ADDITIONAL MATTER:

The following item is added to the previously announced agenda:

D. Personnel Items

1. Personal Services Contract with Quality Technology Company, Lebo, Kansas, for Development and Implementation of a Program for the Identification, Investigation, and Reporting of Employee-Raised Issues of Concern, with Special Emphasis on those Issues Dealing with Nuclear Safety at TVA Facilities; Requested by Nuclear Safety Review Staff.

CONTACT PERSON FOR MORE INFORMATION: Craven H. Crowell, Jr., Director of Information, or a member of his staff can respond to requests for information about this meeting. Call 615-632-800, Knoxville, Tennessee. Information is also available at TVA's Washington Office, 202-245-0101.

SUPPLEMENTARY INFORMATION:

TVA Board Action

The TVA Board of Directors has found, the public interest not requiring otherwise, that TVA business requires the subject matter of this meeting be changed to include the additional item shown above and that no earlier announcement of this change was possible.

The members of the TVA Board voted to approve the above findings and their approvals are recorded below:

Approved:

C.H. Dean, Jr.,

Director and Chairman.

Richard M. Freeman,

Director.

John B. Waters,

Director.

Dated: May 3, 1985.

[FR Doc. 85-11571 Filed 5-9-85; 12:38 pm]

BILLING CODE 8120-01-M

federal register

Monday
May 13, 1985

Part II

Department of Health and Human Services

Social Security Administration

Availability of Funding for Planned Secondary Resettlements of Refugees; Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Social Security Administration

Availability of Funding for Planned Secondary Resettlements (PSR) of Refugees

AGENCY: Office of Refugee Resettlement (ORR), SSA, HHS.

ACTION: Notice of availability of funding for grants to assist interested refugees to effect planned secondary resettlements to favorable communities.

SUMMARY: This announcement governs the award of grants to public or private non-profit organizations or agencies for the purpose of providing assistance to eligible refugees in high welfare dependency areas who wish to relocate in a planned way to communities offering favorable employment and resettlement opportunities. Eligible refugees include those who have experienced recurrent or continuing unemployment and/or public assistance dependency. Planned secondary resettlement (PSR) grants will be conducted in two phases: A planning phase to assess and prepare prospective receiving communities and to identify and prepare interested refugees for participation in PSR; and a resettlement phase to implement a planned relocation, involving the provision of services to facilitate prompt employment and a positive resettlement. Planned secondary resettlement is distinguished from "secondary migration" in that planned secondary resettlement involves a considered assessment of the resettlement area prior to relocation, pre-relocation identification of employment opportunities, and consultations with, and advance notification to, appropriate government authorities.

DATE: *Closing Date:* Not Applicable. This is a standing announcement. Grant applications will be reviewed periodically. (See *Review and Award Procedures* for a schedule of proposal due dates and panel review dates.) Applications received later than July 15, 1985 will only be considered for funding in Fiscal Year 1986. Proposals will be evaluated by an independent panel on the basis of the weighted criteria listed in Section V of this Notice. However, all final funding decisions rest with the Director, ORR. Grants will be awarded subject to the availability of funds.

Authorization

Authority for this activity is contained in section 412(c) of the Immigration and Nationality Act (INA), as amended by the Refugee Act of 1980 (Pub. L. 96-212), 8 U.S.C. 1522(c).

Available Funds

Approximately $600,000 will be available for this grant program in Fiscal Year 1985. The Director estimates these funds could support up to four grant awards, at an average cost of $150,000 each. The anticipated range for these grants is $75,000 to $300,000 depending on the distance from sending site to receiving site, the size of the population to be resettled, the number of sending and receiving sites to be involved, and the availability of other support. The anticipated range for planning phase costs is $10,000 to $25,000; the range for resettlement phase costs is estimated at $65,000 to $135,000. Higher funding amounts will be considered for applications involving multiple sites. These anticipated ranges are intended to serve as benchmarks only. These estimates do not bind the Office of Refugee Resettlement to a specific number of grants or to the amount of any grant unless that amount is otherwise specified by statute or regulation.

Future Fiscal Year funding for this grants program will be contingent upon appropriations. If adequate funds are available, the Director, ORR, anticipates continuation of this program.

Awards will not exceed an 18 month period of performance for planning and resettlement phases combined.

Application and Funding Process

Applicants shall submit one application which addresses both phases (planning and resettlement) of a proposed project. While applicants will be expected to describe proposed activities and costs in both phases with as much specifity as possible, the description of the proposed resettlement phase plan will be viewed as preliminary and subject to revision during the course of the planning phase.

Funding of PSR grants shall be incremental. Applicants approved for funding shall receive funds for the planning phase only. Release of resettlement phase funding will be contingent upon the submission of an acceptable final resettlement plan at the conclusion of the planning phase. The resettlement plan will be evaluated by the Office of Refugee Resettlement on the basis of the quality and completeness of all components of the plan as specified in Section II, 4. Grantees will be expected to provide a detailed description of proposed resettlement activities and budget at that time.

Should a grantee fail to provide an acceptable resettlement plan, ORR reserves the right not to continue the grant beyond the planning phase. Under such circumstances it would be considered against the Government's best interests to proceed with funds release for the resettlement phase.

Eligible Grantees

State agencies responsible for the administration of State refugee programs, public and private non-profit organizations that have had demonstrated experience in the provision of services to refugees, such as refugee mutual assistance associations (MAAs) and national or local voluntary resettlement agencies, are eligible to apply for funds under the PSR program. Applicants will be required to demonstrate clearly how they will maintain communication with the refugee community in which the identified group of refugees currently resides.

Any combination or consortium of qualified organizations may join together to make application so long as one organization is clearly identified as the responsible grantee. Examples of possible combinations include, but are not limited to: a consortium of MAAs; MAAs and voluntary agencies; States and voluntary agencies; a national voluntary agency with local affiliates; MAAs and States; or any combination of the above.

It is anticipated that, in most cases, the participant organization representing the receiving site will be the primary applicant. However, linkages, through contractual arrangements, with organizations representing sending sites are not only encouraged, but are desired. If a refugee group or an organization (e.g., MAAs or voluntary agencies) representing refugees interested in relocating to a favorable site wishes to initiate a PSR, they are encouraged to link with an established organization or agency in a receiving site to make application.

Program Information

I. Purpose

The purpose of this announcement is to provide an opportunity for refugees residing in high welfare dependency/high unemployment areas [1] who have

[1] For purposes of this announcement, these areas include areas with high welfare dependency or high unemployment among time-expired refugees (over 36 months) as well as areas with a high dependency or unemployment rate among time-eligible refugees. High welfare dependency shall be defined as any rate of over 55% in a given locale.

not been able to find employment to relocate to areas in the U.S. that offer favorable prospects for employment and positive resettlement. The Planned Secondary Resettlement Program serves two objectives:

- To increase refugee self-sufficiency while reducing welfare dependency and/or high unemployment; and
- To increase the use of underutilized communities while seeking to ease the burden of heavily impacted communities.

Planned secondary resettlements should be viewed as a self-sufficiency strategy of last resort and as such should be considered only for those refugees who have little or no chance of obtaining full-time employment where they currently reside.

Accordingly, grants provided for under this program are intended to be applied to groups of refugees who have experienced particularly severe labor market problems and are at risk of long term welfare dependency in the areas in which they reside. While not limited to any ethnic or nationality group, refugee resettlement program experience to date suggests that certain populations are particularly at risk, such as the Highland Lao ethnic groups, as well as segments of the Khmer population.

Resettlement supported under PSR grants must be keyed to assisting refugees to relocate to communities which provide significantly better opportunities for full employment of heads of household than exist in the refugees' current community. Central to a planned secondary resettlement if the pre-relocation identification of employment opportunities that will enhance the economic self-sufficiency of participating refugees. No grants will be awarded to support resettlements in high welfare utilization areas or in areas where the job market is insufficient to accommodate the refugee population residing in those areas.

Resettlements to be supported under PSR grants must proceed from a clear expression of interest and readiness on the part of the refugee group to participate in a resettlement.

II. Program Description

1. It is expected that each planned secondary resettlement grant will involve a minimum of one, and a maximum of 5, sending sites and no more than 2 receiving sites. That is, in each PSR project, eligible and interested refugees could be recruited from one to five different communities for secondary resettlement in one or two favorable communities. It is anticipated that the total number of refugees to be resettled under PSR will not be less than 40 per receiving community, nor more than 200 per grant.

2. Planned secondary resettlements shall be conducted in two phases: A planning phase and a resettlement phase.

3. *Planning phase:* The planning phase is for the purpose of undertaking all preparatory activities needed to ensure a smooth and successful planned resettlement. Such activities shall include at a minimum:

- Pre-resettlement consultations with the designated State refugee agency when the applicant is not the State agency; pre-resettlement consultations with local refugee and resettlement organizations when the applicant is the State agency.
- A detailed assessment of the capacity of the receiving community to provide tangible opportunities for employment, appropriate social services, adequate and affordable housing, health care, favorable educational facilities for children, and a receptive community climate for refugees.
- Introductory visits by representatives of the receiving site to prospective sending site(s) to make presentations to interested refugees, refugee community leaders and other interested parties, on available opportunities in the prospective receiving community.
- On-site visits by prospective PSR refugees and/or refugee community representatives to the proposed receiving site for a first-hand assessment of the community and its resources.
- Identification of eligible refugees in the sending site(s) who wish to relocate to the proposed receiving site(s).
- Preparation of a final resettlement plan if the planning phase indicates feasibility of a resettlement project.
- Other reasonable planning-related activities in support of project goals.

Applicants are advised in developing a planning phase budget to allow for a sufficient number of on-site visits by prospective PSR refugees and their leaders to the receiving site. Such visits should be limited to the number necessary to permit prospective refugees seeking relocation to assess the receiving site. The budget should reflect an emphasis on these types of visits rather than on visits by receiving site representatives to sending sites.

The period of performance for planning phase activities normally shall not exceed 6 months from the date of award. ORR will consider a longer time period if good cause is clearly indicated in the application.

4. *Resettlement Plan.* Upon completion of the planning phase, grantees will be required to submit a detailed resettlement plan which contains the following elements:

a. A description of all activities undertaken during the planning phase, including documentation of refugee involvement and interest.

b. A breakdown of the numbers of individuals and families to be resettled, from each sending site and to each receiving site, and a proposed timetable for resettlement.

c. Statements of intent, signed by the heads of household of the participating families, indicating an interest and commitment to relocate to the proposed site and to accept employment in the new site. (A sample Statement of Intent is included at the conclusion of this announcement.)

d. A detailed description of the characteristics of each refugee family identified for planned resettlement, in terms of time in the U.S., current public assistance and/or employment status, employment/unemployment history in the U.S., and ethnicity.

e. An updated assessment (both qualitative and quantitative) of the capacity of the prospective resettlement community to receive the planned refugee population with particular regard to:

- Available employment opportunities
- Available and affordable housing
- Available and affordable health care services
- Supportive social services such as interpreter/translator services.

f. Evidence that the receiving site offers immediate or imminent prospects for full employment with advancement potential, and that local employers would be interested in hiring relocated refugees.

g. A plan which establishes timeliness for securing employment for relocated refugees.

h. Evidence of the availability of adequate and affordable health insurance for PSR refugees through employer-provided health benefits.

i. Evidence of consultation with the appropriate State Refugee Coordinator(s) for the receiving site(s) if the State agency is not the applicant.

j. Certification of acceptability of the resettlement plan on the part of the sending organization and at least one adult member of each participating refugee family.

k. A final detailed plan for the organization, delivery and coordination of social services, including the identities of proposed service providers

at the resettlement site, the specific services to be provided, the methods by which service needs of the resettlement population were determined, and the period of performance for each proposed service provider funded from the grant.

l. A plan for the provision of housing and resettlement allowances to the participating families.

m. A final itemized budget with complete narrative justification for the resettlement phase.

Funds for the resettlement phase of a PSR grant will be released to the grantee once a resettlement plan is received and found to be acceptable by ORR. The acceptability of a plan will be evaluated by ORR on the basis of the quality and completeness of all components of the plan as specified above. Should the plan be unacceptable, ORR is under no obligation to fund the resettlement phase.

5. *Resettlement Phase:* The planned secondary resettlement shall be implemented during this phase. Allowable activities include:

- Any priority social service (as recognized by ORR);
- Day care services for preschool children to enable secondary wage earners to obtain employment;
- Short-term emergency health coverage;
- Targeted training expenses in cases where employers guarantee employment for refugees successfully completing on-the-job training;
- Training stipends for employees in unpaid or reduced wage training programs;
- Resettlement allowances as noted below;
- Information management/data tracking services to permit monitoring and evaluation of PSR results.

6. *Resettlement Allowance:* To enable participating refugees to meet transportation and basic food and shelter expenses during the initial resettlement period, a resettlement allowance will be an allowable cost item under PSR grants. Such allowances will be restricted to the following costs:

- Reasonable transportation and moving costs
- Living expenses for a period not to exceed 60 days, including food, shelter, utilities and local transportation costs, whose monthly total shall not exceed local AFDC payment levels. Monthly totals exceeding the local AFDC level will be considered by ORR only if fully justified by special circumstances.
- One-time-only security deposits for housing and utilities.

These expenses shall be covered only in cases where wages/income are not immediately available to meet these essential costs during the initial resettlement period.

Resettlement allowances must be justified in the resettlement plan on the basis of need of the defined resettlement group. Resettlement allowances may be paid by the grantee directly to the qualifying head of household, or to an agency or organization designated to coordinate or supervise the resettlement. The resettlement allowances must be applied in full to expense items noted above.

It is expected that applicants will make a good faith effort to obtain funds for this purpose from private sources before applying for resettlement allowances under the PSR program. For example, a major source of support for cases of intra-state resettlements might be the relocation assistance allowance for Work Incentive Program (WIN) registered refugees. (See 45 CFR 224.33.)

7. *Eligible Refugee Populations:* The eligible population under this grant program is limited to refugees (single adults and families) who have lived in the U.S. for at least 18 months and have experienced recurrent or continuing unemployment during their period of residency and/or are receiving public assistance. These eligibility criteria must be met by the primary adult wage earner in each participating family. The following special exception will be made regarding these eligibility criteria: Recently arrived refugees (those who have been in the U.S. less than 18 months) may participate in a planned resettlement with their anchor relatives (relatives with whom recently arrived refugees have been reunited) as long as 80% of the refugees proposed for PSR meet the eligible population criteria.

8. *Eligible Sending Sites:* Eligible sending sites will be limited to communities where there is a high welfare dependency (over 55%) or unemployment rate among the refugee population (including time-expired refugees). Under special circumstances, the Director may determine additional sites to be eligible as sending sites.

9. *Characteristics of Receiving Sites:* It is expected that receiving sites proposed for PSR will have demonstrably favorable conditions for refugee resettlement. In general, the following conditions are required to be present in proposed receiving sites:

- The existence of a stable refugee community of the same ethnicity as the refugees proposed for relocation;
- The availability of full-time employment at skill levels appropriate to PSR refugees, with health benefits or accessible and affordable health services within the community;
- The capacity to provide job placement, ESL and other social services on a timely and ethnically appropriate basis;
- A high employment rate and, concomitantly, a low welfare dependency rate (30% or below) among the existing refugee population;
- An expanding job market in skill areas in which PSR refugees would be qualified; and
- A minimum of racial discrimination or community tension likely to have an adverse effect on refugees.

III. Application Content

The application should set forth in detail the following:

1. An identification of proposed sending and receiving sites.

2. An identification of the refugee welfare dependency rate and refugee unemployment rate in each proposed sending site.

3. A description of the suitability of each proposed receiving site including: Specific refugee employment opportunities; availability of employee health benefits; availability of adequate housing and health care services; ethnicity, size, employment and welfare rates within the receiving refugee community; availability of refugee social services; and an analysis of the local economy regarding the likelihood of stable and expended employment opportunities for refugees.

4. A description of the proposed resettlement population in terms of numbers to be resettled, ethnicity, length of time in the U.S., employment history, and public assistance status.

5. A description of proposed planning phase activities and sequence (timelines and milestones) for achieving the objectives of the planning phase, including the development of a resettlement plan. The applicant should specify a plan for on-site visits by prospective PSR refugees and refugee community representatives to the receiving site(s), with a budget justification for the proposed number of individuals to be included in site visits. A plan for conducting a detailed presentation in prospective sending communities which describes the economic and social conditions in the receiving site(s) should also be provided. Applicants shall describe in detail, the type of presentation proposed and the scope of information to be provided.

6. A preliminary plan for the resettlement phase, including an outline of services to be provided, the identification of proposed service deliverers, a plan for coordination of

services and a proposed timetable for relocation of participating families. (A fully developed resettlement phase plan will be required of grantees at the conclusion of the planning phase.)

7. An identification of the organizations/agencies proposed for participation in the PSR project; a clear delineation of their proposed responsibilities; a description of their qualifications in relation to those responsibilities; and the mechanism for coordination among these organizations. Evidence shall be provided of the fiscal management capacity of the organization which will be responsible for the disbursement of resettlement allowance funds. Proposed sending organization(s) should be identified and their qualifications described.

8. A detailed management plan which: Indicates who will have fiscal and overall program responsibility, identifies the organizational structure and the lines of authority, and describes the proposed staffing plan and staff qualifications.

9. A plan which describes how linkage and communication will be established and maintained with the targeted refugee community in the proposed sending site(s).

10. A description of steps the applicant has taken, or plans to take, to coordinate proposed activities with existing mutual assistance associations or other refugee representatives in the receiving and sending sites.

11. An itemized budget with complete narrative justification for the planning phase and a preliminary, itemized budget for the resettlement phase.

IV. Criteria for Evaluating Applications

Grant applications will be evaluated according to the following criteria:

1. The extent to which the proposed resettlement population conforms with the eligible population criteria stated in this announcement. (15 points)

- Evidence that the proposed target population is currently unemployed and has had a history of unemployment and/or welfare dependency in the U.S.;
- The extent to which the proposed population consists of refugees who have been in the U.S. for 18 months or more.

2. The extent to which the narrative description of the proposed receiving site(s) provides justification for their selection. (15 points)

- The existence of a stable refugee community of the same ethnicity as the refugees proposed for relocation;
- The availability of full-time employment at skill levels appropriate to PSR refugees, with health benefits or available health services which are affordable;
- The availability of affordable housing;
- The capacity to provide job placement, ESL and other social services on a timely and ethnically appropriate basis;
- A high employment rate and, concomitantly, a low welfare dependency rate, among the existing refugee population;
- An expanding job market suitable to refugees.

3. The extent to which the proposed sending sites conform with the eligible sending site criteria stated in this announcement. (10 points)

- Existence of a high welfare dependency or unemployment rate among the resident refugee population;

4. The reasonableness and specificity of proposed planning phase activities, sequence, and timeliness. (15 points)

- Reasonableness of proposed activities and timeliness in achieving the objectives of the planning phase;
- Adequacy of plan for on-site visits by prospective PSR refugees and refugee community representatives to the receiving community;
- Adequacy of the proposed community presentation in conveying a comprehensive view of the economic and social conditions in the receiving site(s), including a realistic view of available resources and opportunities.

5. The reasonableness of proposed resettlement phase activities, sequence, and timeliness; (15 points)

- Relevance of proposed resettlement services to the needs of the refugees to be resettled;
- Reasonableness of proposed timetable for relocation of participating families.
- Reasonableness of proposed resettlement services in relation to existing refugee services in the receiving community.

6. The quality of proposed participating organizations, project management and staffing (15 points)

- Adequacy of qualifications of participating organizations in relation to proposed roles. Extent to which proposed organizations have demonstrated track records as providers of services to refugees;
- Extent to which the organization to be responsible for the disbursement of resettlement allowance monies has a demonstrated capability in fiscal management.
- Extent to which the proposed receiving organization(s) has an established, positive relationship with the resident refugee community;
- Adequacy of project management plan and plan for coordination among participating organizations;
- Adequacy of staffing patterns and qualifications.

7. The extent to which the applicant has coordinated or plans to coordinate proposed activities with existing mutual assistance associations or other refugee representatives in both sending and receiving sites. (15 points)

8. The adequacy of the budget narrative and the reasonableness of the proposed budget in relation to proposed planning activities. (10 points)

9. The reasonableness of the proposed budget for the resettlement phase, in relation to the activities proposed. (10 points)

SUPPLEMENTARY INFORMATION:

Review and Award Procedures

Applications will be evaluated by a review panel of ORR staff and other experts according to the above criteria, and in accordance with the HHS Grants Administration Manual. Final funding decisions will be made by the Director, ORR.

Following is a schedule of panel review dates and the corresponding proposal due dates.

Proposed due dates	Panel review dates
July 15, 1985	July 29, 1985.
September 27, 1985	Oct. 21, 1985.
December 16, 1985	Jan. 13, 1986.
April 4, 1986	Apr. 21, 1986.

The Office of Refugee Resettlement reserves the right to cancel or reschedule panel review dates in cases where the number of applications received would not, in the judgment of the Director, warrant the expenditure of public monies to convene a panel review. In such instances, all eligible applicants will be notified in writing of the schedule adjustment at least ten calendar days before the scheduled review date.

Executive Order 12372 Notification Process

These applications are covered by the requirements of Executive Order 12372, "Intergovernmental Review of Federal Programs," and 45 CFR Part 100, "Intergovernmental Review of Department of Health and Human Services Programs and Activities." Applicants should contact the designated Single Point of Contact (SPOC) in their State as early as possible to alert the SPOC of the prospective application and receive specific instructions regarding the State's review process. Applicants should submit the material required by the State to the SPOC. State SPOC offices are encouraged to send their comments on the application to ORR as soon as possible for consideration prior to the award process. Directly affected State, area-wide, regional, and local officials and entities have 60 days to comment on the application from the deadline date for final application submission to ORR through the process established by the State. SPOCs' comments should be transmitted to Office of Refugee Resettlement, Grants Management Office, Room 1229, Switzer Building, 330 C St. SW., Washington, D.C. 20201 or to the applicant to be forwarded to ORR. A list of State SPOCs is included at the end of this announcement.

Application Request and Submission

Eligible Applicants may request grant applications (Standard Form 424 "Federal Assistance") from the Office of Refugee Resettlement, HHS, Grants Management Office, Room 1229, Switzer Building, 330 C Street, SW., Washington, D.C. 20201, Betsy Andress, (202) 245–1715. For program related information, contact Toyo Biddle, telephone: (202) 245–1966.

To be considered for funding from Fiscal Year 1985 funds, prospective grantees must submit a signed original application and one copy to the Grants Management Office by 5:00 p.m., Eastern Daylight Time on July 15, 1985, or send by first class mail post-marked by 11:59 p.m. A second copy should be sent concurrently to the appropriate Regional Director, ORR. Proposals received or after the above noted date and time will be retained for review at the next scheduled panel review date.

The Director, ORR, encourages pre-application before the submission of a formal grant application. Pre-applications will be received at any time and reviewed by Office of Refugee Resettlement staff within 30 days of receipt. The submission of a pre-application proposal will: (a) Establish communication between the applicant and the ORR; (b) enable early determination of the applicant's eligibility; and (c) determine how well the project might fare in the panel review process, in order to discourage proposals which have little or no chance for Federal funding before applicants incur significant expenditures in preparing an application. The pre-application process provides technical assistance to applicants to aid them in improving their submissions. Pre-applications should contain enough detail around the critical elements of the proposed project to enable ORR to make a considered judgment. Pre-applications are not mandatory.

Prospective grantees who wish to submit a pre-application prior to submitting a formal application by July 15, 1985, must do so no later than June 3, 1985, to permit adequate review and response time.

Applications Delivered by Mail

An application sent by mail must be addressed to the U.S. Department of Health and Human Services, Social Security Administration, Office of Refugee Resettlement, Grants Management Office, Room 1229, Switzer Building, 330 C Street, SW., Washington, D.C. 20201. ATTN: Mr. Stan Le.

An application must show proof of mailing consisting of one of the following:

(1) A legibly dated U.S. Postal Service postmark.

(2) A legible mail receipt with the date of mailing stamped by the U.S. Postal Service.

If an application is sent through the U.S. Postal Service, the Director does not accept either of the following as proof of mailing: (1) A private metered postmark or (2) a mail receipt that is not dated by the U.S. Postal Service.

Applicants should note that the U.S. Postal Service does not uniformly provide a date postmark. Before relying on this method, the applicant should check with its local post office. Applicants are encouraged to use registered, or at least first class mail.

Applications Delivered by Hand

An application that is hand-delivered should be taken to the U.S. Department of Health and Human Services, Social Security Administration, Office of Refugee Resettlement, Grants Management Office, Room 1229, Switzer Building, 330 C Street, S.W. Washington, D.C. 20201. The Grants Management Office will accept a hand-delivered application between 8:30 a.m. and 5:00 p.m. Eastern Daylight Time daily, except Saturdays, Sundays, and Federal holidays.

An application that is hand-delivered after 5:00 p.m. on July 15, 1985 will be accepted, but will not be reviewed until the first panel review for FY 1986.

FOR FURTHER INFORMATION CONTRACT:

Mr. Jack Anderson, Regional Director, ORR, Region I, Room 2403, J.F.K. Federal Bldg., Government Center, Boston, MA 02203, 617–223–6180

Mr. William Neary, Regional Director, ORR, Region III, Room 10400, 3535 Market Street, P.O. Box 13716, 215–596–0210

Mr. James Turman, Regional Director, ORR, Region VI, Room 1630, 1200 Main Tower, Dallas, TX 75202, 214–767–4301

Mr. Edwin LaPedis, Regional Director, ORR, Region VIII, Rm. 1185, Federal Building, 19th & Stout Street, Denver, CO 80294, 303–837–8387

Ms. Suanne Brooks, Regional Director, ORR, Region IV, Suit 2112, 101 Marietta Tower, Atlanta, GA 30323, 404–221–2250

Mr. Derek Schoen, Regional Director, ORR, Region V, 35th Floor, 300 S. Wacker Drive, Chicago, IL 60606, 312–353–5182

Mr. John Crossman, Regional Director, ORR, Region X, Mail Stop 212, 2901 Third Avenue, Seattle, WA 98121, 206–442–8049

Ms. Toyo Biddle, Division of Operations, Room 1229, Switzer Bldg., 330 C street

SW., Washington, D.C. 20201, 202–245–1966

Mr. Larry Laverentz, Assistant Regional Director, ORR, Region VIII, 601 East 12th Street, Rm 210, Kansas City, MO 64106, 816–758–7081

Ms. Sharon Fujii, Regional Director, ORR, Region IX, Room 352 (Mail Stop 352), 50 United Nations Plaza, San Francisco, CA 94102, 415–556–8582

Mr. Manuel R. Fleitas, Director, Florida Office, ORR, 701 SW 27th Avenue, Room 701, Coral Gables, FL, 305–643–2667.

IX. A–95 Notification Process

The PSRP grants are not covered by the requirements of OMB Circular A–95.

Applicable Regulations

The following HHS regulations apply to grants under this Notice:

45 CFR Part 16—Department Grant Appeals Process;

45 CFR Part 74—Administration of Grants;

45 CFR Part 75—Informal Grant Appeals Process;

45 CFR Part 80—Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services Effectuation of Title VI of the Civil Rights Act of 1964;

45 CFR Part 81—Practice and Procedures for Hearings Under Part 80 of this Title;

45 CFR Part 84—Nondiscrimination on the Basis of Handicap in Programs and Activities Benefitting from Federal Financial Assistance;

45 CFR Part 90—Nondiscrimination on the Basis of Age in Programs or Activities Receiving Federal Financial Assistance.

Records and Reports

Grantees will be required to report financial status and program progress quarterly, and separately from ORR's regular Refugee Resettlement Program.

