I. For those Title XVIII services not otherwise covered by the Title XIX State Plan, the Medicaid agency will establish rates for those services at 80% of the full Medicare allowable charge for use in determining the amount of coinsurance and deductible due the provider.

II. Full co-insurance is applicable to Medicare Part A skilled nursing services.

10-02 III. For certain drugs and medical supplies provided by a pharmacy or DME provider only when covered by Medicare, the Department will pay the full coinsurance and deductible amounts. When not covered by Medicare, the Department will reimburse the pharmacy or DME provider according to its regular Medicaid reimbursement methodologies. A detailed list of the applicable drugs and supplies is available on the IDPA web site www.state.il.us/dpa/. The Department will alert enrolled pharmacies and outpatient hospital pharmacies of any additions, deletions, and changes to this list via a "Informational Notice" to those providers.

07/09 IV. For Qualified Medicare Beneficiaries (QMBs) enrolled in Medicare Advantage Plans, excluding Private Fee-For-Service (PFFS) Plans ~~Plus Choice Health Maintenance Organizations (HMOs)~~, the capitated payment for co-insurance and deductibles will be negotiated with the Plan ~~HMO~~. The maximum monthly capitated payment rates will be determined as follows, using ~~State fiscal year 1994 data~~ the most recent year for which fee-for-service data is considered complete by the Department:

a) Segregate the eligible QMB population into separate categories according to Age (less than 65, and 65 and older).~~:~~

~~1) The geographic rate-setting areas utilized in determining the capitated payment rates for Medicaid managed care organizations;~~

~~2) Age (less than 65 years, 65 to 74, 75 to 84, 85 to 94 and greater than or equal to 95); and~~

~~3) Gender~~

b) Within each eligible QMB category, the total Medicare Part A and Part B deductibles and co-payments paid by the Department will be compiled and then divided by the total eligible months for QMBs of that category. The resulting average expenditure amount will be the monthly fee-for-service equivalent for that eligible QMB category.

c) ~~Rate cells will be combined if the respective fee-for-service equivalents are not statistically different, or if the population for a cell is not great enough for a valid average utilization calculation.~~ Actuarially based adjustments will be applied to the monthly fee-for-service equivalent rates to account for differences in Medicare Advantage Plan cost sharing as well as any allowable administrative costs.

d) ~~For maximum rates to be paid for State fiscal year 1995 services, the FY1994 fee-for-service equivalent will be inflated according to the 1994 fourth quarter DRI Health Care Cost Inflation Index for the North Central States. For the maximum rates to be paid for State fiscal years 1996 and later, the base FY1994 claims will be inflated by the average of the four quarters of the DRI inflators for each year through the year for which the maximum rate will be calculated.~~ The adjusted fee-for-service equivalent rates will be trended to the midpoint of the rate period for which they are being set.

e) ~~The inflated fee-for-service equivalent will then be multiplied by 0.92 for an eight~~

~~percent cost savings, thus establishing the HMO maximum rates for QMBs.~~ Maximum monthly capitated payment rates shall be recalculated every three years.

V. For QMBs enrolled in PFFS Plans, coinsurance and deductible amounts will be paid to providers and determined similar to the amounts calculated for beneficiaries enrolled in original Medicare.