Unfunded Mandates Reform Act of 1995 (UMRA) (Public Law 104–4).

This action does not involve any technical standards that would require Agency consideration of voluntary consensus standards pursuant to section 12(d) of the National Technology Transfer and Advancement Act of 1995 (NTTAA), Public Law 104–113, section 12(d) (15 U.S.C. 272 note).

VII. Congressional Review Act

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of this final rule in the **Federal Register**. This final rule is not a "major rule" as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pests, Reporting and recordkeeping requirements.

Dated: May 14, 2010.

Lois Rossi,

Director, Registration Division, Office of Pesticide Programs.

■ Therefore, 40 CFR chapter I is amended as follows:

PART 180—[AMENDED]

■ 1. The authority citation for part 180 continues to read as follows:

Authority: 21 U.S.C. 321(q), 346a and 371.

■ 2. Section 180.598 is amended in paragraph (a) as follows:

i. Add alphabetically "Grain, aspirated fractions"; "Hog, kidney"; "Hog, liver"; "Poultry, kidney"; "Poultry, liver"; "Sorghum, grain, forage"; "Sorghum, grain, grain"; and "Sorghum, grain, stover" to the table; and

ii. Revise the entries for "Egg"; "Hog, fat"; "Hog, meat"; "Hog, meat byproducts"; "Poultry, fat"; "Poultry, meat"; and "Poultry, meat byproducts." The added and revised entries to read as follows:

§180.598 Novaluron; tolerances for residues.

(a) * * *

Commodity	Parts per million
* * *	* *
Egg	1.5
* * *	* *
Grain, aspirated fractions	25
* * *	* *
Hog, fat	1.5
Hog, kidney	0.10
Hog, liver	0.10
Hog, meat	0.07
Hog, meat byproducts	0.10
* * *	* *
Poultry, fat	7.0
Poultry, kidney	0.80
Poultry, liver	0.80
Poultry, meat	0.40
Poultry, meat byproducts	0.80
* * *	* *
Sorghum, grain, forage	6.0
Sorghum, grain, grain	3.0
Sorghum, grain, stover	40
* * *	* *

* * * * *

[FR Doc. 2010–12649 Filed 5–25–10; 8:45 am]

BILLING CODE 6560–50–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

42 CFR Part 5a

RIN 0906–AA86

Public Health Service Act, Rural Physician Training Grant Program, Definition of "Underserved Rural Community"

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS).

ACTION: Interim final rule with request for comment.

SUMMARY: This interim final rule (IFR) with request for comment is meant to comply with the statutory directive to issue a regulation defining "underserved rural community" for purposes of the Rural Physician Training Grant Program in section 749B of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act of 2010. This IFR is technical in nature. It will not change grant or funding eligibility for any other grant program currently available through the Office of Rural Health Policy (ORHP) or HRSA. For purposes of the Rural Physician Training Grant Program only, HRSA has combined existing definitions of "underserved" and "rural" by using the definition of rural utilized by the ORHP Rural Health Grant programs and the definition of "underserved" established by HRSA's Office of Shortage Designation (OSD) in the Bureau of Health Professions (BHPr).

DATES: *Effective Date:* This interim final rule is effective 30 days after May 26, 2010.

Comment Date: To be assured consideration, written or electronic comments must be received at one of the addresses provided below, no later than 5 p.m. on July 26, 2010.

ADDRESSES: You may submit comments, identified by the Regulatory Information Number (RIN), by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *E-mail: mgoodman@hrsa.gov.* Include RIN 0906–AA86 in the subject line of the message.
- *Mail:* Michelle Goodman, MAA, Office of Rural Health Policy, Health Resources and Services Administration, 5600 Fishers Lane, Parklawn Building, 10B–45, Rockville, MD 20857.

Instructions: All submissions received must include the agency name and RIN for this rulemaking. All comments received will be available for public inspection and copying, including any personal information provided, at Parklawn Building, 5600 Fishers Lane, Room 10B–45, Rockville, Maryland 20857, weekdays (Federal holidays excepted) between the hours of 8:30 a.m. and 5 p.m.

