Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: FY2024-FY2044

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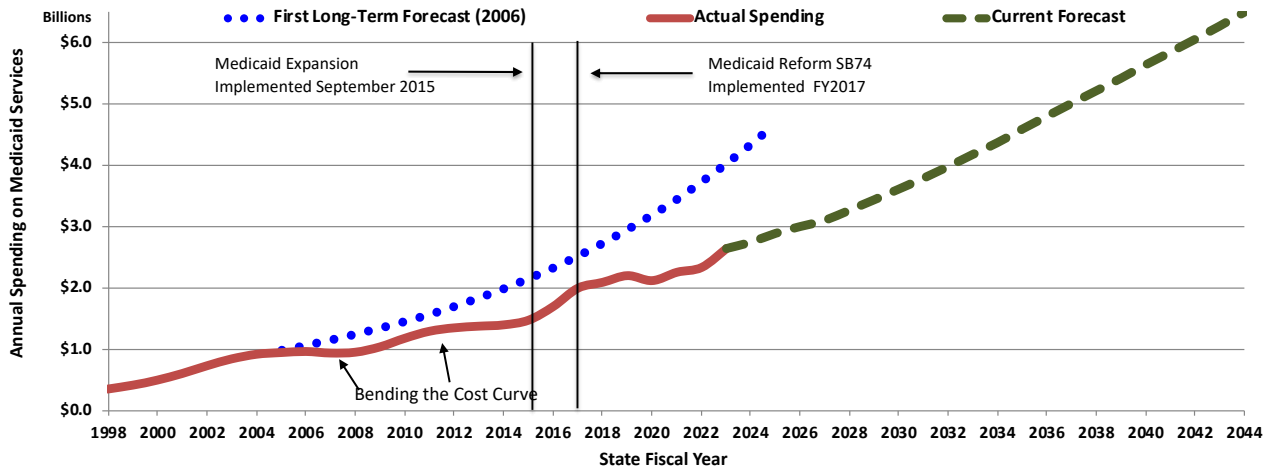
Executive Summary

This forecast is an update to the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025*, which was released by the Alaska Department of Health and Social Services (DHSS), now the Department of Health (DOH), in February 2006. In this update, we develop long-term forecasts of enrollment in and spending on services provided by Alaska's Medicaid program for fiscal year (FY) 2024 through FY2044. The projections presented in this report are based on the Medicaid policies, services offered, and eligibility requirements in place today. Alaska's Medicaid program has changed considerably since 2006 and will likely continue to evolve and change over the next 20 years. Nevertheless, the purpose of the long-term forecast is to inform decision makers about how Medicaid spending in Alaska will likely evolve given the structure of the program as it exists today.

Summary of the Long-Term Forecast of Medicaid Enrollment and Spending in Alaska

Figure 1 shows actual spending on Medicaid services beginning in FY1998 (solid red line), projected spending from the first long-term Medicaid forecast (blue dotted line), and the current projection of Medicaid spending (green dashed line). Actual spending on Medicaid services in FY2023 was nearly $1.4 billion less than was projected in the first long-term Medicaid forecast. Much of this difference is attributable to cost saving efforts by the Alaska Legislature and DHSS, which helped "bend the cost curve" on Medicaid spending. We project total spending on Medicaid services will reach nearly $6.5 billion by 2044.

Figure 1: Spending on Medicaid Services – Actual and Projected, FY1998 – FY2044

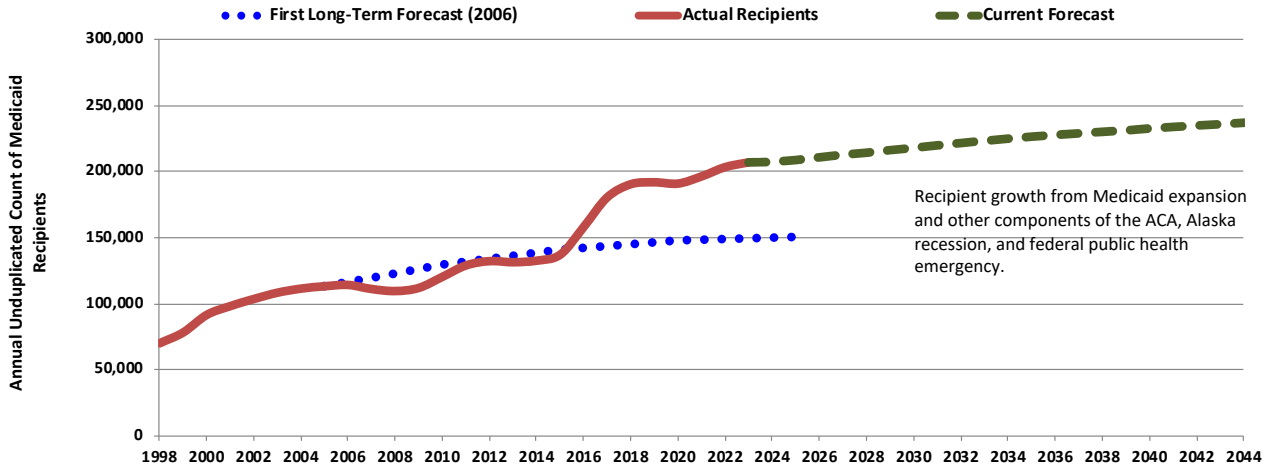


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Figure 2 shows the number of Medicaid enrollees who received Medicaid services (referred to as "recipients") each year beginning in FY1998 and the projected number of Medicaid recipients from the first long-term Medicaid forecast and for the current forecast.[1] Between FY2006 and FY2015, the actual number of Medicaid recipients tracked closely to the number of recipients projected in the 2006 forecast. However, with the initiation of Medicaid expansion in September 2015, enrollment in Medicaid increased considerably through FY2023, which in turn led to substantial growth in the number of recipients of Medicaid services.

The number of recipients decreased slightly in FY2020 as some elective procedures were canceled by providers and many Medicaid enrollees chose to postpone visits to healthcare providers due to concerns related to COVID-19. However, growth in utilization of Medicaid services has since rebounded and, for the current forecast, we expect the number of Medicaid recipients to continue to grow, but at a decreasing rate through the projection period.

Figure 2: Medicaid Recipients – Actual and Projected, FY1998 – FY2044



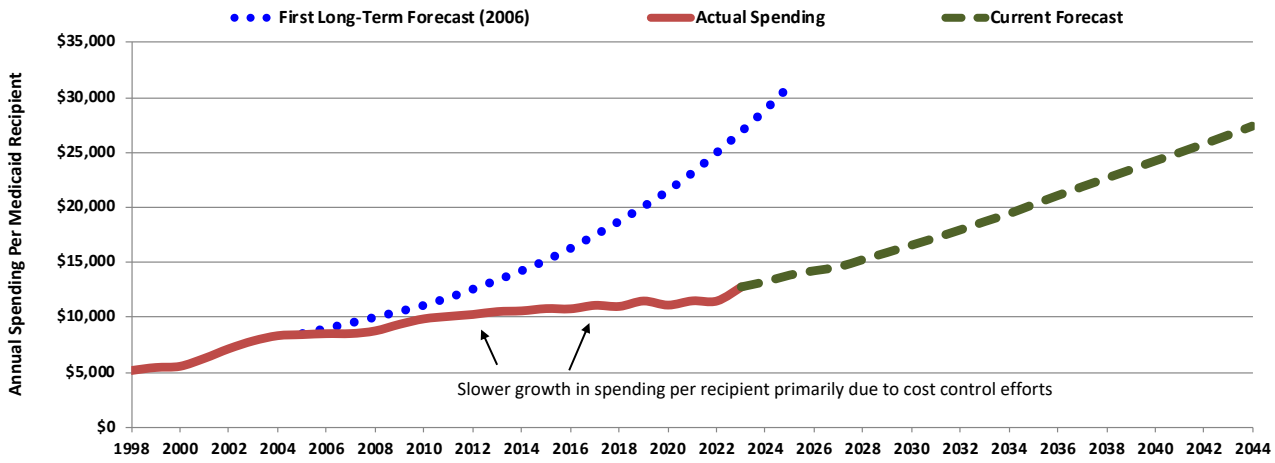
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

As noted, spending on Alaska's Medicaid program is considerably less today than was projected in the first long-term Medicaid forecast. At the same time, the number of Medicaid recipients is much greater today than was projected in 2006. The net effect of lower-than-projected spending and greater-than-projected numbers of recipients is much lower-than-projected average spending per Medicaid recipient. Figure 3 shows actual average annual spending per recipient (red line), as

[1] The term "Medicaid enrollee" refers to an individual enrolled in the Medicaid program at any time during a fiscal year regardless of whether the individual utilized any services provided by the Medicaid program.
The term "Medicaid recipient" refers to a Medicaid enrollee who utilized Medicaid services at least one time during a fiscal year. In FY2023, 73 percent of Medicaid enrollees were also recipients, which means that about one of every four (27%) Medicaid enrollees did not receive any Medicaid services in FY2023.

well as projected spending per recipient from the current and the first long-term Medicaid forecasts.

Figure 3: Medicaid Spending per Recipient – Actual and Projected, FY1998 – FY2044



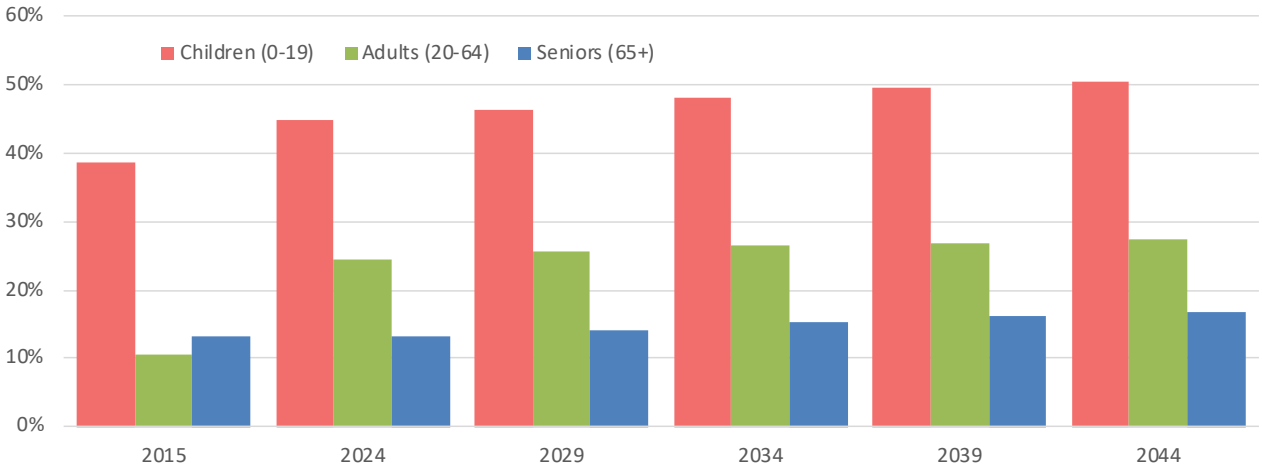
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Across all age cohorts, the proportion of Alaskans receiving services through the Medicaid program has grown, and we expect it to continue to grow—though at a much slower rate. Figure 4 shows the proportion of Alaska children,[2] adults, and seniors who received Medicaid services in FY2015—the fiscal year prior to the initiation of Medicaid expansion—and are projected to receive Medicaid services over the next 20 years.

Due primarily to Medicaid expansion, approximately 24 percent of adults will receive services through Alaska's Medicaid program in FY2024, up from just 10.6 percent in FY2015. We project that 26 percent of Alaska adults will be Medicaid recipients by FY2034 and that approximately 27 percent will be recipients by FY2044. We project that the proportion of seniors receiving Medicaid services will grow from 13.1 percent in FY2024 to 17 percent by FY2044, and that the proportion of Alaska children receiving Medicaid services (or services through the Children's Health Insurance Program [CHIP]) will grow from 45 percent in FY2024 to 51 percent in FY2044.

[2] Throughout this report, we use three general age categories: children to refer to anyone under 20 years of age, adults to refer to those 20 to 64 years of age, and seniors to refer to anyone 65 years of age or older.

Figure 4: Medicaid Recipients as a Proportion of Alaska's Population for Selected Fiscal Years



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

We project that total spending on Medicaid services will increase from $2.74 billion in FY2024 to nearly $6.5 billion in FY2044—an average of 4.4 percent per year. This projected rate of growth in Medicaid spending is substantially lower than the projected growth rate from the first long-term forecast completed in 2006, but greater than the rate projected last year due to higher inflation expectations over the next two decades. We project that spending on Medicaid services by the State of Alaska (from state general funds) will grow on average by 4.9 percent and federal spending will grow by 4.2 percent per year through FY2044 (Table 1). The greater projected rate of growth in spending for the State of Alaska is due to the sunsetting of the additional federal financial participation as part of the federal COVID-19 pandemic emergency.

Table 1: Projected State and Federal Spending on Medicaid Services (in Millions $)

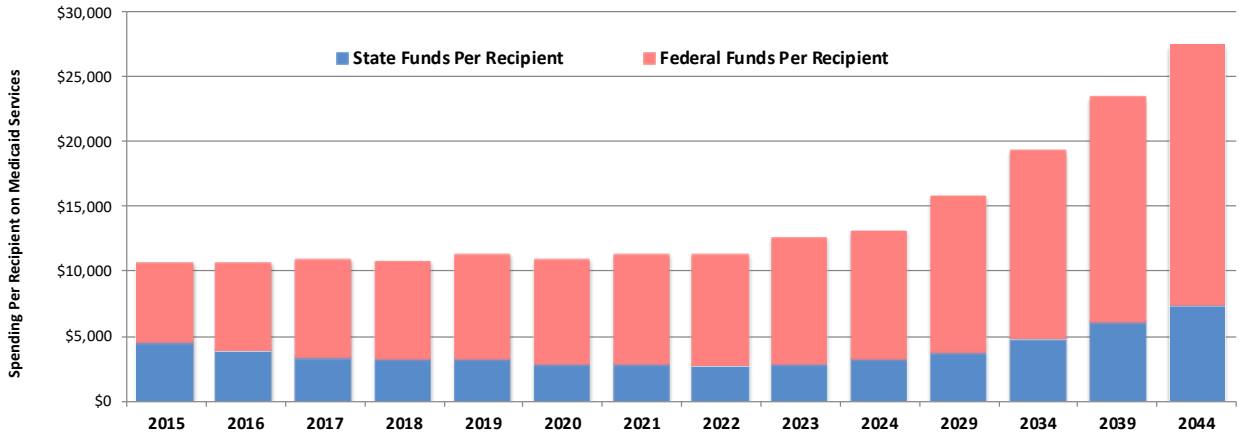
Fund Source	2015	2024	2029	2034	2039	2044	Annual Growth*
State General Funds	$681.1	$696.5	$886.7	$1,151.0	$1,482.8	$1,829.9	4.9%
Federal	$900.7	$2,046.2	$2,547.4	$3,217.3	$3,935.8	$4,666.8	4.2%
Total Spending*	**$1,581.8**	**$2,742.7**	**$3,434.1**	**$4,368.3**	**$5,418.5**	**$6,496.7**	**4.4%**

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Annual growth computed from FY2024 to FY2044.

Figure 5 shows recent actual and projected future spending per Medicaid recipient. Between FY2015 and FY2022, spending per Medicaid recipient was flat, and the proportion paid with state general funds decreased substantially. Between FY2022 and FY2023, average spending per recipient grew by nearly $1,300 (11.2%), but average general fund spending per recipient grew by only 6 percent. Over the next 20 years, we project average spending per recipient to increase by

about 3.7 percent per year due to growth in reimbursement rates paid to providers and to aging of the Medicaid population.[3]

Figure 5: Average State and Federal Spending Per Medicaid Recipient by Fiscal Year*



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* By date of service; FY2015 – FY2022 are actuals, FY2023 is estimated, FY2024 – FY2044 are projected.

Key Findings from the Long-Term Medicaid Forecast

The following bulleted lists present important findings from our analysis, each of which is explained in greater detail in the report.

Key Findings—Medicaid Enrollment and Spending Projection

- Between 2024 and 2044, the Alaska Department of Labor and Workforce Development projects that Alaska's population will grow by only 21,170.[4]
    - The number of Alaskans under 20 years of age will *shrink* by 11,871.
    - The number of Alaskans 20 to 64 years of age will grow by 18,778.
    - The number of Alaskans 65 years of age and older will grow by 14,263.
- Between FY2010 through FY2023, spending per Medicaid recipient grew on average by 2 percent per year, with much of that growth occurring between FY2022 and FY2023.
- Between FY2024 and FY2044, we project spending per recipient will grow by 3.7 percent per year.

[3] Reimbursement rates paid to providers by the Medicaid program are based on fee schedules for covered medical and related services. https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Sites/FeeSchedule.html
[4] Alaska Department of Labor and Workforce Development, Research and Analysis. 2020. *Alaska Population Projections 2021 to 2050*. http://live.laborstats.alaska.gov/pop/projections.cfm

- After remaining well below Alaska's rate of medical price inflation for years, Medicaid reimbursement rates paid to providers grew faster than medical price inflation in FY2021, FY2022, and FY2023.
- We project Medicaid reimbursement rates will grow on average by about 2.7 percent per year through FY2044, which is below the expected rate of medical price inflation but greater than historical Medicaid reimbursement rate growth.
- Through FY2044, total spending on Medicaid services will grow on an average annual basis by 4.4 percent; general fund spending will grow by 4.9 percent.
    - We project total spending on Medicaid services will be nearly $6.5 billion in FY2044.
    - We project general fund spending on Medicaid services will be just over $1.7 billion.

Key Findings – Impact of Chronic Conditions on Medicaid Spending

- In FY2023, about two out of every five Medicaid recipients (85,226 individuals) were diagnosed with one or more chronic conditions.
- The prevalence of chronic conditions increases with age, which is the primary reason why average spending per Medicaid recipient increases with age.
- For recipients without a diagnosed chronic condition, age has little impact on Medicaid spending, except for recipients aged 75 and older.
- Average Medicaid spending per recipient with a diagnosed chronic condition was $24,587 in FY2023, compared to $4,376 for recipients without a diagnosed chronic condition.
- We estimate that 82 percent of spending on Medicaid services in FY2044 will be for recipients with one or more diagnosed chronic conditions; currently, it is about 77 percent.

1 Introduction

This document presents the results of the FY2024-FY2044 projection of enrollment in and spending on the Medicaid program in Alaska. It is the eighteenth update to the original long-term Medicaid forecast, which the Lewin Group completed in January 2006.

