1047TH—MEETING—Continued

[Open Meeting September 20, 2018 10:00 p.m.]

Item No.	Docket No.	Company
	OR18–12–000	BP Products North America, Inc., Trafigura Trading LLC, and TCPU, Inc. v. Colonial Pipeline Company.
	OR18–17–000	TransMontaigne Product Services LLC v. Colonial Pipeline Company.
	OR18–21–000 (consolidated)	CITGO Petroleum Corporation v. Colonial Pipeline Company.
HYDRO		
H–1	EL18–56–000 P–12966–005	Utah Board of Water Resources.
H–2	P–2611–087	Hydro-Kennebec LLC.
CERTIFICATES		
C–1	CP09–465–002	Northern Natural Gas Company.
C–2	CP17–219–000	Southern Star Central Gas Pipeline, Inc.

Issued: September 13, 2018.

Kimberly D. Bose,

Secretary.

A free webcast of this event is available through *http://ferc.capitolconnection.org/.* Anyone with internet access who desires to view this event can do so by navigating to *www.ferc.gov's* Calendar of Events and locating this event in the Calendar. The event will contain a link to its webcast. The Capitol Connection provides technical support for the free webcasts. It also offers access to this event via television in the DC area and via phone bridge for a fee. If you have any questions, visit *http://ferc.capitolconnection.org/* or contact Danelle Springer or David Reininger at 703–993–3100.

Immediately following the conclusion of the Commission Meeting, a press briefing will be held in the Commission Meeting Room. Members of the public may view this briefing in the designated overflow room. This statement is intended to notify the public that the press briefings that follow Commission meetings may now be viewed remotely at Commission headquarters, but will not be telecast through the Capitol Connection service.

[FR Doc. 2018–20619 Filed 9–18–18; 4:15 pm]

BILLING CODE 6717–01–P

FEDERAL ELECTION COMMISSION

Sunshine Act Meetings

TIME AND DATE: Tuesday, September 25, 2018 at 10:00 a.m.

PLACE: 1050 First Street NE, Washington, DC.

STATUS: This Meeting will be Closed to the Public.

MATTERS TO BE CONSIDERED: Compliance matters pursuant to 52 U.S.C. 30109. Matters concerning participation in civil actions or proceedings or arbitration.

* * * * *

CONTACT PERSON FOR MORE INFORMATION: Judith Ingram, Press Officer, Telephone: (202) 694–1220.

Laura E. Sinram,

Deputy Secretary of the Commission.

[FR Doc. 2018–20632 Filed 9–18–18; 4:15 pm]

BILLING CODE 6715–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Supplemental Evidence and Data Request on Depression in Children: Systematic Review

AGENCY: Agency for Healthcare Research and Quality (AHRQ), HHS.

ACTION: Request for Supplemental Evidence and Data Submissions.

SUMMARY: The Agency for Healthcare Research and Quality (AHRQ) is seeking scientific information submissions from the public. Scientific information is being solicited to inform our review of *Depression in Children: Systematic Review,* which is currently being conducted by the AHRQ's Evidence-based Practice Centers (EPC) Program. Access to published and unpublished pertinent scientific information will improve the quality of this review.

DATES: *Submission Deadline* on or before October 22, 2018.

ADDRESSES:

Email submissions: epc@ahrq.hhs.gov.

Print submissions:

Mailing Address: Center for Evidence and Practice Improvement, Agency for Healthcare Research and Quality, ATTN: EPC SEADs Coordinator, 5600 Fishers Lane, Mail Stop 06E53A, Rockville, MD 20857.

