DNV GL's hospital accreditation program.

IV. Provisions of the Final Notice

A. Differences Between DNV GL's Standards and Requirements for Accreditation and Medicare Conditions and Survey Requirements

We compared DNV GL's hospital accreditation program requirements and survey process with the Medicare CoPs at 42 CFR part 482, and the survey and certification process requirements of Parts 488 and 489. Our review and evaluation of DNV GL's hospital application, which were conducted as described in section III of this final notice, yielded the following areas where, as of the date of this notice, DNV GL has revised its standards and certification processes in order to meet the requirements at:

- Section 482.11 through 482.58, to ensure its standards replace the use of the word "shall" to "must" in all

situations where CMS regulations use the word "must" or, clarify in DNV's glossary the intended definition of the word "shall" means "must."

- State Operations Manual, Section 3012, to ensure that DNV GL's policies related to the timeframe(s) for follow-up activities, including follow-up surveys, for facilities that have previously demonstrated non-compliance at the condition level.

- Section 488.5(a)(4)(iv), to ensure that the hospital and provider-based locations (or a sample when allowed) are included in the hospital survey and deficiencies cited under the appropriate CoPs.

- Section 488.5(a)(11)(ii), to ensure that the data submitted in to CMS is timely, complete and accurate.

- Section 488.5(a)(12), to ensure a clearly defined complaint investigation process is in place that meets the requirements in the State Operations Manual Chapter 5 Section 5010 and Chapter 5 Section 5075.2 that includes the following:

- ++ Complete and accurate tracking of complaints as well as a process for maintaining a documented record of contacts made (for example, phone, email and United States mail) with the complainant, and others, if applicable;

- ++ Define the number of contact attempts required before closing out a complaint, if the complainant does not respond;

- ++ Educate DNV GL complaint intake staff that when complaint allegations could potentially result in condition-level non-compliance affecting the health and safety of patients, a survey is to be considered regardless if the allegation also involves payment related allegations; and,

- ++ The complaint must be investigated onsite within an appropriate timeframe.

- Section 488.26(b), to ensure that DNV GL survey documentation includes a detailed deficiency statement that clearly supports the manner and degree of non-compliance and that all observed non-compliance is cited at the appropriate level (condition verses standard level).

- Section 488.26(c)(4), to ensure that DNV GL surveyors review a sufficient number of inpatient and outpatient medical records during the survey process; the appropriate number of documents, logs, personnel and credentialing files are reviewed during the survey process; the document sources are clearly identified in the survey file; and that DNV GL surveyors have been appropriately trained and determined by DNV GL to be competent in identifying Immediate Jeopardy (IJ)

situations and appropriateness of facility actions to mitigate IJ risk factors prior to the exit of the survey team.

- Section 488.28(a), to ensure that the corrective action plan submitted by hospitals fully addresses the deficiencies cited and that the hospital's corrective actions are hospital wide and not focused solely on the area in which the deficiency was identified.

- Section 488.28(d), to ensure that all corrective action plans contain an expected correction completion date, consistent with CMS requirements.

- Section 488.18(a), to ensure all observations of non-compliance are adequately documented in the survey report and ensure corrective action is required by the hospital.

B. Term of Approval

Based on our review and observations described in section III of this final notice, we approve DNV GL as a national accreditation organization for hospitals that request participation in the Medicare program, effective August 17, 2018 through September 26, 2022.

To verify DNV GL's continued compliance with the provisions of this final notice, CMS will conduct a follow-up corporate on-site visit and survey observation within 18 months of the publication date of this notice.

V. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Dated: August 6, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2018-17815 Filed 8-16-18; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects: LIHEAP Household Report FRN1 Clearance.

Title: Annual Report on Households Assisted by the Low Income Home Energy Assistance (LIHEAP).

OMB No.: 0970-0060.

Description: This report is an annual activity required by statute (42 U.S.C. 8629) and Federal regulations (45 CFR 96.92) for the Low Income Home Energy Assistance Program (LIHEAP). Submission of the completed report is one requirement for LIHEAP grantees applying for Federal LIHEAP block grant funds.

States, the District of Columbia, and the Commonwealth of Puerto Rico are required to report statistics for the previous Federal fiscal year on:

- Assisted and applicant households, by type of LIHEAP assistance;
- Assisted and applicant households, by type of LIHEAP assistance and poverty level;
- Assisted households receiving nominal payments of \$50 or less;
- Assisted households receiving only utility payment assistance; this information will automatically be

transferred to the grantee's Performance Data Form.

- Assisted households, regardless of the type(s) of LIHEAP assistance, excluding households that only receive nominal payments of \$50 or less;

- Assisted households, by type of LIHEAP assistance, having at least one vulnerable member who is at least 60 years or older, disabled, or five years old or younger;

- Assisted households, by type of LIHEAP assistance, with at least one member age 2 years or under;

- Assisted households, by type of LIHEAP assistance, with at least one member ages 3 years through 5 years; and

- Assisted households, regardless of the type(s) of LIHEAP assistance, having at least one member 60 years or older, disabled, or five years old or younger. Insular areas (other than the Commonwealth of Puerto Rico) and Indian Tribal Grantees are required to submit data only on the number of households receiving heating, cooling, energy crisis, and/or weatherization benefits.

The information is being collected for the Department's annual LIHEAP Report to Congress. The data also provides information about the need for LIHEAP funds. Finally, the data are used in the calculation of LIHEAP performance measures under the Government Performance and Results Act of 1993. The data elements will allow the accuracy of measuring LIHEAP targeting performance and LIHEAP cost efficiency.

Respondents: State Governments, Tribal Governments, Insular Areas, and the District of Columbia.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Assisted Household Report-Long Form	56	1	39	2,184
Assisted Household Report-Short Form	160	1	1	160
Estimated Total Annual Burden Hours				2,344

In compliance with the requirements of the Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chap. 35), the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and

Families, Office of Planning, Research and Evaluation, 330 C Street SW, Washington, DC 20201. Attn: ACF Reports Clearance Officer. Email address: infocollection@acf.hhs.gov. All requests should be identified by the title of the information collection.

The Department specifically requests comments 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) 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