Medicaid is a federal entitlement program established by Title XIX of the Social Security Act in 1965 to provide payment for healthcare services for low-income families and individuals. Medicaid is jointly funded by the federal government and individual states, with each state managing its own program. State participation in the Medicaid program is optional, but all states do participate in the program and in doing so must follow certain federal guidelines pertaining to eligibility and services provided.

The federal government covers at least 50 percent of the cost of most services.[5] In state fiscal year (FY) 2014 and FY2015, prior to Alaska undergoing Medicaid expansion, the federal government paid approximately 57 percent of the cost of services provided through Alaska's Medicaid program.[6] Since then, federal financial participation has grown rapidly due to Medicaid expansion, tribal refinancing efforts by the Department of Health (DOH), and additional funds made available to the states by the U.S. Department of Health and Human Services (HHS) in response to the COVID-19 pandemic.[7] Federal financial participation for FY2023 had grown to nearly 77 percent.

The Consolidated Appropriations Act, 2023, began phasing out the additional funds from HHS related to the COVID-19 pandemic on March 1, 2023, and completed the phase-out on December 31, 2023. We estimate that federal financial participation will be about 74 percent for FY2024 and, for the remainder of the forecast, will range between 71 percent and 72 percent.

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[5] The few services for which the federal government does not cover at least 50 percent of the cost are referred to as "state-only" services.

[6] The overall rate of federal financial participation is an average of multiple Federal Medical Assistance Percentage (FMAP) rates weighted by the amount of spending associated with each rate. See the subsection titled State Spending on Medicaid Services (Section 2.5.1) for a discussion of the rate of federal financial participation associated with each FMAP.
Unless otherwise stated, all references to fiscal year are state fiscal year, which begins July 1 and ends June 30. For example, FY2023 for Alaska began July 1, 2022, and ended June 30, 2023. In comparison, federal fiscal years begin October 1 and end September 30.

[7] For more information on tribal refinancing, please see Alaska Department of Health. "Tribal Refinancing." https://health.alaska.gov/dhcs/Pages/Tribal-Health/Tribal-Refinancing.aspx

People qualify for Medicaid by meeting income standards and specified eligibility requirements related to age, family status, and disability status. Traditionally, Medicaid covered only aged,[8] blind, or disabled persons, children, and adults with dependent children. Medicaid extended coverage in 1998 through the Children's Health Insurance Program (CHIP) to children whose family income is too high to qualify for regular Medicaid but too low to afford private health insurance. As we describe in greater detail below, Alaska again extended Medicaid coverage in 2015, this time for adults who met certain income requirements but were not previously eligible for Medicaid.[9]

In Alaska, the Division of Health Care Services (HCS) administers Medicaid and CHIP, while the Division of Public Assistance (DPA) determines eligibility for the two programs.[10] Alaska Medicaid reimburses hospitals, physicians, and others for healthcare and associated services provided to Medicaid recipients. In Alaska, Medicaid operates as a fee-for-service program, meaning that it reimburses (pays) providers per unit of service rendered according to established rates of payment.

1.1 Impact of COVID-19 on the Alaska Medicaid Program

In March 2020, Governor Mike Dunleavy issued a declaration of public health disaster emergency in response to the anticipated breakout of COVID-19 in Alaska. The initial impact of COVID-19 on the healthcare sector in Alaska and across the U.S. was a substantial reduction in utilization and spending on healthcare services as hospitals, clinics, and other providers canceled or postponed elective procedures.[11] At the same time, some individuals, wary of the risk of COVID-19 transmission, avoided visiting hospitals, emergency rooms, or even their primary care physician for medical concerns or treatment not related to COVID.[12]

Utilization and spending did pick back up after the initial shock, and trends in utilization and spending have largely reverted to pre-COVID rates of growth. Consequently, despite the substantial impact that COVID-19 has had on Alaska communities, businesses, and healthcare

[8] Under Medicaid descriptions of eligibility, "aged" refers to persons 65 years of age or older. Throughout this report, we refer to this population as "seniors" except when referring to Medicaid eligibility.
[9] Throughout this report, we use three general age categories: children to refer to anyone under 20 years of age, adults to refer to those 20 to 64 years of age, and seniors to refer to anyone 65 years of age or older.
[10] Both divisions are within the Alaska Department of Health.
[11] Cynthia Cox and Krutika Amin, "How Have Health Spending and Utilization Changed During the Coronavirus Pandemic?" *Peterson-KFF Health System Tracker*, posted December 1, 2020. https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-start
[12] Kevin Loria, "Many People Avoided Hospitals During the Pandemic. The Effect Was Dire," *Consumer Reports*, July 10, 2020. https://www.consumerreports.org/coronavirus/many-people-avoided-hospitals-during-the-pandemic-the-effect-was-dire/

providers, it does not appear that the pandemic will have a long-term effect on the utilization of and spending on Medicaid services in Alaska.

1.1.1 Medicaid Continuous Enrollment

The Families First Coronavirus Response Act (FFCRA), passed by Congress in March 2020, required states to ensure that individuals enrolled in Medicaid would not lose their coverage during the public health emergency. Under this policy, states received a temporary increase in federal funding for their Medicaid program—the Federal Medical Assistance Percentage (FMAP)—with the condition that states would not disenroll members during the public health emergency, regardless of any change in employment, income, or other covered circumstance. Before the continuous enrollment requirement, states typically conducted Medicaid redetermination—the process by which states periodically review the eligibility of individuals to ensure they still meet the necessary requirements to receive Medicaid benefits—on an annual basis, though the timing varied depending on state-specific rules and the circumstances of the enrollees.

States were required to maintain Medicaid eligibility for individuals who were enrolled in Medicaid as of March 18, 2020, or who enrolled during the public health emergency and were not allowed to terminate coverage unless the individual requested termination or moved out of state. Routine redetermination of Medicaid eligibility by the states was suspended; therefore, enrollees did not have to report changes in income or other circumstances that typically would affect their eligibility. In addition to ensuring access to care during the pandemic, the increased FMAP provided additional funds to state Medicaid programs during a time of substantial health and economic uncertainty.

As a result of this policy, Medicaid enrollment increased significantly in Alaska and across the U.S. as people who might otherwise have lost eligibility due to changes in income or other factors remained covered. Between March 2020 and April 2023, *monthly* enrollment in Alaska's Medicaid program grew by 39,000 persons (from 233,000 persons to approximately 272,000 persons). If not for the continuous enrollment mandate, we estimate monthly enrollment would have grown by about 11,000 persons (to 244,000 persons).

1.1.2 Medicaid Unwinding

While other governmental mandates related to the pandemic were eased and then abandoned once vaccination became widely available and many Americans achieved at least some level of natural immunity, the end of the federal continuous enrollment mandate did not occur until March 31, 2023. Alaska and other states began conducting redeterminations of Medicaid eligibility (commonly referred to as "Medicaid unwinding") in April 2023.[13] States have 12 months from the

[13] In Alaska, the Division of Public Assistance is responsible for conducting Medicaid eligibility determinations.

beginning of the unwinding process to return to normal eligibility and enrollment operations. It is a substantial undertaking, requiring careful management to ensure that those who remain eligible for Medicaid retain their coverage without interruption. Given the scale and scope of the unwinding process, verifying eligibility for all Medicaid enrollees in just 12 months requires substantial DOH staff resources and extensive training. The task is further complicated by the dramatic increase in Medicaid enrollment (from 232,173 persons in February 2020 to 272,212 persons in March 2023) during the three-year continuous enrollment period and the fact that DOH staff have not performed this function over the past three years.

Each month, the DPA notifies a proportion of Medicaid enrollees that it is time to renew their coverage and provides them with instructions on what information they are required to provide to the DPA (e.g., income, family size, and any other factors that may affect their eligibility for Medicaid). Enrollees may also need to submit documentation to support their eligibility, such as pay stubs, tax returns, or proof of residency. The DPA reviews the submitted information to determine if the individual or family still qualifies for Medicaid benefits. In some instances, the DPA may request additional information to make their determination. After reviewing the submitted information, the DPA determines if the individual or family remains eligible for Medicaid coverage. If they are not eligible, their coverage will end the following month, and they will receive a notice of termination and information regarding how to appeal the decision if they so choose. A Medicaid enrollee who loses coverage has up to six months to appeal the decision.

Of particular concern to DOH is that some otherwise Medicaid-eligible individuals and families may lose their Medicaid coverage if they do not respond to requests for information in a timely manner or otherwise fail to provide all necessary information required for redetermination. DOH has utilized multiple forms of media (e.g., TV, radio, billboards) to communicate to Medicaid enrollees the importance of updating their contact information to ensure they receive notices and can respond accordingly. For those determined to be no longer eligible for Medicaid, the DPA assists with the transition to other forms of health insurance coverage, such as through the Affordable Care Act (ACA) marketplace.

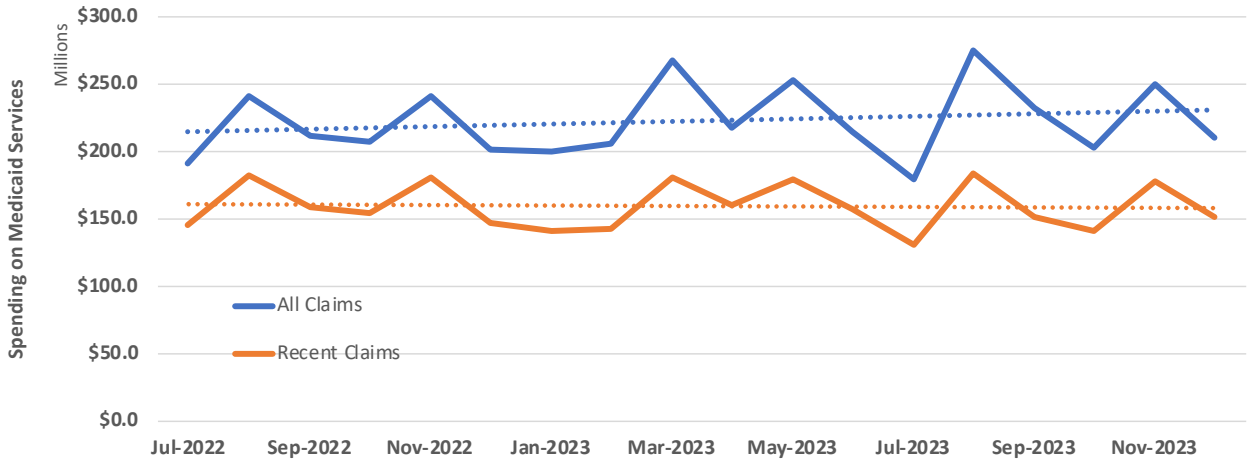
Impact of Unwinding on Medicaid Spending

While unwinding has impacted the number of individuals enrolled in Medicaid, it has not, to date, impacted spending on Medicaid services. Figure 6 shows monthly spending on Medicaid claims for FY2023 and the first six months of FY2024 (July 1, 2023 – December 31, 2023). The upper (blue) line shows total spending on all claims paid during each month regardless of when the Medicaid service occurred. The dotted blue line shows the linear trend in total monthly spending, which is slightly positive. Most Medicaid claims are paid within 90 days, but providers have up to 12 months to submit claims (or resubmit if a claim is denied). If Medicaid unwinding was leading to fewer Medicaid recipients receiving services, we *might* expect total monthly spending to trend modestly downward. The fact that it is trending upward could be due to spending on older claims that predate the period of Medicaid unwinding, or it could simply show that Medicaid unwinding

has not, to date, had a substantial impact on Medicaid recipients—i.e., those Medicaid enrollees that utilize Medicaid services.

The lower (orange) line shows spending on recent claims, which are defined as claims for services received during the current month or in the previous month.[14] There is no upward or downward trend in spending on recent claims, which suggests that Medicaid unwinding has not, to date, impacted utilization or spending on Medicaid services. In other words, it appears that while Medicaid unwinding has led to a reduction in the number of persons enrolled in Medicaid since April 2023, it has not had a material impact on the number of persons receiving Medicaid services.

Figure 6: Monthly Spending on Medicaid Claims, July 2022 - December 2023



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

1.1.3 Impact of Post-COVID on Alaska's Medicaid Population

Some people who have been infected with COVID-19 can experience long-term effects from their infection, known as post-COVID conditions or long COVID.[15] In June 2021, the Centers for Disease Control and Prevention (CDC) announced the creation of a diagnosis code for tracking the costs of healthcare services provided to individuals displaying symptoms consistent with post-COVID.[16] The diagnosis code (ICD10 "U09.9") became effective October 1, 2021. Over the ensuing eight months, the number of Medicaid recipients diagnosed with post-COVID conditions fluctuated, but generally grew, topping 155 persons in May 2022 (Figure 7). Since then, the number of recipients diagnosed

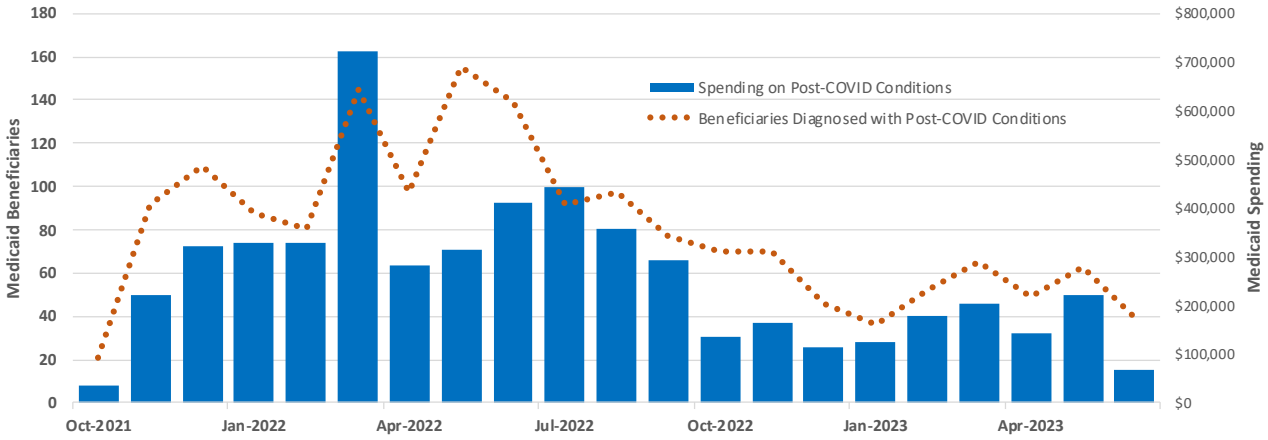
[14] For example, in December 2023, $151.3 million was spent on claims for Medicaid services that were received in November and December 2023.

[15] Centers for Disease Control and Prevention, "Long COVID or Post-COVID Conditions," updated September 1, 2022. https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html

[16] American Academy of Physical Medicine and Rehabilitation (AAPM&R), "CDC Announces Approval of ICD-10 Code for Post-Acute Sequelae of COVID-19," July 20, 2021. https://www.aapmr.org/members-publications/member-news/member-news-details/2021/07/20/cdc-announces-approval-of-icd-10-code-for-post-acute-sequelae-of-covid-19

with post-COVID conditions has trended downward, falling below 40 persons in June 2023. The trend in total spending on Medicaid services to treat post-COVID conditions closely followed the trend in diagnoses, dropping below $100,000 in June 2023.

Figure 7: Spending on Medicaid Services that Included a Diagnosis of Post-COVID Conditions



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

1.2 Recent Initiatives That May Affect Alaska's Medicaid Program in the Next Few Years

The information in this section was provided by leaders of operational divisions within DOH as a summary of initiatives that were recently enacted or are in the process of being enacted and that may impact future utilization and spending on Medicaid services.

1.2.1 Behavioral Health System Reform

Substance Use Disorder and Behavioral Health Program

Alaska's 1115 Medicaid waiver, the *Alaska Substance Use Disorder and Behavioral Health Program*, was approved for the original demonstration period of January 1, 2019 through December 31, 2023. On March 2, 2023, the Division of Behavioral Health (DBH) submitted a renewal application to the Centers for Medicare and Medicaid Services (CMS). Alaska received a temporary extension approval on December 18, 2023, which extended Alaska's 1115 Waiver demonstration period through March 31, 2024. DOH leadership will continue to work with CMS for an anticipated renewal prior to the current expiration.

Continuing efforts to address behavioral health system reform were addressed in House Bill (HB) 172, with the goal of creating a strong system of care that is easy to access by Alaskans with behavioral health needs. Best practice core services in developing community-based crisis care include:

1. Someone to talk to;

2. Someone to respond; and
3. A place to go.

Alaska's previous crisis continuum included the first two core services but lacked the ability to implement the third component. HB 172 allowed for the development of crisis stabilization centers up to a 23-hour stay or up to seven days to care for individuals with an acute mental health crisis. These alternatives provide therapeutic options for care for individuals in crisis that are less restrictive and can reduce the number of individuals held in emergency rooms, correctional facilities, and psychiatric hospitals. This addition to Alaska's continuum of crisis care addressed a gap in care that often resulted in a higher level of behavioral health treatment and greater costs to the Medicaid program.

In December 2023, the DBH announced that in 2024 it will transition claims processing for all behavioral health professional Medicaid claims—which include state plan Community Behavioral Health Center (CBHC), Autism, and Independent Practitioners as well as 1115 Waiver Substance Use Disorder and Behavioral Health services—from the Administrative Services Organization (ASO), Optum, to the State's Medicaid Management Information System (MMIS). This aligns with CMS expectations for the DOH to design and implement projects and programs that are cohesive and unified. This transition will also reduce some administrative burden for the provider community by having one place to submit Medicaid claims and improve timely payments to providers, potentially increasing their ability to provide services to more participants.

The DBH will move forward with a Request for Proposal (RFP) for a Behavioral Health Organization (BHO). The Division's ASO contract with Optum expires on December 31, 2024, and this RFP intends to replace that contract by soliciting a vendor to fully implement and realize the services available under the 1115 Alaska substance use disorder (SUD) and behavioral health (BH) waiver. Contract deliverables will include developing regional provider capacity and support, conducting participant outreach, developing communication and support tools, providing technical assistance to providers, facilitating provider quality and outcome efforts, providing data management, and improving overall access and service outcomes. Many of these outcomes are part of the current ASO contract, which has been unable to be realized due to difficulties with claims processing and focused capacity in that area.