Shipping Address (FedEx, UPS, etc.): Center for Evidence and Practice Improvement, Agency for Healthcare Research and Quality, ATTN: EPC SEADs Coordinator, 5600 Fishers Lane, Mail Stop 06E77D, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: Jenae Benns, Telephone: 301–427–1496 or Email: *epc@ahrq.hhs.gov.*

SUPPLEMENTARY INFORMATION: The Agency for Healthcare Research and Quality has commissioned the Evidence-based Practice Centers (EPC) Program to complete a review of the evidence for *Depression in Children: Systematic Review.* AHRQ is conducting this systematic review pursuant to Section 902(a) of the Public Health Service Act, 42 U.S.C. 299a(a). The EPC Program is dedicated to identifying as many studies as possible that are relevant to the questions for each of its reviews. In order to do so, we are supplementing the usual manual and electronic database searches of the literature by requesting information from the public (*e.g.,* details of studies conducted). We are looking for studies that report on *Depression in Children: Systematic Review,* including those that describe adverse events. The entire research protocol, including the key questions, is also available online at: *https://effectivehealthcare.ahrq.gov/topic/childhood-depression/protocol*

This is to notify the public that the EPC Program would find the following

information on *Depression in Children: Systematic Review* helpful:

- A list of completed studies that your organization has sponsored for this indication. In the list, please *indicate whether results are available on ClinicalTrials.gov along with the ClinicalTrials.gov trial number.*
- *For completed studies that do not have results on ClinicalTrials.gov,* please provide a summary, including the following elements: Study number, study period, design, methodology, indication and diagnosis, proper use instructions, inclusion and exclusion criteria, primary and secondary outcomes, baseline characteristics, number of patients screened/eligible/enrolled/lost to follow-up/withdrawn/analyzed, effectiveness/efficacy, and safety results.
- *A list of ongoing studies that your organization has sponsored for this indication.* In the list, please provide the ClinicalTrials.gov trial number or, if the trial is not registered, the protocol for the study including a study number, the study period, design, methodology, indication and diagnosis, proper use instructions, inclusion and exclusion criteria, and primary and secondary outcomes.
- Description of whether the above studies constitute ALL Phase II and above clinical trials sponsored by your organization for this indication and an index outlining the relevant information in each submitted file.

Your contribution will be very beneficial to the EPC Program. Materials submitted must be publicly available or able to be made public. Materials that are considered confidential; marketing materials; study types not included in the review; or information on indications not included in the review cannot be used by the EPC Program. This is a voluntary request for information, and all costs for complying with this request must be borne by the submitter.

The draft of this review will be posted on AHRQ's EPC Program website and available for public comment for a period of 4 weeks. If you would like to be notified when the draft is posted, please sign up for the email list at: *https://www.effectivehealthcare.ahrq.gov/email-updates.*

The systematic review will answer the following questions. This information is provided as background. AHRQ is not requesting that the public provide answers to these questions.

The Key Questions (KQs)

1a. In adolescents and children, what are the benefits and harms of nonpharmacological interventions for depressive disorders (defined as MDD or PDD/DD)?

1b. How do these benefits and harms vary by subpopulation (*e.g.,* patient characteristics, parent/caregiver characteristics, disorder characteristics, history of previous treatment, comorbid condition, exposure to a traumatic life event)?

2a. In adolescents and children, what are the benefits and harms of pharmacological interventions for depressive disorders (defined as MDD or PDD/DD)?

2b. How do the benefits and harms vary by subpopulation (*e.g.,* patient characteristics, disorder characteristics, history of previous treatment, comorbid condition, exposure to a traumatic life event?

3a. In adolescents and children, what are the benefits and harms of combination interventions for depressive disorders (defined as MDD or PDD/DD)?

3b. How do the benefits and harms vary by subpopulation (*e.g.,* patient characteristics, disorder characteristics, history of previous treatment, comorbid condition, exposure to a traumatic life event)?

4a: In adolescents and children, what are the benefits and harms of collaborative care interventions for depressive disorders (defined as MDD or PDD/DD)?

4b: How do the benefits and harms vary by subpopulation (*e.g.,* patient characteristics, disorder characteristics, history of previous treatment, comorbid condition, exposure to a traumatic life event)?

