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 40-13.030 Adjustment of Blind Pension Payments

PURPOSE: This regulation is to establish the procedures and methods by which the Department of Social Services will reduce pension payments to blind pensioners where the funds at the disposal of or may be obtained by the department for payment of blind pension payments are insufficient to pay the full pension payment to each person entitled to a blind pension payment as authorized in section 209.040.2, RSMo.

(1) Purpose and Scope. This regulation establishes the procedure and method by which the Department of Social Services will reduce pension payments to blind pensioners where the funds at the disposal of or may be obtained by the department for payment of blind pension payments are insufficient to pay the full pension payment to each person entitled to a blind pension payment as authorized in section 209.040.2, RSMo.

(2) Definitions. For the purposes of this section—

(A) "Budget reserve fund" means the budget reserve fund established in Art. IV, section 27(a) of the *Missouri Constitution*;

(B) "Cash operating transfers" means cash operating transfers as defined in Art. IV, section 27(a) of the *Missouri Constitution*.

(C) "Department" means the Missouri Department of Social Services;

(D) "Family Support Division" or "FSD" means the Family Support Division of the Department of Social Services;

(E) "Funds at the disposal of the department" means total actual or estimated revenues to the blind pension fund and any balance in the fund at the beginning of a fiscal year; and

(F) "The fund" means the Blind Pension Fund established under Art. III, section 38(b) of the *Missouri Constitution* and administered by the department pursuant to Chapters 207, 209, and 660, RSMo.

(3) Methodology.

(A) Within thirty (30) days of the effective date of this regulation and thereafter on an annual basis, no later than thirty (30) days after the beginning of each fiscal year, the department shall determine whether the total revenues and other revenues which the department knows or reasonably expects to be deposited in the blind pension fund minus known or anticipated obligations from the fund will be sufficient to pay the full amount of benefits to each blind pensioner until the end of the first calendar month following the current fiscal year. If the total amount of estimated, blind pension payments, calculated pursuant to section 209.040.4, RSMo plus other obligations from the fund, exceeds the funds at the disposal of or which may be obtained by the department for that purpose, then the department will calculate the amount of pro rata reduction for each pension payment. The department shall determine whether the total tax revenues and other revenues deposited in the fund minus obligations are sufficient to pay the full amount of benefits to each blind pensioner through the end of the first calendar month following the current fiscal year utilizing the following methodology:

Amount of pension payment reduction = r = p (1-(a/o))
Prorated maximum monthly blind pension payment = pp = p – r where:

p = the blind pension payment for the fiscal year in question calculated according to the formula set forth in section 209.040.4, RSMo;
a = funds at the disposal of or which may be obtained by the department for payment of benefits for the time period under assessment minus any mandatory legal obligations of the fund other than pension payments; and
o = the total amount of blind pension payments obligated during the time period under assessment.

If the department determines that there are insufficient monies in the fund to make a full pension payment to each pensioner each month through the end of the current fiscal year, the department shall reduce the amount of each pensioner's pension payment to the prorated maximum monthly blind pension payment. The monthly, prorated, blind pension payment to each Supplemental Aid to the Blind (SAB) participant shall be calculated as follows:

Prorated maximum monthly SAB pension payment = pp – s

Where:

pp = Prorated maximum monthly blind pension payment calculated above; and
s = the individual blind pensioner's monthly SSI payment.

The amount of the pension payment reduction shall be rounded up to the nearest dollar.

Example 1: Calculation of pro rata reduction for State Fiscal Year 2014
FY 12 revenues = $29,500,000
FY 13 revenues = $29,980,000
FY 14 expected revenue = (fy2013-fy2012) + FY2013 = $30,460,000
Monthly maximum grant (p) calculated under section 208.040.4, RSMo = $711
Beginning fund balance for FY 14 = $1,000,000
FY 14 estimated expenditures = $32,240,000

Expected funds available as of August 1, 2013 = ($31,460,000-($32,240,000/12 months) = $28,773,333

Estimated expenditures for August 1, 2013 through June 30, 2014 = ($32,240,000/12 months x 11 months) = $29,553,333

Reduction (r) = $711(1-($28,773,333/$29,553,333)) = $19

Prorated maximum monthly pension payment = $711 – $19= $692

Example 2: SSI participant with an SSI grant of $500
Same facts as Example 1
Prorated maximum monthly SAB pension payment = $692 - $500 = $192

(B) If at any time the department determines that there will be insufficient funds in the blind pension fund to pay the full, prorated, blind pension payment to each pensioner that each pensioner is entitled to receive in a calendar month, the department shall prorate the monthly pension payment utilizing the methodology set forth in subsection (3)(A) until either the end of the first calendar month of the following fiscal year or the blind pension fund has a sufficient balance to pay all pensions due at the prorated amount in that month, whichever takes place first. In any month that pensions are not paid under this subsection any monies shall remain in the blind pension fund unless the treasurer sweeps the fund as authorized by Art. III, section 38(b), section 209.130, RSMo, or other applicable law.

(C) Cash operating transfers from the budget reserve fund shall not be considered funds at the disposal of the department or which may be obtained by the department for purposes of all calculations under this regulation.

(4) The department shall notify the blind pensioners when it implements a reduction of blind pension payments under this regulation. Notification shall be served on the pensioners no later than forty-five (45) days prior to the effective date of the reduction. The notification shall be mailed to each pensioner at his or her address of record with the blind pension program; or served on the pensioner by e-mail or some other secure, convenient means of electronic transmission if such means is available to the department. The notification shall specify the amount of the reduction in the payment and shall generally describe the reasons for the department's decision. The notice may be provided separately, or it can be included as part of another notice.

(5) Any reduction in the blind pension payments under this regulation is a mass adjustment to the pension payments for all blind pensioners and is not a decision in an individual case. Individual pensioners shall not have the right to administrative review of the decision.

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.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993, 2014; 209.040, RSMo 1939, amended 1945, 1947, 1949, 1951, 1953, 1955, 1959, 1961, 1963, 1965, 1967, 1969, 1971, 1973, 1975, 1976, 1978, 1980, 1981, 1982, 1983, 1984, 1986, 1991, 2014; and 660.017, RSMo 1993, amended 1995.*

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.*