Behavioral Health Pandemic Response

During the COVID-19 pandemic, the DOH maintained telehealth flexibilities and utilization through Alaska's declaration of a public health disaster emergency. Behavioral health providers were able to offer telemedicine options when face-to-face encounters jeopardized the health and safety of treatment recipients and providers. The Alaskan response to the use of telehealth resulted in HB 265, which was signed into law in July 2023 and created permanent telehealth expansion and flexibilities. Regulations were subsequently finalized in September 2023 to create conformity with changes created by HB 265.

In direct response to provider distress over pandemically-strained staff resources, the DBH also applied for and was granted the flexibility to temporarily suspend service authorization requirements for all Behavioral Health professional services. During this suspension period, DBH staff performed an extensive review of regulatory and statutory language to identify opportunities to clarify language and eliminate administrative burden. After receiving robust public commentary on the drafted edits, a comprehensive revision package for regulation 1115 was submitted for final approval and filing in November 2023.[17] A draft regulation and amendment package for state plan services is anticipated in early 2024 to address parity across the full Behavioral Health continuum of care.

1.2.2 Healthcare and Tribal Health Services Reforms

Telehealth Services

In FY2023, the Medicaid program paid $43.1 million in claims for services delivered via telehealth methods, an increase of 14.4 percent compared to the amount paid for services delivered via telehealth in FY2022. However, this was still down 23 percent overall since FY2021, likely due to the end of the public health emergency. The top service type delivered via telehealth in FY2023 was office visits for established patients. The top diagnoses/conditions were encounters for administrative examinations (such as preventive), opioid dependence, and mixed receptive-expressive language disorder.

Coordinated Care Demonstration Project

Beginning in mid-2018, the DOH executed a contract for a patient-centered medical home model through Providence Family Medicine Center (PFMC). The contract term ended in September 2022. The DOH is preparing for the third-party actuary review obligated under AS 47.07.039(e) to assess the outcomes of the program. The actuarial review is intended to inform a decision to move forward with a formal recommendation to pursue a Primary Care Case Management (PCCM) health home or 1915 (b) waiver program using the insight gained from the demonstration. Further pursuits would target care for high-needs and vulnerable populations while transitioning to a mixed funding model.

The DOH is continuing to explore opportunities to develop additional demonstration projects including coordinated care organizations and new federal opportunities focusing on Health-Related Social Needs and incarcerated individuals.

[17] State of Alaska. "Alaska Administrative Code - Title 7 - Department of Health regulations re: Medicaid Coverage & Payment for 1115 Behavioral Health & Substance Use Disorder Waiver Services." Filed January 3, 2024, effective February 2, 2024. https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=213778

Covered Outpatient Drug Value-Based Purchasing (VBP) Arrangements

The Centers for Medicare and Medicaid Services (CMS) delayed the effective date of final rule CMS-2482-F2 entitled "Medicaid Program; Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third-Party Liability (TPL) Requirements" to July 1, 2022. Once the rule went into effect, state Medicaid programs had the opportunity to enter into VBP arrangements with pharmaceutical manufacturers, outside of a supplemental rebate agreement, when such manufacturers offered the VBP arrangement in the commercial marketspace.[18] As of the release date of this report, the HCS Pharmacy Services Team continues to evaluate current opportunities for VBPs but has not entered into any value-based arrangements.

Federal Financial Participation for Services to American Indians and Alaska Natives

Historically, Alaska's Medicaid program has received 100 percent federal financial participation (FFP) for Medicaid services provided to American Indians/Alaska Natives (AI/AN) only when those services were received through federal or tribal healthcare facilities. CMS's February 2016 State Health Official Letter #16-002 updated the "received through" policy to allow state Medicaid programs to claim 100 percent FFP for services provided to an AI/AN Medicaid recipient by a non-federal or non-tribal healthcare facility, contingent upon the presence of a care coordination agreement between the providers, documentation of a referral by the tribal health provider, and an exchange of medical records of the care received. Under the direction of SB 74, DHSS (now the Department of Health) partnered with tribal health organizations to fully implement this revised federal policy. To date, more than 7,800 care coordination agreements have been signed between tribal and non-tribal providers that have resulted in state general fund savings exceeding $570 million.

Procurement of Fiscal Agent Services

In May 2021, the DOH issued an RFP for a qualified contractor to provide MMIS support services to operate the claims processing system for the Alaska Medicaid program. This was the second phase in the initiative to separate Medicaid program fiscal agent services from technical operations and maintenance of the MMIS database, affording the department greater flexibility in responding to the changing operational and administrative needs of the program. Following this competitive solicitation process, Health Management Services was selected as the new Fiscal Agent vendor and

[18] Federal Register, "Medicaid Program; Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability (TP) Requirements," December 31, 2020, p. 87028. https://www.federalregister.gov/documents/2020/12/31/2020-28567/medicaid-program-establishing-minimum-standards-in-medicaid-state-drug-utilization-review-dur-and

worked closely with the DOH during an extended contract negotiation and operational transition period. Health Management Services took over fiscal agent services on April 1, 2023.

Care Management Services

The Care Management Program (CMP) was established by the Alaska DHSS under the authority of Section 7 of the Alaska Administrative Code (AAC) 105.600 to restrict the use of Medicaid services deemed to be at a frequency or amount that is not appropriate.[19] Historically, the CMP restricted a recipient to a primary care provider (PCP) and a single primary care physician and pharmacy to reduce overuse and misuse of services, encourage continuity of care, and promote communication between the recipient's PCP and pharmacy. The Alaska Medicaid Coordinated Care Initiative (AMCCI), which provides one-on-one case management services to Medicaid recipients, grew by 20 percent between FY2022 and FY2023, while the CMP program grew by 100 percent. The CMP currently has 121 individuals/groups acting in a primary care provider role, and 95 different pharmacies serving the 1,000+ CMP members; this represents an approximately 13 percent increase in unique providers participating compared with FY2022.

1.2.3 Senior and Disabilities Services Reforms

The Division of Senior and Disabilities Services (SDS) saw the following changes to Medicaid-funded services in FY2023:

- SDS worked closely with the DOH's Office of Rate Review (ORR) to complete rebasing for home and community-based services. Most rates were increased, and the new rates took effect May 1, 2023.
- Alaska Senate Bill 57 was passed by the legislature. This bill will allow SDS to create a new Medicaid home and community-based waiver service called Adult Host Home Care. SDS is engaged in stakeholder engagement to solicit input on this service and is working closely with HCS's Residential Licensing Section to create the parameters around the licensing. This service will be another alternative for those on waivers who are seeking to remain in their home community to receive residential support.
- The passage of SB 57 also directed SDS to update state regulations to allow legally responsible individuals to provide Community First Choice Personal Care services (CFC-PCS) under the 1915(k) option. This change may be of value to families that have been unable to find care during this time of workforce shortage.

[19] The Alaska State Legislature. "Title 7 Health and Social Services, Chapter 105 Medicaid Provider and Recipient Participation, Section 600 Restriction of recipient's choice of providers." http://www.akleg.gov/basis/aac.asp#7.105.600

- SDS's newest Medicaid home and community-based services waiver, the Individualized Supports Waiver approved by CMS in 2018, continued its growth and reached its federally approved cap of 600 individuals in early FY2024. A waitlist was implemented for this waiver, with individuals drawn based on the longest length of time waiting.
- SDS received state funding (to be matched with federal Medicaid funding) for three years to implement a new home and community-based waiver assessment tool and develop the methodology for resource allocation and a more person-centered home and community-based waiver system.

SDS is designing and planning implementation for services that will support people with disabilities and co-occurring intense behavioral or medical needs. SDS's goal is to incentivize providers of home and community-based services to create the settings and services that will better support these individuals.

1.2.4 Public Health Initiatives

With the Alaska Native Tribal Health Consortium (ANTHC), the DOH leads the development and implementation of the Healthy Alaskans 2030 (HA2030) plan, which is Alaska's state health improvement plan. HA2030 is a roadmap for how the state can improve on the most significant health issues faced by its residents. The HA2030 plan includes 15 health priority topics containing 30 health objectives, each with a target to reach by 2030. These priorities were selected based on health mortality and morbidity data along with input from Alaskan residents and subject matter experts. Each health objective contains strategies and actions that may be implemented to help move the state toward established targets. If the HA2030 targets are met, Medicaid costs may be reduced, as this will be an indicator of the improved health of all Alaskans.

The DOH is participating in a Case for Coverage project, hosted by the National Association of Chronic Disease Directors in collaboration with the CDC, Division of Diabetes Translation, and the Kem C. Gardner Policy Institute. The goal of the project is to assess the potential impact of the National Diabetes Prevention Program on diabetes prevention and the overall incidence of diabetes as it relates to public health and Medicaid expenditures.

1.3 The Long-Term Medicaid Forecast

Forecasting long-term Medicaid spending is a complex process due to the numerous variables that can affect both the costs of services and the number of people who will be enrolled in Medicaid and will need services. There are competing approaches for projecting Medicaid enrollment and spending, each with their respective strengths and shortcomings. These include actuarial models, expert opinion, top-down models, and a bottom-up modeling approach.

For the Alaska Long-Term Medicaid Forecast, we developed a bottom-up modeling approach that begins with Alaska population forecasts subdivided into 240 geo-demographic groupings based on

age, gender, AI/AN status, and region of the state. We then develop estimates of future Medicaid enrollment based on projected changes in the population by geo-demographic group and analyze trends in Medicaid enrollment for these groups. We then project future growth in utilization of 20 different Medicaid service categories and the intensity of use for each category. Finally, we project growth in Medicaid reimbursement rates based on the historical relationship between reimbursement rates and medical price inflation in Alaska.

The following phenomena are explicitly incorporated into the Alaska Long-Term Forecast.

- **Alaska Population and Demographic Forecast**: On a biennial basis, the Alaska Department of Labor and Workforce Development (DOLWD) publishes population projections for the State of Alaska and for individual communities by gender, age, and race.[20] Population-demographic data are critical for developing the long-term Medicaid forecast as potential changes in the number and demographic mix of Medicaid enrollees will have a substantial impact on Medicaid spending.
- **Trends in Medicaid Enrollment**: We calculate the historical rate of Medicaid enrollment[21] for each of the 240 geo-demographic groups for each year of historical data (FY1998 – FY2023). While enrollment has generally trended up over the past 25 years, rates of Medicaid enrollment differ across the geo-demographic groups. Enrollment rates have also accelerated at times for certain groups (e.g., for individuals aged 18 to 64 in response to Medicaid expansion), and enrollment rates at times do decline—as we expect will occur due to Medicaid unwinding.
- **Trends in Medicaid Spending**: Growth in Medicaid spending is a function of numerous factors—including growth in enrollment and aging of recipients; increases in the prevalence of chronic conditions, which lead to greater morbidity; and changes in medical technology and practices (not all of which lead to higher healthcare costs)—which we refer to as "intensity of use of Medicaid services."
- **Trends in Medicaid Reimbursement Rates and Medical Price Inflation**: Medical price inflation, which includes the costs of medical services, prescription drugs, and medical devices paid by consumers of medical care, has outpaced general price inflation and is the primary long-term driver of healthcare spending in the U.S. Medical price inflation does not directly impact reimbursement rates paid to providers of Medicaid services, but medical price inflation does indirectly influence Medicaid reimbursement rates during periodic rate reviews conducted for each service available through the Medicaid program.

[20] Alaska Department of Labor and Workforce Development, Research and Analysis, *Alaska Population Projections 2021 to 2050*, June 2022. http://live.laborstats.alaska.gov/pop/projections.cfm

[21] Medicaid enrollment ÷ population = rate of Medicaid enrollment

- **Epidemiological Trends**: Changes in disease prevalence and the emergence of new health concerns, such as the COVID-19 pandemic and the explosive growth in the prevalence of and abuse of (illegal) synthetic opioids, can have both short- and long-term impacts on Medicaid spending.
- **Known or Highly Anticipated Changes in Policy or the Regulatory Environment**: Proposed or expected changes in Medicaid policies at the federal and state levels can substantially impact Medicaid enrollment and spending. For example, Medicaid expansion in FY2016 led to an immediate and rapid increase in the number of individuals aged 18 to 64 enrolled in the Medicaid program.

While not *explicitly* considered in the long-term Medicaid forecast, long-trends in socioeconomic factors such as poverty rates, personal income, and workforce participation are *implicitly* represented in the forecast based on enduring historical trends in Medicaid enrollment for each of the 240 geo-demographic groups.

Finally, as the purpose of the long-term Medicaid forecast is to provide DOH leaders and Alaska policy makers with a projection of enrollment in and spending on Medicaid as the program exists today, the forecast does not incorporate the following:

- Speculative future changes in Medicaid eligibility criteria, services, or administrative processes.
- Speculative future changes to the federal or state regulatory environments affecting the Medicaid program.
- Speculative impacts of public health initiatives aimed at improving health outcomes and reducing healthcare costs.

In this study, we develop long-term forecasts of enrollment in Alaska's Medicaid program, as well as utilization of and spending on services provided through the Medicaid program. We aggregate the thousands of services provided by the Medicaid program into 20 categories of services, each of which we project over a 20-year period. We also develop forecasts of spending by gender, by AI/AN status,[22] and for 12 age groups.

The forecast does not assume or consider possible future changes in Medicaid policies, services offered, or eligibility requirements; rather, we develop the forecast as if the policies, services offered, and eligibility requirements in place today will remain in place throughout the forecast period. While it is likely that Alaska's Medicaid program will experience changes during the

[22] Alaska Native, American Indian, and other race categories are based on self-identification by Medicaid enrollees. In FY2023, 90,128 Medicaid enrollees reported their race as either Alaska Native or American Indian.

projection period, the assumption of no change is necessary to show how Medicaid spending in Alaska will likely evolve given the structure of the program as it exists today.

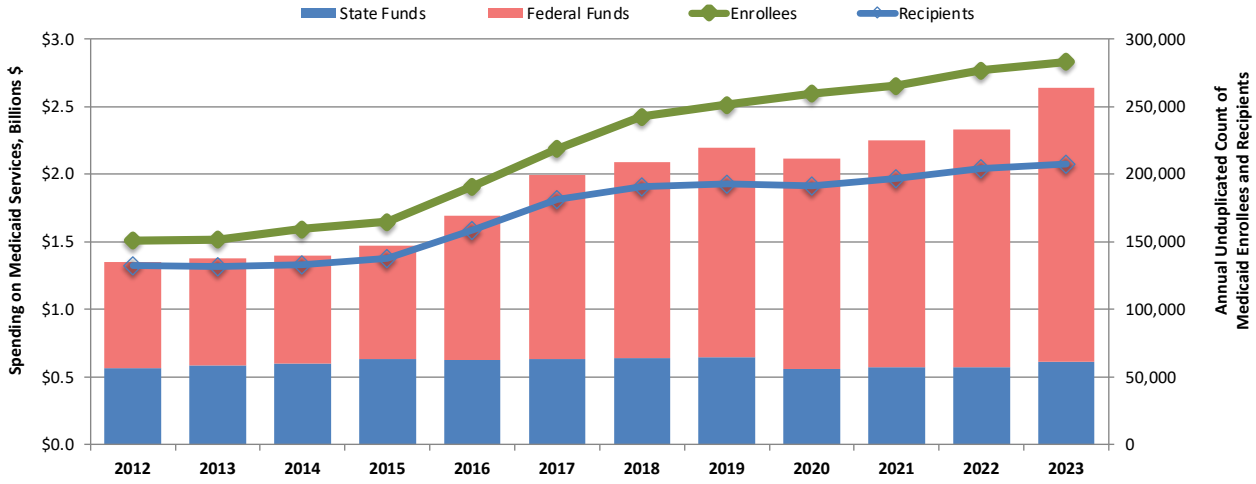
1.4 Recent Historical Trends in Medicaid Spending

Medicaid spending grew slowly between FY2012 and FY2015, increasing on an average annual basis by 2.9 percent. Spending jumped by 15.1 percent in FY2016 and 17.8 percent in FY2017 due primarily to Medicaid expansion, which went into effect in Alaska in September 2015. The rate of growth in Medicaid spending began to slow in FY2018 and decreased in FY2020 with the Governor's declaration of a public health disaster emergency in March 2020. Spending began to increase again in FY2021.

1.4.1 Recent Historical Trends in State Medicaid Spending

While total spending on Medicaid services has increased significantly since FY2015, general fund spending by the State of Alaska has been mostly flat and even decreased in FY2020 due to additional funding by the federal government as part of the Families First Coronavirus Response Act (FFCRA).[23] Figure 8 shows total spending on Medicaid services for FY2012 through FY2023, split by state and federal funding, and the trend in Medicaid enrollment and number of recipients over this same period.[24]

Figure 8: Spending on Medicaid Services, Enrollment in the Medicaid Program, and Recipients of Medicaid Services, Based on Date of Service, FY2012 – FY2023



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group; 2022 estimated.

[23] The FFCRA required state Medicaid programs to keep people continuously enrolled in Medicaid through the end of the COVID-19 public health emergency in exchange for enhanced federal funding (6.4 percentage points for Title XIX services, 4.34 percentage points for Title XXI and BCC [breast and cervical cancer] services) beginning January 1, 2020 and continuing until "termination of the public health emergency."

[24] State spending includes Unrestricted General Fund, Designated General Fund, and Other.

The FFCRA required states to maintain continuous enrollment for individuals regardless of any change in employment, income, or other covered circumstance. As a result, whereas the Medicaid program used to experience month-to-month churn in Medicaid enrollment as individuals entered or exited the program, now enrollment only rises as eligible individuals enter the program, but no one leaves the program except those who move out of state (or die). The Consolidated Appropriations Act 2023 ended the continuous enrollment requirement on March 31, 2023.