5a: In adolescents and children, what are the comparative benefits and harms of treatments (pharmacological, nonpharmacological, combined, collaborative care interventions) for depressive disorders (defined as MDD or PDD/DD)?

5b. How do these benefits and harms vary by subpopulation (*e.g.,* patient characteristics, disorder characteristics, history of previous treatment, comorbid condition, exposure to a traumatic life event)?PICOTS (Populations, Interventions, Comparators, Outcomes, Timing, Settings)

TABLE 1—PICOTS (POPULATIONS, INTERVENTIONS, COMPARATORS, OUTCOMES, TIMING, SETTINGS) AND INCLUSION/EXCLUSION CRITERIA

PICOTS	Inclusion	Exclusion
Population	Children and adolescents (≤18 years old) with a depressive disorder (MDD or PDD/DD) as indicated by a diagnosis made from an established taxonomy (*e.g.,* DSM, ICD) via administration of a structured or semi-structured clinical interview (CIDI, DISC, SCID, PRIME–MD, Kinder-DIPS, K–SADS, DICA, CAS, SADS, DAWBA, SCAN), use of a cutpoint indicative of clinical MDD or PDD/DD as measured by a clinically validated depression scale (BDI, CDI, CESD, PHQ, MFQ, ChilD–S),* or via a clinician diagnosis. Subgroups of interest (KQs 1b, 2b, 3b, 4b, 5b) include those distinguished by patient characteristics (*e.g.,* developmental age—child or adolescent, gender, race/ethnicity), parent/caregiver characteristics, disorder characteristics (*e.g.,* type, severity), history of previous treatment, comorbid condition, and exposure to a traumatic life event.	All other children and adolescents (≤18 years old); all adults >18 years old.
Intervention	Nonpharmacological interventions: *Psychological/psychosocial:* Cognitive behavioral therapy, rational emotive behavior therapy, behavioral activation, other behavioral therapy, interpersonal therapy, directive counseling, Katathym-imaginative Psychotherapy, family therapy, parent education, self-help groups, problem-solving therapy, autonomic training, combined-modality therapy, psychological adaptation therapies.	All other interventions.

TABLE 1—PICOTS (POPULATIONS, INTERVENTIONS, COMPARATORS, OUTCOMES, TIMING, SETTINGS) AND INCLUSION/EXCLUSION CRITERIA—Continued

PICOTS	Inclusion	Exclusion
	Lifestyle: Exercise (physical activity), diet therapy, mindfulness (including mindfulness-based stress reduction), meditation (including mindfulness mediation), relaxation therapy, massage therapy, music therapy, art therapy, integrative restoration, visualization, tai-chi, yoga, spirituality, acupuncture. *Supplements:* St. John's Wort, SAMe, fish oil, melatonin, L-tryptophan, folic acid, 5–HTP, zinc, chromium, gingko biloba, vitamin E, omega-3 fatty acids, hypericum, inositol, selenium. *Other:* Electroconvulsive therapy, transcranial magnetic stimulation, light therapy (phototherapy), hypnotherapy (including self-hypnotherapy), neurofeedback, deep brain stimulation, biofeedback. Pharmacological interventions:. *Selective serotonin reuptake inhibitors (SSRIs):* Citalopram, escitalopram, fluvoxamine, paroxetine, sertraline, vilazodone. *Serotonin and norepinephrine reuptake inhibitors (SNRIs):* Duloxetine, venlafaxine. *Tricyclic antidepressants: Amitriptyline,* desipramine, imipramine, nortriptyline, doxepin, *clomipramine*. *Monoamine oxidase inhibitors: Rasagiline, selegiline, isocarboxazid, phenelzine, tranylcypromine*. *Atypical antidepressants:* Bupropion, mirtazapine, nefazodone, trazodone, vortioxetine. Combination interventions: Any combined treatment that includes two or more types of nonpharmacological, pharmacological, and/or collaborative care interventions, either started together or given as augments to initial treatment types. Collaborative care interventions: Collaborative care, integrated care, integrative care, stepped care, coordinated care, co-managed care, co-located care.	
Comparator	KQ 1: Treatment as usual, sham, attention control, wait list control KQ 2: Placebo, treatment as usual, attention control, wait list control. KQ 3: Treatment as usual, placebo, sham, attention control, wait list control. KQ 4: Treatment as usual, placebo, sham, attention control, wait list control. KQ 5: Any nonpharmacologic, pharmacologic, or collaborative care intervention alone or in combination.	All other comparators.
Outcomes****	Benefits: Remission. Response. Relapse. Depressive symptoms. Suicidality. Mortality. Functional impairment. Harms: Any AEs of intervention (*e.g.,* death, serious adverse events).	All other outcomes.
Time frame	Any publication dates At least 6 weeks of treatment.	Less than 6 weeks of treatment.
Settings	Outpatient care in countries with a very high Human Development Index**.	Inpatient care, studies conducted in countries without a very high Human Development Index.
Study design	For benefits: • Adolescents (sample age >12 and ≤18): randomized controlled trials (RCTs). • Children (sample age ≤12): RCTs or controlled clinical trials (CCTs). For harms: • RCTs, CCTs, and observational studies***. Reference lists of relevant systematic reviews published in 2013 or later will be used to ensure our search strategies captured all relevant studies.	All other designs and studies using included designs that do not meet the sample size criterion.
Language	Studies published in English	Studies published in languages other than English.

