to reach consensus on the substance of the proposed rule. If consensus is reached, the committee will transmit to us a report containing required information for developing a proposed rule and we will use the report as the basis for the proposed rule. The committee is responsible for identifying the key issues, gauging their importance, analyzing the information necessary to resolve the issues, arriving at a consensus, and recommending the text and content of the proposed regulation.

Facilitators

We will be using the services of facilitators from the Federal Mediation and Conciliation Services, specifically, Commissioner Lynn Sylvester and Commissioner Ira B. Lobel.

Agendas for the Public Meetings

At the initial 3-day meeting on October 1–3, 2002, the facilitators will offer an overview of the negotiated rulemaking process, the obligations of committee members, and the substantive issues to be resolved by the committee. The facilitators will conduct a brief training session on negotiation techniques.

The facilitators will propose ground rules for the negotiation committee. These are the procedural rules that the committee will adopt at its first meeting. The facilitators will distribute proposed ground rules, which will address, among other things—

1. The composition of the Committee,
2. The use of alternates;
3. The definition of consensus;
4. The procedures for public participation;
5. Preparation of meeting minutes; and
6. The essential commitment of the members to attend the meetings and participate meaningfully.

The proposed ground rules will emphasize the importance of the members' communication with their constituencies, including keeping them abreast of the negotiations. The proposed ground rules will also address ''bargaining'' in good faith to reach consensus.

At the October 29 through October 31 meeting, the committee will begin to discuss the following issues:

- What and who should be covered by the rule?
- How and by whom will practitioners be certified, credentialed, or licensed?
- What are the special needs that must be addressed, such as dealing with rural areas?
- How will the program be implemented?

This list of issues is preliminary in nature and will serve as the basis to begin the negotiations.

Public Participation

All interested parties are invited to attend both public meetings. No advance registration is required. Seating will be available on a first-come, first-served basis.

Interested parties may comment on the proposed meeting agendas, submit written statements to the Committee regarding substantive issues, and request an opportunity to make a 5-minute oral presentation to the Committee. The Committee has the authority to decide to what extent oral presentations by members of the public may be permitted at the meeting. Oral presentations will be limited to statements of fact and views, and shall not include any questioning of the committee members or other participants unless the facilitators have specifically approved these questions. The number of oral presentations may be limited by the time available.

The deadline for submitting oral presentation requests and comments on the proposed agenda for the October 1 through 3 meeting is 12 noon on September 3, 2002. The deadline for submitting such requests and comments regarding the October 29 through October 31 meeting is 12 noon on October 1, 2002. To assure distribution of written statements to the Committee members before a particular meeting, we encourage interested parties to submit all such statements by the relevant deadline for oral presentation requests and agenda comments. Agenda comments, oral presentation requests, and substantive written statements may be mailed to the following address: Federal Mediation and Conciliation Services, 2100 K Street, NW., Washington, DC 20427, Attention: Lynn Sylvester, or call Lynn Sylvester at (202) 606–9140.

Individuals requiring sign language interpretation for the hearing impaired or other special accommodations should contact Kathryn Cox at the e-mail address specified above or call (410) 786–5954 at least 10 days before the meeting.

Meetings

Subsequent meetings will be held as necessary, although we anticipate that a minimum of six meetings (one meeting per month consisting of 2 or 3 day sessions) will be held. The committee will decide on the dates for the remaining meetings. We will publish notices of future meetings in the **Federal Register**. All future meetings will be open to the public without advance registration.

Authority: Federal Advisory Committee Act (5 U.S.C. App. 2).

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 15, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 02–18614 Filed 7–25–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 413

[CMS–1199–P]

RIN 0938–AL11

Medicare Program; Electronic Submission of Cost Reports

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would amend 42 CFR part 413 by requiring that, for cost reporting periods ending on or after December 31, 2002, all hospices, organ procurement organizations, rural health clinics, federally qualified health centers, community mental health centers, and end-stage renal disease facilities must submit cost reports currently required under the Medicare regulations in a standardized electronic format. This rule also allows a delay or waiver of this requirement when implementation would result in financial hardship for a provider. The provisions of this rule allow for more accurate preparation and more efficient processing of cost reports.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on September 24, 2002.

ADDRESSES: In commenting, please refer to file code CMS–1199–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Mail written comments (one original and three copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1199–P, P.O. Box 8014, Baltimore, MD 21244–8014.

Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

If you prefer, you may deliver (by hand or courier) your written comments (1 original and 3 copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or

Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for commenters wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Tom Talbott, (410) 786–4592.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments

Comments received timely will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call (410) 786–7197.

I. Background

Generally, under the Medicare program, hospices, organ procurement organizations, rural health clinics (RHCs), federally qualified health centers (FQHCs), community mental health centers (CMHCs), and end-stage renal disease (ESRD) facilities are paid for the reasonable costs of the covered items and services they furnish to Medicare beneficiaries. Sections 1815(a) and 1833(e) of the Social Security Act (the Act) provide that no payments will be made to a provider unless it has furnished the information, requested by the Secretary of the Department of Health and Human Services (the Secretary), needed to determine the amount of payments due the provider. In general, providers submit this information through cost reports that cover a 12-month period. Rules governing the submission of cost reports are set forth in §§ 413.20 and 413.24 of the Code of Federal Regulations (CFR).

Under § 413.20(a), all providers participating in the Medicare program are required to maintain sufficient financial records and statistical data for proper determination of costs payable under the program. In addition, providers must use standardized definitions and follow accounting, statistical, and reporting practices that are widely accepted in the health care industry and related fields. Under §§ 413.20(b) and 413.24(f), providers are required to submit cost reports annually, with the reporting period based on the provider's accounting year. Additionally, under § 412.52, all hospitals participating in the prospective payment system must meet cost reporting requirements set forth at §§ 413.20 and 413.24.

Section 1886(f)(l)(B)(i) of the Act requires the Secretary to establish a standardized electronic cost reporting system for all hospitals participating in the Medicare program. This provision was effective for hospital cost reporting periods beginning on or after October 1, 1989. On January 2, 1997, we revised our regulations at § 413.24(f)(4)(ii) to extend the electronic cost reporting requirement to skilled nursing facilities (SNFs) and home health agencies (62 FR 26–31).

The required cost reports must be electronically transmitted to the intermediary in American Standard Code for Information Interchange (ASCII) format. In addition to the electronic file, hospitals, SNFs, and HHAs were initially required to submit a hard copy of the full cost report. We later revised our regulations in § 413.24(f)(4)(iv) to state that providers were required to submit, instead, a hard copy of a one-page settlement summary, a statement of certain worksheet totals found in the electronic file, and a statement signed by the provider's administrator or chief financial officer certifying the accuracy of the electronic file. In order to preserve the integrity of the electronic file, in the January 1997 final rule we specified procedures regarding the processing of the electronic cost report once it is submitted to the intermediary (62 FR 27).

II. Provisions of the Proposed Regulations

In this rule, we propose to apply the current hospital, SNFs, and HHAs electronic cost reporting requirements to hospices, organ procurement organizations, RHCs, FQHCs, CMHCs, and ESRD facilities with the exception that, for the first 2 years, the hard copy of the cost report must be submitted with the electronic cost report. Over that 2-year period, the hard copy will continue to be the official copy. We believe that the use of electronically prepared cost reports will be beneficial for hospices, organ procurement organizations, RHCs, FQHCs, CMHCs, and ESRD facilities because the cost reporting software for these reports will virtually eliminate computational errors and substantially reduce preparation time. Moreover, the use of cost reporting software will save time whenever the provider needs to change individual entries in a cost report.

In this rule we also propose that a hospice, organ procurement organization, RHC, FQHC, CMHC, or ESRD facilities may submit a written request for a waiver or a delay of these requirements if it believes that implementation of the electronic submission requirement would cause a financial hardship. Consistent with the existing regulations (*see* § 413.24), we are continuing to allow providers with low or no Medicare utilization to request a waiver of electronic cost reporting.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA 1995), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.
- We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 413.24—Adequate Cost Data and Cost Finding

Paragraph (f)(4)(ii) requires that, for cost periods ending on or after December 31, 2002, hospices, organ procurement organizations, RHCs,

FQHCs, CMHCs, and ESRD facilities, submit cost reports to fiscal intermediaries in a standardized electronic format readable by the fiscal intermediary's automated system. The electronic file must contain the input data required to complete the cost report and to pass specified edits. Paragraph (f)(4)(iii) requires that the fiscal intermediary make a ''working copy'' of the as-filed electronic cost reports filed by these providers to be used, as necessary, throughout the settlement process (that is, desk review, processing audit adjustments, and final settlement). Paragraph (f)(4)(iv) requires that, for cost reporting periods after December 31, 2002, hospices, organ procurement organizations, RHCs, FQHCs, CMHCs, and ESRD facilities must submit a hard copy of a settlement summary, a statement of certain worksheet totals found within the electronic file, and a statement signed by its administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report. During a transition period (first two cost-reporting periods on or after December 31, 2002), hospices, organ procurement organizations, RHCs, FQHCs, CMHCs, and ESRD facilities must submit a hard copy of the completed cost report forms in addition to the electronic file.

