Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: FY2025-FY2045

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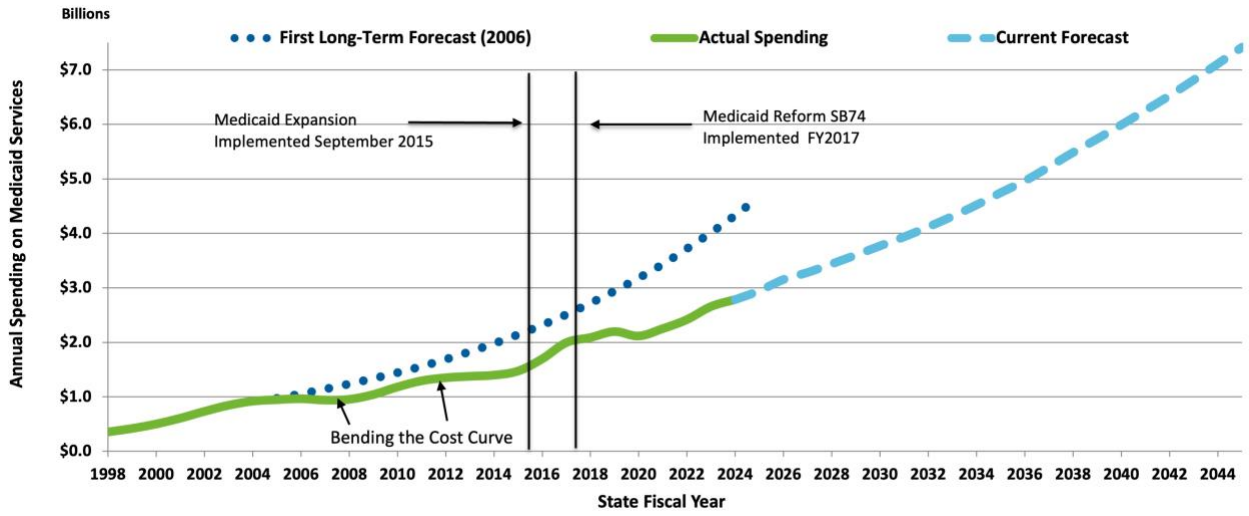
Executive Summary

The forecast presented in this report 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 report, we develop long-term forecasts of enrollment in and spending on services provided by Alaska's Medicaid program for fiscal year (FY) 2025 through FY2045. These projections 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 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 green line), projected spending from the first long-term Medicaid forecast (dark blue dotted line), and the current projection of Medicaid spending (light blue dashed line). Actual spending on Medicaid services in FY2024 was nearly $1.55 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 the DOH, which helped "bend the cost curve" on Medicaid spending. We project total spending on Medicaid services will reach $7.4 billion by FY2045.