* In the absence of clear, clinically validated cutoffs of depression scales used to indicate a either MDD or PDD/DD, the research team will consult two recent systematic reviews [1 2] on the topic and discuss required thresholds with the Technical Expert Panel (TEP) for each scale.

** *http://hdr.undp.org/en/content/human-development-index-hdi*.

*** The research team will evaluate the yield for harms. When studies with sample sizes of 1,000 or more participants are available for a given intervention and comparator, the team plans to restrict the analysis to that group. If large samples are not available, the team plans to include studies with smaller sample sizes.

**** The research team anticipates grading all outcomes but if needed (based on the volume of evidence), they may seek input from the TEP on prioritizing outcomes for strength of evidence grading.

AE = adverse event; BDI = Beck Depression Inventory; CAS: The Child Assessment Schedule; CBT = cognitive behavioral therapy; CCT = controlled clinical trial; CIDI = Composite International Diagnostic Interview; CDI = Children's Depression Inventory; CES–D = Center for Epidemiological Studies Depression Scale; ChilD–S: Children's Depression Screener; DAWBA = The Development and Wellbeing Assessment; DD = dysthymic disorder; DICA = Diagnostic Interview for Children and Adolescents; DISC = Diagnostic Interview Schedule for Children; DSM = *Diagnostic and Statistical Manual;* IPT = interpersonal therapy; Kinder-DIPS = The Diagnostic Interview for Psychiatric Disorders in Children and Adolescents; K–SADS = The Schedule for Affective Disorders and Schizophrenia for School-Age Children; MDD = major depressive disorder; MFQ = Mood and Feelings Questionnaire; PDD = persistent depressive disorder; PHQ = Patient Health Questionnaire; PICOTS = populations, interventions, comparators, outcomes, timing, and setting; PRIME–MD = The Primary Care Evaluation of Mental Disorders; RCT = randomized controlled trial; SADS = The Schedule for Affective Disorders and Schizophrenia; SCAN = Schedules for Clinical Assessment in Neuropsychiatry; SCID = Structured Clinical Interview for DSM disorders.

References

1. Roseman M, Kloda LA, Saadat N, et al. Accuracy of Depression Screening Tools to Detect Major Depression in Children and Adolescents: A Systematic Review. Can J Psychiatry. 2016 Dec;61(12):746–57. doi: 10.1177/0706743716651833. PMID: 27310247.
2. Stockings E, Degenhardt L, Lee YY, et al. Symptom screening scales for detecting major depressive disorder in children and adolescents: a systematic review and meta-analysis of reliability, validity and diagnostic utility. J Affect Disord. 2015 Mar 15;174:447–63. doi: 10.1016/j.jad.2014.11.061. PMID: 25553406.

