ESTIMATED ANNUALIZED BURDEN HOURS—Continued

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden hours
	Focus group	72	1	90/60	108
Phase II: Web Survey					
Women (age 18–40)	Participant screener	3,000	1	5/60	250
	Web Survey	500	1	15/60	125
Total					531

Kimberly S. Lane,

Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. 2012–4380 Filed 2–23–12; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day-12–0210]

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 Kimberly Lane, CDC Reports Clearance Officer, 1600 Clifton Road, MS D–74, 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

List of Ingredients Added to Tobacco in the Manufacture of Cigarette Products—Extension—Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Cigarette smoking is the leading preventable cause of premature death and disability in the United States. Each year, more than 440,000 premature deaths occur as the result of diseases related to cigarette smoking. The Centers for Disease Control and Prevention (CDC), Office on Smoking and Health (OSH) has the primary responsibility for the Department of Health and Human Services (HHS) smoking and health program. HHS's overall goal is to reduce death and disability resulting from cigarette smoking and other forms of tobacco use through programs of information, education and research.

The Comprehensive Smoking Education Act of 1984 (CSEA, 15 U.S.C. 1336 or Pub. L. 98–474) requires each person who manufactures, packages, or imports cigarettes to provide the Secretary of Health and Human Services (HHS) with a list of ingredients added to tobacco in the manufacture of cigarettes. The legislation also authorizes HHS to undertake research, and to report to the Congress (as deemed appropriate) discussing the health effects of these ingredients.

HHS has delegated responsibility for implementing the CSEA's ingredient reporting requirements to CDC's Office on Smoking and Health (OSH). OSH has collected ingredient reports on cigarette products since 1986. Respondents are commercial cigarette manufacturers, packagers, or importers, or their designated representatives. Respondents are not required to submit specific forms, however, they are required to submit a list of all ingredients used in their products. CDC requires the ingredient report to be submitted by chemical name and Chemical Abstract Service (CAS) Registration Number, consistent with accepted reporting practices for other companies currently required to report ingredients added to other consumer products. Typically, respondents submit a summary report to CDC with the ingredient information for multiple products, or a statement that there are no changes to their previously submitted ingredient report. The estimated burden per response is 6.5 hours.

Ingredient reports for new products are due at the time of first importation. Thereafter, ingredient reports are due annually on March 31. Information is submitted to OSH by mailing a written report on the respondent's letterhead, by CD, three-inch floppy disk, or thumb drive. Electronic mail submissions are not accepted. Upon receipt and verification of the annual ingredient report, OSH issues a Certificate of Compliance to the respondent.

There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Cigarette Manufacturers, Packagers, and Importers	77	1	6.5	501

Kimberly Lane,

Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. 2012–4373 Filed 2–23–12; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–6034–N]

Medicaid Program; Announcement of Medicaid Recovery Audit Contractors (RACs) Contingency Fee Update

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

ACTION: Notice.

SUMMARY: This notice announces an increase to the maximum contingency fee, for which Federal financial participation (FFP) will be available, that may be paid to Medicaid Recovery Audit Contractors (RAC) by State Medicaid programs as authorized by section 1902(a)(42)(B) of the Social Security Act (the Act), as amended by the Affordable Care Act, requiring States to establish Medicaid RAC programs. In the September 16, 2011 **Federal Register** (76 FR 57808), we published a final rule that ties the Medicaid RAC contingency fee to the Medicare Recovery Audit Program with an opportunity for the States to request an exception to exceed the highest fee paid to a Medicare Recovery Auditor. Further, we indicated in the final rule that we would make States aware of any modifications to the payment methodology for contingency fee rates and Medicaid RAC maximum contingency fee rates by publishing a notice in the **Federal Register**. Therefore, this notice will inform States that Medicare has increased the maximum contingency fee paid to Recovery Auditors by 5 percent for the recovery of overpayments only for durable medical equipment claims (DME).

DATES: *Effective Date:* This notice is effective on March 26, 2012.

FOR FURTHER INFORMATION CONTACT: Lori Bellan, (410) 786–2048; or Joanne Davis, (410) 786–5127.

SUPPLEMENTARY INFORMATION:

I. Background

In the September 16, 2011 **Federal Register** (76 FR 57808), we published a final rule entitled: ''Medicaid Program; Recovery Audit Contractors.'' This final rule finalized provisions related to the implementation of a Medicaid Recovery Audit Contractor (RAC) program and provided guidance to States related to Federal/State funding of State start-up, operation and maintenance costs of Medicaid RACs and the payment methodology for State payments to Medicaid RACs. In particular, and as stated in 42 CFR 455.510(b), States must determine the contingency fee rate to be paid to Medicaid RACs for the identification and recovery of Medicaid provider overpayments. We also indicated at 42 CFR 455.510(b)(4):

> [T]he contingency fee may not exceed that of the highest Medicare RAC, as specified by CMS in the **Federal Register**, unless the State submits, and CMS approves, a waiver of the specified maximum rate. If a State does not obtain a waiver of the specified maximum rate, any amount exceeding the specified maximum rate is not eligible for FFP, either from the collected overpayment amounts, or in the form of any other administrative or medical assistance claimed expenditure.

The September 16, 2011 final rule contains additional information about the process States must follow to obtain an exception to the specified maximum rate.

II. Provisions of the Notice

In the final rule at 42 CFR 455.510(b)(4), we stated that the contingency fee paid to the Medicaid RAC may not exceed that of the highest fee paid to a Medicare Recovery Auditor, unless the State submits, and CMS approves, an exception to the specified maximum rate, as specified in the **Federal Register**.

On June 1, 2011, we increased the contingency fee by 5 percent for the recovery of overpayments associated with DME claims that were identified by the Medicare Recovery Auditors. Therefore, the modification increases the maximum contingency fee paid to a Medicare Recovery Auditor to 17.5 percent for DME claims only. As a result of this modification, we now authorize States to pay their respective Medicaid RACs a contingency fee up to 17.5 percent of the recovered overpayment, the current highest contingency fee paid to Medicare Recovery Auditors, for the recovery of improper payments made for medical supplies, equipment and appliances suitable for use in the home found within the Medicaid home health services benefit authorized by section 1905(a)(7) of the Act. We note that this increase in the maximum fee for which FFP is available for payments to Medicaid RACs applies only to fees paid for the recovery of improper payments of this subset of claims. The current highest contingency fee paid to Medicare Recovery Auditors for the recovery of improper payments made on all other types of claims remains the same at 12.5 percent; thus, the maximum fee that may be paid to Medicaid RACs for the recovery of improper payments on other types of claims similarly remains at 12.5 percent. This policy is consistent with section 1902(a)(42)(B) of the Act, which requires States to contract with Medicaid RACs ''in the same manner as the Secretary enters into contracts'' with the Medicare Recovery Auditors. The policy is also consistent with guidance provided in the final rule which aligns the Medicare Recovery Audit Program and Medicaid RAC program, to the extent possible.

III. Collection of Information Requirements

This notice does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35). However, it does reference previously approved information collections. As stated in section I of this notice, States must submit justifications to CMS to receive an exception to pay Medicaid RACs a contingency fee that exceeds the highest fee paid to a Medicare Recovery Auditor.

Authority: Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program.