Rules of
Department of Social Services
Division 40—Family Support Division
Chapter 13—Blind Pension

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Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 13—Blind Pension

13 CSR 40-13.020 Vision Re-examination

PURPOSE: This rule establishes the requirements to determine whether an individual previously eligible for a blind pension is required to submit to a re-examination of the individual's vision every five (5) years.

(1) Scope: This rule specifies how and when an individual eligible for a blind pension is required to submit to a re-examination of the individual's vision every five (5) years.

(2) An individual has "no usable vision" when—
(A) One (1) or both of the following two (2) conditions are met:
1. The individual has no vision of any kind; or
2. The individual's vision, with or without proper adjusted glasses, or assistive technology, is determined to be up to, but not including, 5/200, or whose best visual field is five (5) degrees as tested with five (5) millimeter target or perimeter; and
(B) The individual's vision loss at this level is permanent; or is medically unlikely to return or improve, with or without assistive technology.

(3) Applicants for a blind pension and pensioners may apply to the Family Support Division for a waiver of the requirement that they submit to a re-examination of their vision every five (5) years as authorized in section 209.040, RSMo. To qualify for the waiver the individual shall have no usable vision as certified by an ophthalmologist, a physician skilled in diseases of the eye, or an optometrist, designated or approved by the Family Support Division after an examination. The certification required by this section shall be in writing and submitted to the Family Support Division on a form provided by the division or in a letter on the provider's letterhead within ninety (90) days of the examination conducted to determine if the individual has no usable vision. The form or letter shall be personally signed by the health care provider conducting the examination. The form or letter shall include the following information:
(A) The name and license number of the ophthalmologist, physician skilled in disease of the eye, or optometrist who conducted the examination;
(B) The name of the individual examined and the date of the examination;
(C) The ophthalmologist, physician skilled in disease of the eye, or optometrist who conducted the examination shall state whether—
1. The individual has no vision of any kind; or
2. The individual's vision, with or without proper adjusted glasses, is up to, but not including, 5/200, or his/her best visual field is five (5) degrees or less as tested with a five (5) millimeter target or perimeter; and
(D) The ophthalmologist, physician skilled in disease of the eye, or optometrist who conducted the examination shall state whether that the individual's vision loss is—
1. Permanent; or
2. Is medically unlikely to return or improve, with or without glasses or assistive technology.

(4) The Family Support Division shall grant the waiver to applicants for a blind pension and blind pensioners upon receipt of the certification required in section (3).

(5) Blind pensioners who have been granted a waiver under this regulation shall notify the Family Support Division if they experience any improvement in their vision, with or without assistive technology, within sixty (60) days of the change in vision. The notification shall be in writing and shall comply with the requirements of section (5).

(6) Blind pensioners who have been granted a waiver of the vision re-examination shall certify that their vision has not improved at the time of their annual eligibility redetermination. The individual shall provide the following information when making the written certification:
(A) The name of the individual making the certification;
(B) The individual's current physical address;
(C) Mailing address, if different from physical address;
(D) The individual's department client number or Social Security number;
(E) A statement that the pensioner certifies, subject to penalty of perjury, that his or her vision has not improved, with or without glasses or assistive technology; and
(F) The certification shall be signed by the blind pensioner.

(7) Whenever the blind pensioner reports that his or her vision has improved or the Family Support Division otherwise has reasonable cause to believe that a blind pensioner's vision has improved, the Family Support Division shall require the blind pensioner to submit to a vision re-examination to determine whether the individual is still qualified for the waiver or for blind pension benefits. The blind pensioner shall promptly submit to an eye re-examination by ophthalmologist, a physician skilled in diseases of the eye, or an optometrist, designated or approved by the Family Support Division when requested to do so by the division.

(8) The Family Support Division shall deny or terminate a waiver at any time the Family Support Division determines that a blind pensioner who has applied for, or who is under a waiver under this section—
(A) Is not eligible for the waiver;
(B) Has failed to timely notify the Family Support Division of any change in his or her vision, who fails to submit to a re-examination under section (6); or
(C) Who otherwise fails to comply with his or her responsibilities under this section.

