although legal staff likely will be involved in preparing the actual submission to the Commission, and has applied an average hourly wage of $100/hour for their combined labor. Accordingly, staffs best estimate for the total labor costs for up to 15 information requests is $210,000 per year, for a total of $630,000 over the entire three-year period. Staff believes that the capital or other non-labor costs associated with the information requests are minimal. Although the information requests may necessitate that industry members maintain the requested information provided to the Commission, they should already have in place the means to compile and maintain business records.

*Request for comment:* You can file a comment online or on paper. For the Commission to consider your comment, we must receive it on or before October 3, 2011. Write ''Tobacco Reports: Paperwork Comment, FTC File No. P054507'' on your comment. Your comment—including your name and your state—will be placed on the public record of this proceeding, including, to the extent practicable, on the public Commission Web site, at *http://www.ftc.gov/os/publiccomments.shtm.* As a matter of discretion, the Commission tries to remove individuals' home contact information from comments before placing them on the Commission Web site. Because your comment will be made public, you are solely responsible for making sure that your comment does not include any sensitive personal information, such as anyone's Social Security number, date of birth, driver's license number or other state identification number or foreign country equivalent, passport number, financial account number, or credit or debit card number. You are also solely responsible for making sure that your comment does not include any sensitive health information, such as medical records or other individually identifiable health information. In addition, don't include any ''[t]rade secret or any commercial or financial information which is obtained from any person and which is privileged or confidential * * *,'' as provided in Section 6(f) of the FTC Act, 15 U.S.C. 46(f), and FTC Rule 4.10(a)(2), 16 CFR 4.10(a)(2). In particular, don't include competitively sensitive information, such as costs, sales statistics, inventories, formulas, patterns, devices, manufacturing processes, or customer names.

If you want the Commission to give your comment confidential treatment, you must file it in paper form, with a request for confidential treatment, and you have to follow the procedure explained in FTC Rule 4.9(c), 16 CFR 4.9(c).[2] Your comment will be kept confidential only if the FTC General Counsel, in his or her sole discretion, grants your request in accordance with the law and the public interest.

Postal mail addressed to the Commission is subject to delay due to heightened security screening. As a result, we encourage you to submit your comments online, or to send them to the Commission by courier or overnight service. To make sure that the Commission considers your online comment, you must file it at *https://ftcpublic.commentworks.com/ftc/tobaccoreportspra,* by following the instructions on the web-based form. If this Notice appears at *http://www.regulations.gov/#!home,* you also may file a comment through that Web site.

If you file your comment on paper, write ''Tobacco reports: Paperwork Comment, FTC File No. P054507'' on your comment and on the envelope, and mail or deliver it to the following address: Federal Trade Commission, Office of the Secretary, Room H–113 (Annex J), 600 Pennsylvania Avenue, NW., Washington, DC 20580. If possible, submit your paper comment to the Commission by courier or overnight service.

Visit the Commission Web site at *http://www.ftc.gov* to read this Notice and the news release describing it. The FTC Act and other laws that the Commission administers permit the collection of public comments to consider and use in this proceeding as appropriate. The Commission will consider all timely and responsive public comments that it receives on or before October 3, 2011. You can find more information, including routine uses permitted by the Privacy Act, in the Commission's privacy policy, at *http://www.ftc.gov/ftc/privacy.htm.*

**David C. Shonka,**

*Acting General Counsel.*

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[2] In particular, the written request for confidential treatment that accompanies the comment must include the factual and legal basis for the request, and must identify the specific portions of the comment to be withheld from the public record. See FTC Rule 4.9(c), 16 CFR4.9(c).

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

### Statement of Organization, Functions, and Delegations of Authority

Part C (Centers for Disease Control and Prevention) of the Statement of Organization, Functions, and Delegations of Authority of the Department of Health and Human Services (45 FR 67772–76, dated October 14, 1980, and corrected at 45 FR 69296, October 20, 1980, as amended most recently at 76 FR 34075, dated June 10, 2011) is amended to reflect the establishment of the Office of Minority Health and Health Equity (CAW), Office of the Director (CA), Centers for Disease Control and Prevention (C). This will align this office as a direct report to the Director, Centers for Disease Control and Prevention (CDC), pursuant to passage of the Patient Protection and Affordable Care Act (Pub. L. 111–148).

I. Section C–B, Organization and Functions, is hereby amended as follows:

Under Part C, Centers for Disease Control and Prevention (C), Office of the Director (CA), add the following organizational unit after the Office of Diversity Management and Equal Employment Opportunity (CAV):

*Office of Minority Health and Health Equity (CAW):* The mission of the Office of Minority Health and Health Equity (OMHHE) is to accelerate CDC's health impact in the U.S population and to eliminate health disparities for vulnerable populations as defined by race/ethnicity, socio-economic status, geography, gender, age, disability status, risk status related to sex and gender, and among other populations that are identified as at-risk for health disparities. As the Office of the Director's organizational focus for eliminating health disparities, OMHHE: (1) Provides leadership for CDC-wide policies, strategies, action planning, implementation and evaluation to eliminate health disparities; (2) coordinates CDC's response to Presidential Executive Orders, Congressional mandates, Secretarial and HHS/ASH/OPHS Initiatives, and provides timely performance reports on minority health and health equity as required; (3) monitors and reports on the health status of vulnerable populations and the effectiveness of health protection programs; (4) evaluates the impact of policies and programs to achieve health disparities elimination; (5) supports internal/