Both financial status (SF 269s) and program progress reports will be due 30 days after the first calendar day of each quarter following the effective date of the grant award, except for the final financial and program progress reports which shall be due 90 days after the expiration or termination of grant support.

Dated: April 23, 1985.

Phillip N. Hawkes,

Director, Office of Refugee Resettlement.

State Single Point of Contact List

Alabama

Mrs. Donna J. Snowden, SPOC, Alabama State Clearinghouse, Alabama Department of Economic and Community Affairs, 3465 Norman Bridge Road, Post Office Box 2939, Montgomery, Alabama 36105–0939

Arizona

Office of Economic Planning and Development, State of Arizona

Note.—Correspondence and questions concerning the State's E.O. 12372 process should be directed to:

Jo Stephens, Director, Local Government Assistance, Attn: Arizona State Clearinghouse, 1700 West Washington, Room 205, Phoenix, Arizona 85007, Tel. (602) 255–5004

Arkansas

State Clearinghouse, Office of Intergovernmental Services, Department of Finance and Administration, P.O. Box 3278, Little Rock, Arkansas 72203, Tel. (501) 371–2311

California

Office of Planning and Research, 1400 Tenth Street, Sacramento, California 95814, Tel. (916) 445–0282

Colorado

State Clearinghouse, Division of Local Government, 1313 Sherman Street, Room 520, Denver, Colorado 80203, Tel. (303) 866–2156

Connecticut

Gary E. King, Under Secretary, Comprehensive Planning Division, Office of Policy and Management, Hartford, Connecticut 06106–4459

Note.—Correspondence and questions concerning the State's E.O. 12372 process should be directed to:

Intergovernmental Review Coordinator, Comprehensive Planning Division, Office of Policy and Management, 80 Washington Street, Hartford, Connecticut 06106–4459, Tel. (203) 566–4298

Delaware

Executive Department, Thomas Collins Building, Dover, Delaware 19903, Attn: Francine Booth, Tel. (302) 736–4204

Florida

Ron Fahs, Executive Office of the Governor, Office of Planning and Budgeting, The Capitol, Tallahassee, Florida 32301, Tel. (904) 488–8114

Georgia

Charles H. Badger, Administrator, Georgia State Clearinghouse, 270 Washington Street SW., Atlanta, Georgia 30334, Tel. (404) 656–3855

Hawaii

Kent M. Keith, Director, Department of Planning and Economic Development, P.O. Box 2359, Honolulu, Hawaii 96804

For Information Contact: Hawaii State Clearinghouse, Tel. (808) 548–3085

Illinois

Tom Berkshire, Office of the Governor, State of Illinois, Springfield, Illinois 62706, Tel. (217) 782–8639

Indiana

Ms. Susan J. Kennell, State Budget Agency, 212 State House, Indianapolis, Indiana 46204, Tel. (317) 232–5604

Iowa

Office for Planning and Programming, Capital Annex, 532 East 12th Street, Des Moines, Iowa 50319, Tel. (515) 281–3864

Kansas

Judy Krueger, Office of the Secretary, Kansas Department of Human Resources, 401 Topeka Avenue, Topeka, Kansas 66603, Tel. (913) 296–5075

Kentucky

Kentucky State Clearinghouse, 2nd Floor, Capital Plaza Tower, Frankfort, Kentucky 40601, Tel. (502) 564–2382

Louisiana

Michael J. Jefferson, Dept. of Urban and Community Affairs, Office of State Clearinghouse, P.O. Box 44455, Capitol Station, Baton Rouge, Louisiana 70804, Tel. (504) 925–3722

Maine

State Planning Office, Attn: Intergovernmental Review Process, State House Station #38, Augusta, Maine 04333, Tel. (207) 289–3154

Maryland

Guy W. Hager, Director, Maryland State Clearinghouse for Intergovernmental Assistance, Department of State Planning, 301 West Preston Street, Baltimore, Maryland 21201–2365, Tel. (301) 383–7875

Massachusetts

Executive Office of Communities and Development, 100 Cambridge Street, Rm. 1401, Boston, Massachusetts 02202, Tel. (617) 727–7078

Michigan

John H. Reurink, Director, Management Services Bureau, Department of Commerce, P.O. Box 30004, Lansing, Michigan 48909, Tel. (517) 373–0933

Minnesota

Thomas N. Harren, Minnesota State Planning Agency, Capitol Square Building, Room 101, 550 Cedar Street, St. Paul, Minnesota 55101, Tel. (612) 296-3698

Mississippi

Office of Federal State Programs, Department of Planning and Policy, 2000 Walter Sillers Bldg., 500 High Street, Jackson, Mississippi 39202
For Information Contact: Mr. Marlan Baucum, Department of Planning and Policy, Tel. (601) 359-3150

Missouri

Missouri Federal Assistance Clearinghouse, Office of Administration, Division of Budget and Planning, Room 129, Capitol Building, Jefferson City, Missouri 65102, Tel. (314) 751-4834 or 751-2345

Montana

Agnes Zipperian, Intergovernmental Review Clearinghouse, c/o Office of the Lieutenant Governor, Capitol Station, Helena, Montana 59620, Tel. (406) 444-5522

Nebraska

Policy Research Office, P.O. Box 94601, Room 1321, State Capitol, Lincoln, Nebraska 68509, Tel. (402) 471-2414

Nevada

Ms. Linda A. Ryan, Director, Office of Community Services, Capitol Complex, Carson City, Nevada 89710, Tel. (702) 885-4420

Note.—Correspondence and questions concerning the State's E.O. 12372 process should be directed to:

John Walker, Clearinghouse Coordinator, Tel. (702) 885-4420

New Hampshire

David G. Scott, Acting Director, New Hampshire Office of State Planning, 2½ Beacon Street, Concord, New Hampshire 03301, Tel. (603) 271-2155

New Jersey

Mr. Barry Skokowski, Director, Division of Local Government Services, Department of Community Affairs, CN 803, 363 West State Street, Trenton, New Jersey 08625-0803, Tel. (609) 292-6613

Note.—Correspondence and questions concerning the State's E.O. process should be directed to:

Nelson S. Silver, State Review Process, Division of Local Government Services, CN 803, Trenton, New Jersey 08625-0803, Tel. (609) 292-9025

New Mexico

Peter C. Pence, Director, Management and Contracts Review Division, Department of Finance and Administration, State of New Mexico, 515 Don Gaspar, Santa Fe, New Mexico 87503, Tel. (505) 827-3885

New York

Director of the Budget, New York State

Note.—Correspondence and questions concerning the State's E.O. 12372 process should be directed to:

New York State Clearinghouse, Division of the Budget, State Capitol, Albany, New York 12224, Tel. (518) 474-1605

North Carolina

Mrs. Chrys Baggett, Director, State Clearinghouse, Department of Administration, 116 West Jones Street, Raleigh, North Carolina 27611, Tel. (919) 733-4131

North Dakota

Office of Intergovernmental Assistance, Office of Management and Budget, 14th Floor—State Capitol, Bismarck, North Dakota 58505, Tel. (701) 224-2094

Ohio

State Clearinghouse, Office of Budget and Management, 30 East Broad Street, Columbus, Ohio 43215
For Information Contact: Mr. Leonard E. Roberts, Deputy Director, Tel. (614) 466-0699

Oklahoma

Office of Federal Assistance Management, 4545 North Lincoln Blvd., Oklahoma City, Oklahoma 73105, Tel. (405) 528-8200

Oregon

Intergovernmental Relations Division, State Clearinghouse, Executive Building, 155 Cottage Street NE., Salem, Oregon 97310, Tel. (503) 373-1998.

Pennsylvania

Pennsylvania Intergovernmental Council, P.O. Box 1288, Harrisburg, Pennsylvania 17108, Attn: Charles Griffiths, Executive Director, Tel. (717) 783-3700

Rhode Island

Daniel W. Varin, Chief, Rhode Island Statewide Planning Program, 265 Melrose Street, Providence, Rhode Island 02907, Tel. (401) 277-2656

South Carolina

Danny L. Cromer, Grant Services, Office of the Governor, 1205 Pendleton Street, Room 477, Columbia, South Carolina, 29201, Tel. (803) 758-2417

South Dakota

Jeff Stroup, Commissioner of the Bureau of Intergovernmental Relations, Second Floor, Capitol Building, Pierre, South Dakota 57501, Tel. (605) 773-3661

Tennessee

Tennessee State Planning Office, 1800 James K. Polk Building, 505 Deaderick Street, Nashville, Tennessee 37219, Tel. (615) 741-1676

Texas

Bob McPherson, State Planning Director, Office of the Governor, Austin, Texas 78711, Tel. (512) 475-6156

Utah

Michael B. Zuhl, Director, Office of Planning and Budget, State of Utah, 116 State Capitol Building, Salt Lake City, Utah 84114, Tel. (801) 533-5245

Vermont

State Planning Office, Pavilion Office Building, 109 State Street, Montpelier, Vermont 05602, Tel. (802) 828-3326

Virginia

Robert H. Kirby, Intergovernmental Review Officer, Department of Planning and Budget, Post Office Box 1422, Richmond, Virginia 23211, Tel. (804) 786-1921

Washington

Ken Black, Washington Department of Community Development, Ninth and Columbia Building, Olympia, Washington, 98504, Tel. (206) 753-2200

West Virginia

Mr. Fred Cutlip, Director, Community Development Division, Governor's Office of Economic and Community Development, Building #6, Room 553, Charleston, West Virginia 25305, Tel. (304) 348-4010

Wisconsin

Secretary Doris J. Hanson, Wisconsin Department of Administration, 101 South Webster Street, GEF 2, Madison, Wisconsin 53702, Tel. (608) 266-1212

Note.—Correspondence and questions concerning the State's E.O. 12372 process should be directed to:

Thomas Krauskopf, Federal-State Relations Coordinator, Wisconsin Department of Administration, P.O. Box 7864, Madison, WI 53707, Tel. (608) 266-8349

Wyoming

Wyoming State Clearinghouse, State Planning Coordinator's Office, Capitol

Building, Cheyenne, Wyoming 82002, Tel. (307) 777–7574

Virgin Islands

Federal Programs Office, Office of the Governor, The Virgin Islands of the United States, Charlotte Amalie, St. Thomas 00801, Tel. (809) 774–0001

District of Columbia

Pauline Schneider, Director, Office of Intergovernmental Relations, Room 416, District Building, Washington, D.C. 20004, Tel. (202) 727–6265

Puerto Rico

Ms. Patria G. Custodio, Chairman, Puerto Rico Planning Board, Minillas Government Center, P.O. Box 41119, San Juan, Puerto Rico 09940–9985, Tel. (809) 727–4444

Northern Mariana Islands

Planning and Budget Office, Office of the Governor, Saipan, CM 96950

Sample Statement of Intent

(To be presented in English and in the native language of the refugees to be relocated)

1. I certify that I am interested in resettling in _____.

2. I am willing to accept employment and am determined to become self-sufficient.

3. I have received an orientation packet and have studied its contents.

4. I am making this move of my own free will.

Signature of PSR refugee head of household: _____

[FR Doc. 85–11485 Filed 5–10–85; 8:45 am]

BILLING CODE 4190–11–M

federal register

Monday
May 13, 1985

Part III

Department of Health and Human Services

Health Care Financing Administration

42 CFR Part 403

Medicare Program; Recognition of State Reimbursement Control Systems; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 403

[BERC-240-P]

Medicare Program; Recognition of State Reimbursement Control Systems

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule sets forth the conditions and procedures under which HCFA would permit Medicare payments for hospital services to be made in accordance with a State hospital reimbursement control system, rather than under Medicare reimbursement principles. This proposal would implement section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248), section 601(c) of the Social Security Amendments of 1983 (Pub. L. 98-21) and section 2315(a) of the Deficit Reduction Act of 1984 (Pub. L. 98-369).

DATE: To assure consideration, comments must be received by June 27, 1985.

ADDRESS: Address comments in writing to: Health Care Financing Administration, Department of Health and Human Services, Attn: BERC-240-P, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to Room 309-G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, D.C., or to Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland. In commenting, please refer to file code BERC-240-P.

Comments will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, D.C., on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (Phone: 202-245-7890).

Please address a copy of comments on information collection requirements to: Fay Iudicello, Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3208, New Executive Office Building, Washington, D.C. 20503

FOR FURTHER INFORMATION CONTACT: Anthony Lovecchio, (301) 594-4010

SUPPLEMENTARY INFORMATION:

I. Background

A. Tranditional Hospital Reimbursement

Traditionally, Medicare payments for inpatient hospital services under Title XVIII of the Social Security Act (the Act) have been made on a retrospective, reasonable cost basis. Under this reasonable cost reimbursement method, hospitals have been paid for the costs they actually incurred in providing services to Medicare beneficiaries. While this reimbursement method has guaranteed payment for almost all allowable hospital expenditures, it has provided little economic incentive for hospitals to moderate costs.

In recent years, this cost-based reimbursement mechanism has come under increasing criticism as being a major contributor to inflationary pressures on health care costs. Because of this, Medicare has experimented with a number of alternative reimbursement approaches, including a variety of prospective reimbursement and State ratesetting demonstration projects. Medicare participation in these demonstrations is authorized under the Social Security Amendments of 1967 and 1972. Both the dissatisfaction with the retrospective reasonable cost reimbursement system and the experience gained under the ratesetting demonstration projects contributed to recent enactment of the hospital reimbursement reform legislation described in the following section of this preamble.

B. Legislation

Medicare reimbursement has been significantly affected by the passage of several pieces of legislation. On September 3, 1982, the President signed into law the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248). Section 101 of Pub. L. 97-248 added a new section 1886 to the Act, and made conforming changes in other sections of Title XVIII of the Act. Subsequently, on April 20, 1983, the Social Security Amendments of 1983 (Pub. L. 98-21) were enacted. Section 601 of this legislation amended the new section 1886 of the Act. Further changes to section 1886 of the Act resulted from the enactment of section 2315(a) of the Deficit Reduction Act of 1984 (Pub. L. 98-369), which was signed into law on July 18, 1984.

Under Pub. L. 97-248, section 1886(a) of the act provided for the extension of the routine hospital cost limits, authorized under section 223 of the Social Security Amendments of 1972 (Pub. L. 92-603), to include total operating costs of all inpatient hospital services. (These costs were defined as all routine operating costs special care unit operating costs, and ancillary services operating costs.) Before section 1886(a) was added to the Act, the section 223 limits applied only to operating costs of inpatient general routine care (that is, bed, board, and routine nursing services.)

In addition, the costs to which the expanded limits applied were to be determined on a per discharge or per admission basis, and the limit for each hospital was required to be set based on the mix of types of Medicare cases treated by the hospital. However, under section 1886(a)(1)(D) of the Act, as added by Pub. L. 98-21, the expanded cost limits no longer apply to hospitals whose cost reporting periods begin on or after October 1, 1983, because, except for certain excluded hospitals, the prospective payment system (section 1886 (d) of the Act, enacted as part of Pub. L. 98-21) applies to these hospitals.

Section 1886(b) of the Act provided for a new 3-year limitation on payment for hospital costs, which required that we establish a ceiling level for the allowable rate of increase of hospitals' inpatient operating costs per case.

Section 602(e) of Pub. L. 98-21 added a new paragraph (14) to section 1862(a) of the Act to prohibit payments to hospitals for non-physician services under Part B unless the hospital is granted a waiver by HCFA in accordance with the specified conditions as set forth in section 602(k) of Pub. L. 98-21.

In addition, we note that section 108 of Pub. L. 97-248 established section 1887(a) of the Act, which directs the Secretary to prescribe regulations that distinguish between (1) professional medical sevices that are personally rendered to individual patients and are reimbursed under Part B on a charge basis, and (2) professional medical services performed by a physician that are generally beneficial to patients and are reimbursed on a reasonable costs basis. Reasonable cost reimbursement for provider-based physician services cannot exceed a reasonable compensation equivalent established by the Secretary in regulations. Section 1887(a)(1)(B) of the Act explicitly applies to professional services furnished to patients in hospitals that are reimbursed under section 1886(c) of the Act.

Section 1886(c) of the Act, as established by Pub. L. 97-248 and as since amended by section 601(c) of Pub. L. 98-21 and section 2315(a) of Pub. L. 98-369, generally authorizes Medicare reimbursement for impatient hospital services in accordance with a State's

hospital reimbursement control system, rather than under the Medicare reimbursement method. Under section 1886(c) of the Act, reimbursement may be made under a State's system if one of three alternative sets of requirements are met.

First, under section 1886(c)(1) of the Act, as enacted by Pub. L. 97-248, HCFA has discretion to allow Medicare hospital reimbursement to be made in accordance with a State reimbursement control system ("the State system") if the chief executive officer of the State requests approval of the State system, and if the State system meets specific minimum requirements as summarized below.

1. The State system must apply to substantially all non-Federal acute care hospitals in the State.

2. The State must apply to at least 75 percent of all inpatient revenues or expenses for the State.

3. The State must provide assurances that payors, hospital employees and patients in the State will be treated equitably under its system.

4. The State must provide assurances that its system will not result in greater Medicare expenditures over 36-month periods.

Section 601(c) of Pub. L. 98-21 amended section 1886(c)(1) of the Act to allow continuation of HCFA's discretionary authority for approval, as provided under Pub. L. 97-248, but added two additional requirements as follows.

5. The State system may not preclude health maintenance organizations (HMOs) or competitive medical plans (CMPs) from negotiating directly with hospitals concerning payment for inpatient services under section 1876 of the Act.

6. The State system must prohibit charging individuals for services for which such individuals are entitled to have payment made under Part A of Medicare under section 1866(a)(1)(G) of the Act; and also prohibit, in accordance with section 1862(a)(14) of the Act, payments under Part B of Medicare for nonphysician services provided to inpatients, unless waived by the Secretary in accordance with the regulations at 42 CFR 489.23, published as part of the prospective payment system interim final regulations on September 1, 1983 (48 FR 39838) and as final regulations on January 3, 1984 (49 FR 324).

Second, section 601(c) of Pub. L. 98-21 added section 1886(c)(5) to the Act to specify six additional requirements that, if met by a State system that also meets requirements one through six as presented above, would make HCFA's approval of a request by the State for Medicare reimbursement under its system mandatory. The additional requirements are that the State system must:

7. Be operated directly by the State or an entity designated by State law;

8. Use a payment methodology to be applied prospectively;

9. Provide for hospital reports, as required by the Secretary;

10. Provide satisfactory assurances that it will not result in admission practices that will reduce treatment to uninsured, low income, high cost, or emergency patients;

11. Not reduce payments without 60 days notice to HCFA and to hospitals; and

12. Provide satisfactory assurances that, in developing the program, the State has consulted with local officials concerning its impact on public hospitals.

Third, special provisions apply to those States that currently have demonstration projects with HCFA under section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1) or section 222(a) of the Social Security amendments of 1972 (42 U.S.C. 1395b-1 (note)) for the operation of state reimbursement control system. Under section 1886(c)(4) of the Act, as added by section 601(c) of Pub. L. 98-21 and subsequently amended by section 2315(a) of Pub. L. 98-369, HCFA approval of a State's application to continue the operation of a system upon expiration of the demonstration project is mandatory if, and for so long as, the system meets the requirements one through six presented above.

In addition to the specific requirements discussed above, a general requirement that all hospitals eligible for payment under section 1886(c) of the Act must meet is contained in section 1866(a)(1)(F) of the Act. This latter section was added to the Act by Section 602(f)(1) of Pub. L. 98-21. It requires hospitals, in order to be eligible for Medicare payment under section 1886(c) of the Act, to have and maintain an agreement with a utilization and quality control Peer Review Organizations or in the absence of such agreements with such organizations, agreements with Professional Standard Review Organizations or fiscal intermediaries.

With respect to requirement number four above, section 1886(c)(6) of the Act provides that if the Secretary determines that the assurances have not been met for any 36-month period, the payments to hospitals shall be reduced under either the States system or the Medicare payment system in a an amount equal to the excess over what Medicare would have paid for these services.

Under section 1886(c)(1) of the Act, a State's application for reimbursement under the State's system may not be denied on the basis that the system does not pay on a diagnosis related group (DRG) methodology or on the basis that the State system does not produce savings greater than what would have accrued under the Medicare payment system, either the cost reimbursement or the prospective payment system, whichever is applicable.

Section 1886(c)(1) of the Act also provides parameters regarding a State's discretion, under certain circumstances, to determine how to substantiate the assurance regarding whether the amount of payment that would otherwise have been made under Medicare will be exceeded. If we determine that this comparison is to be made by maintaining payment amounts at no more than a specified percentage increase above the payment amounts in a base period, the State has the option of applying the comparison test on an aggregate payment basis or on the basis of the amount of payment per inpatient discharge or admission. Since we will not be determining whether the State's assurance is acceptable by reference to percentage increases above a base level (except in the case of States with existing demonstration projects), we are not proposing to allow States this option on the method of measurement.

Section 1886((c)(1) of the Act further provides that the State's rate of increase in payments need not be less than the national average rate of increase if the Secretary implements the comparison test by reference to the national average percentage increase in total payments. This provision will generally not be applicable, because, except where required by statute for continuation of existing demonstration projects, we do not intend to assess a State's assurance regarding the amount of payments by reference to the national average rate of increase. Under the proposed regulations, we would measure a State's assurance by comparison to what actual payments would have been under the Medicare system.

HCFA may, under certain conditions, permit an adjustment to take into account previous reductions in Medicare reimbursement amounts that were the result of the effectiveness of a State's reimbursement control system prior to the State's application for Medicare participation. Specifically, section 1886(c)(2) of the Act authorizes this adjustment if, as a result of the State's already existing reimbursement control

system, the State's aggregate rate of increase in hospitals' total operating costs is less than the national aggregate rate of increase in hospitals' total operating costs.

Under section 1886(c)(4) of the Act, HCFA would judge the effectiveness of a State system with an existing Medicare demonstration project on the basis of its rate of increase or inflation in inpatient hospital payments for individuals under Medicare, as compared to the national rate of increase or inflation for such payments. The State would retain the option to have the test applied on the basis of the aggregate payment or payments per inpatient admission or discharge during its hospitals' three cost reporting periods beginning on or after October 1, 1983. After the date, however, this test would no longer apply. In this case, the State system would be treated in the same manner as under other waivers authorized by these proposed regulations.

To summarize, HCFA would have discretionary authority to approve Medicare reimbursement under a State system that meets each of the minimum requirements one through six above. This discretionary authority also would apply if a State system meets the minimum requirements and any of the additional requirements seven through twelve. However, if a State system meets all of the requirements, HCFA approval would be mandatory. Furthermore, if a State system was established and operated under an existing Medicare demonstration project and meets the requirements of items one through six above, HCFA approval would be mandatory as long as those minimum requirements continue to be met.

C. Medicare and Medicaid State Rate Control Experience to Date

Under section 402 of the Social Security Amendments of 1967 and section 222(a) of the Social Security Amendments of 1972, HCFA has broad discretion to waive certain Medicare and Medicaid provisions of the Act as necessary to conduct demonstration projects. Under this demonstration authority, HCFA has participated in a variety of efforts to develop, demonstrate and evaluate various prospective reimbursement and State ratesetting programs. These projects have resulted in a comprehensive evaluation of many methods of hospital reimbursement, such as rates based on negotiated budgets, budget reviews, formula methods and diagnostic specific payment rates.

Currently, in the States of Maryland, Massachusetts, New York and New Jersey, both Medicare and Medicaid pay for hospital services in accordance with payment methodologies incorporated in statewide, all payor systems, rather than under the Medicare and Medicaid requirements that would otherwise apply. Under these ratesetting systems, nearly all acute care hospitals are paid at rates determined under the State controlled systems.

Congress provided in section 1814(b) of the Act, which was enacted in 1980, that we could continue Medicare demonstration project reimbursement systems indefinitely so long as certain specified conditions were met. In light of the enactment of section 1886(c) of the Act, which establishes different conditions for the continuation of such demonstration projects, we do not intend to exercise our discretion under section 1814(b) of the Act. Rather, continuation of the projects will be assessed under the provisions of section 1886(c) of the Act.

In addition, Congress included section 603(b) in Pub. L. 98-21 to provide that, upon the request of a State that has an existing demonstration project (or upon the request of a party to the demonstration project agreement) approved under section 402 or section 222(a), the terms of the demonstration project agreement must be modified so that the demonstration project is not required to maintain the rate of increase in Medicare hospital costs in that State below the national rate of increase in Medicare hospital costs. To qualify under this provision, the demonstration project agreement must have been in effect as of March 1, 1983 and must have been approved after August 1982.

We intend to address requests for revisions in demonstration agreements approved under sections 402 or 222(a) under the existing demonstration project procedures and not under the requirements set forth in these proposed regulations.

II. Proposed Requirements for Approval of State Reimbursement Control Systems

In developing these proposed regulations to implement section 1886(c) of the Act, we have set forth requirements that are necessary to facilitate effective administration of the legislation. We believe that these requirements would assure protection for all involved parties, such as Medicare beneficiaries, participating providers, and the Medicare program.

These proposed regulations specify that HCFA *may* approve applications submitted by the Chief Executive Officer of the State for Medicare reimbursement under a State system if the *minimum* requirements presented below are met and *would be required to* approve an application if *all* the requirements are met. We also describe the proposed requirements for those States that had existing Medicare demonstration projects for reimbursement control systems under section 402 or 222(a) in effect on the date of enactment of Pub. L. 98-21 (that is, April 20, 1983).

Section 403.304 of these proposed regulations implements section 1886(c)(1) of the Act by specifying the minimum requirements and assurances that a State system must meet. The system would be required to—

- Apply to substantially all non-Federal acute care hospitals (these hospitals must have and maintain an agreement with a utilization and quality control Peer Review Organization);
- Apply to the review of at least 75 percent of all revenues or expenses in the State for inpatient services;
- Permit an HMO or CMP to negotiate the rate of payment for inpatient hospital services directly with a hospital;
- Limit hospital charges for beneficiaries to deductibles, coinsurance, and services for which the beneficiary would not be entitled to have payment made under Medicare Part A; and prohibit payment under Part B of Medicare for nonphysician services provided to hospital inpatients unless this prohibition is waived in accordance with regulations at 42 CFR 489.23.
- Assure the equitable treatment of all entities that pay hospitals for inpatient hospital services, hospital employees, and hospital patients, as follows—

—Assure that all entities that pay hospitals for inpatient hospital services are treated in a uniform and substantially equal manner in that all payors have equal opportunity to participate under the system and to receive available benefits of the system.

—Assure that the risks and savings are shared equitably by all entities that participate under the system.

—Assure that the State system will not result in reduction of the services or of due process rights to which Medicare beneficiaries are otherwise entitled.

- Assure that the system will provide a means for providers to appeal errors in the calculation of payment rates.
- Assure that Medicare payments made under the system over 36-month periods will not be greater than those that would have otherwise been made

under the Medicare principles of reimbursement.

The proposed § 403.304 would also provide, as noted earlier, that if a State had an existing Medicare demonstration project in effect on April 20, 1983, and requests a waiver under section 1886(c)(4) of the Act, the effectiveness of the State's system may be judged on the basis of the State system's rate of increase or inflation in payments for inpatient hospital services as compared to the national rate of increase or inflation in payment for such services during the State's hospitals' three cost reporting periods beginning on or after October 1, 1983.