1.4.2 The Role of Medicaid in Providing Health Insurance to Alaskans

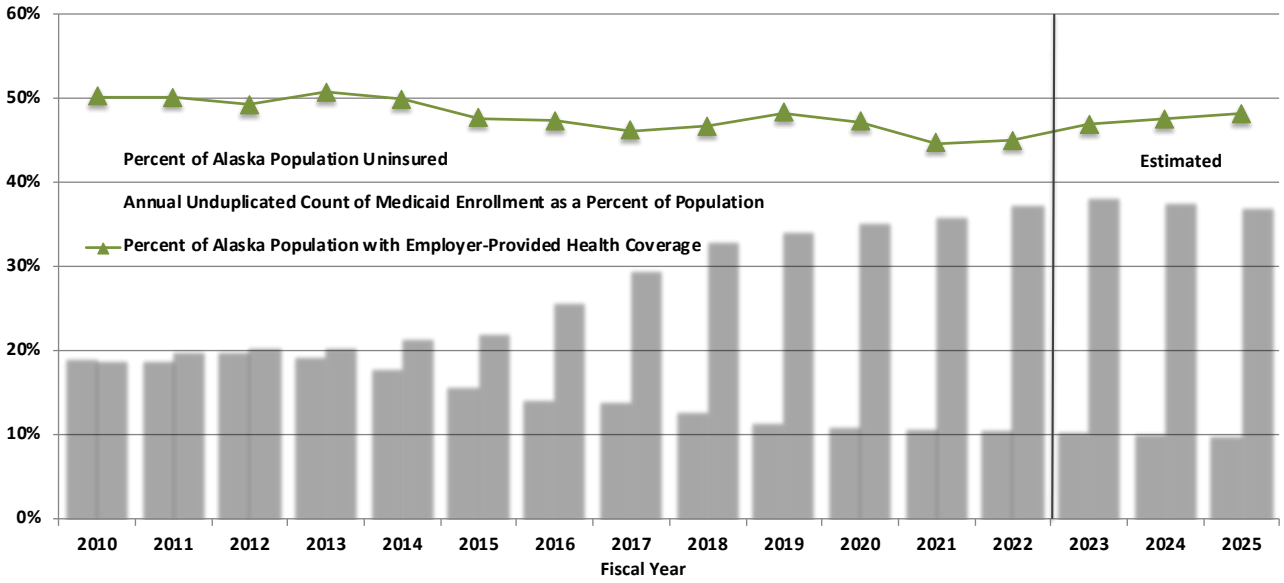
Medicaid's role as a provider of healthcare insurance in Alaska has grown significantly. In FY1998, 14 percent of Alaskans were enrolled in Medicaid all or part of the year, and by FY2023, the proportion had grown to 38.4 percent. Due to Medicaid expansion and other components of the ACA, growth in the proportion of Alaskans enrolled in Medicaid was especially strong after FY2015 (Figure 9). Data from KFF and the U.S. Census indicate that the proportion of uninsured Alaskans decreased from 20.5 percent in calendar year (CY) 2010 to 10.7 percent in CY2022.[25] Evergreen Economics estimates that the proportion of Alaskans without health insurance coverage further decreased slightly in FY2023 to 10.5 percent and will be 10.1 percent in FY2025.[26] The proportion of Alaskans receiving health insurance through an employer decreased from 51.1 percent in CY2010 to 43.3 percent in CY2021, but increased to 46.5 percent in CY2022.[27] We estimate the proportion of Alaskans enrolled in employer-sponsored insurance increased slightly to about 46.8 percent in CY2023 and will reach 48.5 percent in CY2025.

[25] KFF, "KFF's State Health Facts, "Health Coverage & Uninsured." https://www.kff.org/state-category/health-coverage-uninsured/
Katherine Keisler-Starkey and Lisa N. Bunch, "Health Insurance Coverage in the United States: 2019," report number P60-271, Washington, D.C.: U.S. Census Bureau, published September 15, 2020. https://www.census.gov/library/publications/2020/demo/p60-271.html

[26] On December 22, 2017, President Trump signed the Tax Cuts and Jobs Act of 2017, which eliminated the federal tax penalty for violating the individual mandate, starting in 2019.

[27] Josh Bivens and Ben Zipperer, "Health insurance and the COVID-19 shock," Economic Policy Institute, August 26, 2020. https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/

Figure 9: Recent Trends in Health Insurance Coverage in Alaska

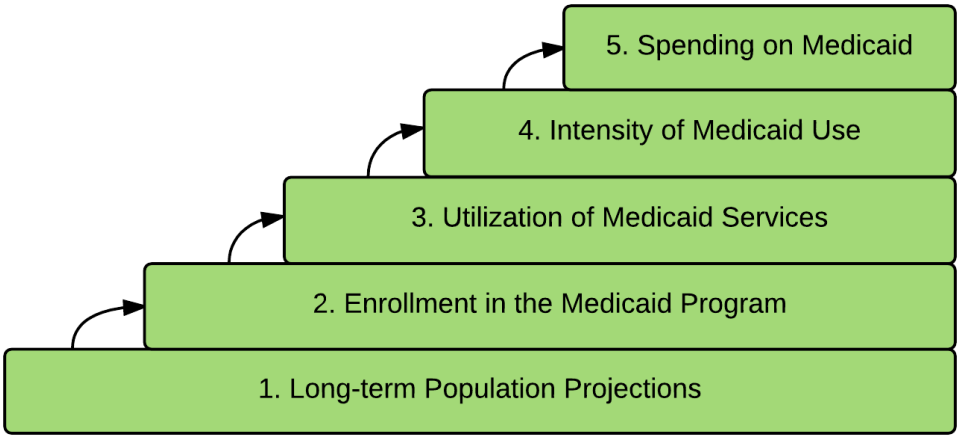


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group and KKF (https://www.kff.org/state-category/health-coverage-uninsured/). Evergreen converted KKF data to fiscal year as the average of two consecutive calendar years (e.g., FY2020 is the average of CY2019 and CY2020).

2 Overview of Projections: FY2024-FY2044

The long-term Medicaid forecast follows a structured modeling approach in which we develop annual estimates of spending on Medicaid services in five steps, with each successive step building on the results of the previous step. As Figure 10 shows, the foundation of the Medicaid spending forecast is the long-term projection of Alaska's population, which, for this update, is based on the Alaska Department of Labor and Workforce Development's (DOLWD's) most recent population forecast.[28] In subsequent steps, we project enrollment in the Medicaid program, utilization of Medicaid services, intensity of use of Medicaid services, and finally, total spending on Medicaid. We summarize the results of each step of the long-term Medicaid forecasting in the same systematic fashion.

Figure 10: The Five Steps to Develop the Alaska Long-Term Medicaid Forecast



2.1 Long-Term Population Projections

The population of Alaska has changed substantially in the years since statehood. In 1960, one year after Alaska became a state, the population was 230,400,[29] and about one in five Alaskans (44,237) lived in Anchorage.[30] The population grew quickly through the 1960s, 1970s, and 1980s in part due to the construction of the Trans-Alaska Pipeline from 1975 to 1977 and other projects related to

[28] Alaska Department of Labor and Workforce Development, Research and Analysis, *Alaska Population Projections 2021 to 2050*, June 2022. http://live.laborstats.alaska.gov/pop/projections.cfm

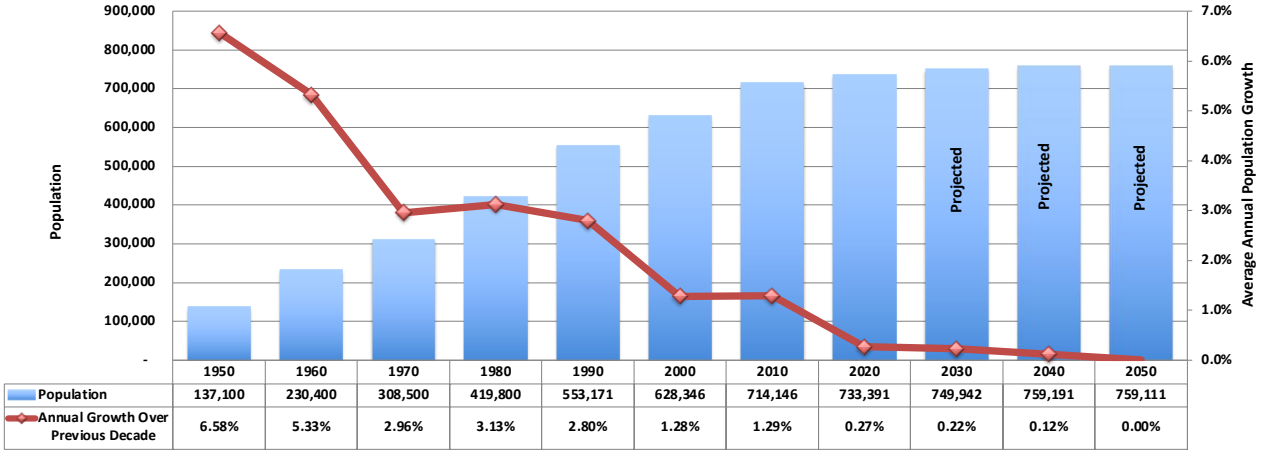
[29] Alaska Department of Labor and Workforce Development, *Alaska Population Overview: 2010 Census and 2011 Estimates*, October 2012. http://live.laborstats.alaska.gov/pop/estimates/pub/1011popover.pdf

[30] U.S. Department of Commerce Bureau of the Census, *1960 Census of Population, Advance Reports: General Social and Economic Characteristics*, April 27, 1962. http://www2.census.gov/prod2/decennial/documents/15611103.pdf

the oil industry.[31] By 1990, the state's population had grown to 550,043, and two in five Alaskans (226,338) lived in Anchorage.[32]

As Alaska's population has grown, its rate of growth has continued to slow (Figure 11). Between 1990 and 2010, population growth averaged just less than 1.3 percent per year and further slowed to 0.27 percent per year between 2010 and 2020. The Alaska DOLWD projects that the population will grow by 0.22 percent annually through 2030, by 0.12 percent per year between 2030 and 2040, and will experience no population growth between 2040 and 2050.[33]

Figure 11: Alaska's Population and Annual Growth Rates from 1950–2050



	1950	1960	1970	1980	1990	2000	2010	2020	2030	2040	2050
Population	137,100	230,400	308,500	419,800	553,171	628,346	714,146	733,391	749,942	759,191	759,111
Annual Growth Over Previous Decade	6.58%	5.33%	2.96%	3.13%	2.80%	1.28%	1.29%	0.27%	0.22%	0.12%	0.00%

Source: U.S. Census Bureau; Alaska Department of Labor and Workforce Development

The Alaska DOLWD projects the distribution of residents by gender and age to change over the next two decades as the female population grows slightly faster than the male population and the overall population ages. The ratio of males to females has moved closer to the national average over the past decades and by 2050, the Alaska DOLWD projects there will be 104 to 105 males for every 100 females.[34] We expect this to have a small effect on the Medicaid program, as women have a longer average life expectancy than men and Medicaid costs are higher for the oldest

[31] For more information on the impact of the Trans-Alaska Pipeline, see Alyeska Pipeline Service Company, "Trans Alaska Pipeline System - The Facts." http://alyeska-pipeline.com/TAPS/PipelineFacts

[32] Alaska Department of Labor and Workforce Development, Alaska Population Estimates, Historical Data: Places, https://live.laborstats.alaska.gov/data-pages/alaska-population-estimates

[33] Alaska Department of Labor and Workforce Development. *Alaska Population Overview: 2010 Census and 2011 Estimates*. October 2012. http://live.laborstats.alaska.gov/pop/estimates/pub/1011popover.pdf

[34] Alaska Department of Labor and Workforce Development. "Alaska Population Projections 2021 to 2050," June 2022. https://live.laborstats.alaska.gov/pop/projections.html; nationally, there are 103 females for every 100 males.

seniors (85+) than for younger seniors, working-age adults, or children.[35]

The DOLWD projects the senior population will grow at a much faster rate than the overall population (0.60% per year for seniors versus 0.14% for the total population) and that the number of children in Alaska will decrease (by 0.31% per year).[36] (Table 2)

Table 2: Alaska's Projected Population by Age Cohort for Selected Calendar Years 2024–2044

Age Group	2024	2029	2034	2039	2044	Avg. Annual Change
Children (0-19)	198,783	193,828	188,481	186,672	186,912	-0.31%
Adults (20-64)	427,626	426,510	434,127	442,133	446,404	0.22%
Seniors (65+)	111,774	126,900	131,516	129,203	126,037	0.60%
Total Population	**738,183**	**747,238**	**754,124**	**758,008**	**759,353**	**0.14%**

Source: Analysis by Evergreen Economics of data from Alaska Department of Labor and Workforce Development, Research and Analysis, *Alaska Population Projections 2021 to 2050*, June 2022. http://live.laborstats.alaska.gov/pop/projections.cfm.

2.2 Enrollment in the Medicaid Program

"Enrollment" refers to the number of individuals who both meet the eligibility requirements for Medicaid at the time of enrollment and register to receive Medicaid services during a fiscal year—regardless of whether the individual receives Medicaid services during the fiscal year or not. There are three primary factors that determine growth in Medicaid enrollment: (1) population growth, (2) changes in the demographic characteristics of the population, and (3) changes in Medicaid eligibility requirements. For this report, we assume that eligibility requirements as they exist today will remain constant over the 20-year projection period.[37]

About 57 percent of Alaska children were enrolled in the Medicaid program during all or some portion of FY2023, compared to only one in three adults aged 20 to 64, and one in seven senior Alaskans. Historically, children were the primary focus of the Medicaid program. However, that changed substantially with the introduction of Medicaid expansion in September 2015. Today, the

[35] There is little difference in average annual spending on Medicaid services for male and female children. For adults, higher average annual spending for women is due primarily to pregnancy and post-pregnancy services. For seniors, higher average annual spending on women is due to a greater average lifespan of women and the high cost of senior care for Medicaid enrollees 85 years of age and older.

[36] Throughout this report, we use three general age categories: children to refer to anyone under 20 years of age, adults to refer to those 20 to 64 years of age, and seniors to refer to anyone 65 years of age or older.

[37] This report accounts for the end of the continuous enrollment requirement on March 31, 2023, as stated in the Consolidated Appropriations Act 2023, and Medicaid unwinding, which began in April 2023 and will continue for 12 months.

Alaska Medicaid program covers more adults 20-64 years of age than children. Between FY2024 and FY2044, we expect the proportion of children enrolled in Medicaid to decrease slightly from 40.6 percent to 39 percent and the proportion of adults 20-64 years of age to decrease from 53.2 percent to 52.4 percent, while the proportion of seniors will increase from 6.2 percent to 8.6 percent.

Alaska experienced an economic recession that began in late 2014 or early 2015 and extended through most of 2019, which likely led to growth in Medicaid enrollment and spending.[38] Enrollment also likely increased due to other changes to the Medicaid program required by the ACA, including (a) changes to the Modified Adjusted Gross Income (MAGI) standard used to determine Medicaid and Children's Health Insurance Program (CHIP) eligibility, which made it easier for individuals to qualify for either program, and (b) the "no wrong door" feature of the federal healthcare exchange, which allows consumers to complete a single streamlined application to determine eligibility for a subsidized health plan, CHIP, or Medicaid. Finally, as discussed earlier, the federal COVID-19 public health emergency mandate that states maintain continuous enrollment for individuals, regardless of any change in employment, income, or other covered circumstance, led to a substantial rise in Medicaid enrollment between March 2000 and April 2023.

"Medicaid recipients" refers to individuals enrolled in Medicaid who received any Medicaid services during a fiscal year regardless of the type of services received.[39] In developing the forecast, we project both enrollment in Medicaid and the number of recipients of Medicaid services. In this report, we primarily focus on recipients because these are the Medicaid enrollees who are utilizing Medicaid services.

We expect that the end of the continuous enrollment mandate will result in moderately declining Medicaid enrollment through FY2026 and then slow growth through the remainder of the projection period. By FY2044, we project Medicaid enrollment will be 288,668, which is only about 5,000 greater than enrollment in FY2023 (see Table 3), but which still represents 38 percent of Alaska's projected 2044 population—the same proportion reached in FY2023 when the federal continuous enrollment mandate was still in place.[40] Given the uncertainty associated with any long-term population forecast, actual Medicaid enrollment could be substantially different.

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[38] J.A. Benitez, V. Perez, and E. Seiber, "Medicaid as a Safety Net: Does Medicaid Generosity Mitigate the Effects of Unemployment During Economic Downturns?" Proceedings from the 7th Conference of the American Society of Health Economists, June 12, 2018.
L. Snyder and R. Rudowitz, "Trends in State Medicaid Programs: Looking Back and Looking Ahead," KFF, June 21, 2016.

[39] To be considered a recipient, the total cost of Medicaid services received by the Medicaid enrollee during the fiscal year must be at least $10.

[40] In comparison, the annual unduplicated count of Medicaid enrollment in FY2019 (251,411) represented 34 percent of Alaska's population in 2019.

Nevertheless, barring any substantive changes in Medicaid eligibility requirements (such as a continuous enrollment mandate), we believe it is unlikely that Alaska's Medicaid enrollment will grow beyond 38 percent of the state's population.

Even while we expect enrollment to decrease over the next few years before slowly growing again, we project the number of recipients—Medicaid enrollees that utilize services—to continue to grow in each year of the forecast (see Table 3). In FY2044, we project that 237,522 Medicaid enrollees will utilize services, which represents 82.3 percent of projected enrollees in FY2044. This proportion is nearly 10 percentage points greater than the ratio of recipients to enrollees observed during the three years in which the continuous enrollment mandate was in place, but is still lower than the average proportion observed between FY2010 and FY2019.

Table 3: Medicaid Enrollment and Recipients by Age Cohort for Selected Fiscal Years

Age Cohort	Measure	2015	2024	2029	2034	2039	2044	*Percent Change**
Children (0-19)	Enrollees	94,799	113,441	108,746	109,391	110,808	113,071	-0.02%
	Recipients	79,540	88,901	89,797	90,912	92,410	94,492	0.31%
Adults (20-64)	Enrollees	58,959	148,278	139,194	144,435	148,201	151,521	0.11%
	Recipients	48,134	104,442	109,114	114,612	118,479	121,780	0.77%
Seniors (65+)	Enrollees	11,189	17,200	20,685	22,840	23,671	24,076	1.70%
	Recipients	9,779	14,822	18,020	20,012	20,848	21,250	1.82%
All Ages**	**Enrollees**	**164,947**	**278,919**	**268,625**	**276,666**	**282,680**	**288,668**	0.17%
	Recipients	**137,453**	**208,165**	**216,931**	**225,536**	**231,737**	**237,522**	0.66%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Average annual percent change between FY2024 and FY2044.
** Due to rounding, some totals may not precisely match the sum of components shown in the table.

In FY2015, 22.4 percent of Alaskans were enrolled in Medicaid during all or part of the fiscal year, and 18.7 percent of Alaskans received Medicaid services (Table 4). At 12.9 percent, adults (20-64) were the least likely of the three age cohorts to be enrolled in Medicaid. This changed dramatically after Alaska expanded Medicaid in September 2015, and we expect that 34.7 percent of adults (20-64) will be enrolled in Medicaid in all or part of FY2024. The proportion of children enrolled in Medicaid has also grown since FY2015 due in part to components of the ACA and the federal continuous enrollment mandate. The proportion of Alaska seniors enrolled in Medicaid has increased only slightly since FY2015. Over the 20-year forecast period, we expect the proportion of Alaskan children and seniors enrolled in Medicaid to increase and the proportion of adults 20-64 years of age to decrease slightly.