external partnerships to advance the science, practice and workforce for eliminating health disparities inside/outside CDC; (6) maintains critical linkages with federal partners including the Office of the Secretary, Department of Health and Human Services, and represents CDC on related scientific and policy committees; (7) establishes external advisory capacity and internal advisory and action capacity; (8) improves support of efforts to improve minority health and achieve health equity in the U.S. by collaborating with CDC's National Centers and other entities; (9) synthesizes, disseminates, and encourages use of scientific evidence regarding effective interventions to achieve health disparities elimination outcomes; (10) analyzes trends in and determinants of health disparities to provide decision support to CDC's Executive Leadership in allocating CDC resources to agency-wide programs for surveillance, research, intervention and evaluation; (11) positions CDC to address relevant provisions in the 2010 Patient Protection and Affordable Care Act that address health disparities; (12) strengthens CDC's global health work to achieve equity; (13) supports CDC's response to public health emergencies in vulnerable populations; and (14) ensures administrative effectiveness and efficiency of agency-wide efforts to achieve health equity.

*II. Delegation of Authority:* All delegations and redelegations of authority made to officials and employees of affected organizational components will continue in them or their successors pending further redelegation, provided they are consistent with this reorganization.

**Authority:** 44 U.S.C. 3101.

Dated: July 27, 2011.

**Carlton Duncan,**

*Acting Chief Operating Officer, Centers for Disease Control and Prevention.*

[FR Doc. 2011–19739 Filed 8–3–11; 8:45 am]

**BILLING CODE 4160–18–M**

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

### Privacy Act of 1974; Report of Modified or Altered System

**AGENCY:** Centers for Medicare & Medicaid Services, Department of Health and Human Services (HHS).

**ACTION:** Notice of Modified or Altered System of Records (SOR).

**SUMMARY:** In accordance with the requirements of the Privacy Act of 1974, we are proposing to modify or alter a SOR titled, ''Medicare Advantage Prescription Drug (MARx) System, No. 09–70–4001,'' last modified at 70 FR 60530 (October 18, 2005). CMS proposes to broaden the data collected and stored by this system as part of a redesign and modernization of the MARx System. On December 8, 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173). MMA amended the Social Security Act (the Act) by adding the Medicare Part D Program under Title XVIII and mandated that CMS establish a voluntary Medicare prescription drug benefit program effective January 1, 2006. Under the Medicare Part D benefit, the Act allows Medicare payment to plans that contract with CMS to provide qualified Part D prescription drug coverage as described in 42 Code of Federal Regulations (CFR) 423.401. The MARx System processes all enrollment/disenrollment transactions associated with the Part D program.

The modified MARx System will accept and store Health Plan-supplied beneficiary residence addresses on an initial Part C and/or Part D enrollment or a subsequent record update transaction from the Plan. The main source of beneficiary residence address is the Social Security Administration (SSA). The address SSA provides, however, may not be the beneficiary's residence address. Beneficiary addresses are initially provided by SSA from the beneficiary's enrollment in Part A and/or Part B, and frequently reflect an address of a representative payee or a Post Office (P.O.) Box, not the residence of the beneficiary. This limits the effectiveness of geographically-sensitive Plan payment decisions. Plans have more accurate beneficiary address information, which is updated on a case-by-case basis. CMS wishes to allow this data to be transmitted in initial enrollment and subsequent record update transactions from the Plans, and additionally translated into valid residence address State and County Codes for subsequent use in service area determination. Support for Plan-supplied residence address will improve the accurate application of geographically sensitive rates in Plan payment calculation. The Plan-supplied beneficiary residence address will be updated and saved with the beneficiary's enrollment data in the MARx System. The residence address provided by the Plan will only apply to periods when the beneficiary is enrolled in that Plan.

We propose to modify existing routine use number 1 that permits disclosure to agency contractors and consultants to include disclosure to CMS grantees who perform a task for the agency. CMS grantees, charges with completing projects or activities that require CMS data to carry out that activity, are classified separate from CMS contractors and/or consultants. The modified routine use will remain as routine use number 1. We will delete routine use number 7 authorizing disclosure to support constituent requests made to a congressional representative. If an authorization for the disclosure has been obtained from the data subject, then no routine use is needed.

We will broaden the scope of published routine uses number 8 and 9, authorizing disclosures to combat fraud and abuse in the Medicare and Medicaid programs to include combating ''waste'' which refers to specific beneficiary/recipient practices that result in unnecessary cost to all Federally-funded health benefit programs. We will add a new routine use authorizing disclosure of individually identifiable information to assist in efforts to respond to a suspected or confirmed breach of the security or confidentiality of information maintained in these systems of records.

We are modifying the language in the remaining routine uses to provide a proper explanation as to the need for the routine use and to provide clarity to CMS's intention to disclose individual-specific information contained in this system. The routine uses will then be prioritized and reordered according to their usage. We will also take the opportunity to update language in the administrative sections to correspond with language used in other CMS SORs. We propose to assign a new CMS identification number to this system to simplify the obsolete and confusing numbering system originally designed to identify the Bureau, Office, or Center that maintained information in the Health Care Financing Administration systems of records. The new assigned identifying number for this system should read: System No. 09–70–0588.

The primary purpose of the SOR is to maintain a master file of Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MA–PD) plan members for accounting and payment control; expedite the exchange of data with MA and MA–PD; control the posting of pro-rata amounts to the Part B deductible of currently enrolled