(9) Any blind pension payment made to a pensioner under a waiver who was not qualified for the waiver shall be a debt immediately due to the state and collected as overpayment. The blind pensioner shall repay the sum of the blind pension payments that the individual was not entitled to receive. Repayment shall be in a lump sum, or may be deducted from the blind pensioner's blind pension payment in equal installments over a period not to exceed sixty (60) months.

(10) Certifications submitted by mail, or any commonly available electronic means such as fax or e-mail, shall be accepted and treated the same as an in-person filing of a certification. A blind pensioner who submits a certification by electronic transmission certifies under penalty of perjury that the certification and the information contained therein is true, accurate, and authentic. The blind pensioner shall retain and provide the original certification to the Family Support Division upon request.

(11) Any blind pensioner who intentionally or knowingly submits, or causes to be submitted, false information to the Family Support Division in support of a waiver under this regulation shall not be deemed a person of good moral character and shall not be eligible for a blind pension.

(12) All information provided to the Missouri Department of Social Services, Family Support Division in the certification shall be true, accurate, and complete.

(13) A blind pensioner who is aggrieved by a

decision of the division under this regulation may appeal the division's decision pursuant to section 209.110, RSMo.

AUTHORITY: section 209.040, RSMo Supp. 2014, and section 660.017, RSMo 2000. Original rule filed Jan. 12, 2015, effective July 30, 2015.*

**Original authority: 209.040, RSMo 1939, amended 1945, 1947, 1949, 1951, 1953, 1955, 1959, 1961, 1963, 1965, 1967, 1969, 1973, 1975, 1976, 1978, 1980, 1981, 1982, 1983, 1984, 1986, 1991, 2014 and 660.017, RSMo 1993, amended 1995.*

13 CSR 40-13.030 Adjustment of Blind Pension Payments
(Rescinded August 30, 2015)

AUTHORITY: sections 207.020.1(5) and 209.040.2, RSMo Supp. 2014, and section 660.017, RSMo 2000. Emergency rule filed Oct. 8, 2014, effective Oct. 18, 2014, expired April 15, 2015. Original rule filed July 28, 2014, effective Jan. 30, 2015. Rescinded: Filed Jan. 27, 2015, effective Aug. 30, 2015.

13 CSR 40-13.040 Blind Pension Prescription Drug Coverage

PURPOSE: This rule establishes the basis on which Medicare-eligible blind pension participants will receive prescription drug coverage.

(1) For purposes of this rule, the following definitions shall apply:

(A) "Benchmark plan" means a prescription drug plan with premiums at or below the low-income benchmark premium amount established for the Missouri region annually by the Centers for Medicare and Medicaid Services (CMS) as set forth in 42 CFR section 423.780, including *de minimis* plans as contemplated in 42 CFR section 423.780(f).

(B) "Covered outpatient drug" has the same meaning as that term is defined in section 1927(k) of the Social Security Act.

(C) "Creditable prescription drug coverage" means non-Medicare coverage as defined in 42 CFR section 423.56, where the actuarial value of that coverage equals or exceeds the actuarial value of defined standard prescription drug coverage under Medicare Part D in effect at the start of each plan year.

(D) "Department" means the Missouri Department of Social Services.

(E) "Prescription drug plan" or "PDP" means prescription drug coverage that is offered under a policy, contract, or plan that has been approved as specified in 42 CFR section 423.272 and that is offered by a PDP sponsor that has a contract with CMS that meets the contract requirements under subpart K of Part 423 of Title 42 of the *Code of Federal Regulations*.

(F) "Participant" means an individual under section 208.151.1(3), RSMo, who is receiving medical assistance by reason of receiving blind pension benefits and who is eligible for Medicare Part D as set forth in 42 CFR section 423.30, who is not otherwise eligible for Medicaid benefits under Title XIX of the Social Security Act.