Figure 1: Spending on Medicaid Services – Actual and Projected, FY1998 – FY2045

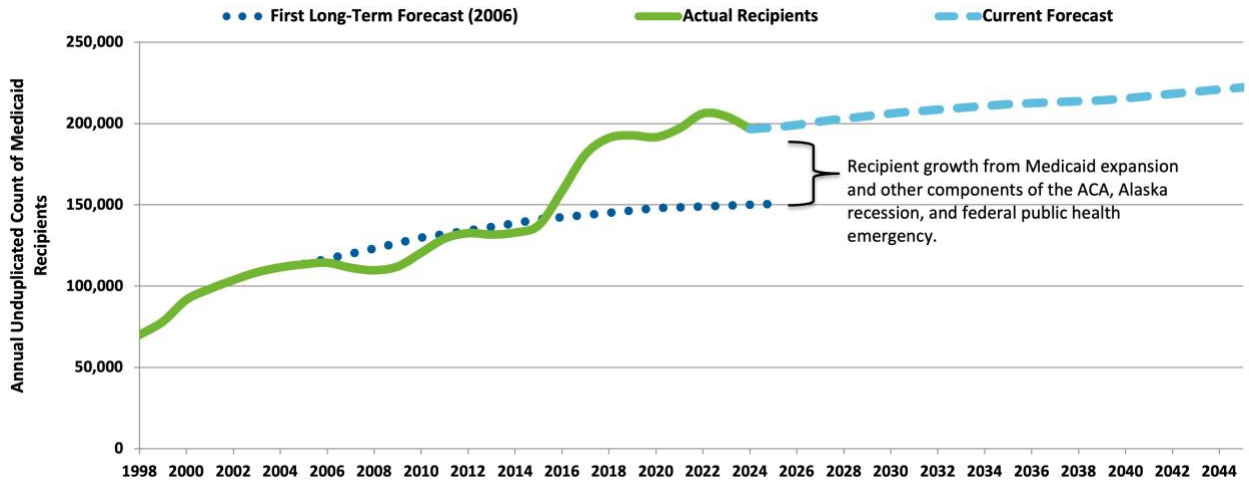


Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

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. Utilization of Medicaid services grew in FY2021 and especially in FY2022, before leveling off through much of FY2023 and then decreasing substantially in FY2024. For the current forecast, we expect the number of Medicaid recipients to grow at a relatively slow rate through the projection period.

Figure 2: Medicaid Recipients – Actual and Projected, FY1998 – FY2045



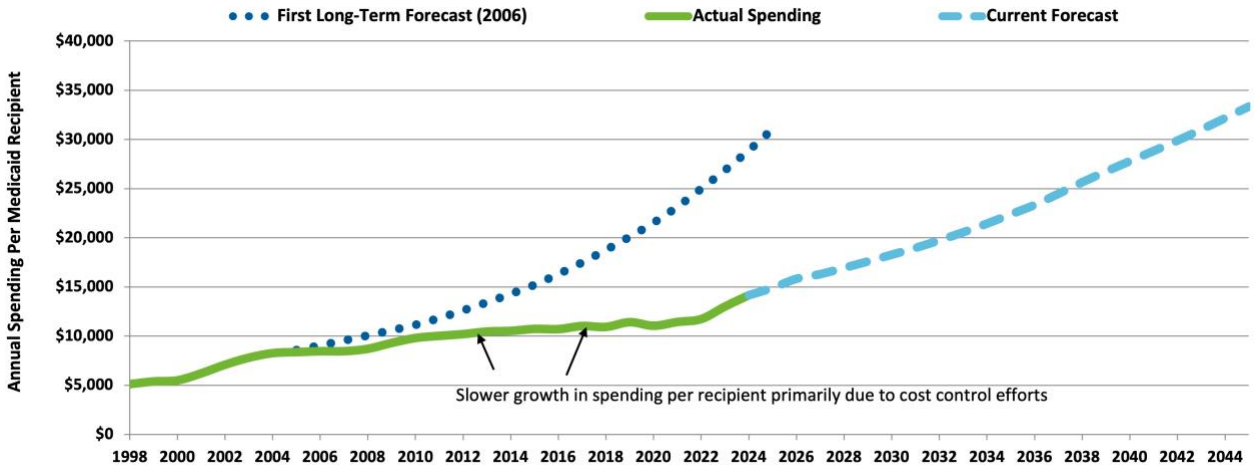
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

As noted, spending on Alaska's Medicaid program today is considerably less 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 (solid green

[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 FY2024, 67 percent of Medicaid enrollees were also recipients, which means that about one of every three (23%) Medicaid enrollees did not receive any Medicaid services in FY2024.

line), as well as projected spending per recipient from the current and the first long-term Medicaid forecasts. Between FY2005 and FY2022, spending per recipient grew on an average annual basis by just 2 percent per year—far less than the 9 percent annual rate the program experienced during the first half of the 2000s. In the two fiscal years since FY2022, spending per recipient has increased rapidly, growing by nearly 10 percent in each of FY2023 and FY2024.