The new § 403.304 would further provide that if the assurances and supporting data pertaining to the cost-effectiveness provisions, as described above, are insufficient, the State would be allowed to provide an additional assurance in order to meet the requirement. The additional assurance would be that the State would control expenditures by agreeing to do one of the following:

- The State would agree that Medicare payments under its system would be limited to the Medicare prospective payment rates. The State would be required to pay hospitals covered by its system any excess payment generated by the system.
- The State would agree on a predetermined percentage relationship between Medicare payments under the State's system and Medicare payments under the prospective payment system. This percentage relationship would be monitored by HCFA on a quarterly basis and the monitoring results would be provided to the State. If the payments show a deviation from the agreed upon predetermined relationship, then Medicare payments to the State would be automatically capped, with the State paying to hospitals under the system the excess over the prospective payment system expenditures. As an alternative to this second option, the State may provide through State legislation or binding regulations that, in accordance with its payment control assurance, reduced payments to hospitals will constitute full and final payment for services rendered to Medicare beneficiaries.

We propose in § 403.306 of these regulations that, if a State system meets the requirements of § 403.304 and meets the additional requirements and assurances specified in section 1886(c)(5) of the Act, HCFA approval of the system would be mandatory. As set forth in this proposal, these additional requirements would be that the system—

- Be operated directly by the State or an entity designated by State law.
- Provide for a methodology (that sets forth exceptions and adjustments if any, as well as any method for changes in the methodology) by which prospectively determined payment rates are established.
- Provide for hospitals to make reports as required by HCFA.
- Provide that the State must notify HCFA and affected hospitals 60 days prior to enactment of reductions or increases in payments that might generate from any material change in the system or the payment methodology. Approval would have to be granted by HCFA prior to the State's effective date for the change in payments.

In addition, under the proposed § 403.306, the State would have to provide satisfactory assurances to HCFA that—

- The operation of the sytem will not result in any change in hospital admissions practices that would result in—

—A significant reduction in the proportion of patients (receiving hospital services covered under the system) who have no third party coverage and who are unable to pay for hospital services;

—A significant reduction in the proportion of individuals admitted to hospitals for inpatient hospital services for which payment is (or is likely to be) less than the anticipated charges for or costs of such services;

—The refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital; or

—The refusal to provide emergency services to any person who is in need of emergency services if the hospital provides such services.

- The State consulted with local government officials, during the development of the system, concerning the impact of the system on public hospitals.

III. Discussion of Proposed Requirements

A. Requested by Chief Executive Officer

The Chief Executive Officer of the State would have to submit the request for approval of the State system on behalf of the State. This requirement is specified at section 1886(c)(1) of the Act and in these proposed regulations at § 403.304(b)(1). Normally, the Chief Executive Officer would be the Governor of the State. However, if a State or territorial constitution or other State or territorial statutory authority designates some other official as the highest official of the State with authority to act with respect to matters covered by these proposed regulations, then that official would qualify to submit the application.

B. Applicable to Substantially All Hospitals

Section 1886(c)(1)(A)(i) of the Act requires, as a condition for approval of a State's hospital reimbursement control system, that the system apply to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the State. Under this statutory requirement, our proposal defines "Federal hospital" in § 403.302 and specifies in § 403.304 the proposed criteria for determining which hospitals must be excluded from the system and which hospitals may, at the State's option, be excluded. The proposed criteria are as follows:

1. Federal Hospitals

We have defined Federal hospitals, for purposes of these proposed regulations, to be those hospitals that are administered by, or that are under exclusive contract with, the Department of Defense, the Veterans Administration, or the Indian Health Service. Since payments for inpatient hospital services in these institutions are prescribed in the statutes and regulations governing these programs, these hospitals must be excluded from the State's system.

2. Acute Care Hospitals

We have generally considered acute care hospitals to be those facilities that are primarily engaged in providing a variety of diagnostic or therapeutic services to inpatients on a short-term basis. Thus, acute care hospitals are short-stay, general facilities as opposed to chronic-care hospitals or long-term care institutions. For the most part, the average length of stay in acute care hospitals does not exceed 25 days. Hospitals that ordinarily treat patients on a long-term or specialty basis, such as rehabilitation, psychiatric, tuberculosis, or childrens' hospitals, may be excluded from a State's reimbursement control system.

We note, however, that the exclusion of non-acute care hospitals would not be mandatory for HCFA's recognition of the system. States may apply their system to these facilities, if they desire, without influencing HCFA's approval of the system.

Section 602(f)(1) of Pub. L. 98-21 amended section 1866 of the Act by

adding section 1866(a)(1)(F), which requires that hospitals receiving payments under section 1886(c) of the Act must have and maintain an agreement with a utilization and quality control Peer Review Organization. Regulations at § 466.78(a), published in the **Federal Register** on April 17, 1985 (50 FR 15331), implement this requirement.

3. Mandatory Statewide Applicability

In order to ease the administration of the statutory requirement concerning applicability to all non-Federal acute care hospitals, we would further specify that the State reimbursement control system must be mandatory statewide. If the proposed system is mandatory as authorized and governed by State legislation or other enforceable mandate, the determination that the system applies to substantially all non-Federal acute care hospitals (except for those hospitals mentioned in item two above) would be relatively straightforward. This would also facilitate a lessening of the administrative burden to determine if the State system continues to meet this requirement. For example, if participation of hospitals was voluntary, at any point in time the State system may not meet the applicability requirements because hospitals may participate or not participate as they choose. The designated State agency or commission responsible for the operation of the system would be required to notify the affected hospitals in writing of the basis for the system and of the State's intention to adhere to mandatory applicability of the system. HCFA's determination would be based on this information.

C. Applies to 75 Percent of Revenues or Expenses for Inpatient Hospital Services

Under section 1886(c)(1)(A)(ii) of the Act, in order to approve Medicare payment under a State system, we must determine that the system applies to review of at least 75 percent of all revenues or expenses in the State for inpatient hospital services and that the State's system applies to 75 percent of revenues or expenses for inpatient hospital services under the State's Medicaid plan.

In implementing this statutory requirement, our proposal specifies that both the Medicare and Medicaid program must participate under the system. In addition, all other private third-party payors must be afforded the opportunity to participate under the system. Although HCFA would be responsible for determining if 75 percent of the revenues or expenses for inpatient hospital services are covered under the system, a State would be required, when applying for approval of its system, to submit an assurance and supporting documentation that this requirement is met. The State's assurance must identify the payors that participate under the system and how the State concluded that the 75 percent requirement is met. HCFA would review and evaluate the assurance and make a determination as to whether this requirement is met.

A State system need not be limited to inpatient services. At the discretion of the Secretary, a State that applies for approval of a State system for inpatient services could also seek approval to have its system cover outpatient services. If the State system applies to outpatient services, the State would be required to submit a separate waiver application subject to the same regulatory requriements of an inpatient waiver application, that is, the application would have to meet all the requirements for mandatory inpatient waiver approval as they apply to outpatient services. For example, the outpatient system would have to apply to all non-Federal acute care hospitals and to 75 percent of revenues or expenses for outpatient hospital services. Furthermore, the State would be required to assure equitable treatment of all entities and that the outpatient system will be cost effective independent of the inpatient system, in that payment for outpatient services will not result in greater Medicare expenditures over a 36 month period. The application for an outpatient waiver would be evaluated independent of the application for an inpatient waiver and would be approved only for those States that have an approved inpatient reimbursement system. The approval of outpatient provisions would be within HCFA's overall discretionary authority for approval of State systems. We recognize the statute specifically authorizes only inpatient hospital services. Therefore, we invite public comments regarding the optional application of State systems approved under section 1886(c) of the Act to outpatient services.

D. Equitable Treatment of All Entities

Section 1886(c)(1)(B) of the Act requires that satisfactory assurances be provided as to the equitable treatment under the system of all entities that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients. Thus, these proposed regulations require a number of assurances by the State in accordance with the statute.

1. Equitable Treatment of All Entities That Pay for Hospital Services

The State would be required to assure that all entities that pay for hospital services are provided equal opportunity to participate under the State system and consequently, share in its risks and benefits. Further, the State would be required to assure that its system provides for uniform treatment of all payors that participate in the system in terms of opportunity. Therefore, it is not necessary that every payor receive benefits under the system that are identical, as long as each payor has an equal opportunity to obtain or qualify for those benefits.

2. Risks and Savings Must Be Shared on an Equitable and Proportionate Basis

These proposed regulations specify that the State system must assure that risks and savings are shared by all third-party payors.

This requirement is in keeping with, and would help to implement, the statutory requirement in 1886(c)(1)(B) of the Act regarding equitable treatment of all payors.

3. Assurances of Equitable Treatment of Hospital Employees and Patients

To implement section 1886(c)(1)(B) of the Act, these proposed regulations require written assurances of equitable treatment of hospital employees and hospital patients. It would not be necessary for a State to include in these assurances a detailed narrative of how the system provides equitable treatment. However, HCFA would be free to request additional information to substantiate the assurances, if necessary.

4. Continuation of Medicare Coverage, Entitlement, and Program Administration

Recognition of State systems under the new law may alter the means by which Medicare inpatient hospital services may be reimbursed. However, section 1886(c) of the Act does not affect the coverage and entitlement provisions of title XVIII of the Act. On the contrary, it requires that each State assure equitable treatment of Medicare beneficiaries under its system by specifying equitable treatment of hospital patients. Threfore, these proposed regulations require the State to agree that it would not restrict Medicare beneficiaries' access to services. Entitlement to Medicare benefits would remain a Federal determination. Additionally, the beneficiaries' benefit package (for example, the days of care, statutory exclusion of certain services,

deductibles and coinsurance provided for by title XVIII of the Act) could not be changed by the State. Further, services currently covered in Medicare's payment rate to hospitals may not be restricted. Under a State system, States would be expected to assure at a minimum that Medicare beneficiaries will continue to receive all reasonable and necessary services as required under the present reimbursement system.

Similarly, section 1886(c) of the Act did not affect title XVIII of the Act with respect to program administration. Therefore, a State's system may not abridge the rights of providers that are assured under their Medicare participation agreements. The current procedures for assuring quality of care inherent in the provider survey and certification process, the present terms of provider agreements, and the Medicare procedures of utilization monitoring would generally remain intact. Further, Medicare intermediaries would continue their claims processing function, with necessary changes to accommodate the State's determination of Medicare reimbursement for providers. Medicare intermediaries would continue to process bills, make payments, and adjudicate and reconsider beneficiary bills and claims. This involves a consideration of the medical reasonableness and necessity of the services for which Medicare reimbursement is claimed. The State would, however, be responsible for provider appeals as discussed in section III.N. of this preamble.

E. Payments May Not Exceed Medicare Reimbursement Levels

Section 1886(c)(1)(C) of the Act requires that the Secretary be provided satisfactory assurances that, over 36-month periods, the first of which begins with the first month in which this provision applies to a State system, the amount of Medicare payments that are to be made under the State's system will not exceed the amount of payments that would otherwise have been made under the Medicare reimbursement principles for items and services provided under Medicare. States that have an existing Medicare demonstration project on April 20, 1983 and that have requested approval of a State system under section 1886(c)(4) of the Act may have the system's effectiveness judged on the basis of the State's system's rate of increase or inflation in payments for Medicare inpatient hospital services as compared to the national rate of increase in payments for such services during the three cost reporting periods beginning on or after October 1, 1983.

We may, under certain conditions, permit an adjustment to take into account previous reductions in the Medicare reimbursement amounts that were the result of the effectiveness of the State's reimbursement control system prior to application for Medicare participation. Specifically, the statute authorizes the Secretary to provide for this adjustment if, as explained in the legislative history for Pub. L. 97-248 (see H.R. Rep. No. 97-760, 97th Cong. 2nd Sess. 422 (1982)), a result of the State's existing system that does not include Medicare is that the State's aggregate rate of increase in hospitals' total operating costs is less than the national aggregate rate of increase in hospitals' total operating costs. Although the statute allows for such discretionary adjustment and we have provided for it in these proposed rules, we are concerned as to how a State entity would establish quantitatively such amounts. Moreover, we are also concerned as to how we would substantiate the savings realized by Medicare in some prior period. We invite specific public comment on the operation of this provision.

As noted below, the State's assurance and projections on cost-effectiveness must be based on the Medicare principles in effect at the time and must also include established future changes to the Medicare system. HCFA will review these projections to determine if the cost-effective assurance is acceptable for purposes of approving the application. However, the test of cost-effectiveness will be based on a comparison of actual expenditures under the State system and the amounts that Medicare would have paid absent the waiver. We wish to emphasize that, in most instances, it would be necessary for a State to make changes to its payment system to adapt to changes that occur in the national Medicare program after the State system is approved. Accordingly, once the application is approved, HCFA will monitor quarterly the Medicare expenditures under the State system and compare these amounts to what Medicare would have paid if the State system had not been in existence. Of course, any changes to the Medicare system would be included in this comparison. If we determine that the assurances have not been met or will not be met with respect to any 36-month period, sections 1886 (c)(3) and (c)(6) of the Act authorizes termination of the approval agreement or a reduction in payment to individual hospitals under the State system. If appropriate, we may reduce payments under the Medicare payment system in an amount equal to the amount by which the Medicare payments under the State system exceed the amount of Medicare payments that otherwise would have been paid to the hospitals involved, including the appropriate recognition of the time value of the excess payments (that is, the interest the Medicare Trust Fund earned, or would have earned, on these amounts). The amount of the overpayment would be recouped on a proportionate basis from each of those hospitals that received payments under the State system that exceeded the payments they would have received under the Medicare system. The hospital's proportionate share would be determined by a comparsion of the hospital's total overpayment to the total amount of excess payments under the State's system over the aggregate payments that the Medicare system would have paid. Recoupment may be accomplished by a hospital's direct payment to the Medicare program or by offsets against future payments to the hospital. If the expenditures test is applied by a rate of increase factor, the amount of excess payment would be determined by comparison of the State system rate of increase to the national rate of increase in order to determine the amount of excess payments to be recouped from each individual hospital.

As an alternative to the recoupment procedures described above, but subject to HCFA's acceptance, the State may provide by legislation or binding regulations for a process and procedure whereby excess payments will be recouped by the Medicare program.

Although the statute requires an assurance that payments under the State's system will not exceed the amount of payment that would have been made under the Medicare reimbursement principles over 36-month periods, these proposed regulations further require detailed and quantitative estimates, data, and reports to demonstrate the projected costs or savings for each hospital. This is necessary to substantiate the assurance that Medicare program expenditures will not exceed what Medicare would have paid over the 36-month period. The estimates and data are also necessary for the following reasons: (1) to provide a uniform basis to review the State's assurance irrespective of the design of the State's system, (2) to protect the Medicare program from excessive expenditures by allowing analysis as to whether it is reasonable to accept the State's assurance that its system will indeed not result in expenditures above the statutory requirements, and (3) to

assist HCFA to determine if payments to hospitals under the State's system or, if applicable, under the Medicare payment system, should be reduced in an amount equal to the excess over what Medicare would have paid during the period the State system was in effect. HCFA would monitor expenditures on a quarterly basis during the period the State system is in effect for purposes of comparision with amounts that would have been paid using the Medicare payment system to determine if excess payments have been made. The projections and supporting data would be especially critical if a State's system fails to meet the statutory requirements during a particular year. For example, if a State's system were to result in the projection of sizable expenditures above the limit in the first year of operation, we could reasonably conclude, unless there were quantitative supportive information to the contrary, that it is not likely that the system would result in payments that would equal the Medicare expenditure over the 36-month period.

Specifically, these proposed regulations require the State to submit estimates and data in support of its assurance. The State would be required to submit for *each hospital* projections for the first 12-month period covered by the assurance, in both the aggregate and on a per discharge basis, of Medicare inpatient expenditures without the State system in effect (that is, using the Medicare principles) and parallel projections of Medicare inpatient expenditures under the State's system, and the resulting cost or savings to the program including the time value of trust fund expenditures during the period the State system expenditures either exceeded or were less than Medicare system payments. The State would also be required to submit separate *statewide* projections for each year of the 36-month period, in both the aggregate and on an average weighted discharge basis, of inpatient expenditures under the State system and under the Medicare system. These projections would have to include a detailed description of the methodology and assumptions used to derive the expenditure amounts under both systems. In instances where the assumptions are different under the sets of projections, the State would have to provide a detailed explanation of the reasons for the differences. At a minimum, the following separate data would be included in the projections for the Medicare principles and for the State's system.

- The base year and the Medicare allowable and reimbursable cost (that is, costs that represent a full accounting period and that have been fully reported and reviewed or audited as appropriate) for each hospital that was used to develop the projections, including the amount of estimated pass through costs (for example, capital).
- The categories of costs that are included in the State system and that are reimbursed differently under the State system than under the Medicare system.
- The number of Medicare, and total, base year discharges and admissions for each hospital.
- The rate of change factor, and method of application of this factor, used to project the base year costs over the 36-month period to which the assurance would apply.
- Any allowance for anticipated growth in the amount of services from the base year. If applicable, the allowance would have to be depicted in separate estimates for population increases or increases in rates of admissions.
- Any adjustments to the projections the State is permitted to take into account due to previous reductions in the Medicare payment amounts that are the result of the effectiveness of the State's system prior to Medicare participation.
- States with existing Medicare demonstration projects that apply for approval under a rate of increase effectiveness test would also be required to submit data projecting the parallel rates of increase during the requisite period.

The estimates and projections of Medicare payments as required for the assurance must take into account all of the Medicare reimbursement principles in effect at the time. This would include the HCFA market basket (a measure that is used to reflect changes in the prices of goods and services that hospitals use in producing general inpatient services, which is explained in detail in the September 1, 1983 **Federal Register** (48 FR 39764)), the provisions of Pub. L. 97–248, and the Medicare prospective payment system.

1. Hospital Outpatient Services

For those State systems that include payment for Medicare outpatient services, these proposed regulations would also require the submission of a *separate* application and assurance for those services, and estimates and data in further support of the State's assurance. The estimates and data that the State would be required to submit include, but are not limited to, projections for the first 12-month period covered by the assurance for each hospital, in both the aggregate and on an average cost and payment per service basis, of Medicare outpatient expenditures without the State's system being in effect (that is, using the Medicare principles); comparable projections of Medicare outpatient expenditures under the State's system; and the resulting cost or savings to the Medicare program. In addition, the State would also be required to submit separate statewide projections of the aggregate outpatient expenditures for each system for each year of the 36-month period. The State would be required to submit the methodology and assumptions used to derive the expenditure amounts under both systems. The minimum requirements regarding the assurance and supportive data would be consistent with those listed for the inpatient hospital projections as described above. The cost-effectiveness test for expenditures for outpatient services would have to be met independently of the cost-effectiveness test for expenditures for inpatient services.

2. HCFA Review of Assurances

HCFA would review the State's assurances and data as a prerequisite to the approval of the State's system. HCFA would compare the State's projections of payment amounts to HCFA data in order to determine if the State's assurances are reasonable and fully supportable. If the assurances and supporting data are by themselves insufficient to provide satisfactory assurance to HCFA, then HCFA may agree that the States adoption of one of the following additional procedures provides a satisfactory assurance:

- The State agrees that the appropriate Medicare intermediaries each month will disburse to the State's hospitals no more Federal funds in the aggregate than would have been disbursed in the absence of the State system. Any additional funds necessary to pay hospitals for Medicare services as required by the State system will be furnished to the intermediaries by the State. These amounts will be refunded to the State by the intermediaries to the extent that, in subsequent months, the State's system requires a smaller aggragate payment for Medicare services than would have been paid in the absence of the State system.
- The State agrees that, as a result of projections that exceed Medicare payments in any particular period, there will be a payment schedule established that would limit State system hospital payments to a predetermined percentage relationship between projected State

system hospital payments and what payments under Medicare would have been. This payment pattern would be monitored on a quarterly basis and any deviation from the agreed upon payment pattern would automatically result in Medicare payments being capped at prospective payment system levels with an offset to recover prior excess payments, and the State would be required to make up the difference in payments. If the State chooses not to make up the difference in payments, the State would be required to have in place legislation or binding regulations that provide that reduced payments to hospitals will constitute full and final payment for services rendered to Medicare beneficiaries during the period covered by the reduced payments.

With regard to existing State systems currently under a HCFA demonstration project, HCFA is required under section 1886(c)(4) of the Act to judge the effectiveness of of the system on the basis of its rate of increase or inflation in inpatient hospital payments for individuals under Medicare as compared to the national rate of increase or inflation for such payments. The States with existing Medicare demonstration projects may retain the option to have the test applied on the basis of the aggregate payment or payments per inpatient admission or discharge during its hospitals' three cost reporting periods beginning on or after October 1, 1983. After that date, at our option the above test would no longer apply, and instead we may apply a test similar to that used for a new State system.

In connection with the maximum expenditure requirements, we believe that it is necessary to discuss our concerns and policy regarding the inclusion of additional categories of costs that are not usually allowable for reimbursement purposes under the Medicare program: for example, (1) the costs associated with bad debts or uncompensated care not attributed to Medicare beneficiaries; (2) the cost of poison control hotlines, etc., and (3) costs resulting from the administration of the State's system, or State taxes or other assessments that are specifically designated for purposes of financing the administration of the State's reimbursement control system. These proposed regulations would not preclude a State system from including these costs in the overall expenditure determination. However, we wish to emphasize that it would be a requirement that the total expenditure must not exceed the amounts that would have otherwise been paid under the Medicare reimbursement principles for items and services provided to Medicare beneficiaries. We believe that inclusion of such non-allowable costs must be monitored closely in order to achieve consistency with the legislative intent that the effect of a State system be budget neutral in terms of what Medicare would otherwise pay for services covered under the Medicare program.

Additionally, these proposed regulations provide that States are not to attain Medicare savings through shifting of costs to other payors, including the Medicaid program. HCFA would monitor this aspect in conjunction with the monitoring of expenditures under the State system. It would be inappropriate to increase Medicaid costs in order to achieve Medicare savings, since this would be inconsistent with the intent of the existing Medicaid upper limit requirement in regulations at § 447.253, and the legislative intent of sections 1902(a)(13)(A) and 1902(a)(30) of the Act, which limit maximum Medicaid payment for inpatient hospital services to that which would have been paid under the Medicare principles of reimbursement. The upper limit requirement in § 447.253 is based on section 1902(a)(30) of the Act and the intent of Congress in enacting section 2173 of Pub. L. 97–35, which amended section 1902(a)(13) of the Act. (See the Conference Report on Pub. L. 97–35, H.R. Rep. No. 97–208, 97th Cong. 1st Sess. 962 (1981).) The upper limit requirement was not affected by either section 101 of Pub. L. 97–248 or section 601 of Pub. L. 98–21. Therefore, these proposed regulations specify that the State's system must not produce aggregate expenditures for the Medicaid program in excess of what those expenditures would have been if the Medicare payment principles were used.

F. Exception for Health Maintenance Organizations (HMOs)

In section 1886(c)(1)(D) of the Act, Congress recognized that HMOs offer a competitive alternative to traditional health care providers. (See the Report of the Committee on Ways and Means on H.R. 1900, H.R. Rep. No. 98–25, 98th Cong., 1st Sess. 148 (1983).) Through years of study with various HMO demonstrations, it has been concluded that health care utilization of HMO enrollees is somewhat different than that of the population generally. Often this difference is reflected in lower hospital admission rates for inpatient care. This characteristic of their enrollees' utilization of services permits many HMOs to negotiate individual prepayment plans with the hospitals furnishing services to enrollees, such as monthly per capita payments. The payment plans that result from these negotiations may not be consistent with the State system. Thus, section 1886(c)(1)(D) of the Act and these proposed regulations specify that State systems must provide that HMOs or CMPs, as defined by section 1876(b) of the Act, may negotiate their own inpatient hospital service reimbursement rates. It is the intent of Congress that, to avoid undermining the State system and to provide the exception afforded HMOs or CMPs, the definition in section 1876(b) of the Act be narrowly interpreted. (See Report of the Committee on Ways and Means on H.R. 1900, H.R. Rep. No. 98–25, 98th Cong., 1st Sess. 146 (1983).) If an HMO or CMP chooses not to negotiate special reimbursement arrangements with hospitals, the usual State reimbursement rates and controls as provided under the State system would apply.

G. Operated Directly by the State or Designated Entity

In accordance with the provisions of section 1886(c)(5)(B)(i) of the Act, these proposed regulations give each State the option to operate its State system itself or to designate a legal entity to operate the system in accordance with State law.

H. Prospectively Determined Rates

Section 1886(c)(5)(B)(ii) of the Act requires that the system must provide for payment rates that are prospectively determined. Under these proposed regulations, the application for approval would have to include a detailed description of the methodology used in determining the rates. Although the rate, once computed, is final, the system would allow for exceptions and adjustments that could arise from possible computation errors. Flexibility in the development of the methodology may be considered to allow for possible changes in the methodology where needed. However, such changes could not include or entail additional Federal expenditures for items and services that are not covered by the Medicare program and that were not included in the original ratesetting methodology and in the agreement regarding that methodology unless the State advises HCFA at least 60 days prior to the proposed effective date and HCFA approves such changes in advance of the effective date.

I. Required Reports.

We would require hospitals covered by a State's system, in accordance with

section 1886(c)(5)(B)(iii) of the Act, to submit either Medicare cost reports or approved substitute reports in lieu of cost reports to HCFA or its intermediaries in order that proper monitoring of the State's assurances (discussed previously) may be accomplished. The States in turn would be responsible for the design, and for obtaining HCFA approval, of substitute reports. Furthermore, we would require the States to submit financial, statistical, administrative, or any other reports that may be needed to satisfy the requirements in sections 1886(c)(1) (A), (C), and (E) of the Act, which pertain to the level of revenues, expenses or payments controlled or incurred by the operation of the State system.

J. Admission Practice Assurances

The State would have to provide satisfactory assurances that operation of the cost control system would not result in any change in the patient admission practices of participating hospitals, as required by section 1886(c)(5)(C) of the Act.

1. Financially Distressed Patients

Two assurances would be required by the State regarding the admission practices of financially distressed patients. The first assurance requires that the system would not result in any change in hospital admission practices that results in a significant reduction in the proportion of patients (receiving hospital services covered under the system) who have no third party coverage and who are unable to pay for hospital services. The second assurance is that the system would not result in any change in hospital admission practices that results in a significant reduction in the proportion of patients for which payment is (or is likely to be) less than the anticipated charge for, or cost of, such services.

2. High Cost or Prolonged Length of Stay Patients

As proposed, the State would have to assure that the operation of the system would not result in a refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital.

3. Emergency Service Patients

The State would be required to assure that the operation of the system would not result in the refusal to provide services to patients who are in need of emergency services if the hospital provides those services.

K. Material Changes in Payments

As required in section 1886(c)(5)(D) of the Act, we are stating in these proposed regulations that any change in the State system that has the effect of materially reducing or increasing payments to hospitals would take effect only upon 60 days advance notice to HCFA and to the hospitals whose payments are likely to be materially affected by the change. HCFA would respond prior to the effective date, granting or denying the proposed change. Generally, the basis for approval of a particular State payment system would be that the system is expected to yield certain results. Thus, we believe that, for purposes of accountability and adherence to the basis on which the system is initially approved, any material change in the system that would alter those results should be subject to approval prior to implementation. Therefore, we propose to require not only that notice of all material changes must be provided to HCFA but also that the changes be subject to HCFA's approval.