Table 4: Medicaid Enrollment and Recipients as a Proportion of Alaska's Population, For FY2015 and Selected Future Fiscal Years

Age Cohort	Measure	2015	2024	2029	2034	2039	2044
Children (0-19)	Enrollees	46.0%	57.1%	56.1%	58.0%	59.4%	60.5%
	Recipients	38.6%	44.7%	46.3%	48.2%	49.5%	50.6%
Adults (20-64)	Enrollees	12.9%	34.7%	32.6%	33.3%	33.5%	33.9%
	Recipients	10.6%	24.4%	25.6%	26.4%	26.8%	27.3%
Seniors (65+)	Enrollees	15.0%	15.4%	16.3%	17.4%	18.3%	19.1%
	Recipients	13.1%	13.3%	14.2%	15.2%	16.1%	16.9%
All Ages	**Enrollees**	**22.4%**	**37.8%**	**35.9%**	**36.7%**	**37.3%**	**38.0%**
	Recipients	**18.7%**	**28.2%**	**29.0%**	**29.9%**	**30.6%**	**31.3%**

Source: Alaska Department of Labor and Workforce Development.

Table 5 shows the forecast of Medicaid enrollment and recipients by broad eligibility category. On a percentage basis, growth will be greatest for the Aged or Disabled eligibility group. Comparatively, we expect slower enrollment and recipient growth through Medicaid expansion and other eligibility categories.

Table 5: Medicaid Enrollees and Recipients by Broad Eligibility, FY2024 – FY2044

Eligibility Group	Measure	2024	2029	2034	2039	2044	Annual Growth
Aged or Disabled	Enrollees	31,306	33,701	36,617	38,202	39,553	1.18%
	Recipients	27,669	31,437	33,735	34,685	35,295	1.22%
Medicaid Expansion*	Enrollees	76,620	69,258	70,618	73,443	74,405	-0.15%
	Recipients	51,212	49,735	50,982	53,189	53,910	0.26%
All Other Eligibilities	Enrollees	170,993	165,666	169,431	171,034	174,710	0.11%
	Recipients	129,284	135,759	140,819	143,862	148,317	0.69%
Total**	**Enrollees**	278,919	268,625	276,666	282,680	288,668	0.17%
	Recipients	208,165	216,931	225,536	231,737	237,522	0.66%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* An individual's Medicaid eligibility can change during a fiscal year. Enrollment through Medicaid expansion is comprised of persons projected to be (a) enrolled in Medicaid through expansion at the end of the fiscal year, or (b) enrolled in Medicaid through expansion during an earlier month of the fiscal year and not enrolled through traditional Medicaid during any month.
** Due to rounding, some totals may not precisely match the sum of components shown in table.

2.3 Utilization of Medicaid Services

The term "utilization" has multiple meanings in healthcare. For the purpose of the long-term Medicaid forecast, we define utilization as the annual unduplicated count of Medicaid enrollees who received a particular Medicaid service during a fiscal year. We refer to a Medicaid enrollee

who received a Medicaid service as a recipient, and we count an enrollee as a recipient only once per year for any given service category regardless of the number of times during the year the individual utilized the service, or the intensity of the service received.[41] For the long-term Medicaid forecast, we project the number of Medicaid enrollees who will use each of the 20 service categories listed in Table 6—without regard for the intensity of use—during each of the 20 years of the forecast period.[42] A more detailed description of each service category is provided in the appendix of this report.

Table 6: Service Category Designations Used in the Long-Term Medicaid Forecast

Service Group	Service Category
Behavioral Health Services	Inpatient Psychiatric & Residential Psychiatric / BRC[43]
	Outpatient Mental Health
	1115 Waiver[44]
Long-Term Care Services	Nursing Home
Long Term Services & Supports	State Plan Personal Care Services
	Community First Choice (1915(k)) Services[45]
	Home and Community-based 1915(c) Waivers[46]
Healthcare, Direct Medical Services	Inpatient Hospital
	Outpatient Hospital

[41] We count an enrollee as a recipient if he or she received Medicaid services that resulted in a paid claim. In FY2010, 89 percent of Medicaid enrollees were recipients. In FY2015, the proportion of Medicaid enrollees who were also recipients had dropped to 84 percent, and in FY2023, only 73 percent of Medicaid enrollees were recipients. We project 82.3 percent of enrollees will be recipients in FY2044.

[42] We consider "intensity of use" in the subsequent step of the long-term Medicaid forecast.

[43] BRC stands for Behavioral Rehabilitation Centers.

[44] Medicaid Section 1115 Demonstration Waivers provide states with flexibility to test new approaches within Medicaid to aid in redesigning and improving their health system without increasing costs. Alaska's 1115 Waiver is an integrated behavioral health system of care for Alaskans experiencing serious mental illness, severe emotional disturbance, substance use disorder (SUD), co-occurring substance use and mental illness, and at-risk families and children.

[45] Community First Choice (CFC), or 1915(k) services, include CFC personal care services, personal emergency response systems, and chore services. To be eligible for CFC, an enrollee must require a level of care that would otherwise be provided in an institution such as a nursing home or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

[46] Alaska has five different home- and community-based 1915(c) waivers. Eligibility for 1915(c) waiver services depends on participants requiring a level of care that would otherwise be provided in an institution, such as a nursing home or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

Service Group	Service Category
	Health Clinic
	Physician / Practitioner
	Dental
	Lab / X-Ray
	EPSDT[47]
	Therapy / Rehabilitation
	Vision
	Home Health / Hospice
Healthcare, Other Services	Pharmacy
	DME[48] / Supplies
	Transportation

2.3.1 Variability in the Utilization of Medicaid Services

There is and will likely continue to be substantial variability among enrollees in the rate of service utilization. In recent fiscal years, including FY2023, one in four enrollees did not utilize any Medicaid services, while a small number of recipients utilized 10 or more different service categories during a fiscal year. Some of this variability is correlated with age as children utilize on average fewer Medicaid service categories than adults, and adults (those 20 to 64 years of age) utilize on average fewer Medicaid service categories than seniors.

A primary factor driving utilization of Medicaid services is being diagnosed with one or more chronic conditions, the probability of which increases with age.[49] In FY2023, Medicaid recipients with no diagnosed chronic conditions utilized on average 2.9 Medicaid service categories (Table 7). In comparison, Medicaid recipients with one diagnosed chronic condition utilized on average 4.4 service categories, recipients with two to four diagnosed chronic conditions utilized on average 5.2 Medicaid service categories, and recipients with five or more chronic conditions utilized on average 6.5 Medicaid service categories.

[47] EPSDT stands for Early and Periodic Screening, Diagnosis, and Treatment.
[48] DME stands for Durable Medical Equipment.
[49] We present findings from our analysis of chronic conditions within the Medicaid population in Section 12.6.

Table 7: Number of Medicaid Service Categories Utilized in FY2023

Number of Diagnosed Chronic Conditions	Number of Service Categories Utilized
No Diagnosed Chronic Conditions	2.9
One Diagnosed Chronic Condition	4.4
Two to Four Diagnosed Chronic Conditions	5.2
Five or More Diagnosed Chronic Conditions	6.5
Average of All Medicaid Recipients	3.7

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

We project that utilization per Medicaid recipient will grow on average by about 0.6 percent per year over the next 20 years as the Medicaid population continues to age and the prevalence of chronic conditions continues to grow.

2.4 Intensity of Use of Medicaid Services

While utilization refers to the number of different Medicaid service categories a recipient uses, intensity of use refers to the *amount* of a particular service category a typical recipient receives. To estimate intensity of use, we analyzed spending per Medicaid enrollee for each of the 20 service categories for each fiscal year from FY2016 through FY2023. Over this period, Alaska consumers experienced substantial price inflation for medical services, which averaged 4.6 percent per year but fluctuated year-to-year from a low of 3 percent in FY2017 to a high of 6.8 percent in FY2019.[50] To isolate the effects of intensity of use, we attempt to remove the price effects associated with changes in reimbursement rates to Medicaid providers from each year of spending data, resulting in estimates of spending on Medicaid services as if there were no increases in Medicaid reimbursement rates.[51] With rate inflation removed, year-to-year differences in average spending per Medicaid recipient represent changes in the intensity of use of Medicaid services provided to recipients.

We used the resulting inflation-adjusted spending data to estimate statistical models to explain intensity of use as a function of (1) demographic characteristics and (2) a time-trend. We then used the coefficients estimated in these models to predict intensity of use for each of the 20 service categories through FY2044. On a weighted average basis across the 20 service categories,

[50] U.S. Bureau of Labor Statistics, "Consumer Price Index," data for medical care in urban Alaska, https://www.bls.gov/cpi/data.htm; converted to Alaska state fiscal year by Evergreen Economics.

[51] Our annual estimates of changes in Medicaid reimbursement rates are discussed in Section 12.5. For simplicity, we assume a single annual change in Medicaid reimbursement rates for all Medicaid services, while in fact, the rate of change in any given year varies—even considerably—by Medicaid service.

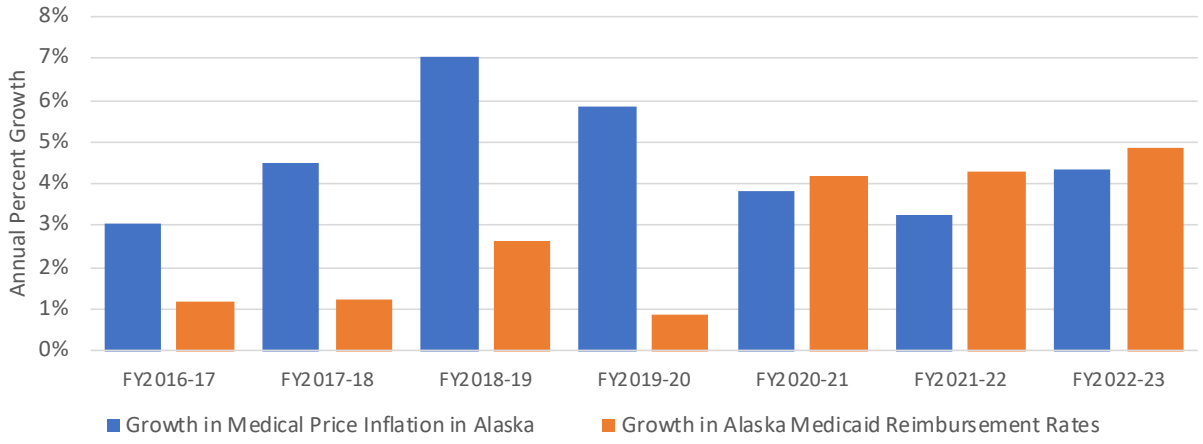
we project that intensity of use will increase on average by only about 0.7 percent per year through FY2044.[52]

2.5 Total Spending on Medicaid Services

The final step (Figure 10) of the Alaska long-term forecasting model is to develop estimates of total spending for each Medicaid service category through FY2044. To do this, we first project future changes in the rates paid by the Medicaid program for services provided to Medicaid recipients.[53] These changes in reimbursement rates are the Medicaid program's equivalent to medical price inflation, which measures changes in prices for medical services and health insurance premiums paid by consumers.

Evergreen Economics analyzed the per-unit rates of growth in reimbursement rates paid to Medicaid service providers from FY2016 to FY2023 and compared them to the rates of medical price inflation in Alaska over the same period. We found Medicaid reimbursement rates grew very slowly relative to medical price inflation each year from FY2016 through FY2020 (Figure 12), but reimbursement rates increased at a slightly faster pace than medical price inflation between FY2020 and FY2021, by one percentage point faster between FY2021 and FY2022, and by one-half percentage point faster between FY2022 and FY2023.

Figure 12: Annual Percent Change in Medicaid Reimbursement Rates and Medical Price Inflation in Alaska, FY2016 – FY2023



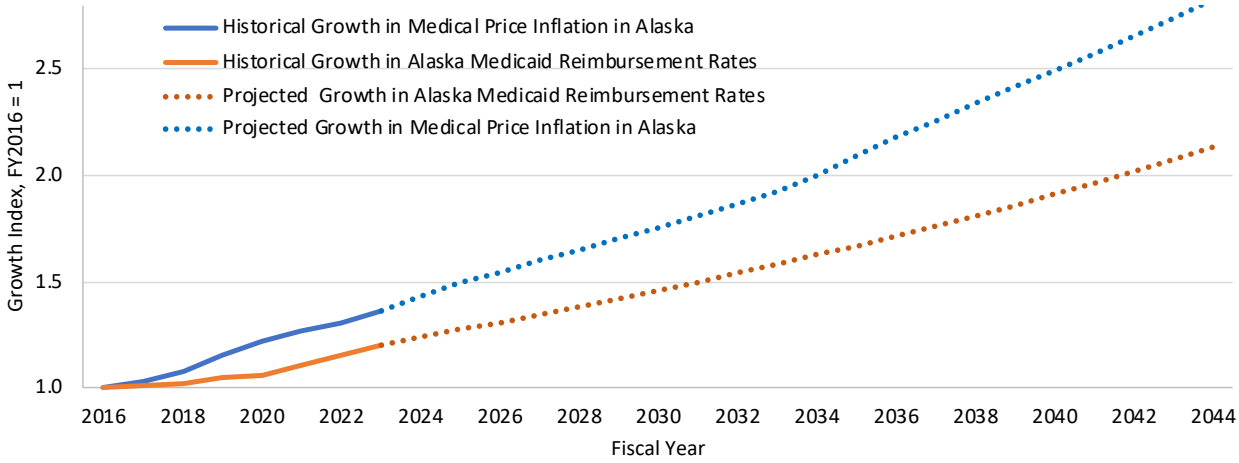
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group and the U.S. Bureau of Labor Statistics.

[52] We relied on the *Consumer Price Index for All Urban Consumers: Medical Care in Urban Alaska* index as the measure of historical healthcare price inflation, which is a measure of changes in prices paid "out of pocket" by consumers for medical care and health insurance premiums. U.S. Bureau of Labor Statistics, "Consumer Price Index." www.bls.gov/cpi.

[53] Alaska Medicaid fee schedules and covered codes are available at https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Sites/ArchivedFeeSchedule.html

Each Medicaid reimbursement rate is reviewed either annually, biennially, or triennially, and periodically updated based on these reviews.[54] Figure 13 shows Evergreen Economics' indices of projected growth in Medicaid reimbursement rates and medical price inflation through FY2044. We project that Medicaid reimbursement rates will increase by about 2.7 percent per year through FY2044, while medical price inflation will increase by nearly 3.5 percent per year over this period. The slower rate of growth in Medicaid reimbursement rates—relative to medical price inflation in Alaska—will result in growing discrepancies between the prices paid by Alaska's Medicaid program for services provided to Medicaid recipients and the out-of-pocket prices paid by Alaskan consumers for medical services and insurance premiums.

Figure 13: Projected Growth in Medical Price Inflation and Medicaid Reimbursement Rates in Alaska Through FY2044 (FY2016 = 1.0)



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group and U.S. Bureau of Labor Statistics.

Table 8 shows projected spending by Medicaid service group. We project that total Medicaid spending on Medicaid services will increase on average by 4.4 percent per year between FY2024 and FY2044, reaching nearly $6.5 billion. Over this period, growth in spending on long-term care services will outpace other service groups—6.2 percent for long-term care services versus 3.6 percent for behavioral health services, 4.1 percent for healthcare services that are medical in nature (e.g., inpatient hospital, provider services, dental services), and 3.5 percent for healthcare services that are non-medical in nature (e.g., transportation services).

[54] There are likely many factors considered when reviewing Medicaid reimbursement rates, including the costs of providing medical and related services, which are impacted by medical price inflation.

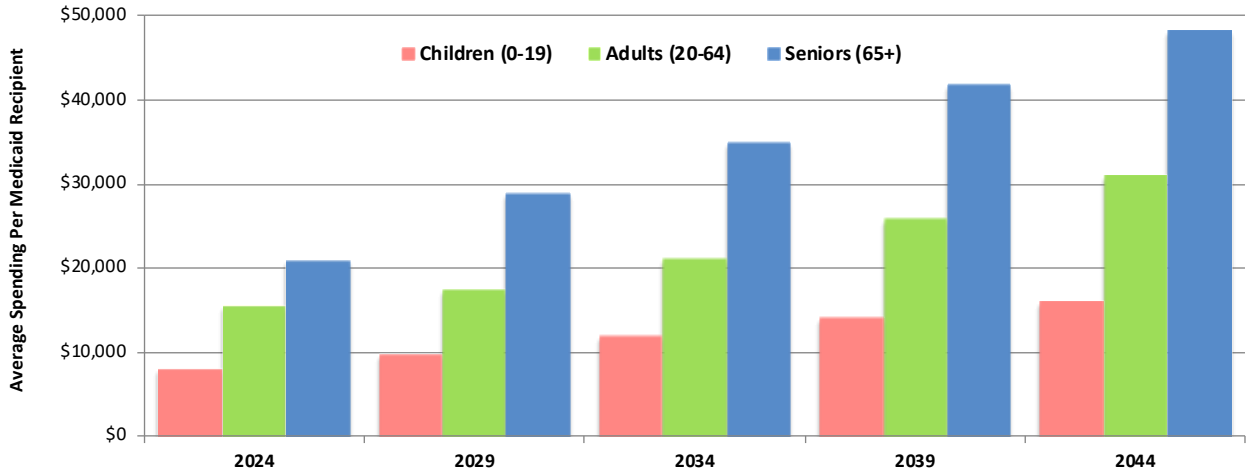
Table 8: Medicaid Spending by Medicaid Service Group, FY2024 – FY2044 (Millions $)

Service Group*	2024	2029	2034	2039	2044	Annual Growth
Behavioral Health	$360.8	$423.1	$509.5	$612.8	$731.6	3.6%
Long-Term Care	$193.8	$286.7	$399.3	$525.5	$644.4	6.2%
Long Term Services & Supports	$416.7	$631.3	$860.0	$1,089.8	$1,270.9	5.7%
Healthcare Direct Medical	$1,403.4	$1,672.2	$2,086.5	$2,571.9	$3,114.6	4.1%
Healthcare Other Services	$368.0	$420.9	$512.9	$618.6	$735.2	3.5%
Total	**$2,742.7**	**$3,434.1**	**$4,368.3**	**$5,418.5**	**$6,496.7**	**4.4%**

* See Table 14 for listing and descriptions of Medicaid services included in each service group.
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Figure 14 shows projected spending per recipient on Medicaid services. For FY2024, we estimate that for children, average spending per recipient will be about $8,000, while for adults and seniors, average spending per recipient will be about $15,500 and $21,000, respectively. By FY2044, we project average spending per child recipient will be nearly $16,000, while the average spending per adult recipient will be $31,000 and the average spending per senior recipient will be $48,200.