We believe the burden associated with these provisions will actually reduce the amount of time currently spent on preparing and collating hardcopy documents. Because we are unsure how much time will be saved for the various providers, however, we are requesting comments on these provisions so that we can more accurately determine how much time may be saved.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Information Services, DCES, SSG, ATTN.: John Burke, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503. Attn: Brenda Aguilar, CMS Desk Officer.

IV. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the major comments in the preamble to that document.

V. Regulatory Impact Statement

We have examined the impacts of this rule as required by Executive Order 12866 (September 19, 1980 Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980 Pub. L. 96–354). 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 annually). This rule is not considered to have a significant economic impact on hospices, organ procurement organizations, RHCs, FQHCs, CMHCs, and ESRD facilities, like hospitals, and, therefore, is not considered a major rule. There are no requirements for hospices, organ procurement organizations, RHCs, FQHCs, CMHCs, and ESRD facilities to initiate new processes of care, and reporting; to increase the amount of time spent on providing or documenting patient care services; or to purchase computer software.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having annual receipts of $5 million to $25 million or less annually (See 65 FR 69432). For purposes of the RFA, all providers and small businesses that distribute cost-report software to providers are considered small entities. Our intermediaries are not considered small entities for the purposes of the RFA. Individuals and States are not included in the definition of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds.

We are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined, and we certify, that this rule will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

As stated above, under §§ 413.20(b) and 413.24(f), providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. This proposed rule would require hospices, organ procurement organizations, RHCs, FQHCs, CMHCs, and ESRD facilities, like hospitals, SNFs and HHAs, to submit their Medicare cost reports in a standardized electronic format. We anticipate that this requirement would take effect for cost reporting periods ending on or after December 31, 2002, meaning that the first electronic cost reports would be due May 31, 2003.

Currently, approximately 55 percent of all hospices, organ procurement organizations, RHCs, FQHCs, CMHCs, and ESRD facilities submit a hard copy of an electronically prepared cost report to the intermediary. We believe that the provisions of this proposed rule would have little or no effect on these providers, except to reduce the time involved in copying and collating a hard copy of the report for intermediaries. Under this proposed rule, instead of submitting a complete hard copy of the report, providers would be required to submit only hard copies of a settlement summary, statement of certain worksheet totals, and a statement signed by the administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report. In addition to the 55 percent of providers that currently use electronic cost reporting, this rule would not affect those providers that do not file a full cost report and, as stated above, would not be required to submit cost reports electronically.

This proposed rule may have an impact on those providers who do not prepare electronic cost reports, some of whom may have to purchase computer equipment, obtain the necessary software, and train staff to use the software. However, as discussed below, we believe that the potential impact of this proposed rule on those providers who do not prepare electronic cost reports would be insignificant.

First, a small number of the 45 percent of providers that do not submit electronic cost reports may have to

purchase computer equipment to comply with the provisions of this proposed rule. These providers are generally owned and operated by one or two individuals and are often located in rural areas. They include approximately 1500 RHCs and 1500 FQHCs. We estimate that 1350 of the 3000 RHCs and FQHCs may not have the necessary computer equipment. We believe, however, that most providers already have access to computer equipment, which they are now using for internal record keeping purposes, as well as for submitting electronically generated bills to their fiscal intermediaries, for example. Thus, we do not believe that obtaining computer equipment would be a major obstacle to electronic cost reporting for most providers. For those providers that would have to purchase computer equipment, we note that, in accordance with current regulations governing payment of provider costs, we would pay for the cost of the equipment as an overhead cost. Rural health clinics and FQHCs would be reimbursed subject to a payment limit; organ procurement organizations reimbursed based on costs; hospices reimbursed according to fee schedule; ESRDs paid a composite rate, and CMHCs would be reimbursed through a blend of prospective payment (PPS) and cost.