L. Consultation With Local Government Officials

The State, as a requirement of section 1886(c)(5)(E) of the Act, would assure HCFA that in developing the cost control system, the State consulted with local government officials concerning the effect of the system on publicly owned or operated hospitals. As part of this assurance, the State would be required to describe the consultation efforts it undertook with all local governmental officials, and to summarize the comments it received and the actions taken to respond to those comments.

M. Beneficiary Liability and Nonphysician Services

Under section 1886(c)(1)(E) of the Act, we would require that the State system limit hospital charges for beneficiaries to deductibles and coinsurance and to noncovered services, and prohibit payment to hospitals for nonphysician services under Part B unless the hospital is granted a waiver by HCFA in accordance with § 489.23 of the regulations. The system would also have to conform to the Medicare requirements that hospitals agree not to charge beneficiaries or the Medicare program for denied services due to inappropriate or unnecessary admissions or other inappropriate medical or other practices.

In accordance with § 489.23 a waiver may be granted by HCFA only during the prospective payment system transition period (that is, Federal fiscal years 1984–1986) in the case of hospitals that have allowed direct billing under Part B so extensively that immediate compliance with such restrictions would threaten the stability of patient care.

Except in instances where a waiver is granted in accordance with § 489.23, State systems and hospitals are required to comply with the rebundling requirements as set forth in sections 1862(a)(14) and 1866(a)(1)(H) of the Act, which apply the Medicare coverage provisions to *all* hospitals participating and entitled to payment under Medicare. The State systems would also be required to comply with the provider-based physician rules of section 1887(A) of the Act and implementing regulations at §§ 405.480–405.482 and §§ 405.550–405.557, without exception.

It should be noted that the authority provided the Secretary in section 1886(c) of the Act for approval of State systems does not extend to reimbursement for physician services. Therefore, we would expect that State systems would not seek waivers for such services under section 1886(c) of the Act. Rather, waivers for these types of projects would be sought and carried out under the various authorities granted to HCFA for research and demonstration activities under Medicare and Medicaid.

N. Provider Appeal Process

These proposed regulations require that the State reimbursement control system have an appeals process. Since the Medicare intermediary would not be setting the payment rates, it would not be the appropriate entity to resolve disputes over payment rates. Similarly, since the Medicare Provider Reimbursement Review Board (PRRB) is not intended to be knowledgeable regarding the State's procedures for ratesetting, it would not be an efficient or appropriate use of resources to involve the PRRB in appeals of State actions.

Providers would still be given the opportunity to present evidence and receive redress, if their payment is inaccurate as a result of errors arising from incomplete or inaccurate data, errors in calculations, etc. Although not specifically provided for in the statute, we believe that this requirement would be consistent with the legislative intent of section 1886(c)(1)(B) of the Act, which requires equitable treatment, and the provisions of 1886(c)(5)(B)(ii) of the Act, which indicate that the payment system should provide for exceptions and adjustments as well as for a method for changes in the methodology. The mechanism for appeals and the type of

appeals permitted would be at the State's discretion; however, the system may not permit providers to file administrative appeals that could lead to retroactive revision of a prospectively determined payment rate. Details of the appeals process would be included in the application for approval of the system, and the applicant would be required to provide additional information if HCFA requests it.

Beneficiary appeals would continue to be processed by a Medicare intermediary, or carrier, or the HHS Administrative Law Judges in accordance with the requirement for continuation of Medicare coverage, entitlement, and program administration. (See section III.D.4. of this preamble.) Beneficiary appeals generally would involve actions taken by the intermediary in applying the Medicare entitlement and coverage provisions under the State's system when processing claims.

O. Reporting and Billing

We propose that the State system must provide for timely provider reporting and billing and for submission of any reports required by HCFA, or substitute forms developed by the State and approved by HCFA.

Since the Medicare intermediary would continue to process claims under the State reimbursement control system, it is necessary that the system continue to use Medicare billing forms and that such forms be submitted to the appropriate Medicare intermediary.

IV. Evaluation and Approval

A. Evaluation

States that wish to obtain Medicare recognition of statewide reimbursement control systems would submit their applications to HCFA. HCFA would review each complete application for consistency with the requirements of the law and regulations and respond to the State within 60 days of receipt of the request. If questions arose during the evaluation, HCFA would contact the State for additional information or for clarification of specific aspects of the application. If HCFA concludes that further information is necessary from the State, a new 60-day period would begin when all the required information is received. Once HCFA completes its evaluation of the State's application, it would then notify the State of its decision.

B. Reconsideration of Denied Applications

The proposed regulations state that if HCFA denies approval of an application of a State system, and if the State is dissatisfied with the determination because it believes it has met all of the requirements for mandatory approval under § 403.306 or § 403.308, the State may request reconsideration of the denial by HCFA. The request would have to be submitted within 60 days of the date of the notice of HCFA's denial. HCFA would then notify the State of the results of its reconsideration within 60 days after HCFA receives the State's request.

C. Approval

If HCFA approves a State's application for Medicare recognition of the State reimbursement control system under 1886(c) of the Act, the Administrator of HCFA or his or her designee will enter into an agreement with the Chief Executive Officer of the State or his or her designee, or with the Chief Executive Officer of the entity designated by State law. The agreement would have to grant HCFA access to the State's records, and to provider records as authorized by section 1815(a) of the Act. Other conditions of the agreement would include the requirements of these proposed regulations and any other items that may be agreed upon by the parties to the agreement. These may include such features as time limitations, options for renewal, administrative and operating procedures, and reporting requirements.

D. Termination of Agreements

Section 1886(c)(3) of the Act authorizes the Secretary to terminate Medicare participation in an approved State system if there is reason to believe that the system no longer meets or will not be able to meet certain requirements set forth in section 1886(c) of the Act. Thus, the proposed regulations set forth rules regarding termination of agreements for Medicare recognition of State systems. HCFA would review the State's system quarterly and advise the State of its performance regarding compliance with section 1886(c) of the Act. If it is determined that the system is not operating as the State has assured, the agreement may be terminated. For example, if Medicare costs under the system are significantly exceeding projected or agreed upon expenditure levels so that it appears that the system will not meet the expenditure test over a 3-year period, or if applicable, the rate of increase test, the agreement may be terminated and offsets against future payments to hospitals would be made for the excess payments. The statutory requirements at sections 1886(c)(1)(C), 1886(c)(3) and 1886(c)(6) of the Act provide for these actions that may be taken either in conjunction with the State system or under the Medicare payment system if or when the State system is terminated.

HCFA would notify the State of the decision to terminate at least 90 days in advance of the termination date. The termination date would be the last day of a calendar quarter. The advance notice would provide the State with an opportunity to present evidence to substantiate why the system should be continued. A State may voluntarily terminate an agreement after giving notice at least 90 days in advance of the last day of the calendar quarter in which the State intends to terminate the agreement.

V. Impact Analyses

A. Executive Order 12291

Executive Order 12291 requires us to prepare and make available to the public a regulatory impact analysis for any regulations likely to have an annual effect on the economy of $100 million or more, cause a major increase in costs or prices, or meet other threshold criteria specified in section 1(b) of the Order. We have determined that these proposed regulations do not meet the criteria for a "major rule" under section 1(b). Therefore, a regulatory impact analysis is not required.

We expect that State systems for Medicare reimbursement, particularly in conjunction with the implementation of the prospective payment system for Medicare inpatient hospital services under Pub. L. 98-21, will have a significant economic effect. However, the extent of this impact will depend on the choices made by States concerning whether to utilize a State reimbursement control system; whether to bring any such system under the Medicare program in accordance with these proposed regulations; and on the behavioral changes of providers in responding to whatever systems are developed by States. Some of the factors that would affect the extent of this impact include:

- Applying these requirements statewide and to substantially all acute care hospitals in the State; and
- Requiring a review of at least 75 percent of the State's revenues or expenses for inpatient hospital services, instead of a lesser percentage.

The types of effects that can be expected are discussed in some detail in the impact analysis for the regulations establishing the Medicare prospective payment system (48 FR 39804-07, 39852, September 1, 1983, and 49 FR 301, January 3, 1984). One of the effects

expected of this proposal, however, is to increase the number of hospitals that do not participate in the national Medicare hospital prospective payment system, because they will be subject to State systems.

Because the law and these proposed regulations are designed to encourage the establishment of systems using incentives and controls that would restrain increases in the costs of hospital care, and because the statute requires that the amount of Medicare payments, over 36-month periods, made under a State's system will not exceed the amount of payments that would otherwise have been made under Medicare reimbursement principles, we expect the system may produce some Medicare program savings. To the extent that State systems result in State Medicaid savings, we expect concomitant savings on Federal financial participation payments. In addition, State controls may result in reductions in expenditures for other payors, such as non-governmental insurers and private parties. The effects could be very wide-ranging, extending to diverse factors such as insurance premium levels, copayment obligations, bad debt levels, and hospital bond ratings.

Because of the number of economic factors involved, the range and extent of potential effects, and the contingency of those effects on future and unpredictable actions on the parts of States, providers, insurers, and consumers, the effects are inestimable in dollar terms. Moreover, the effects are primarily the result of statutory changes made by section 101 of Pub. L. 97-248, section 601 of Pub. L. 98-21, and section 2315(a) of Pub. L. 98-369. The administrative discretion exercised through these proposed regulations is minor compared to the impact of the statute and decisions made by States that will affect their hospitals. Based on our experience, we do not believe that, in the near term, these proposed rules will result in an annual economic impact of $100 million, or otherwise meet the threshold criteria for a "major rule". Therefore, a regulatory impact analysis is not required. However, we do solicit public comments on the economic impacts that would result from these provisions to assist us in the identification of potential economic impacts on hospitals.

B. Regulatory Flexibility Act

The Secretary certifies, under 5 U.S.C. 605(b), as enacted by the Regulatory Flexibility Act (Pub. L. 96-354), that these proposed regulations would not have a significant impact on a substantial number of small entities. That Act requires us to prepare and make available to the public an initial regulation flexibility analysis, under 5 U.S.C. 603(b), unless the Secretary so certifies. The purpose of the analysis would be to explain the expected impact of the proposed regulations and to analyze alternatives that might reduce negative effects of regulations on small entities. (A small entity is a small business, a nonprofit enterprise, or a government jurisdiction with a population of less than 50,000.)

Nearly all hospitals are small entities under the Regulatory Flexibility Act. In any State implementing a system under these proposed regulations, a substantial number of hospitals (non-Federal, acute care hospitals) would be affected. Many of those hospitals may be significantly affected. However, the impact of the State systems must be considered in view of the implementation of the prospective payment system for Medicare inpatient hospital services under Pub. L. 98-21. The Medicare prospective payment system and State systems have mutually exclusive impacts, in that they are explicitly established as alternatives and will not both affect any particular hospital at the same time. The effects of State systems are inestimable before the characteristics of such systems are known in detail, so the effects on hospitals cannot be analyzed at this time. Furthermore, any effects would be primarily the result of the implementation of the statutory requirements of Pub. L. 98-248, Pub. L. 98-21, and Pub. L. 98-369, as noted earlier, and not the result of these proposed regulations.

C. Paperwork Burden

Sections 403.318 and 403.320 of this proposed rule contain general information collection requirements that would be imposed on States. As required by the Paperwork Reduction Act of 1980, we will be submitting a copy of this proposed rule to the Executive Office of Management and Budget (EOMB) for its review of these information collection requirements.

VI. Public Comments

Because of the large number of pieces of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments contained in correspondence that we receive by the date specified in the "DATES" section of this preamble and, if we decide to proceed with a final rule, we will respond to the comments in the preamble of that rule.

VII. List of Subjects in 42 CFR Part 403

Agreements, Federal hospitals, Hospitals, Inpatients, Medicare, Medicare supplemental health insurance panel, Medicare supplemental insurance, Reporting requirements, State reimbursement control system, Voluntary certification program.

PART 403—SPECIAL PROGRAMS AND PROJECTS

42 CFR Part 403 would be amended as set forth below:

1. A new Subpart C is added to the table of contents to read as follows:

Subpart C—Recognition of State Reimbursement Control Systems

Authority: Sections 1102, 1862(a)(14), 1866(a)(1)(F), 1871 and 1886(c) of the Social Security Act (42 U.S.C. 1302, 1395y(a)(14), 1395cc(a)(1)(F), 1395hh and 1395ww(c)).

2. A new Subpart C is added to Part 403 to read as follows:

Subpart C—Recognition of State Reimbursement Control Systems

§ 403.300 Basis and purpose.

(a) *Basis.* This subpart implements section 1886(c) of the Act, which authorizes payment for Medicare inpatient hospital services in accordance with a State's reimbursement control system rather than under the Medicare reimbursement principles as described in HCFA's regulations and instructions.

(b) *Purpose.* Contained in the subpart are—

(1) The basic requirements that a State reimbursement control system

must meet in order to be approved by HCFA:

(2) A description of HCFA's review and evaluation procedures; and

(3) The conditions that apply if the system is approved.

§ 403.302 Definitions.

For purposes of this subpart—

"Federal hospital" means a hospital that is administered by, or that is under exclusive contract with, the Department of Defense, the Veterans Administration, or the Indian Health Service.

§ 403.304 Minimum requirements for State reimbursement control systems—Discretionary approval

(a) *Discretionary approval by HCFA.* HCFA may approve Medicare payments under a State system, if HCFA determines that the system meets the requirements in paragraphs (b) and (c) of this section and, if applicable, paragraph (d) of this section.

(b) *Requirements for State reimbursement control system.* (1) An application for approval of the system must be submitted to HCFA by the Chief Executive Officer of the State.

(2) The State system must apply to substantially all non-Federal acute care hospitals in the State.

(3) All hospitals covered by the system must have and maintain a utilization and quality review agreement with a Peer Review Organization, as required under section 1866(a)(1)(F) of the Act and § 466.78(a) of this chapter.

(4) Federal hospitals must be excluded from the State system.

(5) Nonacute care or specialty hospitals (such as psychiatric, tuberculosis or children's hospitals) may, at the option of the State, be excluded from the State system.

(6) The State system must apply to at least 75 percent of all revenues or expenses—

(i) For inpatient hospital services in the State; and

(ii) For inpatient hospital services under the State's Medicaid plan.

(7) Under the system, HMOs and competitive medical plans, as defined by section 1876(b) of the Act, must be allowed to negotiate payment rates with hospitals.

(8) The system must limit hospital charges for Medicare beneficiaries to deductibles, coinsurance or non-covered services.

(9) Unless a waiver is granted by HCFA under § 489.23 of this chapter, the system must prohibit payment under Part B of Medicare for nonphysician services provided to hospital inpatients, as required under section 1862(a)(14) of the Act and § 405.310(m) of this chapter.

(10) The system must require hospitals to submit Medicare cost reports or approved reports in lieu of Medicare cost reports as required.

(11) The system must require—

(i) Preparation, collection, or retention by the State of reports (such as financial, administrative, or statistical reports) that may be necessary, as determined by HCFA, to review and monitor the State's assurances; and

(ii) Submission of the reports to HCFA upon request.

(12) The system must provide hospitals an opportunity to appeal errors that they believe have been made in the determination of their payment rates. The system, if it is prospective, may not permit providers to file administrative appeals that would result in a retroactive revision of prospectively determined payment rates.

(c) *Satisfactory assurances.* The State must provide to HCFA satisfactory assurance as to the following:

(1) The system provides for equitable treatment of hospital patients and hospital employees.

(2) The system provides for equitable treatment of all entities that pay hospitals for inpatient hospital services, including Federal and State programs. Under this requirement, the following conditions must be met:

(i) Both the Medicare and Medicaid programs must participate under the system.

(ii) The State must assure equitable and uniform treatment under the system of third-party payors of inpatient hospital services in terms of opportunity. Equitable opportunity must include, but need not be limited to, participation in the system and availability of discounts.

(iii) The State must assure that all third-party payors that participate under the system share in the system's risks and benefits.

(3) The amount of Medicare payments made under the system over 36-month periods may not exceed the amount of Medicare payment that would otherwise have been made under the Medicare principles of reimbursement for Medicare items and services had the State reimbursement control system not been in effect. States must submit the assurance and supporting data as required by § 403.320 to document that the payment limit is not exceeded. States that have an existing Medicare demonstration project in effect on April 20, 1983, and that have requested approval of a State system under section 1886(c)(4) of the Act, may elect to have the effectiveness of the State system under this paragraph judged on the basis of the State system's rate of increase or inflation in Medicare inpatient hospital payments as compared to the national rate of increase or inflation for such payments during the three cost reporting periods of the hospitals in the State beginning on or after October 1, 1983.

(d) *Additional cost-effectiveness assurance.* If the assurances and supporting data required under paragraph (c)(3) of this section are insufficient to provide assurance satisfactory to HCFA regarding the cost-effectiveness of the State's system, the State may additionally submit one of the following assurances in order to meet the cost-effectiveness test:

(1) The State must agree that each month Medicare intermediaries will disburse to the State's hospitals Federal funds that in the aggregate equal no more than would have been disbursed in the absence of the State system. Any additional funds necessary to pay hospitals for Medicare services required by the State's system will be paid to the intermediaries by the State. These additional amounts will be refunded to the State by the intermediaries to the extent that, in subsequent months, the State's system requires a smaller aggregate payment for Medicare services than would have been paid in the absence of the State's system.

(2) The State must agree that as a result of the projections that exceed what Medicare would pay in any particular period, the State and HCFA will establish an agreed upon payment schedule that will limit payments under the State's system based on a predetermined percentage relationship between projected State payments and what payments would have been under Medicare.

(3) If deviation from the predetermined relationship described in paragraph (d)(2) of this section occurs, the State must further agree that—

(i) Medicare payments would be capped automatically at payment levels based on the rates used for the Medicare prospective payment system and the State would be required to pay the difference to individual hospitals in its system; or

(ii) The State may provide by legislation or legally binding regulations that any reduced payments to hospitals under the system that result from this cost-effectiveness assurance will constitute full and final payment for hospital services rendered to Medicare beneficiaries for the period covered by these reduced payments.

§ 403.306 Additional requirements for State reimbursement control systems—Mandatory approval.

(a) *General policy.*—(1) *Mandatory approval.* HCFA will approve an application for Medicare reimbursement under a State system if the system meets all of the requirements of § 403.304 and of paragraph (b) of this section.

(2) *Exception.* HCFA may approve an application if the State system meets all of the requirements of § 403.304 but only some of the requirements of paragraph (b) of this section.

(3) *Time limit.* HCFA will respond to applications submitted by States under this section within 60 days after receipt of the application. HCFA's response may be in the form of a request for additional information. If HCFA concludes that further information from the State is necessary, a new 60-day period begins when all the required information is received by HCFA.

(b) *Additional requirements.*—(1) *Operation of system.* The system must—

(i) Be operated directly by the State or by an entity designated under State law;

(ii) Provide for payments to hospitals using a methodology under which—

(A) Prospectively determined payment rates are established; and

(B) Exceptions, adjustments, and methods for changes in the methodology are set forth;

(iii) Provide that a change by the State in the system that has the effect of materially changing payments to hospitals can take effect only upon 60 days notice to HCFA and to the hospitals likely to be materially affected by the change and upon HCFA's approval of the change.

(2) *Satisfactory assurances.*—(i) *Admissions practice.* The State must assure that the operation of the system will not result in any change in hospital admission practices that result in—

(A) A significant reduction in the proportion of patients receiving hospital services covered under the system who have no third-party coverage and who are unable to pay for hospital services;

(B) A significant reduction in the proportion of individuals admitted to hospitals for inpatient hospital services for which payment is less, or is likely to be less, than the anticipated charges for or costs of the services;

(C) A refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital; or

(D) A refusal to provide emergency services to any person who is in need of emergency services, if the hospital provides the services.

(ii) *Consultation with local government officials.* The State must provide documentation that it has consulted with local government officials concerning the impact of the system on publicly owned or operated hospitals.

§ 403.308 State reimbursement control systems under demonstration projects—Mandatory approval.

HCFA will approve an application from a State for a State reimbursement control system if—

(a) The system was in effect prior to April 20, 1983; and

(b) The minimum requirements and assurances for approval of a State system are met under § 403.304 (b) and (c), and, if appropriate § 403.304(d)

§ 403.310 Reductions in payments.

(a) *General rule.* If HCFA determines that the satisfactory assurances required of a State under § 403.304(c) and, if applicable, § 403.304(d) have not been met, or will not be met, with respect to any 36-month period, HCFA will reduce Medicare payments to individual hospitals being reimbursed under the State's system or, if applicable, under the Medicare payment system, in an amount equal to the amount by which the Medicare payments under the system exceed the amount of Medicare payments to such hospitals that otherwise would have been made not using the State system, including the appropriate recognition of the time value of the excess payments (that is, the interest the Medicare Trust Fund earned, or would have earned, on these amounts).

(b) *Recoupment procedures.* The amount of the overpayment will be recouped on a proportionate basis from each of those hospitals that received payments under the State system that exceeded the payments they would have received under the Medicare payment system. Each hospital's share of the aggregate excess payment will be determined on the basis of a comparison of the hospital's proportionate share of the aggregate payment received under the State system that is in excess of what the aggregate payment would have been under the Medicare payment system. Recoupments may be accomplished by a hospital's direct payment to the Medicare program or by offsets to future payments made to the hospital.

(c) *Alternative recoupment procedures.* As an alternative to the recoupment procedures described in paragraph (b) of this section and subject to HCFA's acceptance, the State may provide, by legislation or legally binding regulations, procedures for the recoupment of the amount of payments that exceed the amount of payments that otherwise would have been paid by Medicare if the State system had not been in effect.

(d) *Rule for existing Medicare demonstration projects.* In cases of existing Medicare demonstration projects where the expenditure test is to be applied by a rate of increase factor, the amount of the excess payment will be determined, for the three hospital cost reporting periods beginning before October 1, 1986, by a comparison of the State system's rate of increase to the national rate of increase. Recoupment of excessive payments will be assessed and recouped as described in this section.

§ 403.312 Submittal of application.

The Chief Executive Officer of the State is responsible for—

(a) Submittal of the application to HCFA for approval; and

(b) Supplying the assurances and necessary documentation as required under §§403.304–403.308.

§ 403.314 Evaluation of State reimbursement control systems.

(a) *HCFA review.* HCFA will evaluate all State applications for approval of State systems and will request additional information if necessary. States must furnish the additional information requested by HCFA.

(b) *Notification.* HCFA will notify the State of its determination concerning approval of the application within 60 days of receipt of a complete application and background information.

(c) *Resubmittal of application.* A State may submit an amended reimbursement control system application under this subpart if HCFA denies the initial application.

§ 403.316 Reconsideration of denied applications.

(a) *Request for reconsideration.* If HCFA denies an application for a State reimbursement control system, the State may request that HCFA reconsider the denial if the State believes that its system meets all of the requirements in §§ 403.304 and 403.306 or, in the case of a State with a system operating under an existing demonstration, the applicable requirements of §§ 403.304 and 403.308.

(b) *Time limit.* (1) The State must submit its request for reconsideration within 60 days after the date of HCFA's notice that the application was denied.

(2) HCFA will notify the State of the results of its reconsideration within 60

days after it receives the request for reconsideration.

§ 403.318 Approval of State reimbursement control systems.

(a) *Approval agreement.* If HCFA approves a State reimbursement control system, a written agreement will be executed between HCFA and the Chief Executive Officer of the State. The agreement must incorporate any terms of the State's application for approval of the system as agreed to by the parties and, as a minimum, must contain provisions that require the following:

(1) The system is operated directly by the State or an entity designated by State law.

(2) For purposes of the Medicare program, the State's system applies only to Medicare payments for hospital services.

(3) The system conforms to applicable Medicare law and regulations other than those relating to the amount of reimbursement for inpatient hospital services, or for inpatient and outpatient services, whichever the State system covers. Applicable regulations include, for example, those specifying Medicare benefits and entitlement requirements for program beneficiaries, as specified in Parts 408 and 409 of this chapter; the requirements at Part 405, Subpart J of this chapter specifying conditions of participation for hospitals; and the requirements at Part 405, Subparts A, G, and S of this chapter on Medicare program administration.

(4) The State must obtain HCFA's approval of the State's reporting forms and of provider cost reporting forms or other forms that have not been approved by HCFA but that are necessary for the collection of required information.

(b) *Effective date.* An approved State system may not be effective earlier than the date of the approval agreement, which may not be retroactive.

§ 403.320 HCFA review and monitoring of State reimbursement control systems.

(a) *General rule.* The State must submit an assurance and detailed and quantitative studies of provider cost and financial data and projections to support the effectiveness of its system, as required by paragraphs (b) and (c) of this section.

(b) *Required information.* (1) Under § 403.304(c)(3) an assurance is required that the system will not result in greater payments over a 36-month period than would have otherwise been made under Medicare not using such system. If a State that has an existing demonstration project in effect on April 20, 1983 elects under § 403.304(c)(3) to have the effectiveness of its system judged on the basis of a rate of increase factor, the State must submit an assurance that its rate of increase or inflation in inpatient hospital payments does not exceed, for that portion of the 36-month period that is subject to this test, the national rate of increase or inflation in Medicare inpatient hospital payments. The election of the rate of increase test applies only to the three cost reporting periods beginning on or after October 1, 1983. At the end of these cost reporting periods, the State must assure, beginning with the first month after the expiration of the third cost reporting period beginning after October 1, 1983, that payments under its system will not exceed over the remainder of the 36-month period what Medicare payments would have been.

(2) Estimates and data are required to support the State's assurance, required under § 403.304(c)(3), that expenditures under the State system will not exceed what Medicare would have paid over a 36-month period. The estimates and projections of what Medicare would have otherwise paid must take into account all the Medicare reimbursement principles in effect at the time and, for any period in which payments either exceed or are less than Medicare levels, the value of interest the Medicare Trust Fund earned, or would have earned, on these amounts. Upon application for approval, the State must submit projections for each hospital for the first 12-month period covered by the assurance, in both the aggregate and on a per discharge basis, of Medicare inpatient expenditures under Medicare principles of reimbursement and parallel projections of Medicare inpatient expenditures under the State's system and the resulting cost or savings to Medicare. The State must also submit separate statewide projections for each year of the 36-month period, in both the aggregate and on a weighted average discharge basis, of inpatient expenditures under the State system and under the Medicare principles of reimbursement.

(3) The projection submitted under paragraph (b)(2) of this section must include a detailed description of the methodology and assumptions used to derive the expenditure amounts under both systems. In instances where the assumptions are different under the projections cited in paragraph (b)(2)(of this section, the State must provide a detailed explanation of the reasons for the differences. At a minimum, the following separate data and assumptions are to be included in the projections for the Medicare principles and for the State's system.

(i) The base and the Medicare allowable and reimbursable cost of each hospital that the State used to develop the projections, including the amount of estimated pass through costs.

(ii) The categories of costs that are included in the States system and are reimbursed differently under the State system than under the Medicare system.

(iii) The number of Medicare and total base year discharges and admissions for each hospital.

(iv) The rate of change factor (and the method of application of this factor) used to project the base year costs over the 36-month period to which the assurance would apply.

(v) Any allowance for anticipated growth in the amount of services from the base year (if applicable, the allowance must be presented in separate estimates for population increases or for increases in rates of admissions or both).