FOR FURTHER INFORMATION CONTACT: Michelle Goodman, MAA, at the mail or e-mail address above or by telephone at 301–443–0835.

SUPPLEMENTARY INFORMATION:

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I. Background

The ORHP was authorized in December 1987 through Public Law 100–203 and is located in the HRSA. Congress charged ORHP with informing and advising HHS on matters affecting rural hospitals and health care and

coordinating activities within HHS that relate to rural health care.

Section 10501(l) of Public Law 111–148 adds Section 749B to the Public Health Service Act (42 U.S.C. 293k *et seq.*) by authorizing the Rural Physician Training Grant Program. HRSA is authorized to establish this new grant program for the purposes of assisting eligible entities in recruiting students most likely to practice medicine in underserved rural communities; providing rural-focused training and experience; and increasing the number of recent allopathic and osteopathic medical school graduates who practice in underserved rural communities. As required by section 749B(f), not later than 60 days after the date of enactment of Public Law 111–148, the Secretary shall, by regulation, define "underserved rural community" for purposes of this section. HRSA must create an operational definition of "underserved rural community" to help in determining how to allocate funding for the approved activities in the grant.

II. Waiver of Proposed Rulemaking and Comment

We note that ordinarily we publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. However, for the reasons that follow, the agency has determined to proceed directly with this IFR with request for comment pursuant to 5 U.S.C. 553(b)(3)(B) because it has determined that good cause exists which makes the usual notice and comment procedure impractical, unnecessary, and contrary to the public interest. Nevertheless, we are providing the public with a 60-day period following publication of this document to submit comments on the IFR, and appropriate comments received will be used to determine whether to amend this rule and/or will be used to inform the development of the program guidance which will delineate the structure and requirements for the grant program (upon appropriation of funds to implement the grant).

As mentioned above, section 749B(f) requires the Secretary to publish this regulation 60 days after the date of enactment of Public Law 111–148. We have determined that the usual notice and comment procedure would be impractical in this case because those procedures take significantly longer than 60 days.

We also believe it is unnecessary to undertake rulemaking involving prior notice and comment because this IFR will have limited impact, as it defines "underserved rural communities" only for purposes of the Rural Physician Training Grant Program and will not change grant or funding eligibility for any other grant program currently available through ORHP or HRSA.

Additionally, we believe it is unnecessary to undertake prior notice and comment rulemaking because, while funds for this program have not yet been appropriated, such funds might become available with little notice and awarding the funds quickly would serve an important public interest because of the necessity of assisting underserved rural communities to attract and retain needed allopathic and osteopathic medical school graduates to serve in their communities.

III. Definition of "Underserved Rural Community"

HRSA proposes to combine two existing definitions for "underserved" and "rural" by using the rural definition utilized by the ORHP Rural Health Grant Programs and the geographic based Health Professions Shortage Area (HPSA) and Medically Underserved Area (MUA) definitions as established by HRSA's OSD in the BHPr.

A. Definition of Rural

For the purposes of the Rural Physician Training Grant Program outlined in section 749B of the Public Health Services Act, HRSA must define "underserved rural communities." In order to maintain consistency through the various Rural Health Grant Programs, we propose to use the definition for "rural" that is used for the ORHP Rural Health Grant Programs. ORHP uses a two-tiered method to determine geographic eligibility for its grant programs. All counties that are not designated as part of a Metropolitan Statistical Area (MSAs) by the Office of Management and Budget (OMB) are considered rural. This means that counties classified as part of a Micropolitan area are also considered rural. Metropolitan and Micropolitan statistical areas (metro and micro areas) are geographic entities defined by the OMB for use by Federal statistical agencies in collecting, tabulating, and publishing Federal statistics. A metro area contains a core urban area of 50,000 or more population, and a micro area contains an urban core of at least 10,000 (but less than 50,000) population. Each metro or micro area consists of one or more counties and includes the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core. The current list of MSAs and updates are available on the Internet at *http://www.census.gov/population/www/metroareas/metrodef.html.*