We recognize that a potential cost for providers that do not submit electronic cost reports would be that of training staff to use the software. Since most hospices, organ procurement organizations, RHCs, FQHCs, CMHCs, and ESRD facilities currently use computers, we do not believe that training staff to use the new software would impose a large burden on providers. An additional cost would be the cost of the software offered by commercial vendors. However, providers could eliminate this cost by obtaining the necessary software from us, free of charge. In those instances when these requirements may cause hardship, a waiver can be granted.

The requirement that hospitals submit cost reports in a standardized electronic format has been in place since October 1989. Since that time, the accuracy of cost reports has increased and we have received very few requests for waivers. Additionally, we have not received any comments from the hospital industry indicating that the use of electronic cost reporting is overly burdensome. We believe that electronic cost reporting would be equally effective for hospices, organ procurement organizations, RHCs, FQHCs, CMHCs, and ESRD facilities, with the benefits (such as increased accuracy and decreased preparation time) outweighing the costs of implementation for most providers. We solicit comments on the potential benefits and implementation costs of these rules for all providers.

Section 202 of the Unfunded Mandate Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, that exceeds the inflation-adjusted threshold of $110 million. This rule does not impose any costs that would exceed the $110 million threshold on the governments mentioned, or the private sector.

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 compliance costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have examined this proposed rule and have determined that this rule will not have a negative impact on the rights, rules, and responsibilities of State, local, or tribal governments.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as follows:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

2. Section 413.24 is amended by revising existing paragraphs (f)(4)(i) through (f)(4)(v) to read as follows:

§ 413.24 Adequate cost data and cost finding.

* * * * *

(f) *Cost reports.* * * *

(4) *Electronic submission of cost reports.* (i) As used in this paragraph, ''provider'' means a hospital, skilled nursing facility, home health agency, hospice, organ procurement organization, rural health clinic, federally qualified health clinic, community mental health center, or end-stage renal disease facility.

(ii) Effective for cost reporting periods beginning on or after October 1, 1989 for hospitals, cost reporting periods ending on or after December 31, 1996 for skilled nursing facilities and home health agencies, and cost reporting periods ending on December 31, 2002 for hospices, organ procurement organizations, rural health clinics, federally qualified health centers, community mental health centers, and end-stage renal disease facilities, a provider is required to submit cost reports in a standardized electronic format. The provider's electronic program must be capable of producing the CMS standardized output file in a form that can be read by the fiscal intermediary's automated system. This electronic file, which must contain the input data required to complete the cost report and to pass specified edits, must be forwarded to the fiscal intermediary for processing through its system.

(iii) The fiscal intermediary stores the provider's as-filed electronic cost report and may not alter that file for any reason. The fiscal intermediary makes a ''working copy'' of the as-filed electronic cost report to be used, as necessary, throughout the settlement process (that is, desk review, processing audit adjustments, and final settlement). The provider's electronic program must be able to disclose if any changes have been made to the as-filed electronic cost report after acceptance by the intermediary. If the as-filed electronic cost report does not pass all specified edits, the fiscal intermediary must return it to the provider for correction. For purposes of the requirements in paragraph (f)(2) of this section concerning due dates, an electronic cost report is not considered to be filed until it is accepted by the intermediary.

(iv) Effective for cost reporting periods ending on or after September 30, 1994 for hospitals, cost reporting periods ending on or after December 31, 1996 for skilled nursing facilities and home health agencies, and cost reporting periods ending on or after December 31, 2002 for hospices, organ procurement organizations, rural health clinics, federally qualified health centers, community mental health centers, and end-stage renal disease facilities, a provider must submit a hard copy of a settlement summary, a statement of certain worksheet totals found within the electronic file, and a statement signed by its administrator or chief financial officer certifying the

accuracy of the electronic file or the manually prepared cost report. During a transition period (first two cost-reporting periods on or after December 31, 2002), hospices, organ procurement organizations, rural health clinics, federally qualified health centers, community mental health centers, and end-stage renal disease facilities must submit a hard copy of the completed cost report forms in addition to the electronic file. The following statement must immediately precede the dated signature of the provider's administrator or chief financial officer:

I hereby certify that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted the cost report and the Balance Sheet Statement of Revenue and Expenses prepared by _____ (Provider Name(s) and Number(s)) for the cost reporting period beginning ___ and ending ___ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(v) A provider may request a delay or waiver of the electronic submission requirement in paragraph (f)(4)(ii) of this section if this requirement would cause a financial hardship or if the provider qualifies as a low or no Medicare utilization provider. The provider must submit a written request for delay or waiver with necessary supporting documentation to its intermediary no later than 30 days after the end of its cost reporting period. The intermediary reviews the request and forwards it, with a recommendation for approval or denial, to CMS central office within 30 days of receipt of the request. CMS central office either approves or denies the request and notifies the intermediary within 60 days of receipt of the request.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: March 4, 2002.