(2) All participants shall receive prescription drug coverage through a benchmark plan unless they otherwise demonstrate to the department that they receive creditable prescription drug coverage.

(A) Participants shall be responsible for initial and subsequent enrollment in a benchmark plan as set forth in 42 CFR section 423.32.

(B) Participants shall provide the department with notice of enrollment in a benchmark plan by December 15th of each year. Notice of enrollment may be made in writing on a form made available by the department, or by phone, email, facsimile, or other commonly available electronic means, and shall include, at a minimum:

1. The participant's name, Departmental Client Number (DCN), and Medicare Health Insurance Claim (HIC) number; and

2. The name and Plan ID number of the benchmark plan.

(C) A participant may authorize the department to act on the participant's behalf to enroll him or her in a benchmark plan selected by the department by providing written authorization and any information necessary for the department to do so no later than the midpoint of the annual open enrollment period.

(D) Participants shall provide the department with written notice of disenrollment from a benchmark plan for any reason within fifteen (15) days of the participant receiving notice of disenrollment from the benchmark plan. A participant who voluntarily disenrolls from a benchmark plan and is not able to, or elects not to, reenroll in a benchmark plan shall be responsible for any late enrollment penalty that results from his or her voluntarily disenrollment.

(E) Participants receiving creditable prescription drug coverage shall notify the department in writing of such coverage with sufficient information to identify the entity providing creditable prescription drug coverage, including the participant's policy number and the insuring entity's name.

(F) A participant receiving creditable prescription drug coverage, who involuntarily loses such coverage, shall notify the department in writing or by phone, email, facsimile, or other commonly available electronic means of his or her loss of creditable prescription drug coverage within thirty (30) days of receiving notice of loss of creditable prescription drug coverage.

(3) The department shall notify a participant prior to the open enrollment period if the participant's PDP will not be considered a benchmark plan for the upcoming plan year. Participants affected by a change in benchmark plan status shall enroll in a benchmark plan for the upcoming plan year.

(A) Participants affected by a change in benchmark plan status shall notify the department by the midpoint of the annual open enrollment period, in writing or by phone, email, facsimile, or other commonly available electronic means, of an intention to enroll in a benchmark plan.

(B) A participant may authorize the department to act on the participant's behalf to enroll him or her in a benchmark plan selected by the department as set out in subsection (2)(C) above.

(C) If a participant has not notified the department of an intention to enroll in a benchmark plan by the midpoint of the annual open enrollment period, the department may act on the participant's behalf to enroll him or her in a benchmark plan for the upcoming plan year. Participants so enrolled shall be notified promptly of the enrollment and—

1. The procedures by which the participant may disenroll from the benchmark plan and enroll in a different benchmark plan;

2. The existence of alternative benchmark plans; and

3. The manner in which the participant may change his or her enrollment to an alternative benchmark plan, or obtain assistance in doing so.

(4) The department shall pay all premiums, deductibles, copayments, and coinsurance associated with a participant's prescription drug coverage under his or her benchmark plan.

(A) The department may pay the prescription drug costs incurred by a participant for covered outpatient drugs that are not part of his or her benchmark plan's formulary or are obtained from a pharmacy that is not in his or her benchmark plan's network. Such payments will comply with the MO HealthNet Division's Pharmacy program set out in Chapter 20 of Division 70 of Title 13 of the *Code of State Regulations*.

(B) The department will not pay any costs associated with a participant's enrollment in a PDP that is not a benchmark plan.

(5) The procedures set forth in subpart M of Part 423 of Title 42 of the *Code of Federal Regulations* shall be the participant's exclusive remedies for grievances, coverage determinations, redeterminations, and reconsiderations regarding prescription drug coverage under this section, except that payment determinations made under subsection (4)(A) above shall be afforded administrative hearing rights under section 208.080, RSMo.

AUTHORITY: sections 207.020 and 209.010, RSMo Supp. 2014. Original rule filed Oct. 8, 2014, effective May 30, 2015.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993, 2014 and 209.010, RSMo 1939, amended 2014.*