(vi) Any adjustment in which the State is permitted by HCFA to take into account previous reductions in the Medicare payment amounts that were the result of the effectiveness of the State's system even though Medicare was not a part of that system.

(vii) States applying under a rate of increase effectiveness test under § 403.304(c)(3) must also submit data projecting the parallel rates of increase during the requisite period.

(4) the projection must include both the aggregate payments and the payments per discharge for the individual hospitals and for the State as a whole.

(5) On a case by case basis, HCFA may require additional data and documentation as needed to complete its review and monitoring.

(6) For existing Medicare demonstration projects in effect on April 20, 1983, the assurance and data as required by paragraphs (a) and (b) of this section, if appropriate, may be based on aggregate payments or payments per inpatient admission or discharge. HCFA will judge the effectiveness of these systems on the basis of the rate of increase or inflation in Medicare inpatient hospital payments compared to the national rate of increase or inflation for such payments during the State's hospitals' three cost reporting periods beginning on or after October 1, 1983. The data submitted by the State for the period subject to the rate of increase test must include the rate of increase projection for that particular period of time. For the subsequent period of time, the State must assure that payments under its system will not exceed what Medicare

payments would have been, as described in § 403.304(c)(3).

(7) If the amount of Medicare payments under the State system exceeds what would have been paid under the Medicare reimbursement principles in any given year, the State must also submit quantitative evidence that the system will result in expenditures that do not exceed what Medicare expenditures would have been over the 36 month period beginning with the first month that the State system is operating. For a State that has an existing demonstration project in effect on April 20, 1983 and that elects under § 403.304(c)(3) to have a rate of increase test apply, if the State's rate of increase or inflation exceeds the national rate of increase or inflation in a given year, the State must submit quantitative evidence that, over 36 months, its payments will not exceed the national rate of increase or inflation. Furthermore, if payments under the State's system must be compared to actual Medicare expenditures, at the end of the third cost reporting period, as described in paragraph (b)(1) of this section, and payments under the State's system exceed what Medicare would have paid in a given year, the State must submit quantitative evidence that, over 36 months, payments under its system will not exceed what Medicare would have paid.

(c) *Hospital Outpatient Services.* HCFA may approve a State's application to have the State's system apply to Medicare outpatient services if the following conditions are met:

(1) The State's inpatient system is approved.

(2) The State's outpatient application meets the requirements of § 403.304 (b) and (c), and § 403.306 (b)(1) and (b)(2)(ii).

(3) The State submits a separate application that provides separate assurances and estimates and data in further support of its assurance submitted under paragraph (b)(1) of this section, as follows:

(i) Upon application for approval, the State must submit estimates and data that include, but are not limited to, projections for the first 12-month period covered by the assurance for each hospital, in both the aggregate and on an average cost per service and payment basis, of Medicare outpatient expenditures under Medicare principles of reimbursement; parallel projections of Medicare outpatient expenditures under the State's reimbursement control system; and the resulting cost or savings to Medicare independent of the reimbursement system for hospital inpatient services.

(ii) The State must submit separate statewide projections for each year of the 36-month period of the aggregate outpatient expenditures for each system. The projections submitted under this paragraph must—

(A) Comply with the requirements of paragraphs (b) (3) and (5) of this section regarding a detailed description of the methodology used to derive the expenditure amounts;

(B) Include the data and assumptions set forth in paragraphs (b)(3) (i), (ii), (iii), (iv), and (v) of this section; and

(C) Include any assumption the State has adopted for establishing the number of Medicare and total base year outpatient services for each hospital.

(iii) The State must provide a detailed explanation of the reasons for any difference between the data or assumptions used for the separate projections.

(d) *Review of assurances regarding expenditures.* HCFA will review the State's assurances and data submitted under this section, as a prerequisite to the approval of the State's system. HCFA will compare the State's projections of payment amounts to HCFA data in order to determine if the State's assurance is reasonable and fully supportable. If the HCFA data indicate that the State's system would result in payment amounts that would be more than that which would have been paid under the Medicare principles, the State's assurances would not be acceptable. For States applying in accordance with § 403.308, if HCFA data indicate that the State's system would result in a rate of increase or inflation that would be more than the national rate of increase or inflation, the State's assurances would not be acceptable.

(e) *Medicaid upper limit.* In accordance with § 447.253 of this chapter, the State system may not result in aggregate payments for Medicaid inpatient hospital services that would exceed the amount that would have otherwise have been paid under the Medicare principles.

(f) *Monitoring of Medicare expenditures.* HCFA will monitor on a quarterly basis expenditures under the State's system as compared to what Medicare expenditures would have been if the system had not been in effect. If HCFA determines at any time that the payments made under the State's system exceed the State's projections, as established by the satisfactory assurances required under § 403.304.(c) and, if appropriate, the predetermined percentage relationship of the payments as required under § 403.304(d), HCFA will—

(1) Conclude that payments under State's system over a 36-month period will exceed what Medicare would have paid;

(2) Terminate the waiver; and

(3) Recoup overpayments to the affected hospitals in accordance with the procedures described in § 403.310.

§ 403.322 Termination of agreements for Medicare recognition of State reimbursement control systems.

(a) *Termination of agreements.* (1) HCFA may terminate any approved agreement if it finds, after the procedures described in this paragraph are followed, that the State system does not satisfactorily meet the requirements of section 1886(c) of the Act or the regulations in this subpart. A termination must be effective on the last day of a calendar quarter.

(2) HCFA will give the State reasonable notice of the proposed termination of an agreement and of the reasons for the termination at least 90 days before the effective date of the termination.

(3) HCFA will give the State the opportunity to present evidence to refute the finding.

(4) HCFA will issue a final notice of termination upon a final review and determination on the State's evidence.

(b) *Termination by State.* A State may voluntarily terminate a Medicare reimbursement control system by giving HCFA notice of its intent to terminate. A termination must be effective on the last day of a calendar quarter. The State must notify HCFA of its intent to terminate at least 90 days before the effective date of the termination.

(Catalog of Domestic Assistance Program No. 13.773 Medicare—Hospital Insurance)

Dated: December 23, 1983.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: August 21, 1984.

Margaret M. Heckler,

Secretary.

[FR Doc. 85-11502 Filed 5-10-85; 8:45 am]

BILLING CODE 4120-01-M

federal register

Monday
May 13, 1985

Part IV

Office of Personnel Management

5 CFR Part 831

Retirement; Interim Rule With Request for Comments

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 831

Retirement; Interim Rule with Request for Comments

AGENCY: Office of Personnel Management.

ACTION: Interim rule with request for comments.

SUMMARY: The Office of Personnel Management is issuing interim rules and requesting comment on the rules to implement the Civil Service Retirement Spouse Equity Act of 1984. The interim rules also incorporate current regulations concerning the subjects covered by the Act, specifically civil service retirement survivor annuities, court orders affecting civil service retirement benefits, and lump-sum payments under the civil service retirement system.

DATE: Interm rules effective May 7, 1985; comments must be received on or before July 12, 1985.

ADDRESS: Send comments to Jean M. Barber, Assistant Director for Pay and Benefits Policy, Compensation Group, P.O. Box 57, Washington, D.C. 20044, or deliver to OPM, Room 4351, 1900 E. Street, NW., Wash., D.C.

FOR FURTHER INFORMATION CONTACT: Harold L. Siegelman, (202) 632–4684, on provisions relating to survivor annuities and court orders affecting retirement benefits. Contract Francis J. Derby, (202) 632–4634, on provisions relating to lump-sum payments.

SUPPLEMENTARY INFORMATION: The Civil Service Retirement Spouse Equity Act (CSRSEA) of 1984, Pub. L. 98–615, amended the Civil Service Retirement Act (1) to require a joint waiver by annuitant and spouse of survivor benefits at the time of retirement; (2) to require that we recognize court orders granting survivor benefits to former spouses of Federal employees and retirees; (3) to require notice before payment of lump-sum refunds of contributions to the Civil Service Retirement System be given to some current spouses and former spouses entitled to survivor benefits, or a portion or an annuity, or a portion of the refund; (4) to provide that Federal retirees may elect survivor annuity for former spouses; (5) to provide that certain Federal retirees who were previously denied the option of providing survivor benefits to their current spouses will be permitted to provide such benefits; and (6) to provide survivor benefits payments to certain former spouses of Federal retirees who were divorced prior to the effective date of this legislation.

CSRSEA generally does not apply in the case of retirements or divorces before its effective date (May 7, 1985). However, under CSRSEA, some former spouses of annuitants who retire or died before the effective date of the Act will be eligible for a survivor benefit, which will not affect the annuity of the retired employee or Member. To qualify, the former spouse *must*: (1) Have been divorced after September 14, 1978; (2) not have remarried before age 55; (3) have been married to the annuitant during 10 years of creditable service; (4) be age 50 or older; (5) not be entitled to any other pension (other than benefits under title II of the Social Security Act or section 8345(j) of title 5, United States Code); and (6) apply for the benefit before May 9, 1987.

The interim regulations implementing CSRSEA apply primarily to persons who die in service on or after May 7, 1985, or retire on or after that date. Unless otherwise specified in the interim regulations only §§ 831.609 through 831.611, 831.615, 831.616, 831.619 through 831.624, and 831.627 and the portions of Subpart Q concerning court orders affecting employee retirement benefits apply to persons retired before May 7, 1985.

1. Consolidation of Existing Regulation

The current subpart F is entitled "Types of Annuities." The interim regulations consist of a new Subpart F, entitled "Survivor Annuities," which consolidates the current Subpart F, portions of Subpart J that regulate survivor annuities, and new regulations necessitated by the portions of CSRSEA that control entitlement to survivor annuities (without court orders).

The current Subpart J is entitled "Death Benefits." It has information about survivor annuities that belongs with Subpart F and information about lump-sum death benefits that belongs in Subpart T. This new format eliminates Subpart J by consolidating its provisions into Subparts F and T.

The current subpart Q is entitled "Apportionment From Civil Service Retirement Benefits." It implemented Pub. L. 95–366 (Sept. 15, 1978), which requires us to comply with certain State court orders which divide civil service retirement benefits payable to the former Federal employee during his or her lifetime. We are issuing a new Subpart Q, entitled "Court Orders Affecting Civil Service Retirement Benefits," which amends the current Subpart Q to incorporate the changes in handling State court orders on refunds and survivor annuities required by CSRSEA.

The current Subpart T is entitled "Payment of Lump Sums." It regulates payment of lump-sum benefits under the Civil Service Retirement System. The interim rules consolidate the current Subpart T, portions of Subpart J that cover lump-sum payments, and the changes required by CSRSEA into a revised Subpart T that retains its current title.

2. Survivor Annuities

The Terms "fully reduced annuity," "insurable interest annuity," "partially reduced annuity," and "self-only annuity" are used to describe benefits that are payable to former employees and Members. "Current spouse annuities" and "former spouse annuities" are defined as payable to survivors of former employees and Members. The definition of "marriage," although never before promulgated in our regulations, has been used by us in our adjudications relative to survivor benefits since 1979.

"Time of retirement" is defined as the date when a retiree's annuity commences. We considered using the date of separation from the Federal service as the time of retirement. However, employees can separate with title to a deferred annuity many years before they are eligible to begin receiving payments. Using the date of application would cause administrative difficulties because people can file applications before or long after becoming eligible for benefits.

Section 831.604(b) of the interim regulations applies to cases when a former spouse by a court decree has preempted the current spouse annuity under section 8341 of title 5, United States Code. Under these regulations: (1) A qualifying court order that awards a former spouse annuity will require an appropriate reduction in the retiree's annuity (regardless of any election to provide a current spouse annuity); (2) the retiree must make an election regarding the current spouse's survivor annuity at the time of retirement (even though that annuity has been wholly or partially preempted by a court-ordered former spouse annuity); (3) the current spouse's consent must be given (or waived) to permit a retiree to elect less than a fully reduced annuity to provide a current spouse annuity; (4) in the event of the retiree's death, payment of the current spouse annuity will be wholly or partially prevented as long as the former spouse remains eligible for a former spouse annuity.

The reduction in annuity to provide a current spouse annuity under § 831.604 terminates in accordance with the new section 8339(j)(5) of title 5, United States Code. The conditions under which the reduction is terminated are consistent with those provided under the prior section 8339(j)(1) of title 5, United States Code. Generally, the reduction will terminate upon the death of a current spouse for whose benefit the reduction was made or upon dissolution of the marriage to that spouse. Even if the latter condition is met, a reduction will not be terminated when that spouse has acquired entitlement (in the dissolution decree or by election under § 831.612) to a survivor benefit as a former spouse under the new section 8339(j)(5)(A) of title 5, United States Code.

Section 831.605 implements the new sections 8339(j)(3) and (5) of title 5, United States Code, which permits an employee or Member to elect to provide a survivor annuity for a former spouse or spouses at the time of retirement.

Section 831.606 regulates insurable interest annuities under the amended section 8339(k)(1) of title 5, United States Code. Under prior law, only an employee or Member who was unmarried at the time of retirement could make an election to provide an annuity for an individual who had an insurable interest in the employee or Member. Section 8339(k)(1), as amended by CSRSEA, extends this election to married individuals as well.

Section 831.606(a) restates the requirement of section 8339(k)(1) that only a person in good health and retiring on an immediate annuity under section 8336 of title 5, United States Code, or a deferred annuity under section 8338 of title 5, United States Code, is eligible to elect an insurable interest annuity. Persons retiring on disability annuities under section 8337 of title 5, United States Code, are excluded by statute.

Section 831.606(e) promulgates as a regulation our long-standing internal guidelines concerning the degree of relationship that would automatically constitute an insurable interest. Section 831.606(e) also permits us to require documentation of the beneficiary's age that is necessary to compute the rate of reduction.

Because of the large reduction frequently required (up to 40% of the self-only annuity) to elect an insurable interest election, our policy has been to require a written confirmation of election after the retiree has been informed by us of the amount of the reduction. Section 831.606(f) requires that confirmation in all such cases.

Within 2 years after the death or remarriage before age 55 of the former spouse for whom a retiree is providing a former spouse annuity, § 831.606(h) permits a retiree to end an insurable interest reduction elected to provide for a current spouse in order to elect a reduced annuity to provide a current spouse annuity. The conversion will provide a survivor annuity at a lower cost to the retiree than maintaining the insurable interest annuity. However, if the retiree elects to convert, he or she may not thereafter reinstitute the insurable interest annuity to provide for someone else. After conversion of the insurable interest annuity, the aggregate of all survivor annuities cannot exceed 55 percent of the retiree's annuity.

Section 831.606(i) provides that a similar election is not permitted in the reverse situation. Although revised section 8339(j)(5)(B) of title 5, United States Code, authorizes continuation of an annuity reduction to provide a former spouse annuity (after the death or remarriage of the former spouse) for the purpose of providing a current spouse annuity, nothing in CSRSEA authorizes a corresponding continuation to benefit a former spouse after the death of a current spouse.

Section 831.606(j) is the old § 831.601(b).

Section 831.607 implements the spousal consent requirement discussed in connection with § 831.604. Section 831.607(c) imposes a notarization requirement to discourage forged or coerced consent.

Section 831.608 presents the requirements for waiver of spousal consent. Section 2 of CSRSEA requires that we provide that a married employee may elect a self-only or a partially reduced annuity without the spouse's consent only when the spouse's whereabouts are unknown to the employee or, "due to exceptional circumstances" it would be "inappropriate" to require the employee to seek the spouse's consent. We are requiring in § 831.608(a) proof that the employee does not know the spouse's whereabouts before waiver can be granted on that ground. Waiver for exceptional circumstances (e.g., the spouse is suffering from diminished mental capacity, the spouse and the employee have been maintaining separate residences with no financial relationship for several years, the spouse abandoned the employee but, for religious or other reasons, the parties choose not to divorce) are permitted by § 831.608(b). However, before a waiver for exceptional circumstances is allowed, the regulations require documentation from a judicial body that substantiates the request for waiver. This procedure is necessary to guarantee that the current spouse receives due process before he or she loses the right to a survivor annuity without his or her consent.

Section 831.609 restates the rule of the old § 831.601(d), which permits a change of election until we complete the adjudication of the employee's or Member's retirement application. The standard for determining when we have completed adjudication is defined as 30 days after the date of the first regular monthly payment. This standard avoids the inconsistencies inherent in any standard that is controlled by a retiree's action, rather than our action. Under this rule, a retiree will have a reasonable period of time to change the survivor election after OPM has notified the retiree of the effect of the election by means of the annuity statement showing the adjudicated rate of the retiree's annuity as well as the survivor's rate.

Section 831.611 restates the old § 831.601(e).

Section 831.612 (a) and (b) implement the new section 8339(j)(3) of title 5, United States Code, which permits a retired employee or Member to elect to provide a survivor annuity for a former spouse within 2 years after the dissolution of the marriage to that former spouse. Section 831.612(c) implements the deposit requirement of section 8339(j)(3) of title 5, United States Code. Section 831.612(d) implements the new section 8339(j)(5) of title 5, United States Code, that provides for termination of the annuity reduction.

Section 831.613 concerns "post-retirement" elections of survivor benefits for spouses acquired after retirement. Under the pre-CSRSEA law that continues to apply to annuitants who are retired before May 7, 1985, a married employee who elects to provide a survivor benefit at the time of retirement and an employee who is unmarried at the time of retirement may elect to provide a survivor annuity to a new spouse acquired after retirement. In such a case, the retiree had to make the "post-retirement" election within 1 year after the new marriage, and an annuity reduction is continued (or in the case of an employee who was unmarried at the time of retirement is commenced) upon the making of the election. Except as provided in section 4(c) of CSRSEA (implemented in § 831.623), an employee retired before May 7, 1985, married at the time of retirement who did not elect to provide a survivor benefit at retirement may not elect a survivor benefit in the event of a subsequent marriage during retirement. Also, in the event of a marriage during a retirement that commenced before May 7, 1985, the

marriage must have lasted for at least 1 year before a survivor benefit election may be effective.

Section 831.613(a) sets the requirements for post-retirement elections for pre-CSRSEA retirees. Section 4 of CSRSEA provides that the retirement amendments made by section 2 will take effect May 7, 1985, and will apply to any individual who, on or after that date, is married to an employee who retires, dies, or applies for a lump-sum refund of contributions after that date. In other words, CSRSEA generally does not apply to persons retired before May 7, 1985. Accordingly, the prior law and regulations continue to apply to annuitants retired before May 7, 1985, for most purposes.

The 1-year time limit in § 831.613(a) (but not the requirement of an election before the retiree's death) can be waived when the retiree was not notified of the time limit in accordance with Pub. L. 95–317 and he or she exercised due diligence in seeking an annuity reduction to provide a current spouse annuity. This waiver is based on the Merit Systems Protection Board's decision in the case of *Davies* v. *Office of Personnel Management*, 5 MSPB 251 (1981).

Section 831.613(b) implements the CSRSEA provisions on post-retirement survivor elections. New subsections (j)(5)(C) and (k)(2) of section 8339 of title 5, United States Code, contain several changes, which apply to employees and Members who retire on or after May 7, 1985, or die in service on or after that date. First, the length of marriage requirement for eligibility for survivor annuity is reduced from 1 year to 9 months. Second, an employee married at the time of retirement who did not elect survivor benefits will be permitted to make such an election after a post-retirement marriage (provided that the marriage is not to the same spouse to whom the employee was married at retirement). The time limit for making the election is extended from 1 year following the remarriage or marriage, as the case may be, to 2 years.

Section 831.614 (a) and (b) state the general policy of CSRSEA that the total amount of survivor annuity benefits available will not be greater than under existing law. Generally, spousal survivor benefits attributable to the service of an employee or Member may not exceed 55 percent of that employee's or Member's annuity. The CSRSEA continues this policy but does permit this 55 percent to be divided between any former spouses and a current spouse and permits election of an additional insurable interest annuity in some cases.

Sections 831.615 and 831.616 are derived directly from current §§ 831.601(g), 831.1005, and 831.1006 without substantive change.

Section 831.617 on the rate of children's annuities result from the definitions of "former spouse" and "child" in section 8331 and 8341 of title 5, United States Code.

Section 831.618 states the marriage duration requirements before a survivor annuity right attaches based on a death of an annuitant who retired on or after May 7, 1985, or an employee or Member who died while employed in a position under CSRS on or after that date. Section 8341(a) of title 5, United States Code, as amended, provides that a spouse must be married to an employee, Member, or annuitant for only the 9 months immediately preceding death or be the parent of a child of that marriage to be eligible for a survivor annuity. Prior law (which continues to apply to annuitants who retired before May 7, 1985) required 1 year of marriage or a child born of that marriage. New section 8341(i) of title 5, United States Code, provides that the requirement that a surviving spouse of an employee or Member must have been married to an employee or Member for at least 9 months immediately before death should be deemed to be satisfied in any case in which the death was accidental or in which the surviving spouse previously had been married to the individual and the aggregate time married is at least 9 months. These statutory changes are reflected in § 831.618 (a) through (c).

Section 831.618(c) also adopts the reasoning of the recent decision of the Merit Systems Protection Board in *Smith* v. *Office of Personnel Management*, No. AT0831841098, November 15, 1984. In that case, the Board determined that children born out of wedlock who were later legitimated by a marriage of their parents were children of the legitimating marriage for purposes of section 8341(a) of title 5, United States Code. The regulation extends this rule to legitimate children by prior marriages between the same parties. This accomplishes two objectives: (1) It prevents a parent of an illegitimate child from being more favorably treated simply because the child was born out of wedlock and (2) it furthers the policy of CSRSEA by treating children born of the marriage in the same manner as CSRSEA treated the length of the marriage, namely, by considering all time when the current spouse and the employee were married to determine whether the duration requirement has been met.

Section 831.618(d)(1) defines "accidental" for this purpose. All homicides are considered accidental. The definition applicable to non-homicide cases was taken from the accidental death provision of the Federal Employees' Group Life Insurance Program except that death resulting from acts of war are not excluded from the § 831.618(d)(1) definition.

Section 831.618(d)(2) provides that we will accept certain State determinations of the cause of death. Judicial determinations such as the finding, in insurance litigation, that double indemnity is payable or, in a criminal case, that the death was a homicide are typical examples. An administrative finding from a coroner's inquest or similar proceeding is included. Lesser weight will be given to statements on the death certificate. However, without other evidence, the statement on the death certificate will be accepted as proof that the death was accidental.

Section 831.619(a) restates the general rule of the old § 831.1001. Section 831.620 restates the old § 831.1002.

Section 831.621 concerns the voluntary election to provide a former spouse annuity under section 4(b) of CSRSEA. Section 4(b) provides that a former spouse of an annuitant who retired before May 7, 1985, is entitled to a survivor annuity if the annuitant elects in writing before May 9, 1986, to have his or her annuity fully reduced and to deposit in the Civil Service Retirement and Disability Fund an amount reflecting the difference between the rate of a self-only annuity and the amount that he or she would have received if a reduction for the survivor annuity had been in effect since the annuity commenced. If a retired employee makes an election under section 4(b) but does not make the required deposit, we will collect the amount of the deposit by offset against the retiree's annuity up to a maximum of 25 percent of the net annuity payable to the employee.

Former spouses who meet the requirements set forth in § 831.622 will receive 55 percent of the annuity of the retired employee plus cost-of-living adjustments after the death of the retiree. If a retired employee has more than one former spouse who falls within the class of former spouses qualifying under § 831.622, each qualifying former spouse will receive the full survivor annuity.

Paragraph (a)(1) implements the statutory requirement that the marriage must have been dissolved after September 14, 1978, the effective date of Pub. L. 95–366. Pub. L. 95–366 authorized us to comply with certain State court

orders dividing civil service retirement benefits.

Paragraph (a)(3) implements the statutory requirement that the former spouse must not be entitled to any other employer-provided retirement or survivor annuity. Social security benefits under title 42, United States Code, and court awarded benefits under section 8345(j) of title 5, United States Code, are specifically excluded by CSRSEA. In view of the unambiguous language of the statute, receipt of any other employer-provided retirement or survivor annuity, regardless how small, will disqualify a former spouse from receiving an annuity under this section—notwithstanding remarks during the Senate's consideration of CSRSEA that only "substantial" employer-provided benefits should disqualify a former spouse from receiving a section 4(b) annuity. We believe that the statutory language and the legislative history as a whole, including our consultations during the drafting of this legislation, support this interpretation.

Paragraph (b)(1) relates to the application requirement for the above former spouses. We will accept correspondence as an informal application for meeting the timeliness requirements. Any informal application must be followed by an application on the appropriate form.

We require documentary proof that the requirements regarding date of application are met, but accept the former spouse's certification on the application as proof that the other requirements are met.

Section 831.623 implements section 4(c) of CSRSEA that provides that a retireee who retired before May 7, 1985, and who is married to a spouse acquired after retirement for whom the retiree was unable to provide a survivor annuity may provide a survivor annuity to the spouse if (1) the retiree was married at the time of retirement and elected not to provide a survivor annuity; or (2) the retiree notified us of the post-retirement marriage more than 1 year after the marriage and we disallowed the attempt to elect a reduced annuity because it was untimely. Under these circumstances, the retiree may elect in writing, within 1 year after the date of enactment, to provide for a survivor annuity for the current spouse. The retiree must deposit in the Civil Service Retirement and Disability Fund an amount reflecting the difference between what the retiree had received and what would have been received if the election had been in effect since the retiree's annuity commenced. If the retired employee does not make such a deposit, we will collect the amount by offset against the retiree's annuity up to 25 percent of the net annuity. The retiree may change his or her decision to make an election under § 831.623 until 30 days after the date of the first payment at the reduced annuity rate.

Section 831.624 regulates the collection of the deposits (including interest) required in making post-retirement elections under §§ 831.612, 831.613, 831.621, or 831.623. These payments are not subject to the procedures for the collection of annuity overpayments under subpart M because the retiree is deemed to consent to the collection. Reconsideration rights under § 831.109 are available to review whether the amount of the deposit has been correctly calculated.

Section 831.624(d) permits the spouse to complete the deposit if the retiree dies before making the entire deposit. Since the deposit is a prerequisite to payment of a survivor annuity, the deposit must be fully paid before the survivor annuity can be paid.

Section 831.625 regulates current and former spouse annuities in the event of remarriage by the recipient (except for former spouses entitled to survivor annuities under §§ 831.621 or 831.622). Whether age 55 or age 60 is the standard for terminating the annuity based on remarriage is determined by the date of the annuitant's retirement or the employee's or Member's death while serving in a position covered by CSRS, not the date of the remarriage. If the annuitant retired before May 7, 1985, or the employee or Member died in service before that date, the old law (age 60) continues to apply. If the annuitant retires on or after May 7, 1985, or the employee or Member dies in service on or after that date, the CSRSEA rule (age 55) controls. This is based on section 4(a) of CSRSEA that states that the retirement amendments to title 5, United States Code, apply only when the former employee or Member retires, dies in service, or requests a refund after May 7, 1985.