Figure 3: Medicaid Spending per Recipient – Actual and Projected, FY1998 – FY2045



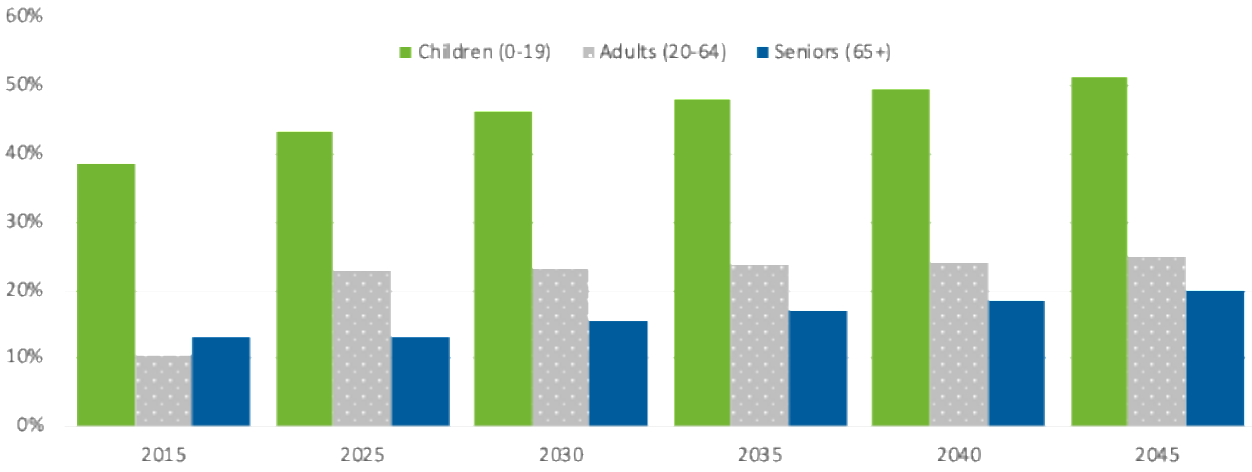
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

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 23 percent of adults will receive services through Alaska's Medicaid program in FY2025, up from just 10.6 percent in FY2015. We project that 23.3 percent of Alaska adults will be Medicaid recipients by FY2035 and just over 25 percent will be recipients by FY2045. We project that the proportion of seniors receiving Medicaid services will grow from 12.9 percent in FY2025 to 19.8 percent by FY2045, and that the proportion of Alaska children receiving Medicaid services (or services through the Children's Health Insurance Program [CHIP]) will grow from 43.3 percent in FY2025 to 51 percent in FY2045.

[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 $2.94 billion in FY2025 to $7.4 billion in FY2045—an average annual growth rate of 4.7 percent. 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 in recent forecasts 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 4.5 percent and federal spending will grow by 4.8 percent per year through FY2045 (Table 1). The greater projected rate of growth in spending for the federal portion is due to ongoing tribal refinancing efforts by the DOH, which are likely to continue to result in increasing federal financial participation (FFP).