Due to the fact that entire counties are designated as Metropolitan when, in fact, large parts of many of these counties may be rural in nature, ORHP has sought a method of identifying sub-county sections of these Metropolitan counties that should also be considered/designated as rural. Rather than exclude large numbers of arguably rural citizens from eligibility for the Rural Health Grant Programs, ORHP sought a rational, data-driven method to identify/designate rural areas inside of Metropolitan counties. ORHP funded the development of "Rural/Urban Commuting Area Codes" (RUCAs), by the WWAMI Rural Research Center at the University of Washington in cooperation with the Department of Agriculture's Economic Research Service, to categorize various levels of rurality and make possible designation of "rural" areas within MSAs. Using commuting data from the Census Bureau, every census tract in the United States is assigned a RUCA code. Currently, there are ten primary RUCA codes with 30 secondary codes based on 2000 Census data and 2004 ZIP Code areas (*see* Table 1).

TABLE 1—RURAL-URBAN COMMUTING AREAS (RUCAS), 2000

1	Metropolitan area core: Primary flow within an urbanized area (UA) 1.0 No additional code. 1.1 Secondary flow 30% to 50% to a larger UA.
2	Metropolitan area high commuting: Primary flow 30% or more to a UA. 2.0 No additional code. 2.1 Secondary flow 30% to 50% to a larger UA.
3	Metropolitan area low commuting: Primary flow 5% to 30% to a UA. 3.0 No additional code.

TABLE 1—RURAL-URBAN COMMUTING AREAS (RUCAS), 2000—Continued

4	Micropolitan area core: Primary flow within an Urban Cluster (UC) of 10,000 to 49,999 (large UC).
	4.0 No additional code.
	4.1 Secondary flow 30% to 50% to a UA.
	4.2 Secondary flow 10% to 30% to a UA.
5	Micropolitan high commuting: Primary flow 30% or more to a large UC.
	5.0 No additional code.
	5.1 Secondary flow 30% to 50% to a UA.
	5.2 Secondary flow 10% to 30% to a UA.
6	Micropolitan low commuting: Primary flow 10% to 30% to a large UC.
	6.0 No additional code.
	6.1 Secondary flow 10% to 30% to a UA.
7	Small town core: Primary flow within an Urban Cluster of 2,500 to 9,999 (small UC).
	7.0 No additional code.
	7.1 Secondary flow 30% to 50% to a UA.
	7.2 Secondary flow 30% to 50% to a large UC.
	7.3 Secondary flow 10% to 30% to a UA.
	7.4 Secondary flow 10% to 30% to a large UC.
8	Small town high commuting: Primary flow 30% or more to a small UC.
	8.0 No additional code.
	8.1 Secondary flow 30% to 50% to a UA.
	8.2 Secondary flow 30% to 50% to a large UC.
	8.3 Secondary flow 10% to 30% to a UA.
	8.4 Secondary flow 10% to 30% to a large UC.
9	Small town low commuting: Primary flow 10% to 30% to a small UC.
	9.0 No additional code.
	9.1 Secondary flow 10% to 30% to a UA.
	9.2 Secondary flow 10% to 30% to a large UC.
10	Rural areas: Primary flow to a tract outside a UA or UC.
	10.0 No additional code.
	10.1 Secondary flow 30% to 50% to a UA.
	10.2 Secondary flow 30% to 50% to a large UC.
	10.3 Secondary flow 30% to 50% to a small UC.
	10.4 Secondary flow 10% to 30% to a UA.
	10.5 Secondary flow 10% to 30% to a large UC.
	10.6 Secondary flow 10% to 30% to a small UC.

Those Census tracts within MSAs that have RUCA codes 4 through 10 are considered rural for the purposes of ORHP Rural Health Grant Programs. In addition, those Census Tracts within MSAs that have RUCA codes 2 or 3, are individually larger than 400 square miles in area, and have a population density of less than 30 people per square mile, also are considered rural. (More information on RUCAs is available at *http://www.ers.usda.gov/briefing/Rurality/RuralUrbanCommutingAreas/* or at *http://depts.washington.edu/uwruca/*.) ORHP has previously used this definition of rural for Rural Health Grant Programs. The RUCA definition is further described in a **Federal Register** Notice published on May 3, 2007 (Vol. 72, No. 85; pgs 24589–24591). In preparing guidance for the Rural Physician Training Grant Program, HRSA will use the most current list of eligible rural counties as determined by the ORHP and published on their Web site at *http://datawarehouse.hrsa.gov/RuralAdvisor/RuralHealthAdvisor.aspx.*