Thomas A Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: April 29, 2002.

Tommy G. Thompson,

Secretary.

[FR Doc. 02–18982 Filed 7–25–02; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF TRANSPORTATION

Research and Special Programs Administration

49 CFR Part 195

[Docket No. RSPA–01–9832]

RIN 2137–AD59

Pipeline Safety: Hazardous Liquid Pipeline Operator Annual Report Form

AGENCY: Office of Pipeline Safety (OPS), Research and Special Programs Administration, Department of Transportation.

ACTION: Notice of proposed rulemaking.

SUMMARY: This notice of proposed rulemaking (NPRM) would require hazardous liquid pipeline operators to submit an annual report (proposed form RSPA F7000–1.1). The report form asks for information that the Research and Special Programs Administration's (RSPA) Office of Pipeline Safety (OPS) does not currently collect, such as: breakout tank location and capacity; hazardous liquid pipeline mileage by State, diameter and decade installed. The report will be due March 15 of each year for the previous calendar year, aligning with the annual reporting schedule for natural gas pipeline operators. RSPA/OPS will use information from the report to more effectively compile national statistics on system inventory; analyze accidents; identify safety problems and potential solutions; and target inspections. The proposed form asks for information similar to information RSPA/OPS currently collects for natural gas pipelines. The proposed information collection is part of RSPA's/OPS's overall strategy for improving the quality of pipeline statistics and addresses a longstanding data gap in hazardous liquid pipeline inventory information.

DATES: Comments on this NPRM must be received on or before September 24, 2002.

ADDRESSES: You may submit written comments by mail or in person by delivering an original and two copies to the Dockets Facility, U.S. Department of Transportation, Room PL–401, 400 Seventh Street, SW., Washington, DC 20590–0001. Or, you may submit written comments to the docket electronically at the following Web address: *http://dms.dot.gov. See* the **SUPPLEMENTARY INFORMATION** section for additional filing information.

FOR FURTHER INFORMATION CONTACT: Roger Little by phone at (202)366–4569, by e-mail at *roger.little@rspa.dot.gov,* or by mail at the Office of Pipeline Safety, Room 7128, 400 7th St. SW., Washington, DC, 20590, regarding the subject matter of this notice or to access comments in the docket.

SUPPLEMENTARY INFORMATION:

Filing Information, Electronic Access, and General Program Information

The Dockets facility is open from 10 a.m. to 5 p.m., Monday through Friday, except Federal holidays. All comments should identify the docket number of this notice, RSPA–01–9832. You should submit the original and one copy. If you wish to receive confirmation of receipt of your comments, you must include a stamped, self-addressed postcard. To file written comments electronically, after logging onto *http://dms.dot.gov,* click on ''Electronic Submission'' and follow the instructions. You can read comments and other material in the docket at this Web address: *http://dms.dot.gov.* General information about our pipeline safety program is available at *http://ops.dot.gov.*

Background

RSPA Pipeline Safety Mission

RSPA's/OPS's mission is to ensure the safe, reliable, and environmentally sound operation of the nation's approximately 154 thousand miles of hazardous liquid pipelines. RSPA/OPS shares responsibility for inspecting and overseeing the nation's pipelines with State pipeline safety offices. Both Federal and State regulators depend on accident reports submitted by pipeline companies to manage inspection programs and to identify trends in hazardous liquid pipeline safety. In recent years, the U.S. Congress, the National Transportation Safety Board (NTSB) and the DOT's Office of the Inspector General (OIG) have urged RSPA/OPS to improve the quality of accident data required to be submitted by hazardous liquid pipeline operators and to seek inventory information sufficient for trending the accident data. RSPA/OPS revised hazardous liquid accident reporting requirements on January 8, 2002 (67 FR 831) as part of the strategy to improve pipeline