Figure 14: Average Spending Per Recipient on Medicaid Services by Age Cohort, FY2024 – FY2044



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

As Alaska's population ages, its Medicaid population also ages. Even without any increase in the number of persons enrolled in Medicaid, the cost of providing Medicaid services will rise due to

the positive relationship between age and spending on healthcare services. In FY2000, the average age of a Medicaid enrollee in Alaska was 21 and the median age was 14;[55] in FY2015—the year before Medicaid expansion—the average age was 23 and the median age was 16. We project that by FY2044, the average age of a Medicaid enrollee will be 30 and the median age will be 25.

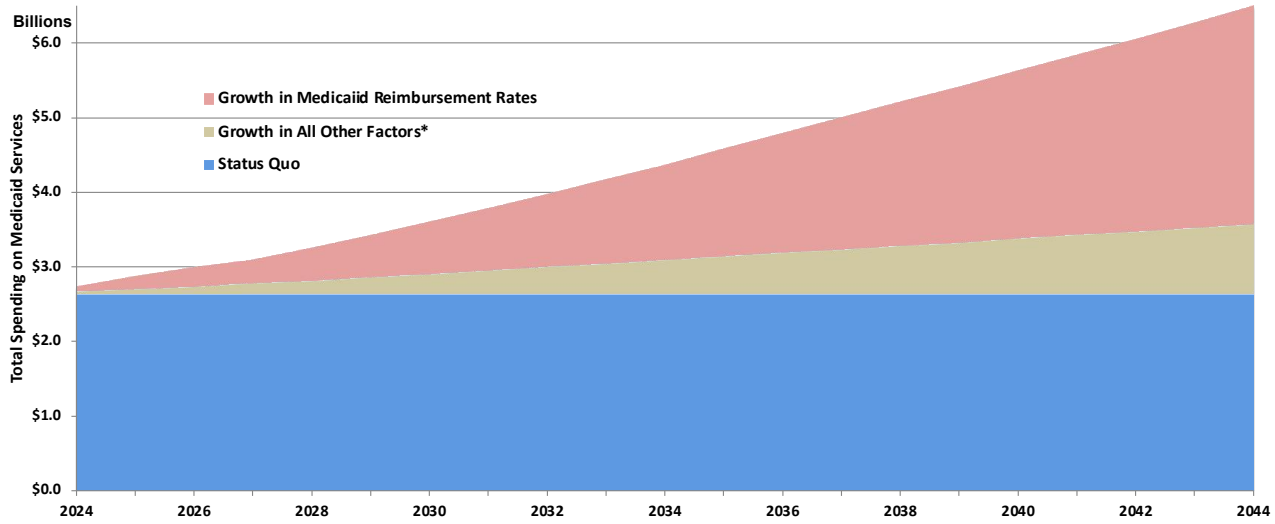
Figure 15 shows our forecast of total spending on Medicaid services by factor affecting spending growth. The figure begins with the *status quo*, which is simply the unchanging level of spending if there were no external or internal factors affecting spending over the next 20 years. The status quo assumes that everything about the Medicaid program remains unchanged (i.e., number of recipients, age distribution, health conditions, etc.) from FY2024 to FY2044. Figure 15 then shows how the spending forecast builds off this base.

The components of spending growth are as follows:

- ***Growth in Medicaid reimbursement rates*** represents increases in the schedule of fees paid to Medicaid service providers.
- ***Growth in all other factors*** represents the population, demographic, economic, and medically related variables that lead to changes in Medicaid spending. Relative to growth in Medicaid reimbursement rates, we believe these factors, collectively, will have only a modest impact on Medicaid spending over the next 20 years and so do not present them individually in Figure 15.
    - ***Population Growth*** represents the additional spending due to growth in the population under the assumption that the rate of Medicaid participation will remain the same for each of the 240 sub-populations considered in the forecast.
    - ***Enrollment Growth Above Population Growth*** is the incremental effect on Medicaid spending due to growth in the rate at which Alaskans enroll in Medicaid.
    - ***Utilization of Medicaid Services*** represents the incremental impact on spending associated with Medicaid enrollees using, on average, a greater number of Medicaid services.
    - ***Intensity of Use of Medicaid Services*** represents the incremental impact on spending associated with greater use of individual Medicaid services possibly, but not necessarily, due to changes in medical technology or practices, or increases in the scope of medical services within a Medicaid service category.

[55] The median represents the midpoint. In FY2000, half of all Medicaid enrollees were under 14 years of age.

Figure 15: Projected Spending on Medicaid Services by Component of Growth, FY2024-FY2044



* All other factors include population growth, growth in enrollment rates, growth in utilization of Medicaid services, and growth in the intensity of use of Medicaid services.
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

As Figure 15 shows, we expect *growth in reimbursement rates* to be the primary driver of spending growth in Alaska's Medicaid program, representing about 45 percent of total spending in FY2044 and 78 percent of the growth in spending between FY2024 and FY2044. Relative to growth in Medicaid reimbursement rates, the combined impact of all other factors that affect growth in Medicaid spending will be modest. Nevertheless, by FY2044, we project that combined growth in all other factors will combine to increase spending on the Medicaid program by about $826 million.

2.5.1 State Spending on Medicaid Services

The state and federal governments share the funding of the Medicaid program. The proportion of the cost of a Medicaid service that the state and federal governments are responsible for is a function of the eligibility status of each Medicaid recipient, the rate of federal financial participation (FFP) associated with each eligibility category, and, in certain cases, the facility in which the recipient receives care.

Each Medicaid service received by an enrollee is eligible for one or more of the following FFP rates:

- Regular Federal Medical Assistance Percentage (FMAP):[56]
    - 56.2 percent FFP from January 1, 2020 through March 31, 2023[57]

[56] CMS sets each state's FMAP rate based on a three-year average of per capita personal income, ranked among states.

- 55 percent FFP from April 1, 2023 through June 30, 2023
- 52.5 percent FFP from July 1, 2023 through September 30, 2023
- 51.51 percent FFP from October 1, 2023 through December 31, 2023
- 50.01 percent FFP beginning January 1, 2024 through September 30, 2024
- 51.54 percent FFP beginning October 1, 2024

- 1915 (K) Community First Choice (CFC):
  - 62.2 percent FFP from January 1, 2020 through March 31, 2023
  - 61 percent FFP from April 1, 2023 through June 30, 2023
  - 58.5 percent FFP from July 1, 2023 through September 30, 2023
  - 57.51 percent FFP from October 1, 2023 through December 31, 2023
  - 56.01 percent FFP beginning January 1, 2024
  - 57.54 percent FFP beginning October 1, 2024
- Enhanced FMAP for CHIP:[58]
  - 80.84 percent FFP From January 1, 2020 through September 30, 2020
  - 69.34 percent FFP from October 1, 2020 through March 31, 2023
  - 68.5 percent FFP from April 1, 2023 through June 30, 2023
  - 66.75 percent FFP from July 1, 2023 through September 30, 2023
  - 66.06 percent FFP from October 1, 2023 through December 31, 2023
  - 65.01 percent FFP beginning January 1, 2024 through September 30, 2024
  - 66.08 percent FFP beginning October 1, 2024
- Breast and Cervical Cancer (BCC):[59]
  - 69.34 percent FFP from January 1, 2020 through March 31, 2023
  - 68.5 percent FFP from April 1, 2023 through June 30, 2023
  - 66.75 percent FFP from July 1, 2023 through September 30, 2023
  - 66.06 percent FFP from October 1, 2023 through December 31, 2023
  - 65.01 percent FFP beginning January 1, 2024 through September 30, 2024
  - 66.08 percent FFP beginning October 1, 2024
- Family Planning: 90 percent FFP

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[57] The additional 6.2 percentage points of FFP is attributable to the declaration by the U.S. Secretary of Health and Human Services related to the COVID-19 pandemic. It was phased out by December 31, 2023. For more information, see"COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies." https://www.medicaid.gov/sites/default/files/2021-01/covid-19-faqs.pdf

[58] Ibid

[59] Ibid

- Indian Health Service (IHS): 100 percent FFP
- Medicaid Expansion: 90 percent FFP [60]
- Medicaid Expansion 1915 (K) CFC: 96 percent FFP
- State-Only Services: 0 percent FFP

When a Medicaid service received by a Medicaid recipient is eligible for more than one FFP rate, the DOH applies the rate with the highest federal participation. The majority of Medicaid spending receives the regular FMAP rate, which is currently 51.01 percent;[61] however, most of the growth in Medicaid spending since FY2015 has received either the Medicaid expansion or IHS FFP rate—90 percent and 100 percent, respectively. FFP rates are set at the federal level and, though they do change periodically, are largely outside of state control. We assume the FFP rates shown above will not change during the projection period. Table 9 shows our forecast of total spending on Medicaid services through FY2044, as well as our forecasts of spending by the State of Alaska and the federal government. We project that total spending on Medicaid services will grow on average by 4.4 percent per year through FY2044, but the rate of growth in spending will be greater for the State of Alaska (4.9%) than for the federal government (4.2%).[62]

Table 9: Projected State and Federal Spending on Medicaid Services (in Millions $)

Fund Source	2024	2029	2034	2039	2044	Annual Growth
State GF and Other Matching Funds	$696.5	$886.7	$1,151.0	$1,482.8	$1,829.9	4.9%
Federal	$2,046.2	$2,547.4	$3,217.3	$3,935.8	$4,666.8	4.2%
Total Spending*	**$2,742.7**	**$3,434.1**	**$4,368.3**	**$5,418.5**	**$6,496.7**	**4.4%**

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Due to rounding, some totals may not precisely match the sum of components shown in the table.

Figure 16 shows recent actual and projected future average spending per Medicaid recipient. Between FY2015 and FY2022, spending per Medicaid recipient stayed essentially flat, and the proportion paid with state general funds decreased considerably. In FY2023, spending per recipient increased by $1,200. Over the next 20 years, we project average spending per recipient

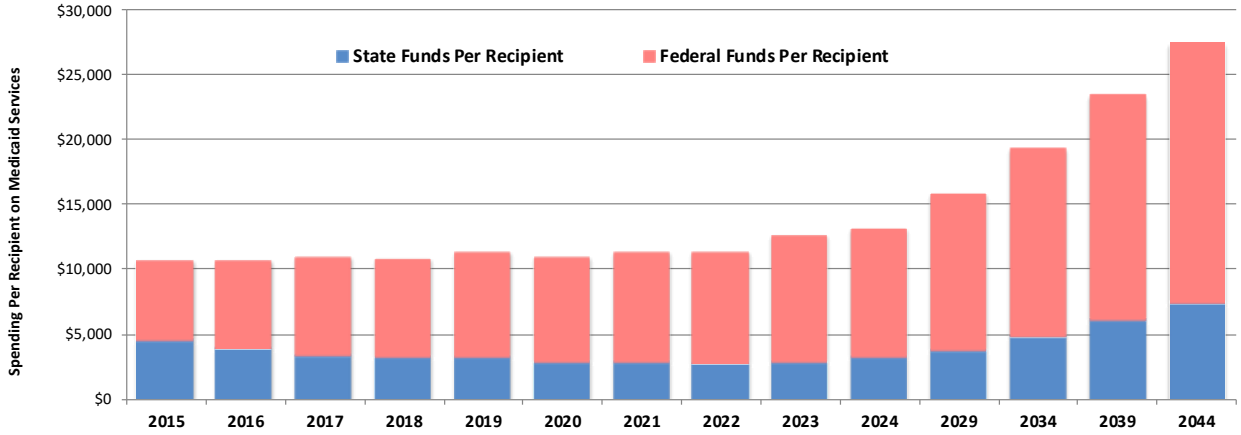
[60] Recipients enrolled through Medicaid expansion who are also Indian Health Service beneficiaries will always receive 100 percent FFP for qualifying services.

[61] Due to the COVID-19 pandemic emergency, regular FMAP was increased by 6.2 percentage points (to 56.2%). This enhancement was phased out by December 31, 2023.

[62] The greater projected rate of growth in spending for the State of Alaska is due to the sunsetting of the additional federal participation as part of the federal COVID-19 pandemic emergency.

will increase by about 3.5 percent per year due primarily to growth in provider reimbursement rates, which are driven by healthcare price inflation, and the aging of Alaska's population.

Figure 16: Average State and Federal Spending Per Medicaid Recipient by Fiscal Year*



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

* By date of service; FY2015 – FY2022 are actual expenditures; FY2023 is estimated; FY2024 – FY2044 are projected.

In FY2023, the weighted average FFP rate for Medicaid services was 76.7 percent, and we project the average FFP rate for FY2024 will be just over 74 percent as the additional FMAP provided in response to the COVID-19 emergency expired December 31, 2023. For the remainder of the forecast period, we expect the weighted average FFP to remain between 73 and 74 percent.[63]

2.5.2 Other Medicaid Payments and Offsets

There are other costs associated with the Medicaid program that are not directly tied to services provided to individual recipients. These other costs can be broadly classified into two categories:

1. Premium payments for Medicare Part A and Part B;[64] and
2. Supplemental Hospital Payments including disproportionate share hospital (DSH) and upper payment limit programs paid to qualifying hospitals that serve many Medicaid or

[63] For FY2028, each percentage point of FFP equates to about $27 million (1% of the projected $2.74 billion in spending), and the importance of each percentage point of FFP will grow as total spending on Alaska's Medicaid program increases.

[64] Medicare is a federal program that provides health insurance to people aged 65 or older, people under the age of 65 with certain disabilities, and people of all ages with end-stage renal disease. The program is voluntary, and beneficiaries must pay monthly premiums. Medicare beneficiaries with low incomes may be eligible for benefits under Medicaid (referred to as being "dual-eligible"). If an individual is dual-eligible, Medicaid pays the premiums for Medicare Part A and Part B because Medicaid is the payer of last resort, and it costs the Medicaid program substantially less to pay the premiums for Medicare coverage than it does to pay the claims for medical and related services.

uninsured individuals, continuing care agreement payments, and tribal dental encounter payments made to IHS and tribal clinics.

The share of total Medicaid spending attributed to these other payments varies from year to year but has trended downward over the past 15 years. In addition, there are offsetting recoveries such as third-party liability collections and drug rebates, which are credited to the Medicaid program and are roughly equal to 2 percent to 3 percent of annual spending on Medicaid services. Table 10 shows the forecast of spending on Medicaid services, estimates of the cost of other Medicaid payments (net of offsetting recoveries), and total projected spending on the Medicaid program.

Table 10: Total Projected Medicaid Spending by Date of Service, FY2024–FY2044, in Millions

		2024	2029	2034	2039	2044
Spending on Medicaid Services	Federal	$2,046.2	$2,547.4	$3,217.3	$3,935.8	$4,666.8
	State Match	$696.5	$886.7	$1,151.0	$1,482.8	$1,829.9
	Total	$2,742.7	$3,434.1	$4,368.3	$5,418.5	$6,496.7
Other Medicaid Payments	Federal	$89.1	$111.6	$142.0	$176.1	$211.1
	State Match	$48.0	$60.1	$76.4	$94.8	$113.7
	Total	$137.1	$171.7	$218.4	$270.9	$324.8
Total Medicaid Spending	**Federal**	$2,135.3	$2,659.0	$3,359.2	$4,111.9	$4,877.9
	State Match	$744.5	$946.8	$1,227.5	$1,577.6	$1,943.6
	Total*	$2,879.8	$3,605.8	$4,586.7	$5,689.4	$6,821.5

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Due to rounding, some totals may not precisely match the sum of components shown in the table.

2.6 Spending on Medicaid Enrollees with Chronic Conditions

Chronic conditions have a significant impact on healthcare spending in Alaska, the U.S., and globally. The U.S. National Center for Health Statistics defines chronic conditions as diseases or other medical conditions lasting three months or more.[65] The Centers for Disease Control and Prevention (CDC) defines chronic conditions as those that last one or more years and require

[65] National Health Council, "About Chronic Diseases." https://nationalhealthcouncil.org/wp-content/uploads/2019/12/AboutChronicDisease.pdf

ongoing medical attention or limit activities of daily living or both.[66] Compared to individuals without chronic conditions, adults with chronic conditions—especially those with multiple chronic conditions—have lower health-related quality of life, greater risk of death, and significantly higher healthcare costs. Chronic conditions affect healthcare costs in many ways, including:

Increased Utilization of Healthcare Services: Relative to individuals without diagnosed chronic conditions, those with chronic conditions typically require more frequent visits to healthcare providers, including specialists, which leads to higher costs. For many chronic conditions, individuals often require frequent and ongoing medical care, monitoring, and management of their conditions.

Long-Term Medications and Treatments: Certain chronic conditions require long-term medication regimens, which are often expensive, especially if the drugs are not available through a generic producer or are specialized for a specific condition. Some chronic conditions also require costly treatments or medical equipment.

Hospitalizations and Emergency Department Care: Chronic conditions can lead to various medical complications that require hospitalization. Alaska Medicaid recipients with diagnosed chronic conditions are also more likely to be *readmitted* for inpatient hospital care and are more likely to seek medical care through an emergency department. Inpatient hospital care and emergency department care are costly and contribute significantly to healthcare spending.

Increased Demand for Long-Term Care Services: Certain chronic conditions such as Alzheimer's disease and severe injuries such as factures of the hip, pelvis, or vertebrae often require long-term care solutions, such as in-home care or residential care facilities, both of which are expensive.

Chronic conditions also have substantial indirect impacts beyond the healthcare system through lost productivity due to absenteeism from work, reduced performance while at work, and early retirement or disability. In addition, for those diagnosed with certain chronic conditions, such as diabetes or heart disease, successful self-management of the condition(s) requires ongoing efforts to manage symptoms.

Particularly daunting is that the incidence of many chronic conditions increases as a population ages, resulting in a greater prevalence of multiple chronic conditions (comorbidities) within the population, which tends to result in even greater medical costs. Although slowing, the average age of Alaska's Medicaid population continues to grow, and we expect the prevalence of many chronic diseases will increase over the next 20 years.