In summary, for the purposes of the Rural Physician Training Grant Program, HRSA is proposing to define the rural portion of the "underserved rural communities" as:

(a) Any non-Metropolitan County, including Micropolitan counties; or

(b) Within a Metropolitan county, all Census Tracts that are assigned a RUCA code of 4–10; or

(c) Census Tracts within a Metropolitan Area with RUCA codes 2 and 3 that are larger than 400 square miles and have population density of less than 30 people per square mile.

B. Definition of Underserved

As previously stated, for the purposes restricted to the Rural Physician Training Grant Program, outlined in section 749B of the Public Health Services Act, HRSA is also required to define the "underserved" portion of the term "underserved rural communities."

HRSA's OSD in the BHPr is responsible for developing shortage/underservice designation criteria and for using the established criteria to decide if a geographic area, population group, or facility is a HPSA or a Medically Underserved Area or Population (MUA/P), or both. Three types of HPSAs may be designated: those with shortages of primary medical care, dental, or mental health providers. Urban or rural geographic areas and population groups may be designated as MUA/P or HPSA; certain medical or other public facilities are also eligible for HPSA designation.

Location in a designated HPSA and MUA/P establishes initial eligibility for many Federal and State programs (such as National Health Service Corps placements, Health Center funding, Federally Qualified Health Center and/or Rural Health Clinic certification). The criteria established to identify geographic areas, population groups, or facilities with shortages of primary health care, dental, or mental health providers are located at 42 CFR Part 5. HPSA designations are based on the population-to-provider ratio in a defined service area, together with other factors indicative of unusually high needs or insufficient capacity. More information on all the factors needed to be designated as a HPSA can be found at the OSD's Web site: *http://bhpr.hrsa.gov/shortage/hpsadesignation.htm.* MUA/P designations utilize an Index of Medical Underservice to calculate a score for each area, based on a weighted combination of four factors: The ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with

incomes below the poverty level, and percentage of the population age 65 or over.

Information on HPSA and MUA/P designation status, including the date of the most recent designation or update, is available on the HRSA Data Warehouse Web site: *http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx,* or at the HRSA Web site *http://hpsafind.hrsa.gov/* and *http://muafind.hrsa.gov.* In preparing guidance for the Rural Physician Training Grant Program, HRSA will use the most current list of eligible HPSAs and MUAs as determined by the OSD and published on their Web site. The OSD Web site list is the most up-to-date list available and removes areas that no longer qualify for designation, even if the **Federal Register** list has not yet been updated.

As required by Section 5602 of Public Law 111–148, HRSA plans to establish a comprehensive methodology and criteria for designation of MUPs and Primary Care HPSAs [under sections 330(b)(3) and 332 of the Public Health Service (PHS) Act, respectively], using a Negotiated Rulemaking process as outlined in the **Federal Register** on May 11, 2010 (Volume 75, Number 90). Any change that HRSA makes to the methodology used to determine designations will not alter the definition for the Rural Physician Training Grant Program.

For the purposes of the Rural Physician Training Grant Program, HRSA is defining the "underserved" portion of the term "underserved rural community" to include current:

(a) Geographic Primary Care Health Professions Shortage Areas (HPSAs), (Federally designated under section 332(a)(1)(A) of the PHS Act) located in rural areas as defined above; or

(b) Medically Underserved Areas (MUAs) (Federally designated under section 330(b)(3) of the PHS Act) located in rural areas as defined above.

HRSA is not including Federally-designated Dental or Mental Health HPSAs for purposes of defining "underserved rural communities" for the Rural Physician Training Grant Program, as this Program is specifically targeted to students at or recent graduates of schools of allopathic and osteopathic medicine (Sec. 749B (a–b)), and therefore not focusing on Mental Health or Dental Health providers.