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

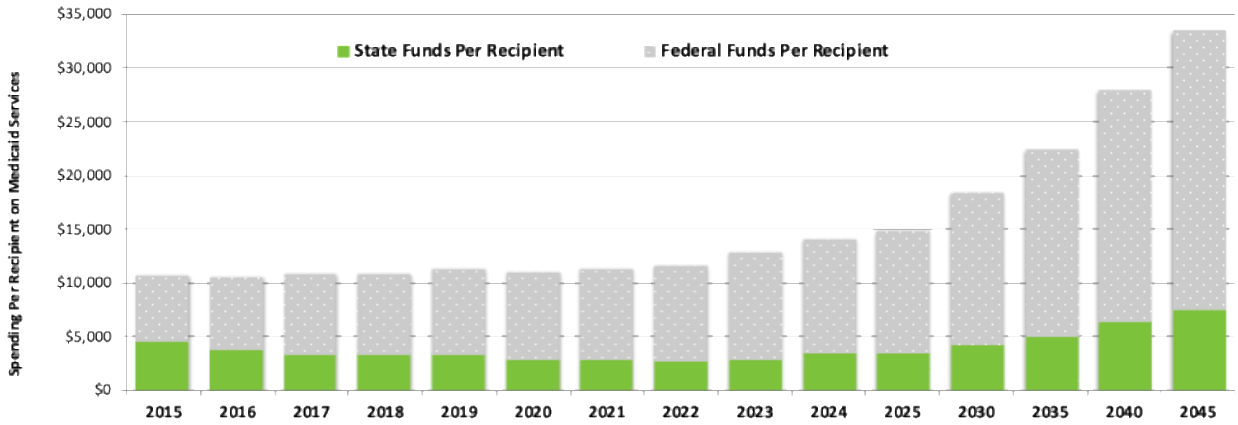
Fund Source	2015	2025	2030	2035	2040	2045	Annual Growth*
State General Funds	$681.1	$710.1	$909.4	$1,153.7	$1,438.4	$1,700.5	4.5%
Federal	$900.7	$2,234.6	$2,859.5	$3,591.3	$4,551.9	$5,714.1	4.8%
Total Spending*	**$1,581.8**	**$2,944.7**	**$3,768.9**	**$4,745.0**	**$5,990.2**	**$7,414.5**	**4.7%**

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Annual growth computed from FY2025 to FY2045.

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. Spending per recipient grew more rapidly in FY2023 and FY2024 than in the previous years, and costs were shifted back to state general funds due to the phasing out of the additional 6.2 percentage points of FFP related to the COVID-19 pandemic (primarily in

FY2024).[3] Over the next 20 years, we project spending per recipient to increase on average by 4.2 percent per year due primarily to growth in reimbursement rates paid to providers and to aging of the Medicaid population.[4]

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 – FY2023 are actuals, FY2024 is estimated, FY2025 – FY2045 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 2025 and 2045, the Alaska Department of Labor and Workforce Development projects that Alaska's population will *decrease* by 6,516.[5]
  - The number of Alaskans under 20 years of age will *decrease* by 20,761.
  - The number of Alaskans 20 to 64 years of age will grow by 5,084.
  - The number of Alaskans 65 years of age and older will grow by 9,161.
- Between FY2010 through FY2024, spending per Medicaid recipient grew on average by 2.7 percent per year, with much of that growth occurring between FY2022 and FY2024.

[3] The phasing out of additional federal funds from the US Department of Health and Human Services related to the COVID-19 pandemic was completed on December 31, 2023.
[4] 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
[5] Alaska Department of Labor and Workforce Development, Research and Analysis. 2024. *Alaska Population Projections 2023 to 2050*. http://live.laborstats.alaska.gov/pop/projections.cfm

- Between FY2025 and FY2045, we project spending per recipient will grow by 4.2 percent per year.
- After growing well below Alaska's rate of medical price inflation for years, Medicaid reimbursement rates paid to providers have grown faster than medical price inflation each year since FY2021.
- We project Medicaid reimbursement rates will grow on average by about 3.0 percent per year through FY2045, which is below the expected rate of medical price inflation but greater than historical Medicaid reimbursement rate growth.
- Through FY2045, total spending on Medicaid services will grow on an average annual basis by 4.7 percent; general fund spending will grow by 4.5 percent.
    - We project total spending on Medicaid services will reach $7.4 billion in FY2045 and that total spending on the Medicaid program, including non-claim related spending, will be nearly $7.8 billion.[6]
    - We project general fund spending on Medicaid services in FY2045 will be $1.7 billion ($1.83 billion including non-claim-related spending).

Key Findings—Impact of Chronic Conditions and High Utilizers on Medicaid Spending

- In FY2024, 43 percent of Medicaid recipients (84,007 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 $26,499 in FY2024, compared to $4,581 for recipients without a diagnosed chronic condition.
- We estimate that 84.5 percent of spending on Medicaid services in FY2045 will be for recipients with one or more diagnosed chronic conditions; currently, it is 81 percent.
- In FY2024, the 10 percent of Medicaid recipients with the highest costs accounted for two-thirds of spending on Medicaid services.