Since no statutory provision permits reinstatement of former spouse annuities, paragraph (d) provides that remarriage permanently extinguishes them. The solemnization of the remarriage is the event terminating the former spouse's entitlement. Accordingly, even if the remarriage is later annulled the entitlement is not reinstated. This rule is necessary for essentially the same policy reasons cited by the Missouri Court of Appeals when finding that alimony should not be reinstated following annulment of a remarriage. In *Glass* v. *Glass*, 546 S.W.2d 738 (Mo. App. 1977), the court supported its decision on the following policy considerations:

> (1) A former husband is entitled to rely on the remarriage ceremony of the former wife to recommit assets previously used for alimony obligations to her. (2) Unless the remarriage ceremony is taken as conclusive, any latent grounds for annulment between the remarried spouse and her new husband may remain suspended until the offended spouse seeks annulment, so that the former husband's alimony obligations may never be certainly determined. (3) Even though both former spouses may be innocent, the more active of the two [the one whose remarriage is later annulled] should bear the loss from the misconduct of a stranger. (At 741.)

Similar policy considerations apply in the context of the former spouse's annuity entitlements. First, the retiree is entitled to rely on the remarriage ceremony to provide a current spouse annuity for a subsequent spouse. Second, unless the remarriage is taken as conclusive, any latent grounds for annulment could prevent a current spouse's entitlement from becoming certain. Third, the spouse whose marriage is annulled should bear the loss rather than the spouse with no involvement whatsoever.

Section 831.626 continues our present procedure of requiring retirees who gain new title to an annuity to make all elections required upon retirement, when they apply to retire under the new annuity right. The elections under this section are made in accordance with the law at the time of the latest retirement.

Section 831.627 states the annual notice requirement of the Civil Service Retirement Act Amendment of July 10, 1978, Pub. L. 95–317, 92 Stat. 382. Section 3 of Pub. L. 95–317 requires that we, "* * * on an annual basis, inform each retiree of such retiree's right of election under sections 8339(j) and 8339(k)(2) of title 5, United States Code." This provision does not appear in the United States Code.

Based on the reasoning of a Merit Systems Protection Board regional office decision, we determined that giving notice each calendar year was inadequate and that notice must be given at least every 12 months. Furthermore, the Merit Systems Protection Board determined in *Davies* v. *OPM*, 5 MSPB 251 (1981) (discussed in connection with § 831.613) that the time limit for making an election could be waived if the retiree did not receive the annual notice and acted with due diligence in making the election.

3. Court Orders Affecting Civil Service Retirement Benefits

State laws and State courts have traditionally controlled matters of domestic relations and property rights. Questions such as an individual's obligations to a former spouse are determined by the courts on a case-by-case basis taking into consideration many factors, such as the financial status of both parties, property settlements, children involved, etc.

As a result of the enactment of Pub. L. 93–647, which added section 459 to the Social Security Act (42 U.S.C. 659), since 1975, civil service retirement benefits have been subject to garnishment, attachment, or similar legal process to enforce support obligations.

In recent years, many State courts have ruled that future retirement benefits earned during a marriage should be considered marital property and subject to division in the event of a legal separation, divorce, or annulment of marriage. The Social Security Act garnishment amendments did not cover property settlements.

Pub. L. 95–366, effective September 15, 1978, required us to pay a portion of an annuity to someone other than the retiree to the extent expressly provided for in the terms of any court decree of divorce, annulment, or legal separation, or the terms of any court order or court-approved property settlement agreement incident to any court decree of divorce, annulment, or legal separation. Final rules implementing Pub. L. 95–366 were published in the **Federal Register** on March 7, 1980 (45 FR 14835). However, survivor benefits still could not be affected by court orders.

Now, under CSRSEA, State courts are permitted to award former spouse annuities to assure former spouses of their property rights regardless of whether the employee spouse survives. Awarding former spouse annuities could also be used to assure continuing support payments to a former spouse.

The revised Subpart Q incorporates this new type of benefit available by court order into the framework established for handling court orders dividing employee retirement benefits under section 8345(j) of title 5, United States Code.

The general rule of section 8346(a) of title 5, United States Code, is that State court orders have no effect on civil service retirement benefits. Subpart Q contains procedures for the exceptional cases when section 8346(a) does not apply.

Nothing in this subpart or anywhere else authorizes the United States, the Office of Personnel Management, or the Civil Service Retirement System to be made a party to divorce proceedings. The sovereign inmunity of the United States bars the attempted joinder.

Our experience has shown that joinders are sought for three reasons:

(1) To obtain information about an individual's contributions to the retirement system;

(2) To divide the retirement benefits; and

(3) To stay payment of benefits.

Under Federal laws and regulations, these ends can be attained despite the court's lack of jurisdiction over the Civil Service Retirement System.

We will release information from retirement records to a court in response to a subpoena. The proper place to submit the subpoena is determined by whether the person has been separated from the Federal service. If the individual about whom the information is sought is not a current Federal employee, the subpoena should be addressed to the Civil Service Retirement System at the Office of Personnel Management.

If the individual is still an active Federal employee, and all of his or her Federal service has been continuous and with the same agency, the records should be with the payroll office of that agency. Service must be made upon the agency in which the individual is employed.

If the individual is currently a Federal employee but has had a break in service or has worked for more than one agency, some of the records will be on file with us while others will still be with the employing agency. In this situation, process must be served on both.

It takes approximately 30 days to respond to a subpoena. Submissions must include the employee's (or former employee's) full name, date of birth and/or social security number or we will not be able to locate the record.

Section 8345(j) of title 5, United States Code, instructs us to divide civil service retirement benefits in accordance with State court orders. The required contents of the court order are set out in § 831.1704 of the the interim regulations. Our guidelines for interpreting language frequently used in orders dividing benefits is an appendix to subpart Q of the interim rules. An application to apportion benefits requires approximately 30 days processing time after receipt.

Finally, court orders may be necessary to maintain the status quo during the time the suit is pending. The way to accomplish this is to obtain an order directing us to pay some or all of the benefits that may become due to the court. Such an order should be served upon the Associate Director for Compensation.

We cannot pay any money into the court before it would be payable to the employee or retiree. Employee contributions in the retirement fund are not payable in a lump sum to an employee until he or she separates from the Federal service and submits an application for refund.

The definition of "employee retirement benefits" was taken from the definition of "retirement benefits" in the old § 831.1702. These are the benefits that were subject to court orders under Pub. L. 95–366 because they are payable to the person who performed the Federal service on which they are based.

The definition of "former spouse" contains two usages for the term. In connection with divisions of employee retirement benefits under section 8345(j) of title 5, United States Code, "former spouse" has the same meaning that it had under the old § 831.1703. In connection with awards of survivor annuities under section 8339(h) of title 5, United States Code, "former spouse" has the meaning given to it in section 8331(23) of title 5, United States Code.

The definition of "gross annuity" is taken from the Guidelines for Interpreting State Court Orders Dividing Civil Service Retirement Benefits (49 FR 26746, June 29, 1984, corrected by 49 FR 27647, July 5, 1984).

The definition of "net annuity" is derived directly from the old § 831.1705(a).

Section 831.1704(b) is a restatement of the old § 831.1703(c). It was rewritten to eliminate the confusion and clarify our original intent to exclude orders requiring us to compute the value of a variable about which we have no knowledge.

Section 831.1704(c)(1) rephrases the rule of the old § 831.1703(b) for clarity. The language is taken from Guidelines for Interpreting State Court Orders Dividing Civil Service Retirement Benefits (49 FR 26746, June 29, 1984, corrected by 49 FR 27647, July 5, 1984). The interpretation of Pub. L. 95–366 expressed in the old § 831.1703(b) has been upheld by the United States Court of Appeals in *McDannell* v. *Office of Personnel Management*, 716 F.2d 1063 (5th Cir. 1983).

Section 831.1704(c)(2) states a broader rule for honoring orders awarding former spouse annuities. No legitimate purpose could be served by denying effect to an order directing the retiree to provide a former spouse annuity.

Section 831.1705 contains the application requirements for all persons

seeking compliance with qualifying court orders. Section 831.1705(a) allows the application to be made in any writing. We recommend use of a letter. A special form is required only when payments must terminate upon remarriage.

Section 831.1705(b) contains the documentation requirements that must accompany the application. Previously we required that the certification of the court order be "recent." This requirement failed to serve any useful purpose. Accordingly, future applications will require only a proper certification; we are no longer requiring that the certification be "recent."

The quantity of identifying information required under § 831.1705(b)(3) varies with the type of civil service retirement benefit to be affected. Current retirees can be identified with only the name and claim number, date of birth, or social security number. The date of birth is essential in all other types of cases. Without the date of birth, we cannot effectively identify future incoming records.

The certification requirement of § 831.1705(c) applies to former spouse annuities of persons who have not attained age 55, and court orders affecting employee retirement benefits that terminate on remarriage. An example of the latter type order would be an alimony award to be paid from a civil service annuity.

Section 831.1706(a) and (b) are the old § 831.1705(b).

Section 831.1706(c) states the maximum amount available to comply with court orders. The limitations of the Federal Consumer Credit Protection Act (15 U.S.C. 1673(b)(2)) do not apply to court orders under this subpart.

Section 831.1707 states the preliminary review procedure of the old § 831.1706. Upon receipt of an order, we will check to see whether immediate action is necessary because either benefits are immediately payable or an immediate reduction in annuity is necessary to provide a former spouse annuity. If neither of the conditions is met, § 831.1707(a)(1) provides that we will acknowledge receipt of the court order and file the order for future consideration. Only after one of those conditions has been met will the order be reviewed.

Section 831.1707(b) provides that if, as a result of the preliminary review, the initial determination is that the order could be a qualifying court order, all interested parties will be given the notices provided in § 831.1708. On the other hand, if the initial determination is that the order does not qualify, § 831.1707(c) requires that the former spouse be given an explanation of the reasons that the order fails to qualify and a notice of his or her administrative review right. The former employee or Member will be notified that we have received a court order even when, as a result of the preliminary review, we determine that we will not honor the order.

Section 831.1709 retains the decision procedure from the old § 831.1708. The former spouse's claims will be disallowed only if the court order does not meet the requirements of § 831.1704 or a court determines that it should not be honored. Anyone adversely affected by a decision under § 831.1709 may request reconsideration under § 831.109. Section 831.109(g) prohibits us from implementing decisions under § 831.1709 until the administrative review process is completed.

Section 831.1711 states the timing requirement applicable to court orders. Section 831.1711(a)(1) states the rule under section 8345(j) of title 5, United States Code, that orders affecting employee retirement benefits can be honored regardless of when the orders were issued. On the other hand, § 831.1711(b)(1) states the rule under CSRSEA that orders creating a former spouse annuity are effective only if the marriage to the employee or Member was in force on or after May 7, 1985, and the employee or Member retires under the civil service retirement system or dies in a covered position on or after May 7, 1985.

Section 831.1712 contains procedures for handling employee retirement benefits that were being paid to a former spouse who dies. In 1980, when we promulgated regulations (45 FR 14835, March 7, 1980) to implement section 8345(j) of title 5, United States Code, we stated that we would promulgate a rule to provide restrictions and procedures applicable to payments after the death of the former spouse after further study. Section 831.1712 now establishes restrictions and procedures for these payments. (It should be noted that section 8345(j) of title 5, United States Code, requires that an apportionment of employee retirement benefits must terminate if the annuity benefit is suspended or terminated. This statute relieves us from the obligation of paying an apportioned benefit after the death of an *annuitant*.)

In cases when a former spouse dies while entitled to a portion of a retiree's payments in accordance with a court order, § 831.1712 requires that we request guidance from the court that issued the apportionment order. The court could then make further provision for future payments. This approach was chosen only after concluding that automatically paying the former spouse's share to the court was unfeasible because too many courts would not have procedures to handle and account for the funds.

Section 831.1713 is taken from the old §§ 831.1710 and 831.1711. Sections 831.1713 (a) through (d) are derived from the old § 831.1710 (a) through (d). Section 831.1713(e) is the old § 831.1711(c).

Section 831.1714 provides for publication and indexing of interpretive guidelines. We have received approximately 1000 State court orders dividing civil service retirement benefits. In implementing these orders, we have been forced to interpret many terms that are capable of more than one meaning. To insure consistency in interpretation and to simplify the task of interpreting ambiguous terms that are frequently used, we have developed a set of guidelines that we will use to interpret State court orders.

The legal community has attempted to draft orders dividing civil service retirement benefits that minimize the potential confusion generated in interpreting the orders. However, without knowledge that a term used in a decree has a technical meaning within the civil service retirement law, unclear orders frequently resulted. The guidelines for interpreting these technical terms should assist the legal community in drafting orders that will be interpreted by us to produce the intended result.

The guidelines contain no regulatory language. The original guidelines were published at 49 FR 26746, June 29, 1984, corrected by 49 FR 27647, July 5, 1984. These guidelines are appended to subpart Q in the interim rules and apply to court orders dividing employee retirement benefits but not to court orders awarding survivor annuities.

Section 831.1715 restates the old § 831.1711(a).

Section 831.1716 provides for handling multiple court orders against one former employee or Member. Section 831.1716(a) states the order-of-issuance rule required by CSRSEA for formal spouse annuity cases whenever two or more former spouses are involved. Section 831.1716(b) states the usual rule for determining the effect of court judgments for cases when conflicting judgments affect the same parties.

Section 831.1717 restates the old § 831.1710(e). Section 831.1718 restates the old § 831.1711(d).

4. Payment of Lump Sums

Pub. L. 98–615 also affected lump-sum credit payments (refunds) of accumulated retirement deductions. A former employee's or Member's current spouse must be notified of the former employee's or Member's application for a lump-sum payment after May 6, 1985. Any former spouse from whom the employee was *divorced after May 6, 1985,* must also be notified of the application for lump-sum payment.

If the employee's or Member's current or former spouse does not acknowledge notification, the employee or Member may submit a signed postal return receipt as proof that he or she has mailed the notification to the current or former spouse. Alternatively, the employee or Member may submit affidavits signed by two individuals who witnessed the employee's or Member's personal attempt to obtain the current or former spouse's signature on the notification form. This is in substantial conformance with regulations found at old § 831.601(c) to Title 5, Code of Federal Regulations, which governed spousal notification of survivor annuity elections at the time of retirement under previous law, and which the Congress expressed its intent that we follow. (House Report No. 98–1054, September 24, 1984, p. 15.) The burden of proving a *bona fide* effort to notify the spouse or former spouse is placed upon the employee or Member, with the intent of keeping any delay in paying the refund within reasonable limits.

If the employee or Member is unable to obtain the acknowledgement of any *former* spouse, the employee or Member may, instead, submit a divorce decree, community property settlement or similar court-approved document wherein the former spouse has relinquished any rights to the annuity or the annuity was wholly awarded to the employee or Member. The object here is to require proof that the former spouse's entitlement to any benefit from the employee's or Member's annuity has been relinquished. If that is the case, there is no benefit which the former spouse could lose by the refund being paid and, therefore, notification would serve no reasonable purpose.

If the spouse's whereabouts are unknown, § 831.2008 sets out the conditions necessary for a waiver of the notification requirement.

The lump-sum payment will also be subject to any court order or decree *issued after May 6, 1985,* which directly relates to the lump-sum credit, if the payment of the lump-sum would adversely affect a former spouse's entitlement to a court-ordered share of an annuity and/or a survivor annuity. These regulations set forth procedures that we will follow to implement these provisions.

Sections 831.2005 and 831.2006 are the former §§ 831.1003 and 831.1004. Section 831.2001 has been expanded to include more definitions. Sections 831.2002 through 2004 remain essentially unchanged except that they are made subject to the restrictions of these new regulations and to section 3716 of title 5, United States Code, on administrative offset for government claims.

I find that there is good reason to make these amendments effective in less than 30 days (5 U.S.C. 533(d)(3)). The regulations are effective on May 7, 1985, to prevent irreparable harm to persons entitled to benefits under CSRSEA. Delaying rulemaking would be contrary to the public interest as expressed in CSRSEA because such a delay would require delayed payments in cases authorized by the revised statute most of which becomes effective May 7, 1985, until implementing regulations could be put in place. Although later payments could be retroactive to May 7, 1985, when entitlement attached on that date, delay could seriously harm entitled persons with an immediate need for payment.

Furthermore, CSRSEA imposes restrictions on the time in which application under sections 4(b) and 4(c) of the Act can be made. The 30-month period under section 4(b) and the 18-month period under section 4(c) began to run on November 9, 1984. It would be unconscionable to further delay processing applications while awaiting comments.

E.O. 12291, Federal Regulation

I have determined that this is not a major rule as defined under section 1(b) of E.O. 12291, Federal Regulation.

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities because the regulation will only affect retirement payments to retired Government employees and spouses.

List of Subjects in 5 CFR Part 831

Administrative practice and procedure, Claims, Disability benefits, Firefighters, Government employees, Income taxes, Intergovernmental relations, Law enforcement officers, Pensions, Personnel Management Office, Retirement.

U.S. Office of Personnel Management.

Loretta Cornelius,

Acting Director.

PART 821—[AMENDED]

Accordingly, OPM is amending 5 CFR Part 831, as follows:

1. By revising Subpart F to read as follows:

Subpart F—Survivor Annuities

Sec.

Authority: 5 U.S.C. 8347.

Subpart F—Survivor Annuities

§ 831.601 Purpose.

This subpart explains the annuity benefits payable in the event of the

death of employees, retirees, and Members; the actions that employees, retirees, Members, and their current spouses, former spouses, and eligible children must take to qualify for survivor annuities; and the types of evidence required to demonstrate entitlement to provide survivor annuities or qualify for survivor annuities.

§ 831.602 Relation to other regulations.

(a) Subpart Q of this part contains information about former spouses' entitlement to survivor annuities based on provisions in court orders or court-approved property settlement agreements.

(b) Subpart T of this part contains information about entitlement to lump-sum death benefits.

(c) Parts 870, 871, 872 and 873 of this chapter contain information about coverage under the Federal Employees' Group Life Insurance Program.

(d) Part 890 of this chapter contains information about coverage under the Federal Employees Health Benefits Program.

(e) Section 831.109 contains information about the administrative review rights available to a person who has been denied a survivor annuity or an opportunty to make an election under this subpart.

§ 831.603 Definitions.

As used in this subpart—

"CSRS" means subchapter III of chapter 83 of title 5, United States Code.

"Current spouse" means a living person who is married to the employee, Member, or retiree at the time of the employee's, Member's, or retiree's death.

"Current spouse annuity" means a recurring benefit under CSRS that is payable (after the employee's, Member's, or retiree's death) to a current spouse who meets the requirements of § 831.618.

"Deposit" means a deposit required by the Civil Service Retirement Spouse Equity Act of 1984, Pub. L. 98-615, 98 Stat. 3195. "Deposit," as used in this subpart does not include a service credit deposit or redeposit under sections 8334(c) or (d) of title 5, United States Code.

"First regular monthly payment" means the first annuity check payable on a recurring basis (other than an estimated payment or an adjustment check) after OPM has initially adjudicated the regular rate of annuity payable under CSRS and has paid the annuity accrued since the time of retirement. The "first regular monthly payment" is generally preceded by estimated payments before the claim can be adjudicated and by an adjustment check (including the difference between the estimated rate and the initially adjudicated rate).

"Former spouse" means a living person who was married for at least 9 months to an employee, Member, or retiree who performed at least 18 months of creditable service in a position covered by CSRS and whose marriage to the employee was terminated prior to the death of the employee, Member, or retiree.

"Former spouse annuity" means a recurring benefit under CSRS that is payable to a former spouse after the employee's, Member's, or retiree's death.

"Fully reduced annuity" means the recurring payments under CSRS received by a retiree who has elected the maximum allowable reduction in annuity to provide a current spouse annuity and/or a former spouse annuity or annuities.

"Insurable interest annuity" means the recurring payments under CSRS to a retiree who has elected a reduction in annuity to provide a survivor annuity to a person with an insurable interest in the retiree.

"Marriage" means a marriage recognized in law or equity under the whole law of the jurisdiction with the most significant interest in the marital status of the employee, Member, or retiree unless the law of that jurisdiction is contrary to the public policy of the United States. If a jurisdiction would recognize more than one marriage in law or equity, the Office of Personnel Management (OPM) will recognize only one marriage, but will defer to the local courts to determine which marriage should be recognized.

"Member" means a Member of Congress.

"Net annuity" means the net annuity as defined in § 831.1703.

"Partially reduced annuity" means the recurring payments under CSRS to a retiree who has elected less than the maximum allowable reduction in annuity to provide a current spouse annuity or a former spouse annuity.

"Qualifying court order" means a court order that meets the qualifications of § 831.1704.

"Retiree" means a former employee or Member who is receiving recurring payments under CSRS based on service by the employee or Member. "Retiree," as used in this subpart, does not include a current spouse, former spouse, child, or person with an insurable interest receiving a survivor annuity.

"Self-only annuity" means the recurring unreduced payments under CSRS to a retiree with no survivor annuity to anyone.

"Time of retirement" means the date when a retired employee's or Member's annuity entitlement commences.

§ 831.604 Election at time of retirement of fully reduced annuity to provide a current spouse annuity.

(a) A married employee or Member retiring under CSRS will receive a fully reduced annuity to provide a current spouse annuity unless—

(1) The employee or Member, with the consent of the current spouse, elects a self-only annuity, a partially reduced annuity, or a fully reduced annuity to provide a former spouse annuity, in accordance with § 831.605(b) or § 831.607; or

(2) The employee or Member elects a self-only annuity, a partially reduced annuity or a fully reduced annuity to provide a former spouse annuity, and current spousal consent is waived in accordance with § 831.608.

(b) Qualifying court orders that award former spouse annuities prevent payment of current spouse annuities to the extent necessary to comply with the court order and § 831.614.

§ 831.605 Election at time of retirement of fully reduced annuity or partially reduced annuity to provide a former spouse annuity.

(a) An unmarried employee or Member retiring under CSRS may elect a fully reduced annuity or a partially reduced annuity to provide a former spouse annuity or annuities.

(b) A married employee or Member retiring under CSRS may elect a fully reduced annuity or a partially reduced annuity to provide a former spouse annuity or annuities instead of a fully reduced annuity to provide a current spouse annuity, if the current spouse consents to the election in accordance with § 831.607 or spousal consent is waived in accordance with § 831.608.

(c) An election under paragraphs (a) or (b) of this section is void if it—

(1) Conflicts with a qualifying court order; or

(2) Would cause the total of current spouse annuities and former spouse annuities payable based on the employee's or Member's service to exceed 55 percent of the self-only annuity to which the employee or Member would be entitled.

(d) Any reduction in an annuity to provide a former spouse annuity will terminate on the first day of the month after the former spouse dies or remarries before age 55, unless—

(1) The retiree elects, within 2 years after the former spouse's death or remarriage, to continue the reduction to

provide or increase a former spouse annuity for another former spouse, or to provide or increase a current spouse annuity; or

(2) A qualifying court order requires the retiree to provide another former spouse annuity.

§ 831.606 Election of insurable interest annuity.

(a) At the time of retirement, an employee or Member in good health, who is applying for a non-disability annuity, may elect an insurable interest annuity. Spousal consent is not required, but an election under this section does not exempt a married employee or Member from the provisions of § 831.604(a).

(b) An insurable interest annuity may be elected by an employee or Member electing a fully reduced annuity or a partially reduced annuity to provide a current spouse annuity or a former spouse annuity or annuities.

(c) An employee or Member may elect an insurable interest annuity to benefit a current or former spouse who, upon the retiree's death, will also be entitled to a current spouse annuity or a former spouse annuity.

(d) To elect an insurable interest annuity, an employee or Member must indicate the intention to make the election on the application for retirement and must submit evidence to demonstrate that he or she is in good health. OPM may also require a medical examination to demonstrate that the employee or Member is in good health.

(e) An insurable interest annuity may be elected to provide a survivor benefit only for a person who has an insurable interest in the retiring employee or Member.

(1) An insurable interest is presumed to exist with—

(i) The current spouse;

(ii) A blood or adopted relative closer than first cousins;

(iii) A former spouse;

(iv) A person to whom the employee or Member is engaged to be married;

(v) A person with whom the employee or Member is living in a relationship which would constitute a common-law marriage in jurisdictions recognizing common-law marriages.

(2) When an insurable interest in not presumed, the employee or Member must submit affidavits from one or more persons with personal knowledge of the named beneficiary's insurable interest in the employee or Member. The affidavits must set forth the relationship, if any, between the named beneficiary and the employee or Member, the extent to which the named beneficiary is dependent on the employee or Member, and the reasons why the named beneficiary might reasonably expect to derive financial benefit from the continued life of the employee or Member.

(3) The employee or Member may be required to submit documentary evidence to establish the named beneficiary's date of birth.

(f) After receipt of all required evidence to support an election of an insurable interest annuity, OPM will notify the employee or Member of initial monthly annuity rates with and without the election of an insurable interest annuity and the initial rate payable to the named beneficiary. No election of an insurable interest annuity is effective unless the employee or Member confirms the election in writing, dies, or becomes incompetent no later than 60 days after the date of the notice described in this paragraph.

(g) When an employee or Member elects both an insurable interest annuity and a fully reduced annuity or a partially reduced annuity to provide a current spouse annuity and/or a former spouse annuity or annuities, each reduction is computed based on the self-only annuity computation. The combined reduction may exceed the maximum 40 percent reduction in the retired employee's or Member's annuity permitted under section 8339(k)(1) of title 5, United States Code, applicable to insurable interest annuities.

(h) Except as provided in § 831.625(d), if a retiree who is receiving a fully reduced annuity or a partially reduced annuity to provide a former spouse annuity has also elected an insurable interest annuity to benefit a current spouse and if the eligible former spouse dies or remarries before age 55 and no other former spouse is entitled to a survivor annuity based on an election made in accordance with § 831.612 or a qualifying court order, the retiree may elect, within 2 years after the former spouse's death or remarriage, to convert the insurable interest annuity to a fully reduced annuity to provide a current spouse annuity, effective on the first day of the month following the death or remarriage of the former spouse.

(i) Upon the death of the current spouse, a retiree whose annuity is reduced to provide both a current spouse annuity and an insurable interest benefit for a former spouse is not permitted to convert the insurable interest annuity to a reduced annuity to provide a former spouse annuity.

(j) An employee or Member may name only one natural person as the named beneficiary of an insurable interest annuity. OPM will not accept the designation of contingent beneficiaries and such a designation is void.

§ 831.607 Election of a self-only annuity or partially reduced annuity by married employees and Members.

(a) A married employee may not elect a self-only annuity or a partially reduced annuity to provide a current spouse annuity without the consent of the current spouse or a waiver of spousal consent by OPM in accordance with § 831.608.

(b) Evidence of spousal consent or a request for waiver of spousal consent must be filed on a form prescribed by OPM.

(c) The form will require that a notary public or other official authorized to administer oaths certify that the current spouse presented identification, gave consent, signed or marked the form, and acknowledged that the consent was given freely in the notary's or official's presence.

§ 831.608 Waiver of spousal consent requirement.

(a) The spousal consent requirement will be waived upon a showing that the spouse's whereabouts cannot be determined. A request for waiver on this basis must be accompanied by—

(1) A judicial determination that the spouse's whereabouts cannot be determined; or

(2) (i) Affidavits by the employee or Member and two other persons, at least one of whom is not related to the employee or Member, attesting to the inability to locate the current spouse and stating the efforts made to locate the spouse; and

(ii) Documentary corroboration such as tax returns filed separately or newspaper stories about the spouse's disappearance.

(b) The spousal consent requirement will be waived based on exceptional circumstances if—

(1) The employee or Member is considered unmarried at the time of retirement based on § 831.610; or

(2) The employee or Member presents a judicial determination regarding the current spouse that would warrant waiver of the consent requirement based on exceptional circumstances.