For purposes of defining "underserved rural communities" for the Rural Physician Training Grant Program, HRSA is not including population-based HPSA designations, MUP designations, or facility-based HPSA designations.

The operational definition of "underserved rural community" will be applied to determine whether applicants meet the statutory eligibility and priority criteria of the Rural Physician Training Grant program. These requirements are based on the ability to identify geographic places. The MUP and population HPSA designations are used to target a group of people, not a geographic place. The facility-based designation is given to an actual facility. While there is a geographic boundary within which qualifying underserved populations are located, this boundary also contains many people who are not underserved (*e.g.* homeless populations within a community that would otherwise not be underserved). Using this boundary as if it captures the same level of underservice as geographic shortage areas (without additional restrictions on the specific patient population within that boundary) could easily result in qualifying programs and program designs which do not fulfill the grant program's intended purpose.

HRSA is seeking public comments, through this IFR, on the following definition for "Underserved Rural Community—Those communities that:

(a) Located in:

i. Any non-Metropolitan County, including Micropolitan counties; or

ii. Within a Metropolitan county, all Census Tracts that are assigned Rural-Urban Commuting Area Codes (RUCAs) code of 4–10; or

iii. Census Tracts within a Metropolitan Area with RUCA codes 2 and 3 that are larger than 400 square miles and have population density of less than 30 people per square mile; and

(b) Being in a current:

i. Federally-designated Primary Health Care Geographic Health Professions Shortage Area (HPSA), (under section 332(a)(1)(A) of the PHS Act) or

ii. Federally-designated Medically Underserved Area (MUA) (under section 330(b)(3) of the PHS Act).

IV. Collection of Information Requirements

This IFR contains no new information collection requirements subject to review by OMB under the Paperwork Reduction Act.

V. Regulatory Impact Analysis

A. Introduction

This IFR is technical in nature. This new regulation is meant to define "underserved rural communities" solely for purposes related to the Rural Physician Training Grant Program, as outlined in section 749B of the Public Health Service Act. This will not change grant or funding eligibility for any other grant program administered through ORHP or HRSA.

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993, as further amended), the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*), section 202 of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1532) (UMRA), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

B. Why Is This Rule Needed?

This regulation is required to implement section 749B of the Public Health Service Act (42 U.S.C. 293) as amended by section 10501(l) of Public Law 111–148.

C. Costs and Benefits

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year). We have determined that this IFR is not an economically significant rule. Moreover, the Secretary has determined that this IFR is not a "major rule" within the meaning of the statute providing for Congressional Review of Agency Rulemaking, 5 U.S.C. 801.

D. Regulatory Flexibility Act Analysis

The Regulatory Flexibility Act requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The Secretary has determined that no resources are required to implement the requirements in this IFR. Therefore, in accordance with the Regulatory Flexibility Act of 1980 and the Small Business Regulatory Enforcement Act of 1996, which amended the Regulatory Flexibility Act, the Secretary certifies that this IFR will not, if implemented, have a significant impact on a substantial number of small entities.

E. Executive Order 13132—Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final

rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. The Secretary has reviewed this IFR in accordance with Executive Order 13132 regarding federalism, and has determined that it does not have "federalism implications." This rule would not "have substantial direct effects on the States, or on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government."

F. Unfunded Mandates Reform Act of 1995

Title II of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) requires cost-benefit and other analyses before any rulemaking if the rule includes a "Federal mandate that may result in the expenditure by State, local, and Tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more (adjusted annually for inflation) in any 1 year." The current inflation adjusted statutory threshold is approximately $130 million. The Department has determined that this rule would not constitute a significant rule under the Unfunded Mandates Reform Act, because it would impose no mandates.

In accordance with the provisions in Executive Order 12866, this IFR was reviewed by OMB.

Dated: May 18, 2010.

Mary Wakefield,

Administrator, Health Resources and Services Administration.

Approved: May 20, 2010.

Kathleen Sebelius,

Secretary.

List of Subjects in 42 CFR Part 5a

Grants administration, Health professions, Physicians, Rural areas, Shortages, Underserved.