[66] Centers for Disease Control and Prevention, "About Chronic Diseases." https://www.cdc.gov/chronicdisease/about/index.htm

2.6.1 Identifying Medicaid Recipients with a Chronic Condition

We analyzed claims data from the Alaska Medicaid Management Information System (MMIS) and the Administrative Service Organization (ASO) to identify Medicaid recipients who had a paid Medicaid claim that included diagnosis codes indicating the individual received treatment for any of the chronic conditions listed in Table 11 during FY2023. There were about 7.1 million Medicaid claims and more than 11.5 million claim lines for services provided to recipients in FY2023.[67] Each Medicaid claim line corresponds to an individual billable service provided by a hospital, health clinic, or other provider of services associated with the Medicaid claim.

Most, but not all, claim records also include one or more medical diagnosis codes assigned by a healthcare provider, which indicate the medical reason for the service.[68] We examined up to four diagnosis codes for each Medicaid claim line in FY2023 to identify if the service was associated with any of the chronic conditions listed in Table 11, which we arranged into 24 chronic condition groups based on the characteristics of the condition and/or the body system affected.

Table 11: Chronic Conditions Considered in Long-Term Forecast

	Chronic Condition Group	Chronic Conditions
1	Blood	Anemia
2	Cancer	Breast, Colorectal, Endometrial, Lung, Prostate Cancers, Leukemias / Lymphomas
3	Cardiovascular	Atrial Fibrillation, Heart Attack or Ischemic Heart Disease, Heart Failure, Hypertension, Peripheral Vascular Disease (PVD)
4	Congenital Disorders	Cystic Fibrosis
5	Diabetes	Type I and Type II Diabetes
6	Drug & Alcohol Abuse	Alcohol Use Disorders, Drug Use Disorders including Opioid Use Disorder
7	Ear Condition	SDHI - Sensory - disabling hearing impairment
8	Eye Condition	Cataract, Glaucoma, SBVI - Sensory - blindness and visual impairment
9	Injuries and Accidents	Hip or Pelvic Fracture, Spinal Cord Injury, Traumatic Brain Injury
10	Liver Disease	Cirrhosis / Liver Disease, Viral Hepatitis
11	Lung Disease	COPD, Bronchiectasis
12	Mental Health	ADHD / Hyperkinetic Syndrome, Anxiety Disorders including PTSD, Autism Spectrum Disorders, Depression or Depressive Disorder,

[67] About 62 percent of Medicaid claims in FY2020 consisted of a single claim line, and 94 percent of claims were composed of 10 or fewer claim lines.

[68] In FY2023, 2.42 million claims (21%) did not include a diagnosis code. Of these, nearly all were (99.8%) were either pharmacy- (76.6%) or dental- (23.2%).

	Chronic Condition Group	Chronic Conditions
		Developmental Delays, Intellectual Disabilities, Learning Disabilities, Personality Disorders
13	Mobility Impairments	Mobility Impairments
14	Musculoskeletal	Fibromyalgia, Chronic Fatigue Syndrome, Muscular Dystrophy, Osteoporosis, Rheumatoid Arthritis / Osteoarthritis
15	Neurological	Dementia, Alzheimer's
16	Other Neurological	Cerebral Palsy, Epilepsy, Migraine / Chronic Headache, MS or Transverse Myelitis, Spina Bifida
17	Obesity	Obesity
18	Other Metabolic and Endocrine	Acquired Hypothyroidism, Hyperlipidemia
19	Renal and Urogenital	Benign Prostatic Hyperplasia, Chronic Kidney Disease
20	Respiratory	Asthma
21	Skin	Ulcers
22	Sexually Transmitted Infection	HIV AIDS
23	Stroke	Stroke, Transient Ischemic Attack
24	Tobacco	Smoking, Vaping, or Chewing Tobacco Use

Source: Analysis by Evergreen Economics of data from the CDC.

Each chronic condition is identified by one or more International Classification of Diseases (ICD) diagnosis codes. The ICD codes are updated periodically, with the most recent update occurring on October 1, 2015 with the conversion from ICD-9 to ICD-10.[69] For each chronic condition, we relied on the Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Data Warehouse to determine which ICD-10 codes indicated the respective chronic condition. This approach to identifying the presence of a chronic condition represents a limitation in the study in that we may *underestimate* the prevalence of each chronic condition within the Medicaid population because we only observe an individual as having a chronic condition if (a) he or she receives treatment for the condition through the Medicaid program and (b) the care facility assigns a diagnosis code indicating the recipient received treatment for the chronic condition.[70]

Evergreen Economics used a single criterion to define a Medicaid recipient as having one of the chronic conditions shown in Table 11: the Medicaid recipient had at least two Medicaid claims in

[69] Note: The full acronyms are ICD-9-CM and ICD-10-CM, where "CM" stands for Clinical Modification. It is a common practice to drop the "-CM." ICD-10 codes provide greater specificity about the medical encounter; there are approximately 68,000 ICD-10 codes.

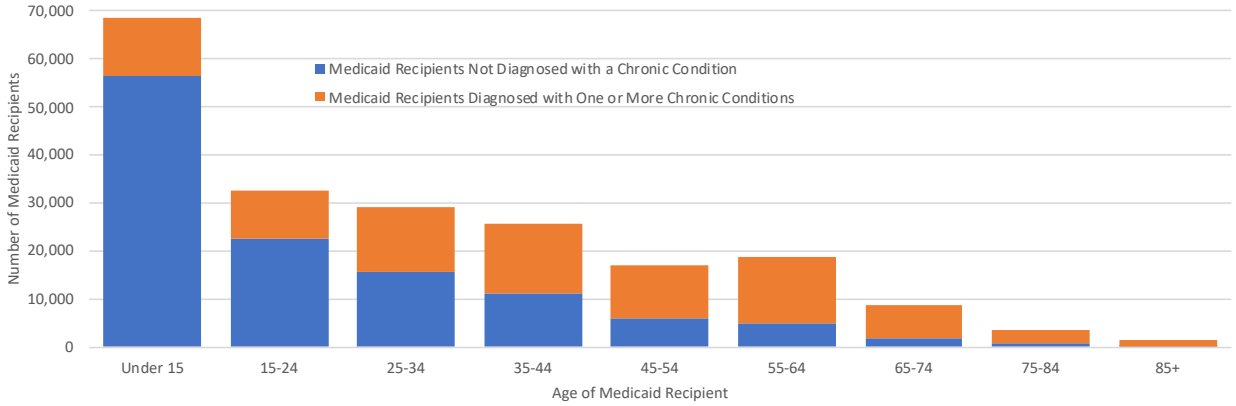
[70] The likelihood of underestimating the prevalence of chronic conditions within the Medicaid population is especially pronounced for those Medicaid recipients who have dual eligibility with Medicare—this would include Medicaid recipients 65 years of age or older, recipients younger than 65 with disabilities, and any recipient with end-stage renal disease.

FY2023 with a diagnosis code specifying the chronic condition as defined in the CMS Chronic Conditions Data Warehouse.[71] In FY2023, the unduplicated count of Medicaid enrollees was 283,296, of which 207,785 were recipients of Medicaid services. Applying the criterion described above, we identified 85,226 Medicaid recipients as being diagnosed with one or more chronic conditions.

2.6.2 Characteristics of Recipients with Chronic Conditions

Figure 17 shows the distribution of Medicaid recipients by age and whether the recipient was diagnosed with one or more chronic conditions in FY2023. The prevalence of being diagnosed with a chronic condition increases with age and/or is linked to the aging process.[72] While the number of Medicaid recipients has generally increased each year, the distribution shown in Figure 17 has not materially changed.

Figure 17: Medicaid Recipients by Age and Diagnosis of One or More Chronic Conditions, FY2023



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Approximately 18 percent of recipients under 15 years of age had a diagnosed chronic condition. The rate increases to 30 percent for recipients 15 to 24 years of age and continues to increase with each age group. The prevalence of chronic conditions increases to 79 percent for seniors 65 to 74 years of age and to 83 to 84 percent for seniors 75 or older. Medicaid recipients 65 and older are dually eligible for Medicare, which would have been the payer of many of the medical services they received in FY2023. Because of this, we likely underestimate the true prevalence of chronic conditions within these oldest age groups as the prevalence of certain chronic conditions (e.g., dementia, stroke) is highly positively correlated with age.

[71] These criteria were developed by Evergreen Economics specifically for this analysis.

[72] See, for example, Virginia M. Fried, Amy B. Bernstein, and Mary Ann Bush, "Multiple Chronic Conditions Among Adults Aged 45 and Over: Trends Over the Past 10 Years." U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2012. https://www.cdc.gov/nchs/products/databriefs/db100.htm

Table 12 shows average spending per recipient on Medicaid services in FY2023 by age of the recipient for *all* Medicaid recipients (column b), per recipient without a diagnosed chronic condition (column c), and per recipient with one or more diagnosed chronic conditions (column d).

Considering the data on average spending per recipient shown in column b (without regard for a chronic condition diagnosis), the data appear to show a strong, though imperfect, positive relationship between age and spending on Medicaid services. In comparison, spending per recipient for those without a chronic condition (column c) does not appear to be related to age (apart from the 75-84 and 85+ age groups). Likewise, spending per recipient for those with one or more chronic conditions (column d) does not increase with age (apart from the 75-84 and 85+ age groups). Collectively, columns b, c, and d show that age, in and of itself, has relatively little impact on Medicaid spending. Instead, Medicaid spending is primarily driven by the cost of services directly or indirectly related to chronic conditions. Average spending per recipient *without a diagnosis of a chronic condition* was $4,376 in FY2023, while average spending per recipient with *one or more chronic condition diagnoses* was nearly six times greater at $24,587.

Table 12: Spending Per Medicaid Recipient and Incremental Cost of Chronic Conditions, FY2023

a.	b.	c.	d.	e.
Age of Recipient	Avg. Spending per Recipient - All Recipients	Avg. Spending per Recipient - Without a Diagnosed Chronic Condition	Avg. Spending per Recipient - One or More Chronic Condition Diagnoses	Incremental Cost of Chronic Condition (d – c)
Under 5	$9,264	$5,774	$30,349	$24,575
05-09	$5,648	$3,234	$16,415	$13,181
10-14	$7,117	$3,516	$20,907	$17,391
15-19	$10,575	$4,162	$27,776	$23,614
20-24	$10,840	$4,401	$22,701	$18,300
25-34	$13,652	$4,874	$23,746	$18,872
35-44	$15,389	$4,459	$24,050	$19,591
45-54	$17,776	$3,967	$25,102	$21,136
55-64	$20,247	$3,977	$26,111	$22,135
65-74	$16,213	$3,994	$19,424	$15,429
75-84	$27,721	$10,650	$31,267	$20,617
85+	$51,858	$27,593	$56,519	$28,927
All Recipients	**$12,808**	**$4,376**	**$24,587**	**$20,211**

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Table 13 shows the distribution of Medicaid recipients by number of diagnosed chronic conditions in FY2023, average spending per recipient, and total spending on all recipients. Most (59%) Medicaid recipients have no diagnosed chronic conditions.[73] These recipients account for 20.3 percent of total spending on Medicaid services. In comparison, 19 percent of recipients have one diagnosed chronic condition and account for 23.5 percent of spending, and 22 percent of recipients have two or more chronic conditions and account for 56.2 percent of total spending on Medicaid services.

Table 13: Distribution of Medicaid Recipients and the Cost of Providing Medicaid Services by the Number of Diagnosed Chronic Conditions, FY2023

Diagnosed Chronic Conditions	Medicaid Recipients	Percent of Recipients	Average Spending Per Recipient	Total Spending	Percentage of Spending
0	122,559	59.0%	$4,376	$536,339,644	20.3%
1	39,213	18.9%	$15,652	$618,861,118	23.5%
2	19,655	9.5%	$23,208	$456,150,929	17.3%
3	11,786	5.7%	$30,433	$358,678,637	13.6%
4	7,026	3.4%	$35,436	$248,974,116	9.4%
5	3,908	1.9%	$49,381	$192,979,477	7.3%
6	2,006	1.0%	$55,203	$110,737,594	4.2%
7	941	0.5%	$61,642	$58,005,218	2.2%
8 or More	691	0.3%	$81,272	$56,159,293	2.1%
All Recipients	**207,785**	**100.0%**	**$12,808**	**$2,636,886,025**	**100.0%**

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

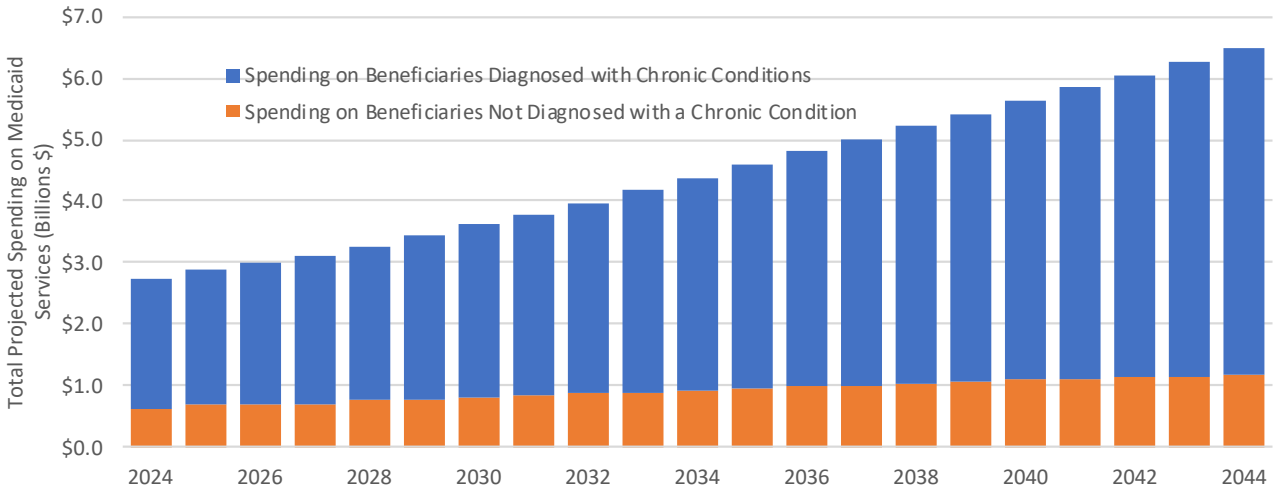
2.6.3 Projected Spending on Medicaid Services for Recipients with Chronic Conditions

We used recipient-level data from the MMIS and ASO databases and the Medicaid enrollment forecast presented earlier in this report to project spending on services for Medicaid recipients diagnosed with one or more of the chronic conditions shown in Table 11 each year through

[73] This estimate is based on the criterion that the Medicaid recipient did not receive at least two diagnoses (based on ICD-10 codes) for any of the chronic conditions listed in Table 11 on Medicaid claims incurred during FY2023. If a Medicaid recipient had a chronic condition in FY2023, but that condition went unreported in the MMIS or ASO systems in FY2023 – for any reason – we would categorize that recipient as not having a chronic condition in FY2023.

FY2044.[74] Figure 18 shows that over this period, we project that Medicaid spending on recipients diagnosed with one or more chronic conditions will grow from $2.1 billion (77% of total Medicaid spending) in FY2024 to $5.3 billion (82% of total Medicaid spending) in FY2044. Comparatively, we project that spending on recipients *not* diagnosed with a chronic condition will increase from $629 million to $1.18 billion between FY2024 and FY2044, which, though increasing by nearly $550 million over the 20-year period, will decrease as a proportion of total spending from 23 percent in FY2024 to 18 percent in FY2044.

Figure 18: Projected Spending on Medicaid Services, FY2024–FY2044



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

2.6.4 Using "Food as Medicine" to Treat Chronic Conditions

The U.S. Department of Health and Human Services (HHS) developed a "*food as medicine*" initiative to reduce nutrition-related chronic conditions.[75] Through Section 1115 of the Social Security Act, the Secretary of Health and Human Services is authorized to approve experimental, pilot, or demonstration projects proposed by states.[76] These "waivers" allow states to try new

[74] The spending forecast accounts for projected changes in the demographic makeup of the Medicaid population but does not attempt to project changes in the prevalence of each chronic condition within each demographic subgroup.
[75] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. "Food is Medicine: A Project to Unify and Advance Collective Action." https://health.gov/our-work/nutrition-physical-activity/food-medicine
[76] Centers for Medicare & Medicaid Services. "About Section 1115 Demonstrations." https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html#:~:text=Section%201115%20of%20the%20Social,objectives%20of%20the%20Medicaid%20program.

approaches to treat the health needs of Medicaid recipients, including health related social needs.[77]

The goal of a food as medicine approach is to use diet and nutrition to prevent, manage, and, in some circumstances, treat certain chronic and other health conditions in the following ways:

- **Disease Prevention**: A diet rich in nutritious foods can act to bolster the immune system and reduce the risk of lifestyle-related chronic diseases such as obesity, type 2 diabetes, cardiovascular disease, and some forms of cancer. For example, foods such as whole grains, fruits, and vegetables, which are rich in antioxidants, vitamins, and minerals, can have health-promoting and disease-preventing properties.
- **Disease Management**: For individuals with certain health conditions, diet can be a crucial part of managing symptoms and disease progression. Specific diets, such as a low-sodium diet for those with hypertension or a low-sugar diet for diabetics, act therapeutically against certain conditions.
- **Culinary Medicine:** This is an emerging evidence-based medical field that merges the art of food preparation and cooking with the science of medicine.[78] The goal of culinary medicine is to educate individuals in immediate need on what to eat to treat their condition and how to prepare it.[79] An underlying tenet of culinary medicine is that food is condition-specific; different medical conditions require different foods and meals.
- **Healthcare Integration:** Increasingly, food as medicine programs are being integrated into healthcare systems through nutritional counseling and providing support for low-income individuals and families to purchase fresh produce and other healthy foods.

While not a substitute for medical treatment, a "food as medicine" program, when provided under the guidance of healthcare professionals in conjunction with traditional medical care, can improve health outcomes for many individuals living with chronic conditions and in turn reduce utilization of Medicaid services.