§ 831.609 Changes of election before final adjudication.

An employee or Member may name a new survivor or change his election of type of annuity if, not later than 30 days after the date of the first regular monthly payment, the named survivor dies or the employee or Member files with OPM a new written election. All required evidence of spousal consent or

justification for waiver of spousal consent, if applicable, must accompany any new written election under this section.

§ 831.610 Marital status at time of retirement.

An employee or Member is unmarried at the time of retirement for all purposes under this subpart only if the employee or Member was unmarried on the date that the annuity begins to accrue.

§ 831.611 Changes of election after final adjudication.

Except as provided in section 8339 (j) or (k) of title 5, United States Code or § 831.621 or § 831.623, an employee or Member may not revoke or change the election or name another survivor, later than 30 days after the date of the first regular monthly payment.

§ 831.612 Post-retirement election of fully reduced annuity or partially reduced annuity to provide a former spouse annuity.

(a) Except as provided in paragraphs (b) and (c) of this section, a retiree who retired on or after May 7, 1985, may elect in writing a fully reduced annuity or a partially reduced annuity to provide a former spouse annuity. Such an election must be filed with OPM within 2 years after the retiree's marriage to the former spouse terminates.

(b) An election under paragraph (a) of this section will not be permitted—

(1) If it conflicts with a qualifying court order; or

(2) If it would cause the combined current and former spouse annuities to exceed 55 percent of the retiree's annuity; or

(3) In the case of a married retiree, if the current spouse does not consent to the election on the form described in § 831.607(c) and spousal consent is not waived by OPM in accordance with § 831.608; or

(4) To the extent that it provides a former spouse annuity for the spouse who was married to the retiree at the time of retirement in an amount that is inconsistent with any joint designation or waiver made at the time of retirement under § 831.604 (a)(1) or (a)(2).

(c) An election under this section is not permitted unless the retiree agrees to deposit the amount equal to the difference between the amount of annuity actually paid to the retiree and the amount of annuity that would have been paid if the reduction elected under paragraph (a) of this section had been in effect continuously since the time of retirement, plus 6 percent annual interest, computed under § 831.105, from the date when each difference occurred.

(d) The annuity reduction under this section terminates under the conditions stated in § 831.605(d).

§ 831.613 Post-retirement election of fully reduced annuity or partially reduced annuity to provide a current spouse annuity.

(a) In cases of retirees who retired before May 7, 1985:

(1) A retiree who was unmarried at the time of retirement may elect, within 1 year after a post-retirement marriage, a fully reduced annuity or a partially reduced annuity to provide a current spouse annuity.

(2) A retiree who was married and elected a fully reduced annuity or a partially reduced annuity at the time of retirement may elect, within 1 year after a post-retirement marriage, to provide a current spouse annuity.

(3) The reduction under paragraphs (a)(1) or (a)(2) of this section commences on the first day of the month beginning 1 year after the date of the post-retirement marriage.

(b) In cases involving retirees who retired on or after May 7, 1985:

(1) Except as provided in paragraph (b)(3) of this section, a retiree who was unmarried at the time of retirement may elect, within 2 years after a post-retirement marriage, a fully reduced annuity or a partially reduced annuity to provide a current spouse annuity.

(2) Except as provided in paragraph (b)(3) of this section, a retiree who was married at the time of retirement may elect, within 2 years after a post-retirement marriage, a fully reduced annuity or a partially reduced annuity to provide a current spouse annuity if—

(i) The retiree was awarded a fully reduced annuity under § 831.604 at the time of retirement; or

(ii) The election at the time of retirement was made with a waiver of spousal consent in accordance with § 831.608; or

(iii) The marriage at the time of retirement was to a person other than the spouse who would receive a current spouse annuity based on the post-retirement election.

(3) An election under paragraph (b)(1) or (b)(2) of this section is not effective if it conflicts with a qualifying court order or would cause the combined current and former spouse annuities to exceed 55 percent of the retiree's annuity.

(4) A retiree making an election under this section must deposit an amount equal to the difference between the amount of annuity actually paid to the retiree and the amount of annuity that would have been paid if the reduction elected under paragraph (b)(1) or (b)(2) of this section had been in effect continuously since the time of retirement, plus 6 percent annual interest, computed under § 831.105, from the date when each difference occurred.

(5) Any reduction in an annuity to provide a current spouse annuity will terminate effective on the first day of the month after the marriage to the current spouse ends, unless—

(i) The retiree elects, within 2 years after a divorce terminates the marriage, to continue the reduction to provide for a former spouse annuity; or

(ii) A qualifying court order requires the retiree to provide a former spouse annuity.

§ 831.614 Division of a survivor annuity.

(a) Except as provided in § 831.622, the maximum combined total of all current and former spouse annuities (not including any benefits based on an election of an insurable interest annuity) payable based on the service of a former employee or Member equals 55 percent of the rate of the self-only annuity that otherwise would have been paid to the employee, Member, or retiree.

(b) By using the elections available under this subpart or to comply with a court order under Subpart Q, a survivor annuity may be divided into a combination of former spouse annuities and a current spouse annuity so long as the aggregate total of current and former spouse annuities does not exceed the maximum limitation in paragraph (a) of this section.

(c) Upon termination of former spouse annuity payments because of death or remarriage of the former spouse, or by operation of a court order, the current spouse will be entitled to a current spouse annuity or an increased current spouse annuity if—

(1) The employee or Member died while employed in a position covered under CSRS; or

(2) The current spouse was married to the employee or Member continuously from the time of retirement and did not consent to an election not to provide a current spouse annuity; or

(3) The current spouse married a retiree after retirement and the retiree elected, under § 831.613, to provide a current spouse annuity for that spouse in the event that the former spouse annuity payments terminate.

§ 831.615 Child's annuity during school attendance.

For a child to be eligible for continuation of annuity beyond age 18 because of student status, the child, in addition to meeting all other requirements applicable to a child survivor who has not attained age 18,

must present a certificate on a form prescribed by OPM from the educational or training institution that certifies that the child is regularly pursuing a full-time day or evening course of resident study or training. For this purpose, a full-time course of resident study or training means a day or evening noncorrespondence course that contemplates school attendance at the rate of at least 36 weeks per academic year with a subject load sufficient, if successfully completed, to attain the educational or training objective within the period generally accepted as minimum for completion, by a full-time day student, of the academic or training program concerned.

§ 831.616 Proof of dependency.

(a) To be eligible for survivor annuity benefits, a child must have been dependent on the employee, Member, or retiree at the time of the employee's, Member's, or retiree's death.

(b) A child is considered to have been dependent on the deceased employee, Member, or retiree if he or she is—

(1) A legitimate child; or

(2) An adopted child; or

(3) A child who lived with, and for whom a petition of adoption was filed by, the employee, Member, or retiree, and who was adopted by the surviving spouse of the employee, Member, or retiree after the employee's, Member's, or retiree's death; or

(4) A stepchild or recognized natural child who lived with the employee, Member, or retiree in a regular parent-child relationship at the time of the employee's, Member's, or retiree's death; or

(5) A recognized natural child for whom a judicial determination of support was obtained; or

(6) A recognized natural child to whose support the employee, Member, or retiree made regular and substantial contributions.

(c) The following are examples of proofs of regular and substantial support. More than one of the following proofs may be required to show support of a natural child who did not live with the employee, Member, or retiree in a regular parent-child relationship and for whom a judicial determination of support was not obtained.

(1) Evidence of eligibility as a dependent child for benefits under other State or Federal programs; and

(2) Proof of inclusion of the child as a dependent on the decedent's income tax returns for the years immediately before the employee's, Member's, or retiree's death; and

(3) Cancelled checks, money orders, or receipts for periodic payments received from the employee, Member, or retiree for or on behalf of the child; and

(4) Evidence of goods or services that show regular contributions of considerable value; and

(5) Proof of coverage of the child as a family member under the employee's Member's, or retiree's Federal Employees Health Benefits enrollment; and

(6) Other proof of a similar nature that OPM may find to be sufficient to demonstrate support or parentage.

(d) Survivor benefits may be denied—

(1) If evidence shows that the deceased employee, Member, or retiree did not recognize the claimant as his or her own despite a willingness to support the child; or

(2) If evidence casts doubt upon the parentage of the claimant, despite the deceased employee's, Member's, or retiree's recognition and support of the child.

§ 831.617 Rates of child annuities.

(a) (1) Subject to paragraphs (a)(2) and (a)(3) of this section, the rate of annuity payable to a child survivor is computed under section 8341(e)(1) (A) through (C) of title 5, United States Code, with adjustments in accordance with section 8340 of title 5, United States Code, whenever a deceased employee, Member, or retiree is survived by a current spouse or a former spouse who is the natural or adoptive parent of a surviving child of the employee, Member or retiree.

(2) When paragraph (a)(1) of this section applies because of the existence of a current spouse:

(i) Paragraph (a)(1) of this section applies even if the current spouse is not entitled to a current spouse annuity.

(ii) Paragraph (a)(1) of this section applies to all children of the former employee or Member, including children who are not the offspring of the current spouse.

(3) When paragraph (a)(1) of this section applies only because of the existence of a former spouse who is the natural or adoptive parent of a surviving child of the employee, Member, or retiree:

(i) Paragraph (a)(1) of this section applies even if the former spouse is not entitled to a former spouse annuity.

(ii) Paragraph (a)(1) of this section applies to all children of the former employee or Member, including children who are not the offspring of the former spouse.

(iii) Paragraph (a)(1) of this section does not apply to any child of the former employee or Member if the former spouse has no offspring entitled to an annuity.

(b) The rate of annuity payable to a child survivor is computed under section 8341(e)(1) (i) through (iii) of title 5, United States Code, with adjustment in accordance with section 8340 of title 5, United States Code, when the deceased employee, Member, or retiree is not survived by a current spouse or a former spouse who is the natural or adoptive parent of a surviving child (who is entitled to a child's annuity) of the former employee or Member.

(c) On the death of the current spouse or the former spouse or termination of the annuity of a child, the annuity of any other child or children is recomputed and paid as though the spouse, former spouse, or child had not survived the former employee or Member.

§ 831.618 Marriage duration requirements.

(a) The surviving spouse of a retiree who retired on or after May 7, 1985, or of an employee or Member who dies while serving in a position covered by CSRS on or after May 7, 1985, can qualify for a current spouse annuity only if—

(1) The surviving spouse and the employee, Member, or retiree had been married for at least 9 months, as explained in paragraph (b) of this section; or

(2) A child was born of the marriage, as explained in paragraph (c) of this section; or

(3) The death of the employee, Member, or retiree was accidental as explained in paragraph (d) of this section.

(b) For satisfying the 9-month marriage requirement of paragraph (a)(1) of this section, the aggregate time of all marriages between the spouse applying for a current spouse annuity and the employee, Member, or retiree is included.

(c) For satisfying the child-born-of-the-marriage requirement of paragraph (a)(2) of this section, any child, including a posthumous child, born to the spouse and the employee, Member, or retiree is included. This includes a child born out of wedlock or of a prior marriage between the same parties.

(d)(1) A death is accidental if it results from homicide or from bodily injuries incurred solely through violent, external, and accidental means.

(i) Caused wholly or partially, directly or indirectly, by disease or bodily or mental infirmity, or by medical or surgical treatment or diagnosis thereof; or

(ii) Caused wholly or partially, directly, or indirectly, by ptomaine, by bacterial infection, except only septic infection of and through a visible wound

sustained solely through violent, external, and accidental means; or

(iii) Caused wholly or partially, directly or indirectly, by hernia, no matter how or when sustained; or

(iv) Caused by or the result of intentional self-destruction or intentionally self-inflicted injury, while sane or insane.

(2) A State judicial or administrative adjudication of the cause of death for criminal or insurance purposes is conclusive evidence of whether a death is accidental.

(3) A death certificate showing the cause of death as accident or homicide is *prima facie* evidence that the death was accidental.

§ 831.619 Time for filing applications for death benefits.

(a) A survivor of a deceased employee, Member, or retiree, may file an application for annuity, personally or through a representative, at any time within 30 years after the death of the employee, Member, or retiree.

(b) A former spouse claimng eligibility for an annuity based on § 831.622 may file an application at any time between November 8, 1984 and May 9, 1987. Within this period, the date that the first correspondence indicating a desire to file a claim is received by OPM will be treated as the application date for meeting timeliness deadlines and determining the commencing date of the survivor annuity under § 831.622 if the former spouse is eligible on that date.

§ 831.620 Commending and terminating dates of survivor annuities.

(a) A survivor annuity payable from the Civil Service Retirement and Disability Fund commences the day after (1) death of the employee, Member, or retiree; (2) attainment of age 50 when, under section 12 of the Civil Service Retirement Act Amendments of February 29, 1948, the annuity is deferred until age 50; (3) a claim is received in OPM when an annuity is authorized for unremarried widows and widowers by section 2 of the Civil Service Retirement Act Amendments of June 25, 1958, 72 Stat. 218; or (4) the later of the date of death of the retiree or the first day of the second month after the date the application for annuity is filed under § 831.622.

(b) A survivor annuity terminates at the end of the month preceding death or any other terminating event.

(c) A current spouse annuity terminated for reasons other than death may be restored under conditions defined in sections 8341(e)(2) and 8341(g) of title 5, United States Code.

(d) A survivor annuity accrues on a daily basis, one-thirtieth of the monthly rate constituting the daily rate. An annuity does not accrue for the 31st day of any month, except in the initial month if the survivor's (of a deceased employee) annuity commences on the 31st day. For accrual purposes, the last day of a 28-day month constitutes 3 days and the last day of a 29-day month constitutes 2 days.

§ 831.621 Election by a retiree who retired before May 7, 1985, to provide a former spouse annuity.

(a) A retiree who retired before May 7, 1985, including a retiree receiving a fully reduced annuity to provide a current spouse annuity, may elect a fully reduced annuity to provide a former spouse annuity.

(b) The election should be made by letter addressed to OPM. The election must—

(1) Be in writing; and

(2) Agree to pay any deposit due under paragraph (d) of this section; and

(3) Be signed by the retiree; and

(4) Be filed with OPM before May 9, 1986.

(c)(1) If a retiree who is receiving an insurable interest annuity elects a fully reduced annuity under this seciton to benefit the same person, the insurable interest annuity terminates. A retiree who is receiving an insurable interest annuity at the time that an annuity is elected under this section does not owe any further deposit if a fully reduced annuity is elected under this section.

(2) A retiree who elects a fully reduced annuity under this section, to provide a former spouse annuity for a former spouse for whom the retiree had elected (during the marriage to that former spouse) a reduced annuity to provide a current spouse annuity must deposit an amount equal to the differences between the rate of annuity actually paid to the retiree and the amount of annuity which would have been paid had a fully reduced annuity been paid continuously since the time of retirement, plus 6 percent annual interest, computed under § 831.105, from the date to which each difference is attributable.

(3) A retiree who elects a fully reduced annuity under this section, and is not covered under paragraphs (c)(1) or (c)(2) of this section, must deposit an amount equal to the difference between the self-only annuity and a fully reduced annuity since the time of retirement, plus 6 percent annual interest, computed under § 831.105, from the date to which each difference is attributable.

(d) If a retiree who is receiving a fully reduced annuity or a partially reduced annuity to provide a current spouse annuity elects a fully reduced annuity under this section to provide a former spouse annuity, the annuity will be reduced separately to provide for the current and former spouse annuities. Each separate reduction will be computed based on the self-only annuity, and the separate reductions are cumulative.

(e)(1) In response to a retiree's inquiry about providing a former spouse annuity under this section, OPM will send an application form. This application will include instructions to assist the retiree in estimating the amount of reduction in the annuity to provide the former spouse annuity and the amount of the required deposit. The application form will include a notice to retirees that filing the application constitutes an official election which cannot be revoked after 30 days after the annuity check in which the annuity reduction first appears.

(2) If the retiree returns the application electing a fully reduced annuity under this section, OPM will notify the retiree of—

(i) The rate of the fully reduced annuity; and

(ii) The rate of the potential former spouse annuity; and

(iii) The amount of the deposit, plus interest, that is due as of the date that the annuity reduction is scheduled to begin; and

(iv) The amount and duration of installment payments if no deposit is made.

(3) The notice under paragraph (e)(2) of this section will advise the retiree that the deposit will be collected in installments under § 831.624, unless lump-sum payment is made within 60 days from the date of the notice.

(4) OPM will reduce the annuity and begin collection of the deposit in installments effective with the first check payable more than 60 days after the date on the notice required under paragraph (e)(2) of this section.

§ 831.622 Annuities for former spouses of employees or Members retired before May 7, 1985.

(a) The former spouse of a retiree who retired before May 7, 1985, is entitled, after the death of the retiree, to a survivor annuity equal to 55 percent of the annuity of the retiree on whose service the survivor annuity is based if the former spouse meets all of the following requirements:

(1) The former spouse's marriage to the retiree was dissolved after September 14, 1978. The date of dissolution of a marriage is the date when the marriage between the former

spouse and the retiree ended under the law of the jurisdiction that terminated the marriage, rather than the date when restrictions on remarriage ended. The date of entry of the decree terminating the marriage will be rebuttably presumed to be the date when the marriage was dissovled.

(2) The former spouse was married to the retiree for at least 10 years of the retiree's creditable civilian service. Creditability of service is determined in accordance with section 8332 of title 5, United States Code, and subpart C.

(3) The former spouse is not receiving any other employer-provided retirement or survivor annuity.

(i) Employer-provided retirement or survivor annuity means recurring retirement or survivor payments (other than benefits under title II of the Social Security Act or under section 8345(j) of title 5, United States Code) that are made by, on behalf of, or under the terms of a contract with an employer and are based on past service of the former employee or Member or the former spouse.

(ii) Employer-provided retirement or survivor annuity to which the former spouse is entitled but not actually receiving because of a failure to apply for the benefit or because the benefits were waived (and the waiver was accepted by the retirement or survivor benefit plan) are not considered employer-provided benefits for purposes of this section.

(4) The former spouse has not remarried before reaching age 55.

(5) The former spouse applies to OPM for a survivor annuity, in accordance with paragraph (b) of this section and § 831.619(b), before May 9, 1987.

(6) The former spouse is at least 50 years old when filing the application.

(b) (1) Application must be filed on the form prescribed for that purpose by OPM. The application form will require the former spouse to certify under the penalty provided by section 1001 of title 18, United States Code, that he or she meets the requirements listed in paragraph (a) of this section.

(2) In addition to the application form required in paragraph (b)(1) of this section, the former spouse must submit proof of his or her age and the date when the marriage to the retiree commenced, and a certified copy of the divorce decree terminating the marriage to the retiree.

(3) Former spouses applying for benefits under this section must meet the requirements of paragraph (a) of this section at the time of application and at all times while a former spouse annuity, under this section, is being paid to that former spouse. A former spouse who is receiving a former spouse annuity under this section must notify OPM within 30 days after he or she ceases to meet any of the qualifications in paragraph (a) of this section.

(c) Survivor annuities payable under this section commence on the later of the day after the date of death of the retiree or the first day of the second month after the application is filed under § 831.619(b).

(d) Cost-of-living adjustments under section 8340 of title 5, United States Code, are applicable to annuities payable under this section.

§ 831.623 Second chance elections to provide survivor benefits.

(a) A married retiree who retired before May 7, 1985, and is not currently receiving a fully or partially reduced annuity to provide a current spouse annuity may elect a fully or partially reduced annuity to provide a current spouse annuity for a spouse acquired after retirement if the following conditions are met:

(1) (i) The retiree was married at the time of retirement and did not elect a survivor annuity at that time; or

(ii) The retiree failed to elect a fully or partially reduced annuity within 1 year after a post-retirement marriage that occurred before November 8, 1984, and the retiree attempted to elect a fully or partially reduced annuity after the time limit expired and that request was disallowed as untimely.

(2) The retiree applies for a fully or partially reduced annuity under this section before November 9, 1985.

(3) The retiree agrees to pay the amount due under paragraph (d) of this section.

(b) Applications must be filed on the form prescribed by OPM, except filing the form is excused when the retiree dies before filing the required form if:

(1) The retiree made a written request, after November 8, 1984, to elect a fully or partially reduced annuity under this section, and

(2) The retiree was denied the opportunity to file the required form because the retiree, without fault, did not receive the form in sufficient time for the retiree to be reasonably expected to complete the form before death.

(c) (1) In response to a retiree's inquiry about providing a current spouse annuity under this section, OPM will send an application form. This application will include instructions to assist the retiree in estimating the amount of reduction in the annuity to provide the current spouse annuity and the amount of the required deposit. The application form will include a notice to retirees that filing the application constitutes an official election which cannot be revoked after 30 days after the annuity check in which the annuity reduction first appears.

(2) If the retiree returns the application electing a fully or partially reduced annuity under this section, OPM will notify the retiree of—

(i) The rate of the fully reduced annuity; and

(ii) The rate of the potential current spouse annuity; and

(iii) The amount of the deposit, plus interest, that is due as of the date that the annuity reduction is scheduled to begin; and

(iv) The amount and duration of installment payments if no deposit is made.

(3) The notice under paragraph (c)(2) of this section will advise the retiree that the deposit will be collected in installments under § 831.624, unless lump-sum payment is made within 60 days from the date of this notice.

(4) OPM will reduce the annuity and begin collection of the deposit in installments effective with the first check payable more than 60 days after the date on the notice required under paragraph (c)(2) of this section.

(d) The retiree must state on the application form whether the application is made under paragraph (a)(1)(i) of this section or paragraph (a)(1)(ii) of this section. If the application is made under paragraph (a)(1)(ii) of this section, the retiree must prove that he or she had attempted to elect a fully reduced annuity and that OPM rejected that application because it was filed too late. The proof must consist of a copy of OPM's letter rejecting the previous election as untimely filed or an affidavit swearing or affirming that he or she made an untimely application which OPM rejected. The affidavit is sufficient documentation to provide proof of the retiree's attempt to elect a reduced annuity, unless the record contains convincing evidence to rebut the certification.

(e) A retiree who elects to provide a current spouse annuity under this section must agree to pay a deposit equal to the difference between the amount of annuity actually paid to the retiree and the amount of annuity that would have been paid if a fully reduced annuity were being paid continuously since the time of retirement, plus 6 percent annual interest, computed under § 831.105, from the date when each difference occurred.

§ 831.624 Payments of required deposits.

(a) The deposits required to elect fully or partially reduced annuities under §§ 831.612, 831.613, 831.621, or 831.623 are not annuity overpayments and their collection is not subject to waiver. They are subject to reconsideration only to determine whether the amount has been correctly computed.

(b) If a retiree fails to make a deposit required under § 831.621 or § 831.623 within 60 days after the date of the notice required by § 831.621(e) or § 831.623(c), the deposit will be collected by offset from his or her annuity in installments equal to 25 percent of the retiree's net annuity (as defined in § 831.1703).

(c) If a retiree fails to make a deposit required by §§ 831.612 or 831.613 within 2 years after the date of the post-retirement marriage or divorce, the deposit will be collected by offset from his or her annuity in installments equal to 25 percent of the retiree's net annuity (as defined in § 831.1703).

(d) If a retiree dies before a deposit required under §§ 831.612, 831.613, 831.621, or 831.623 is fully made, the deposit will be collected from the survivor annuity (for which the election required the deposit) before any payments of the survivor annuity are made.

§ 831.625 Remarriage.

(a) A current spouse annuity based on the death of a retiree who retired before May 7, 1985, or of an employee or Member who died while serving in a position covered under CSRS before May 7, 1985, terminates on the last day of the month before the current spouse remarries before attaining age 60.

(b) A current spouse annuity or a former spouse annuity based on the death of a retiree who retired on or after May 7, 1985, or of an employee or Member who died while serving in a position covered under CSRS on or after May 7, 1985, terminates on the last day of the month before the recipient remarries before attaining age 55.

(c) If a current spouse annuity is terminated because of remarriage of the recipient, the annuity is reinstated on the day of the termination of the remarriage by death, annulment, or divorce if—

(1) The surviving spouse elects to receive this annuity instead of a survivor benefit to which he or she may be entitled, under CSRS or another retirement system for Government employees, by reason of the remarriage; and

(2) Any lump sum paid on termination of the annuity is repaid (in a single payment or by withholding payment of the annuity until the amount of the lump sum has accrued).

(d) If present or future entitlement to a former spouse annuity is terminated because of remarriage of the recipient or potential recipient, the entitlement is permanently extinguished. An annulment of the remarriage does not reinstate the entitlement.

§ 831.626 Elections by previously retired retiree with new title to an annuity.

(a) A reemployed retiree (after 5 or more years of reemployed annuitant service) who elects a redetermined annuity under section 8344 of title 5, United States Code, is subject to §§ 831.604 through 611 at the time of the redetermination.

(b) A disability retiree who recovers from disability or is restored to earning capacity is subject to §§ 831.604 through 611 at the time that he or she retires under section 8336 or 8338 of title 5, United States Code.

(c) A retiree who is dropped from the retirement rolls and subseqently gains a new annuity right by fulfilling the requirements of section 8333(b) of title 5, United States Code, is subject to §§ 831.604 through 611 when he or she retires under that new annuity right.

§ 831.627 Annual notice required by Pub. L. 95-317.

At least once every 12 consecutive months, OPM will send a notice to all retirees to inform them about the survivor annuity elections available to them, under sections 8339(j) and 8339(k)(2) of title 5, United States Code, in the event of post-retirement marriages.

Subpart J—[Removed]

2. By removing Subpart J and reserving it for future use.

3. By revising Subpart Q to read as follows:

Subpart Q—Court Orders Affecting Civil Service Retirement Benefits

Sec.

Authority: 5 U.S.C. 8347

Subpart Q—Court Orders Affecting Civil Service Retirement Benefits

§ 831.1701 Purpose.

This subpart regulates the Office of Personnel Management's adjudication of claims arising out of State court orders that affect civil service retirement benefits. The Office of Personnel Management (OPM) must comply with qualifying court orders, decrees, or court-approved property settlements in connection with divorces, annulments of marriage, or legal separations of employees, Members, or retirees that award a portion of a former employee's or Member's retirement benefits or a survivor annuity to a former spouse. This subpart prescribes the procedures to be followed by—

(a) A former spouse when applying for benefits based on a court order under sections 8345(j) or 8341(h) of title 5, United States Code; and

(b) The Associate Director in honoring court orders and in making payment to the former spouse.

§ 831.1702 Relation to other regulations.

(a) Part 581 of this Chapter contains information about garnishment of Government payments including salaries and civil service retirement benefits.

(b) Parts 294 and 297 of this chapter and § 831.106 contain information about disclosure of information from OPM records.

(c) Subpart F of this part contains information about entitlement to survivor annuities.

(d) Subpart T of this part contains information about entitlement to lump-sum death benefits.

(e) Parts 870, 871, 872, and 873 of this chapter contain information about coverage under the Federal Employees' Group Life Insurance Program.

(f) Part 890 of this chapter contains information about coverage under the Federal Employees Health Benefits Program.

(g) Section 831.109 contains information about the administrative review rights available to a person who has been adversely affected by an OPM action under this subpart.

§ 831.1703 Definitions.

In this subpart:

"Associate Director" means the Associate Director for Compensation in the OPM or an OPM employee officially authorized to act on his or her behalf.

"Court order" means any judgment or property settlement issued by or approved by any court of any State, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, or the Virgin Islands, and any Indian court in connection with, or incident to, the divorce, annulment of marriage, or legal separation of a Federal employee or retiree.