■ For the reasons set forth in the preamble, the Department amends 42 CFR Chapter I to add Part 5a as follows:

PART 5a—RURAL PHYSICIAN TRAINING GRANT PROGRAM

Sec.
5a.1 Statutory basis and purpose.
5a.2 Applicability.
5a.3 Definition of Underserved Rural Community.

Authority: Sec. 749B of the Public Health Service Act (42 U.S.C. 293k) as amended.

§ 5a.1—Statutory basis and purpose.

This part implements section 749B(f) of the Public Health Service Act. These provisions define "underserved rural community" for purposes of the Rural Physician Training Grant Program.

§ 5a.2 Applicability.

This part applies to grants made under section 749B of the Public Health Service Act.

§ 5a.3—Definition of Underserved Rural Community.

Underserved Rural Community means a community:

(a) Located in:

(1) A non-Metropolitan County or Micropolitan county; or

(2) If it is within a Metropolitan county, all Census Tracts that are assigned a Rural-Urban Commuting Area (RUCAs) codes of 4–10; or

(3) Census Tracts within a Metropolitan Area with RUCA codes 2 and 3 that are larger than 400 square miles and have population density of less than 30 people per square mile; and

(b) Located in a current:

(1) Federally-designated Primary Health Care Geographic Health Professions Shortage Area, (under section 332(a)(1)(A) of the Public Health Service Act) or

(2) Federally-designated Medically Underserved Area (under section 330(b)(3) of the Public Health Service Act).

[FR Doc. 2010–12557 Filed 5–21–10; 11:15 am]

BILLING CODE 4165–15–P

FEDERAL MARITIME COMMISSION

46 CFR Part 501, 502, and 535

[Docket No. 10–04]

RIN 3072–AC37

Agency Reorganization and Delegations of Authority

AGENCY: Federal Maritime Commission.

ACTION: Final rule.

SUMMARY: The Federal Maritime Commission (FMC or Commission) amends its regulations relating to agency organization to reflect the reorganization of the agency that took effect January 31, 2010, and to delegate authority to certain FMC bureaus and offices in order to improve the FMC's ability to carry out its statutory responsibilities over the ocean shipping industry in a more responsive manner to the industry's changing needs. This rule also corrects typographical errors in two sections in the Commission's rules.

DATES: Effective May 26, 2010.

FOR FURTHER INFORMATION CONTACT: Rebecca A. Fenneman, Deputy General Counsel, Federal Maritime Commission, 800 North Capitol Street, NW., Washington, DC 20573, (202) 523–5740, *GeneralCounsel@fmc.gov.*

SUPPLEMENTARY INFORMATION: The FMC amends Part 501 and § 502.604 of Part 502 of Title 46 of the Code of Federal Regulations to reflect the reorganization of the agency that took effect on January 31, 2010. The FMC was reorganized by restoring the position of the Managing Director to serve as the Commission's Chief Operating Officer responsible for the management and coordination of the Commission's major organizational components to ensure all offices are cohesively directed toward achieving fair and efficient ocean transportation that helps improve the nation's economy. The reorganization also gives heightened priority to the role of the Commission's Office of Consumer Affairs and Dispute Resolution Services (CADRS), which assists exporters and other consumers and works with the public and ocean transportation industry to mediate disputes without costly lawsuits. The Director of CADRS will serve as the Commission's Ombudsman and handle inquiries and complaints about industry issues and Commission services. CADRS will continue to provide the public and ocean transportation industry a variety of impartial, speedy, and confidential alternative dispute resolution (ADR) services, such as mediation and arbitration. As an independent office, it will be able to assist parties in a neutral and confidential manner, enabling disputants to discuss matters while knowing that their discussions and any information revealed in a dispute resolution proceeding will not be made available to any other Commission official or staff members. This rule also corrects typographical errors in § 501.41(a) of Part 501 and § 535.401(g) of Part 535.

Because the changes made in this proceeding only address internal agency operating procedure and organization, which do not require notice and public procedure pursuant to the Administrative Procedure Act, 5 U.S.C. 553, this rule is published as final. The Chairman of the Commission certifies, pursuant to section 605(b) of the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.,* that the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities.

This rule is not a "major rule" under 5 U.S.C. 804(2).