[77] KFF. "Section 1115 Waiver Watch: Approvals to Address Health-Related Social Needs." https://www.kff.org/medicaid/issue-brief/section-1115-waiver-watch-approvals-to-address-health-related-social-needs/

[78] La Puma J, Marx RM. *ChefMD's Big Book of Culinary Medicine*. New York: Crown; 2008

[79] ibid

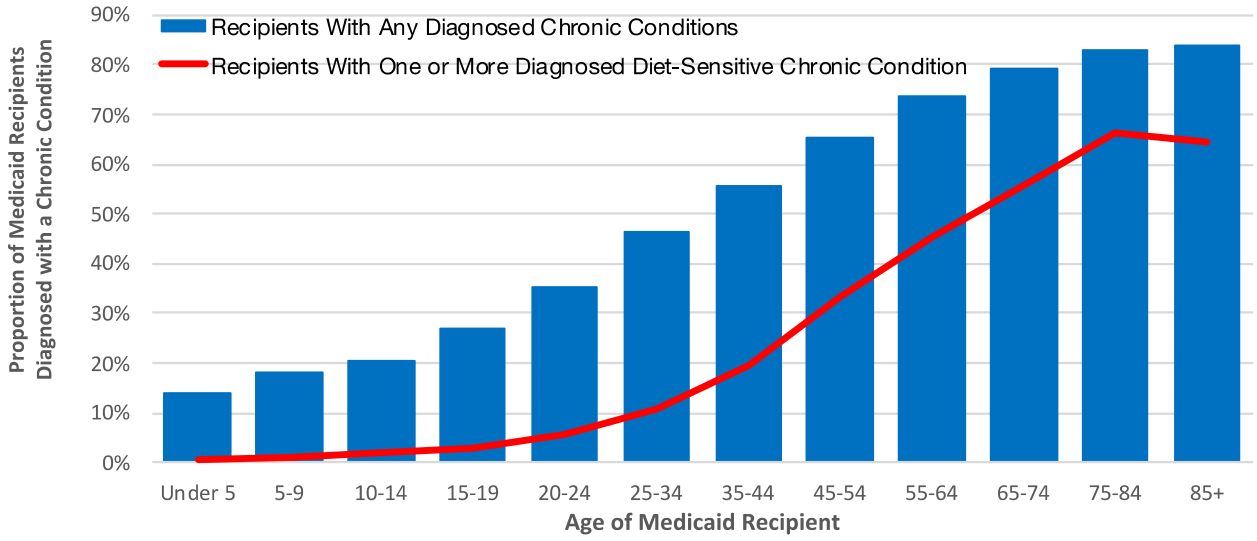
2.6.5 Diet-Sensitive Chronic Conditions Within Alaska's Medicaid Population

The Alaska Division of Public Health provided Evergreen with the following list of chronic conditions that it considers to be particularly "diet sensitive" and may be positively impacted through a food as medicine program:

- Cancer
- Cardiovascular disease
- Diabetes
- Obesity
- Renal disease
- Stroke

Evergreen analyzed Medicaid claims data for FY2023 to determine the prevalence of diet-sensitive chronic conditions (analyzed as a single category of conditions) by age within the Medicaid population. We found that the prevalence of diet-sensitive chronic conditions was low among children and young adults but increased with age. As Figure 19 shows, while about 14 percent of children under five years of age had one or more diagnosed chronic conditions, less than 1 percent of them were diagnosed with a diet-sensitive chronic condition. The prevalence of diet-sensitive chronic conditions was also low for older children and for young adults. For adults 35-44 years of age, the prevalence of diet-sensitive chronic conditions was 19.4 percent, while the prevalence of any diagnosed chronic condition was 55.8 percent. The prevalence of diet-sensitive chronic conditions continues to increase with age at a faster rate than the overall prevalence of chronic conditions.

Figure 19: Proportion of Medicaid Recipients with One or More Diagnosed Chronic Conditions That Do or Do Not Include a Diet-Sensitive Chronic Condition



In FY2023, average spending by Medicaid recipients with one or more diagnosed chronic conditions that included a diet-sensitive chronic condition was $28,667. For recipients with one or more chronic conditions that did *not* include a diet-sensitive condition, average spending was $21,914.[80] The reason for the higher average spending by recipients with diagnosed chronic conditions that include a diet-sensitive chronic condition is that these recipients have, on average, 3.2 diagnosed chronic conditions, while recipients with only non-diet-sensitive chronic conditions average only 1.5 chronic conditions. In fact, 78 percent of Medicaid recipients with a diagnosed diet-sensitive chronic condition also have one or more diagnosed non-diet-sensitive conditions, while only 32 percent of Medicaid recipients with a diagnosed non-diet-sensitive chronic condition also had a diagnosed diet-sensitive chronic condition.

[80] This comparison does not account for the confounding effects of age, gender, AI/AN status, or being diagnosed with both diet-sensitive and non-diet sensitive chronic conditions. When these factors are accounted for ("held constant"), we estimate that the marginal impact on Medicaid spending of being diagnosed with a diet-sensitive chronic condition was $7,553 in FY2023.

Table 14: Medicaid Service Category Descriptions for Long-Term Forecast

Service Group	Service Category	Description
Behavioral Health	Inpatient Psychiatric & Residential Psychiatric / Behavioral Rehabilitation Centers (BRC)	Inpatient psychiatric hospital services; Residential psychiatric treatment centers and BRC
	Outpatient Mental Health	Outpatient mental health services, psychology services, and drug abuse centers
	1115 Waiver	Behavioral health waiver
Long-Term Care	Nursing Home	Skilled nursing and intermediate care facilities including intermediate-care facilities for the intellectually disabled, and temporary long-term care services
Long-Term Services and Supports	Personal Care	Personal care attendant services including agency-based and consumer-directed programs
	Community First Choice 1915(k)	Community First Choice (CFC), or 1915(k) services, include CFC personal care services, personal emergency response systems, and chore services.
	HCB 1915(c) Waivers	Alaska has five different home- and community-based 1915(c) waivers. Eligibility for 1915(c) waiver services depends on participants requiring a level of care that would otherwise be provided in an institution.
Healthcare Services	Dental	Dental services for children and adults
	Durable Medical Equipment (DME)/Supplies	DME, medical supplies, prosthetics, and orthotics
	Early & Periodic Screening, Diagnosis & Treatment (EPSDT)	EPSDT including preventive health checkups, immunizations, and medically necessary treatment
	Health Clinic	Health clinic services including rural health clinics, federally qualified health clinics, and tribal health clinics
	Inpatient Hospital	Inpatient hospital services
	Laboratory/X-Ray	Laboratory, x-ray, and diagnostic services
	Other Services	Other services not classified elsewhere
	Outpatient Hospital	Outpatient hospital services, outpatient surgery services, and end-stage renal disease services

Service Group	Service Category	Description
	Pharmacy	Prescription drugs
	Physician/Practitioner Services	Physician, podiatrist, advanced nurse practitioner, and midwifery services
	Therapy/Rehabilitation	Outpatient rehabilitation, physical therapy, occupational therapy, speech therapy, audiology, and chiropractic services
	Transportation	Emergency and non-emergency medically necessary transportation and accommodation
	Home Health/Hospice	Home health services, hospice care, nutrition services, and private duty nursing
	Vision	Optometrist services and eyeglasses

Table 15: Medicaid Eligibility Classification Descriptions

Eligibility Class	Description
Aid to Families with Dependent Children (AFDC)& Related	Eligible for AFDC-based Family Medicare or Transitional Medicaid
Alien (Foreign)	Illegal, sponsored, or amnesty alien
Exams	Disability, waiver, or pregnancy determination pending
Kids in Custody	Children in custody of the Department of Health
Long-Term Care (LTC) Non-Cash	Aged or disabled individual not receiving SSI or cash supplement
Medicare	Eligible for Medicare cost-sharing assistance only
Other Disabled	Working disabled or eligible due to breast/cervical cancer screening
Pregnancy/Post-Partum	Eligible during pregnancy and for 60 days after giving birth
SSI/APA/LTC Cash	Eligible for SSI or other state cash supplement
Title XIX Kids	Children under age 19 not eligible for coverage under CHIP
Title XXI Kids	Children under age 19 eligible for coverage under CHIP
Expansion	Non-disabled adults 18 – 64 without dependent children

Table 16: Forecast of Population by Demographic Group, FY2024-FY2044

	FY2024	FY2029	FY2034	FY2039	FY2044	Annual % Change
State	738,183	747,238	754,124	758,008	759,353	0.1%
Gender						
Female	359,384	364,687	368,700	370,982	371,665	0.2%
Male	378,799	382,551	385,424	387,026	387,688	0.1%
AI/AN Status						
AI/AN	152,434	157,613	162,824	168,136	172,759	0.6%
Not AI/AN	585,749	589,625	591,300	589,872	586,594	0.0%
Region						
Northern	122,984	124,436	125,478	126,064	126,381	0.1%
Western	43,989	44,745	45,611	46,538	47,588	0.4%
South Central	96,558	96,179	95,678	94,902	93,917	-0.1%
Anchorage/Mat-Su	403,319	411,706	418,482	423,242	426,028	0.3%
Southeast	71,333	70,172	68,875	67,262	65,439	-0.4%
Age Group						
0-4	46,445	46,269	46,429	46,989	46,926	0.1%
5-9	49,335	47,067	46,632	46,798	47,360	-0.2%
10-14	52,261	49,063	46,957	46,523	46,692	-0.6%
15-19	50,742	51,429	48,463	46,362	45,934	-0.5%
20-24	45,976	50,899	51,572	48,617	46,532	0.1%
25-34	103,758	96,954	100,308	105,915	103,696	0.0%
35-44	109,146	111,531	105,396	99,112	102,509	-0.3%
45-54	83,175	92,581	104,180	106,952	101,071	1.0%
55-64	85,571	74,545	72,671	81,537	92,596	0.4%
65-74	72,602	73,633	65,080	55,713	54,284	-1.4%
75-84	31,085	42,345	50,774	51,767	45,215	1.9%
85+	8,087	10,922	15,662	21,723	26,538	6.1%

Source: Analysis by Evergreen Economics of data from the Alaska Department of Labor and Workforce Development.

Table 17: Forecast of Enrollment by Demographic Group, FY2024-FY2044

	FY2024	FY2029	FY2034	FY2039	FY2044	Annual % Change
State	278,919	268,625	276,666	282,680	288,668	0.2%
Gender						
Female	141,124	137,156	141,640	144,939	147,888	0.2%
Male	137,795	131,469	135,027	137,741	140,780	0.1%
AI/AN Status						
AI/AN	90,016	91,338	96,040	100,374	104,564	0.8%
Not AI/AN	188,903	177,287	180,626	182,306	184,105	-0.1%
Region						
Northern	36,841	35,772	36,887	37,758	38,665	0.2%
Western	32,840	32,525	34,007	35,495	36,972	0.6%
South Central	36,953	34,121	34,809	35,252	35,720	-0.2%
Anchorage/Mat-Su	147,054	142,470	147,056	150,284	153,434	0.2%
Southeast	25,231	23,736	23,907	23,891	23,878	-0.3%
Age Group						
0-4	28,001	29,164	30,302	31,316	31,785	0.6%
5-9	29,756	26,922	27,550	28,207	29,079	-0.1%
10-14	28,612	25,755	25,530	25,836	26,465	-0.4%
15-19	27,071	26,905	26,009	25,449	25,742	-0.3%
20-24	21,321	21,443	22,192	21,448	21,167	0.0%
25-34	43,594	39,303	41,276	43,583	43,559	0.0%
35-44	37,157	35,467	35,088	34,319	35,801	-0.2%
45-54	23,047	23,470	26,190	27,200	26,773	0.8%
55-64	23,158	19,511	19,689	21,651	24,220	0.2%
65-74	10,930	11,186	10,451	9,240	9,228	-0.8%
75-84	4,598	7,053	8,860	9,466	8,629	3.2%
85+	1,672	2,446	3,528	4,965	6,219	6.8%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Table 18: Forecast of Spending by Demographic Group (Millions $), FY2024-FY2044

	FY2024	FY2029	FY2034	FY2039	FY2044	Annual % Change
State	$2,742.7	$3,434.1	$4,368.3	$5,418.5	$6,496.7	4.4%
Gender						
Female	$1,471.9	$1,847.9	$2,361.7	$2,944.7	$3,544.0	4.5%
Male	$1,270.8	$1,586.2	$2,006.6	$2,473.8	$2,952.7	4.3%
AI/AN Status						
AI/AN	$1,185.3	$1,483.9	$1,876.7	$2,312.9	$2,759.9	4.3%
Not AI/AN	$1,557.3	$1,950.2	$2,491.6	$3,105.7	$3,736.8	4.5%
Region						
Northern	$307.3	$383.7	$485.5	$598.7	$714.8	4.3%
Western	$340.7	$425.4	$538.3	$663.8	$792.5	4.3%
South Central	$396.1	$494.5	$625.7	$771.7	$921.3	4.3%
Anchorage/Mat-Su	$1,394.3	$1,750.7	$2,238.1	$2,791.5	$3,360.5	4.5%
Southeast	$304.3	$379.8	$480.7	$592.8	$707.7	4.3%
Age Group						
0-4	$234.3	$298.8	$369.1	$439.8	$509.7	4.0%
5-9	$126.2	$140.7	$173.7	$207.0	$239.9	3.3%
10-14	$165.2	$182.9	$225.9	$269.1	$311.9	3.2%
15-19	$224.8	$277.9	$343.2	$409.0	$474.0	3.8%
20-24	$150.9	$188.3	$228.3	$265.5	$308.3	3.6%
25-34	$419.6	$499.2	$683.4	$912.6	$1,093.0	4.9%
35-44	$392.5	$503.7	$638.6	$768.8	$931.2	4.4%
45-54	$304.1	$398.3	$514.1	$624.3	$706.4	4.3%
55-64	$374.3	$385.8	$462.5	$625.8	$868.1	4.3%
65-74	$147.0	$189.1	$237.3	$291.4	$341.9	4.3%
75-84	$116.9	$213.8	$275.8	$338.7	$397.4	6.3%
85+	$86.9	$155.7	$216.4	$266.4	$314.8	6.6%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Table 19: Forecast of Total Spending on Medicaid (Millions $), FY2024-FY2044

Service Category	FY2024	FY2029	FY2034	FY2039	FY2044	Annual % Change
Inpatient Hospital	$423.5	$500.7	$620.8	$761.3	$920.3	4.0%
Outpatient Hospital	$329.7	$381.2	$469.4	$572.7	$687.1	3.7%
Family Planning	$0.2	$0.3	$0.4	$0.4	$0.5	4.4%
Health Clinic	$219.0	$276.7	$358.4	$453.7	$559.8	4.8%
Physician/Practitioner	$229.6	$259.8	$314.1	$376.6	$444.3	3.4%
Dental	$107.1	$130.2	$163.3	$202.7	$248.7	4.3%
Lab/X-ray	$8.5	$9.7	$12.1	$14.9	$18.0	3.8%
EPSDT	$22.2	$33.5	$47.1	$63.8	$82.5	6.8%
Therapy/Rehabilitation	$40.6	$50.8	$63.9	$78.9	$94.8	4.3%
Home Health/Hospice	$11.8	$16.7	$22.0	$29.1	$37.7	6.0%
Vision	$11.1	$12.5	$14.9	$17.7	$20.7	3.2%
Pharmacy	$247.8	$277.7	$336.9	$404.5	$479.9	3.4%
DME/Supplies	$26.1	$32.6	$41.7	$52.0	$62.7	4.5%
Transportation	$94.0	$110.6	$134.3	$162.1	$192.5	3.6%
Inpatient-Res Psych	$50.4	$58.5	$66.6	$76.8	$90.1	2.9%
Outpatient Mental Health	$126.5	$148.3	$180.2	$219.0	$265.1	3.8%
1115 Waver	$183.9	$216.3	$262.7	$317.0	$376.5	3.6%
Nursing Home	$193.8	$286.7	$399.3	$525.5	$644.4	6.2%
State Plan Personal Care Services	$22.9	$37.4	$54.1	$71.9	$87.2	6.9%
Community First Choice (1915(k) Services	$369.0	$553.2	$748.4	$945.3	$1,102.1	5.6%
HCB 1915(c) Waivers	$24.9	$40.7	$57.5	$72.6	$81.6	6.1%
Total Spending on Medicaid Services	$2,742.7	$3,434.1	$4,368.3	$5,418.5	$6,496.7	4.4%
Other Medicaid Payments*	$137.1	$171.7	$218.4	$270.9	$324.8	4.4%
Total Spending on Medicaid Program	$2,879.8	$3,605.8	$4,586.7	$5,689.4	$6,821.5	4.4%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Includes offsets received by the DOH for drug rebates, third-party liability collections, or other reasons.

Table 20: Forecast of State Spending on Medicaid (Millions $), FY2024-FY2044

Service Category	FY2024	FY2029	FY2034	FY2039	FY2044	Annual % Change
Inpatient Hospital	$104.3	$118.3	$147.2	$181.2	$220.6	3.8%
Outpatient Hospital	$58.7	$64.2	$79.3	$97.2	$117.5	3.5%
Family Planning	$169.4	$205.3	$264.2	$330.2	$403.5	4.4%
Health Clinic	$11.1	$11.7	$15.2	$19.3	$24.0	3.9%
Physician/Practitioner	$27.8	$30.2	$36.7	$44.1	$52.4	3.2%
Dental	$2.2	$2.6	$3.2	$4.0	$5.0	4.2%
Lab/X-ray	$0.1	$0.1	$0.1	$0.1	$0.1	3.7%
EPSDT	$3.7	$5.3	$7.4	$10.1	$13.2	6.5%
Therapy/Rehabilitation	$99.6	$121.2	$153.1	$189.8	$229.8	4.3%
Home Health/Hospice	$4.2	$4.5	$5.4	$6.5	$7.6	3.1%
Vision	$12.2	$13.1	$16.0	$19.3	$23.0	3.2%
Pharmacy	$4.6	$5.6	$7.1	$8.9	$10.8	4.4%
DME/Supplies	$37.3	$40.2	$49.0	$59.4	$71.0	3.3%
Transportation	$9.9	$11.2	$12.8	$14.8	$17.5	2.9%
Inpatient-Res Psych	$24.7	$27.5	$33.6	$41.0	$49.9	3.6%
Outpatient Mental Health	$61.0	$68.7	$83.7	$101.5	$121.4	3.5%
1115 Waver	$34.6	$49.6	$69.3	$91.7	$113.2	6.1%
Nursing Home	$18.1	$25.1	$33.2	$44.0	$57.4	5.9%
Personal Care	$13.6	$20.7	$28.6	$36.3	$42.1	5.8%
Community First Choice 1915(k) Services	$11.2	$16.9	$23.5	$30.5	$36.7	6.1%
HCB 1915(c) Waivers	$76.3	$124.1	$175.7	$222.9	$252.2	6.2%
Total Spending on Medicaid Services	$784.5	$965.9	$1,244.2	$1,552.8	$1,869.0	4.4%
Other Medicaid Payments*	$48.0	$60.1	$76.4	$94.8	$113.7	4.4%
Total Spending on Medicaid Program	$832.5	$1,026.0	$1,320.7	$1,647.6	$1,982.6	4.4%

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Includes offsets received by the DOH for drug rebates, third-party liability collections, or other reasons.