[6] Non-claim-related spending includes Medicare Part A and Part B premiums, supplemental hospital payments, and offsetting recoveries, which are credits. For each year of the forecast, we assume non-claim-related spending will be equal to 5 percent of total spending on Medicaid services; we further assume that 65 percent of non-claim-related spending will be paid with federal funds and that 35 percent will be paid with state general funds.

- Over this same period, the half of recipients with the lowest costs accounted for less than 5 percent of spending on Medicaid services.
- High utilizers of Medicaid services are much more likely to have been diagnosed with one or more chronic conditions and to have utilized services from an emergency department on multiple occasions during FY2024.

1 Introduction

This document presents the results of the fiscal year (FY) 2025-FY2045 projection of enrollment in and spending on the Medicaid program in Alaska. It is the nineteenth 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.[7] In state FY2014 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.[8] Since then, federal financial participation has grown rapidly, due in part to additional funds made available to the states by the US Department of Health and Human Services (HHS) in response to the COVID-19 pandemic. Federal financial participation grew to 77 percent for FY2023.

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 75 percent for FY2025 and will slowly increase over the 20-year forecast period, reaching 77 percent by FY2045.

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,[9] 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

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[7] 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.

[8] 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 2.6.1) for a discussion of the rate of federal financial participation associated with each FMAP rate.
Unless otherwise stated, all references to fiscal year are state fiscal year, which begins July 1 and ends June 30. For example, FY2024 for Alaska began July 1, 2023, and ended June 30, 2024. In comparison, federal fiscal years begin October 1 and end September 30.

[9] 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.

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 September 2015, this time for adults who met certain income requirements but were not previously eligible for Medicaid.[10]

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.[11] 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 Unwinding of 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 COVID-19 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.

As a result of this continuous enrollment requirement, Medicaid enrollment increased significantly in Alaska and across the US 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).

Beginning in April 2023, Alaska and other states were permitted to begin conducting redeterminations of Medicaid eligibility (commonly referred to as "Medicaid unwinding").[12] Given 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

[10] 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.
[11] Both divisions are within the Alaska Department of Health.
[12] In Alaska, the Division of Public Assistance is responsible for conducting Medicaid eligibility "redeterminations."

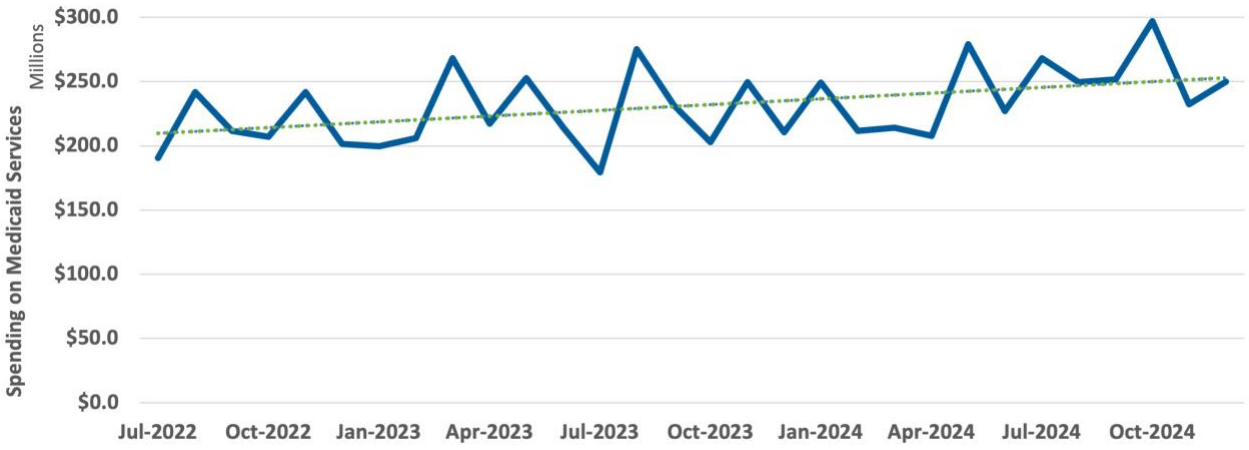
staff had not performed this function over the past three years, verifying eligibility for all Medicaid enrollees has required substantial DOH staff resources and extensive training.