Francis D. Chesley, Jr.,

Deputy Director.

[FR Doc. 2018–20481 Filed 9–19–18; 8:45 am]

BILLING CODE 4160–90–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Performance Review Board Members

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

ACTION: Notice.

SUMMARY: The Centers for Disease Control and Prevention (CDC) located within the Department of Health and Human Services (HHS) is publishing the names of the Performance Review Board Members who are reviewing performance for Fiscal Year 2018.

FOR FURTHER INFORMATION CONTACT: Sandra DeShields, Chief, Compensation and Performance Management Team, Executive and Scientific Resources Office, Human Resources Office, Centers for Disease Control and Prevention, 11 Corporate Square Blvd., Mailstop US11–2, Atlanta, Georgia 30341, Telephone (770) 488–0252.

SUPPLEMENTARY INFORMATION: Title 5, U.S.C. Section 4314(c)(4) of the Civil Service Reform Act of 1978, Public Law 95–454, requires that the appointment of Performance Review Board Members be published in the **Federal Register**. The following persons will serve on the CDC Performance Review Boards or Panels, which will oversee the evaluation of performance appraisals of Senior Executive Service members for the Fiscal Year 2018 review period:

Dean, Hazel Co-Chair
Shelton, Dana Co-Chair
Arispe, Irma
Boyle, Coleen
Branche, Christine
Curlee, Robert C.
Kosmos, Christine
Peeples, Amy
Qualters, Judith
Ruiz, Roberto
Smagh, Kalwant

Dated: September 17, 2018.

Sandra Cashman,

Executive Secretary, Centers for Disease Control and Prevention.

[FR Doc. 2018–20445 Filed 9–19–18; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4184–N]

Medicare Program; Medicare Appeals; Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2019

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

ACTION: Notice.

SUMMARY: This notice announces the annual adjustment in the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review under the Medicare appeals process. The adjustment to the AIC threshold amounts will be effective for requests for ALJ hearings and judicial review filed on or after January 1, 2019. The calendar year 2019 AIC threshold amounts are $160 for ALJ hearings and $1,630 for judicial review.

DATES: This annual adjustment is effective for requests for ALJ hearings and judicial review filed on or after January 1, 2019.

FOR FURTHER INFORMATION CONTACT: Liz Hosna (*Katherine.Hosna@cms.hhs.gov*), (410) 786–4993.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1869(b)(1)(E) of the Social Security Act (the Act), as amended by section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), established the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review at $100 and $1,000, respectively, for Medicare Part A and Part B appeals. Section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), amended section 1869(b)(1)(E) of the Act to require the AIC threshold amounts for ALJ hearings and judicial review to be adjusted annually. Beginning in January 2005, the AIC threshold amounts are to be adjusted by the percentage increase in the medical care component of the consumer price index (CPI) for all urban consumers (U.S. city average) for July 2003 to July of the year preceding the year involved and rounded to the nearest multiple of $10. Section 940(b)(2) of the MMA provided conforming amendments to apply the AIC adjustment requirement to Medicare Part C/Medicare Advantage (MA) appeals and certain health maintenance organization and competitive health plan appeals. Health care prepayment plans are also subject to MA appeals rules, including the AIC adjustment requirement. Section 101 of the MMA provides for the application of the AIC adjustment requirement to Medicare Part D appeals.

A. Medicare Part A and Part B Appeals

The statutory formula for the annual adjustment to the AIC threshold amounts for ALJ hearings and judicial review of Medicare Part A and Part B appeals, set forth at section 1869(b)(1)(E) of the Act, is included in the applicable implementing regulations, 42 CFR 405.1006(b) and (c). The regulations require the Secretary of Health and Human Services (the