"CSRS" means subchapter III of chapter 83 of title 5, United States Code.

"Employee retirement benefits" means employees' and Members' annuities and refunds of retirement contributions but does not include survivor annuities or lump-sum payments made pursuant to section 8342 (c) through (f) of title 5, United States Code.

"Former spouse" means (1) in connection with a court order affecting employee retirement benefits, a living person whose marriage to an employee, Member, or retiree has been subject to a divorce, annulment, or legal separation resulting in a court order; or (2) in connection with a court order awarding a former spouse annuity, a living person who was married for at least 9 months to an employee, Member, or retiree who performed at least 18 months of creditable service in a position covered by CSRS and whose marriage to the employee was terminated prior to the death of the employee, Member, or retiree.

"Former spouse annuity" means a former spouse annuity as defined in § 831.603.

"Gross annuity" means the amount of a self-only annuity less only applicable survivor reduction, but before any other deduction.

"Member" means a Member of Congress.

"Net annuity" means the amount of annuity payable after deducting from the gross annuity any amounts that are (1) owed by the retiree to the United States, (2) deducted for health benefits premiums pursuant to section 8906 of title 5, United States Code, and §§ 891.401 and 891.402 of this title, (3) deducted for life insurance premiums pursuant to section 8714a(d) of title 5, United States Code, (4) deducted for Medicare premiums, or (5) properly withheld for Federal income tax purposes, if amounts withheld are not greater than they would be if the individual claimed all dependents to which he or she was entitled.

"Qualifying court order" means a court order that meets the requirements of § 831.1704.

"Retiree" means a former employee or Member who is receiving recurring payments under CSRS based on service by the employee or Member. "Retiree," as used in the subpart, does not include a current spouse, former spouse, child or person with an insurable interest.

"Self-only annuity" means the recurring payment to a retiree who has elected not to provide a survivor annuity to anyone.

§ 831.1704 Qualifying court orders.

(a) A former spouse is entitled to a portion of an employee's retirement benefits only to the extent that the divison of retirement benefits is expressly provided for by the court order. The court order must divide employee retirement benefits, award a payment from employee retirement benefits, or award a former spouse annuity.

(b) The court order must state the former spouse's share as a fixed amount, a percentage or a fraction of the annuity, or by a formula that does not contain any variables whose value is not readily ascertainable from the face of the order or normal OPM files.

(c)(1) For purposes of payments from employee retirement benefits, OPM will review court orders as a whole to determine whether the language of the order shows an intent by the court that the former spouse should receive a portion of the employee's retirement benefits directly from the United States.

(i) Orders that direct or imply that OPM is to make payment of a portion of employee retirement benefits, or are neutral about the source of payment, will be honored unless the retiree can demonstrate that the order is invalid in accordance with § 831.1709.

(ii) Orders that specifically direct the retiree to pay a portion of employee retirement benefits to a former spouse (and do not contain language to show the court intends payment from the Civil Service Retirement System) will be honored unless the retiree objects to direct payment by OPM within the 30-day notice period prescribed in § 831.1708, but will not be honored even if the retiree raises only a general objection to payment by OPM within that 30-day notice period.

(2) For purposes of awarding a former spouse annuity, the court order must either state the former spouse's entitlement to a survivor annuity or direct an employee, Member, or retiree to provide a former spouse annuity.

(d) For purposes of affecting or awarding a former spouse annuity, a court order is not a qualifying court order whenever—

(1) The marriage was terminated before May 7, 1985; or

(2) The employee or Member on whose service the former spouse annuity is based retired under CSRS before May 7, 1985.

(e) Except in cases when divorces occur after retirement, a court order concerning a survivor annuity will not be honored if it is issued after the retirement of the employee or Member involved.

§ 831.1705 Applications by former spouse.

(a) A former spouse (personally or through a representative) must apply in writing to be eligible for benefits under this subpart. No special form is required.

(b) The application letter must be accompanied by—

(1) A certified copy of the court order granting benefits under CSRS; and

(2) A statement that the court order has not been amended, superseded, or set aside; and

(3) Identifying information concerning the employee, Member, or retiree such as his or her full name, claim number, date of birth, and social security number, if available; and

(4) The mailing address of the former spouse.

(c) When payments are subject to termination upon remarriage, no payment shall be made until the former spouse submits to the Associate Director a statement on the form prescribed by OPM certifying—

(1) That a remarriage has not occurred; and

(2) That the former spouse will notify the Associate Director within 15 calendar days of the occurrence of any remarriage; and

(3) That the former spouse will be personally liable for any overpayment to him or her resulting from a remarriage. The Associate Director may subsequently require recertification of these statements.

§ 831.1706 Amounts payable.

(a) Money held by an executive agency or OPM that may be payable at some future date is not available for payment under court orders unless all of the conditions necessary for payment of the money to the former employee or Member have been met, including, but not limited to—

(1) Separation from a covered position in the Federal service; and

(2) Application for payment of the money by the former employee or Member.

(b) Waivers of employee or Member annuity payments under the terms of Section 8345(d) of title 5, United States Code, exclude the waived portion of the annuity from availability for payment under a court order if such waivers are postmarked before the expiration of the 30-day notice period provided by § 831.1708.

(c) Payment under a court order may not exceed—

(1) In cases involving employee or Member annuities, the net annuity.

(2) In cases involving lump-sum payments (refunds), the amount of the lump-sum credit.

(3) In cases involving former spouse annuities, the amount provided in § 831.614.

(d) In cases in which court orders award former spouse annuities—

(1) Except as provided in paragraph (d)(2) of this section, former spouse annuities based on qualifying court orders will commence and terminate in accordance with the court order.

(2) A court order will not be honored to the extent it would require an annuity to commence prior to the day after the employee, Member, or retiree dies, or the first day of the second month beginning after the date on which OPM receives written notice of the court order together with the additional information required by § 831.1705. Further, a court order will not be honored to the extent it requires an annuity to be terminated contrary to section 8341(h)(3)(B) of title 5, United States Code.

(3) A court order will not be honored to the extent is is inconsistent with any joint designation or waiver previously executed under § 831.607 with respect to the former spouse involved.

§ 831.1707 Preliminary review.

(a)(1) Upon receipt of a court order and documentation required by § 831.1705 affecting the future civil service retirement benefits of an employee or Member who is living and has not applied for benefits under CSRS, the Associate Director will notify the former spouse that OPM has received the court order and documentation. The court order and documentation will be filed for further review when the employee or Member dies or funds become available under § 831.1706.

(2) When OPM has received a court order and documentation required by § 831.1705 affecting an employee or Member who retires, dies, or applies for a lump-sum benefit, the Associate Director will determine whether the court order is a qualifying court order under § 831.1704.

(3) Upon receipt of a court order and necessary documentation required by § 831.1705 affecting employee retirement benefits that are available under § 831.1706 or awarding a former spouse annuity to a former spouse of an employee who retired under CSRS or died, the Associate Director will determine whether the court order is a qualifying court order under § 831.1704.

(b) Upon preliminary determination that the court order is qualifying, the Associate Director will give the notifications required by § 831.1708.

(c) Upon preliminary determination that the court order is not qualifying, the former spouse will be notified of the basis for the determination and the right to reconsideration under § 831.109.

§ 831.1708 Notifications.

(a) In a case in which the court order affects employee retirement benefits:

(1) The Associate Director will notify the employee, Member, or retiree that a court order has been received that appears to require that a portion of his or her retirement benefits be paid to a former spouse and provide the employee, Member, or retiree with a copy of the court order. The notice will inform the former employee or Member—

(i) That OPM intends to honor the court order; and

(ii) Of the effect that the court order will have on the former employee or Member's retirement benefits; and

(iii) That no payments will be made to the former spouse for a period of 30 days from the notice date to enable the former employee or Member to contest the court order.

(2) The Associate Director will notify the former spouse—

(i) That OPM intends to honor the court order; and

(ii) Of the amount that the former spouse is entitled to receive under the court order, and in cases that award a portion of the benefits on a percentage basis or by a formula, how the amount was computed; and

(iii) That payment is being delayed for a period of 30 days to give the former employee or Member an opportunity to contest the court order.

(b) In a case in which the court order awards a former spouse annuity—

(1) The Associate Director will notify the retiree, if living, or, if the employee, Member, or retiree is dead, his or her surviving spouse, or the person entitled to the lump-sum death benefit under section 8342 of title 5, United States Code, if possible, that a court order has been received that requires the payment of a former spouse annuity. The notice will include a copy of the court order. The notice will state—

(i) That OPM intends to honor the court order; and

(ii) The effect it will have on the potential retirement benefit of the person receiving the notice; and

(iii) That any objection to honoring the court order must be filed within 30 days from the notice date.

(2) The former spouse will be notified—

(i) That OPM intends to honor the court order; and

(ii) Of the amount of survivor annuity that he or she will be entitled to receive and how the amount was computed; and

(iii) That anyone adversely affected has a period of 30 days in which to contest the court order.

(c) In a case in which the court order affects employee retirement benefits and awards a former spouse annuity all of the notices under paragraphs (a) and (b) of this section will be provided.

§ 831.1709 Decisions.

(a)(1) When the individual does not respond within the 30-day notice period provided for by § 831.1708, the court order will be honored in accordance with the notification.

(2) When a timely response to the notification is received, the Associate Director will consider the response. The former spouse's claim will be denied and the former spouse will be notified of the right to request reconsideration under § 831.109 whenever is is shown that—

(i) The court order is not a qualifying court order; or

(ii) The court order is inconsistent with a contemporaneous or subsequent court order.

(b) If any person who may lose benefits if OPM honors the court order objects to payment based on the validity of the court order and the record contains reasonable support for the objection, he or she will be granted 30 days to initiate legal action to determine the validity of the objection. If funds are available under § 831.1706 and evidence is submitted that legal action had been started before the 30 days have expired, money will continue to be withheld, but no payment will be made to the former spouse pending judicial determination of the validity of the court order.

§ 831.1710 Lump-sum credits.

Payment of the lump-sum credit to a former employee or Member will be subject to court orders in accordance with § 831.2009.

§ 831.1711 Effective dates.

(a)(1) The provisions of this subpart apply to any employee retirement

benefits regardless of the date of issuance of the court order or the date when the employee or Member retires.

(2) The Associate Director will not increase the amount apportioned from current retirement benefits to satisfy an arrearage due the former spouse unless the court order states the amount of the arrearage and directs that it be paid from the employee retirement benefit. However, the Associate Director will honor the terms of a new or revised court order that either increases or decreases the former spouse's entitlement. These changes will be prospective only.

(3) Benefits payable to a former spouse from a retiree's annuity begin to accrue no earlier than the beginning of the month after receipt of a qualifying court order and the documentation required by § 831.1705, and terminate no later than the last day of the month before the death of the retiree.

(b)(1) The provisions of this subpart concerning former spouse annuities apply only with respect to an individual who, on or after May 7, 1985, is married to an employee or Member who, on or after May 7, 1985, retires under CSRS or dies during employment covered by CSRS.

(2) The survivor annuity for a former spouse commences and terminates in accordance with the court order. However, a court order will not be honored to the extent it would require an annuity to commence before—

(i) The day after the employee, Member, or retiree dies; or

(ii) The first day of the second month beginning after OPM receives the court order, together with such additional information required by § 831.1705, whichever is later. Further, a court order will not be honored to the extent it requires an annuity to be terminated contrary to section 8341(h)(3)(B) of title 5, United States Code.

§ 831.1712 Death of the former spouse.

(a) When the former spouse predeceases the retiree, and further employee retirement benefits that would have been subject to the court order are payable, the Associate Director will seek guidance from the court upon whose order the award to the former spouse was based about the proper disposition of the former spouse's share.

(b) The request for guidance from the court will—

(1) Explain the circumstances that led to the request; and

(2) Inform the court of limitations on payments under § 831.1713 applicable to the case; and

(3) Notify the court of the effect of its failure to provide guidance.

(c) While OPM is awaiting guidance from the court, the retiree will be paid only his or her share of the annuity. The former spouse's share may be disbursed only in accordance with paragraphs (d) and (e) of this section.

(d)(1) If no response (or an inadequate response) is received from the court within 60 days from the date of receipt of the request for guidance, the full annuity will be restored to the retiree effective on the date of the first annuity check due after the death of the former spouse.

(2) Disbursement will be made only after the completion of any reconsideration and appeals procedures required by § 831.109.

(e) Payment of all or part of the former spouse's share may be made only to one of the following—

(1) The retiree; or

(2) A child or children of the retiree (or a court-appointed representative for the benefit of such children); or

(3) The court (or other State, county or municipal agency which serves as a collecting and disbursing agent for the court).

(f) The request for guidance required by this section will be sent by certified mail, return receipt requested, addressed to the clerk of the court. Copies of the request for guidance will be sent by certified mail, return receipt requested, to the retiree and to the representative of the estate of the former spouse (if an address is available).

§ 831.1713 Limitations.

(a) Employee retirement benefits are subject to apportionment by court order only while the former employee or Member is living. Payment of apportioned amounts will be made only to the former spouse and/or the children of the former employee or Member. Payment will not be made to any of the following:

(1) The heirs or legatees of the former spouse; or

(2) The creditors of the former employee or Member, or the former spouse; or

(3) Other assignees of the former employee or Member, or the former spouse.

(b) The amount of payment under this subpart will not be less than one dollar and, in the absence of compelling circumstances, will be in whole dollars.

(c) In honoring and complying with a court order, the Associate Director will not disrupt the scheduled method of accruing retirement benefits or the normal timing for making such payment, despite the existence of a special schedule of accrual or payment of amounts due the former spouse.

(d) Payments from employee retirement benefits under this subpart will be discontinued whenever the retiree's annuity payments are suspended or terminated. If annuity payments to the retiree are restored, payment to the former spouse will also resume.

(e) Since the former spouse is entitled to payments from employee retirement benefits only while the former employee or Member is living, the former spouse is personally liable for any payments from employee retirement benefits received after the death of the retiree.

§ 831.1714 Guidelines on interpreting court orders.

As circumstances require, OPM will publish in the **Federal Register** a notice of the guidelines it uses in interpreting court orders. Upon publication of the notice in the **Federal Register** of such guidelines, they will become an appendix to this subpart.

§ 831.1715 Liability.

OPM is not liable for any payment made from employee retirement benefits pursuant to court order if such payment is made in accordance with the provisions of this subpart.

§ 831.1716 Receipt of multiple court orders.

In the event that OPM receives two or more qualifying court orders—

(a) When there are two or more former spouses, the court orders will be honored in the order in which they were issued to the maximum extent possible under §§ 831.614 and 831.1706.

(b) Where there are two or more court orders relating to the same former spouse, the one issued last will be honored.

§ 831.1717 Cost-of-living adjustments.

In cases where the court order apportions a percentage of the employee retirement benefit, the Associate Director will initially determine the amount of proper payment. That amount will be increased by future cost-of-living increases unless the court directs otherwise.

§ 831.1718 Settlements.

The former spouse may request that an amount be withheld from the retirement benefits that is less than the amount stipulated in the court order. This lower amount will be deemed a complete fulfillment of the obligation of OPM for the period in which the request is in effect.

Appendix A to Subpart Q of Part 831—Guidelines for Interpreting State Court Orders Dividing Civil Service Retirement Benefits

UNITED STATES OF AMERICA

Office of Personnel Management

Compensation Group

Guidelines for Interpreting State Court Orders Dividing Civil Service Retirement Benefits

Recent inquires and controversies resulting from ambiguous court orders seeking to divide civil service retirement benefits have demonstrated a need for written guidelines explaining the interpretation which the Office of Personnel Management will place on terms and phrases frequently used in dividing benefits. These guidelines are intended not only for the use of the Office of Retirement Programs, but also for the legal community as a whole, with the hope that by informing attorneys, in advance, about the manner in which the Office of Personnel Management will interpret terms written into court orders, the resulting orders will be more carefully drafted, using the proper language to accomplish the aims of the court.

I. Cost-of-Living and Salary Adjustments

A. Unless the court directly and unequivocally orders otherwise, decrees which divide annuities either on a percentage basis or by use of a formula will be interpreted as subject to adjustment for cost-of-living and salary adjustments occurring after the issuance of the decree.

B. On the other hand, decrees which award a former spouse a specific dollar amount from the annuity will be interpreted as excluding cost-of-living and salary adjustments unless the court expressly orders their inclusion.

C. Orders which contain both a formula or percentage instruction and a corresponding fixed dollar amount will be interpreted as including the fixed amount only as the court's estimate of the initial amount of payment. The formula or percentage instruction will control in cases where conflicting instructions appear.

D. A formula containing an instruction to calculate the former spouse's share effective at the time of divorce will not be interpreted to prevent cost-of-living or salary adjustments. To award a fixed dollar amount based on the rate of annuity which would have been paid if retirement occurred at the date of divorce, the decree must either state the dollar amount of the award or explain with sufficient clarity that salary adjustments, as well as service, after the date of the decree are to be disregarded in computing the former spouse's share.

II. Types of Annuity

A. Gross annuity will be interpreted as the amount shown as gross annuity on civil service annuity master record printouts, i.e., the annuity payable after any applicable survivor deduction but before any other deduction.

B. To divide an annuity before any applicable survivor deduction the decree must contain language to the effect that the division is to be made on the life rate annuity, or the annuity unreduced for survivor benefit, or equivalent language. A division of "gross annuity" will not accomplish this purpose.

C. Net annuity or disposable annuity will be interpreted to mean net annuity as defined in § 831.1703.

D. Orders which fail to state the type of annuity which they are dividing will be interpreted as dividing gross annuity (defined above).

III. Calculating Time

A. The smallest unit of time which will be used in computing formula in a decree is a month.

1. This policy is based on the provision of section 8332 of title 5, United States Code, which allows credit for service for years or twelfth parts thereof. Requests to calculate smaller units of time will not be honored.

2. Smaller periods of time stated in terms of decimal fractions of a year contained in a decree will be limited in application to simple numerical operations performed using the extra precise number. Time calculations by the Office of Personnel Management will be no more precise than years and twelfth parts. For example, the share of a former spouse awarded a portion of the annuity equal to ½ of the fraction whose numerator is 12.863 years and whose denominator is the total service on which the annuity is based would be computed by taking ½ of the quotient obtained by dividing 12.863 by the total service measured *in years and twelfth parts.*

B. The term "military service" will generally be interpreted to include only periods of service within the definition of military service contained in section 8331(13) of title 5, United States Code, i.e., active duty military service. Civilian service with military organizations will not be included as "military service," except where the exclusion of such civilian service would be manifestly contrary to the intent of the court order.

C. When a decree contains a formula for dividing annuity which requires computation of service and unused sick leave has been used in the annuity computation, the amount of credit attributable to the unused sick leave will be computed as service if the formula instructs the use of "creditable service" (or other phrase using "credit" or its equivalent), but will exclude the time attributable to unused sick leave if the formula is based on "years of service" or "total service." Credit for unused sick leave always accrues on the date of separation for immediate retirement; it is never apportioned over the time when earned.

IV. Distinguishing Between Divisions of Annuity and Contributions

A. Orders which are unclear about whether they are dividing an annuity or contribution will be interpreted as dividing an annuity.

B. Orders using "annuities," "pensions," "retirement benefits," or similar terms will be interpreted as dividing an annuity and whatever other employee benefits became payable, such as refunds. Orders which divide "contributions," "deductions," "deposits," "retirement accounts," "retirement fund," or similar terms will be limited to division of the amount which the employee has paid into the Civil Service Retirement and Disability Fund.

V. Orders Directing the Annuitant To Make Payment

A. Orders which specifically direct the retiree to pay a portion of retirement benefits to a former spouse will be honored unless the retiree objects to direct payment by the Office of Personal Management, but will not be honored even if the retiree raises only a general objection to payment by the Office of Personnel Management.

B. Orders which direct or imply that the Office of Personnel Management is to make payment of a portion of retirement benefits, or are neutral about the source of payment, will be honored unless the retiree can demonstrate that the order is invalid.

4. By revising subpart T to read as follows:

Subpart T—Payment of Lump Sums

Sec.

Authority: 5 U.S.C. 8347.

Subpart T—Payment of Lump Sums

§ 831.2001 Definitions.

"Court order or decree" means the order or decree of any court of any State, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, the Virgin Islands or any Indian court, as defined section 8331(24) of title 5, United States Code.

"Current spouse" means a person who is married to the employee or Member at the time the application for refund is filed.

"Former spouse" means a living person who was married for at least 9 months to an employee or Member who had performed at least 18 months of creditable service in a position covered by the retirement system.

"Retirement system" means the civil service retirement system as described in subchapter III of chapter 83 of title 5, United States Code.

§ 831.2002 Eligibility for lump-sum payment upon filing an Application for Refund of Retirement Deductions (SF 2802).

Except as provided in §§ 831.2007 through 2009 or in section 3716 of title 31, United States Code, on administrative offset for government claims, a former employee or Member who has been separated from a covered position for at least 31 days at the time of filing an application for refund and who is ineligible for an annuity commencing within 31 days after the date of filing an application for refund is eligible for a refund for the total lump-sum credit to his or her credit in the Retirement Fund.

§ 831.2003 Eligibility for lump-sum payment upon death or retirement.

(a) If there is no survivor who is entitled to monthly survivor annuity benefits on the death of a former employee, Member, annuitant, or survivor annuitant, the total lump-sum credit to the former employee's or Member's credit in the Retirement Fund is payable, except as provided in section 3716 of title 31, United States Code, on administrative offset for government claims, to the person(s) entitled in the normal order of precedence described in section 8342(c) of title 5, United States Code.

(b) If an annuity is payable, the former employee, Member or the person entitled in the order of precedence described in section 8342(c) of title 5, United States Code, may be paid, except as provided in section 3716 of title 31, United States Code, administrative offset for government claims, lump-sum payment of—

(1) Retirement deductions withheld from the employee's or Member's pay after he or she became eligible for the maximum annuity, if the employee or Member does not elect to treat those deductions as voluntary contributions toward the purchase of an additional annuity; and

(2) Retirement deductions withheld from the employee's or Member's pay during his or her final period of service if the employee or Member was not subject to the retirement system for at least one of the last 2 years before final separation from service and if the service covered by the deductions is not used for title to annuity; and

(3) Partial redeposits of refunds previously paid; and

(4) Partial deposits for civilian service performed on and after October 1, 1982; and

(5) Partial deposits for post-1956 military service; and

(6) Annuity accrued and unpaid.

(c) A former employee, Member, or survivor who is eligible for an annuity may not be paid a lump-sum payment of—

(1) Partial or completed deposits for nondeduction civilian service performed before October 1, 1982, unless the service covered by the deposit is not creditable under the retirement system; or

(2) Completed deposits for nondeduction civilian service performed on and after October 1, 1982, unless the service covered by the deposit is not creditable under the retirement system; or

(3) Completed deposits for post-1956 military services, unless the service covered by the deposit is not creditable under the retirement system.

Payments of the partial or completed deposits mentioned in this paragraph are subject to 31 U.S.C. 3716 (administrative offset for government claims).

§ 831.2004 Amount of lump-sums.

If applicable, the amount of a refund will include interest computed as described in § 831.105(b).

§ 831.2005 Designation of beneficiary for lump-sum payment.

(a) The Designation of Beneficiary must be in writing, signed, and witnessed,and received in OPM before the death of the designator.

(b) No change or cancellation of beneficiary in a last will or testament, or in any other document not witnessed and filed as required by this section, has any force or effect.

(c) A witness to a Designation of Beneficiary is ineligible to receive payment as a beneficiary.

(d) Any person, firm, corporation, or legal entity may be named as beneficiary.

(e) A change of beneficiary may be made at any time and without the knowledge or consent of the previous beneficiary, and this right cannot be waived or restricted.

§ 831.2006 Designation of agent by next of kin.

When a deceased employee, Member, or annuitant has not named a beneficiary and one of the next of kin entitled makes a claim for lump-sum benefit, other next of kin entitled to share in the lump-sum benefit may designate the one who made the claim to act as their agent to receive their distributive shares.

§ 831.2007 Notification of current and/or former spouse before payment of lump sum.

(a) Payment of the lump-sum credit based on a refund application filed on or after May 7, 1985, may be made only if any current spouse and any former spouse (from whom the employee or Member was divorced after May 6, 1985) are notified of the former employee's or Member's application.

(b) Notification of the former spouse will not be required if the marriage to the former spouse was of less than 9 months duration or if the employee has not completed a total of 18 months of creditable service covered under the retirement system.

(c) Proof of notification will consist of a signed and witnessed statement by the current and/or former spouse on a form provided by OPM acknowledging that he or she has been informed of the former employee's or Member's application for refund and the consequences of the refund on the current or former spouse's possible annuity entitlement. This statement must be presented to the employing agency or OPM when filing the Application for Refund of Retirement Deductions (SF 2802).

(d) If the current and/or former spouse refuses to acknowledge the notification or the employee or Member is otherwise unable to obtain the acknowledgement, the employee or Member must submit—

(1) A signed postal return receipt as evidence that the notification was received at the address of the current or former spouse; or

(2) Affidavits signed by two individuals who witnessed the employee's or Member's attempt to personally notify the current or former spouse. The witnesses must attest that they were in the presence of the employee or Member and the current or former spouse when the notification attempt was made and that the employee's or Member's purpose should have been clear to the current or former spouse.

(e) If a *former* spouse refuses to acknowledge the notification or the employee or Member is otherwise unable to obtain the acknowledgement of a former spouse, the employee or Member may submit a certified copy of a court order or decree wherein the former spouse has relinquished all claim to the employee's or Member's annuity or which awards the annuity wholly to the employee or Member.

§ 831.2008 Waiver of spouse and/or former spouse notification requirement.

The current and/or former spouse notification requirement will be waived upon a showing that the current and/or former spouse's whereabouts cannot be determined. A request for waiver on this basis must be accompanied by—

(a) A judicial or administrative determination that the current and/or former spouse's whereabouts cannot be determined; or

(b) Affidavits by the former employee or Member and two other persons at least one of whom is not related to the former employee or Member attesting to the inability to locate the current and/or former spouse and stating the efforts made to locate the current and/or former spouse.

§ 831.2009 Court orders or decrees preventing payment of lump sums.

(a) Payment of the lump-sum credit to a former employee or Member will be subject to the terms of any court order or decree issued with respect to any former spouse from whom the employee or Member was divorced after May 6, 1985 if—

(1) The court order or decree expressly relates to any portion of the lump-sum credit involved; and

(2) Payment of the lump-sum credit would extinguish entitlement of the former spouse to a survivor annuity under section 8341(h) of title 5, United States Code, or to any portion of an annuity under section 8345(j) of title 5, United States Code.

(b) For paragraph (a) of this section to have effect, OPM must be in receipt of the court order or decree before authorizing payment of the refund.

(c)(1) In the event that OPM receives two or more court orders or decrees—

(i) When there are two former spouses, the court orders or decrees will be honored in the order in which they were issued until the lump-sum has been exhausted.

(ii) When there are two or more court orders or decrees relating to the same former spouse, the one issued last will be honored first.

(2) In no event will the amount paid out exceed the amount of the lump-sum credit.

(d) OPM is not liable for any payment made from money due from or payable by OPM to any individual pursuant to a court order or decree regular on its face, if such payment is made in accordance with this subpart.

[FR Doc. 85–11562 Filed 5–10–85; 8:45 am]

BILLING CODE 6325–01–M