Impact of Unwinding on Medicaid Spending and Recipients

While unwinding has impacted the number of individuals enrolled in Medicaid, it has not, to date, appeared to have impacted spending on Medicaid services. Figure 6 shows monthly spending on Medicaid claims from July 1, 2022 to December 31, 2024. The spending data shown in Figure 6 are based on the month the payment to the provider occurred (as opposed to the month the service occurred). Spending varies month-to-month due to seasonal factors, random variation in the healthcare needs of Medicaid beneficiaries and the timing of invoices submitted to the DOH, and (most importantly) in the number of "check-writes" made by the DOH during a given month.[13]

The blue line shows total spending on all claims paid during each month. The dotted green line shows the linear trend in total monthly spending, which is positive and indicates that, even as the number of individuals enrolled in Medicaid has decreased due to unwinding, spending on Medicaid services continues to increase. Most Medicaid claims are paid within 60 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 may suggest that Medicaid unwinding has not, to date, had a substantial impact on Medicaid utilization.

Figure 6: Monthly Spending on Medicaid Claims, July 2022 - December 2024



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

Figure 7 shows the number of Medicaid recipients each month from July 2022 through December 2024. As with monthly spending on Medicaid claims, Figure 7 shows that there is

[13] Check-writes (remittances to providers) typically occur each Wednesday. Each month contains either four or five Wednesdays. On average, total spending on Medicaid services in months containing five Wednesdays is 25 percent more than months containing only four Wednesdays.

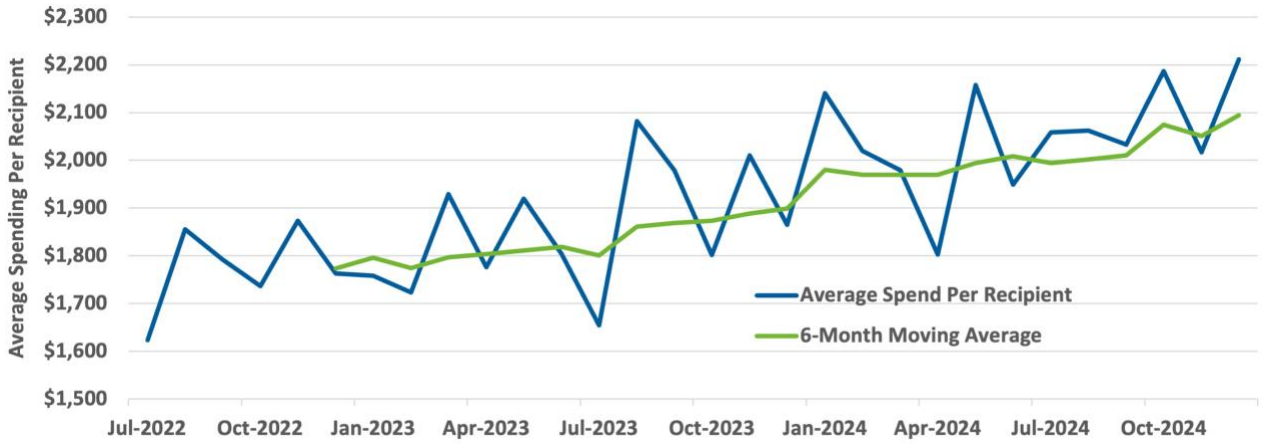
substantial month-to-month variability in the number of recipients with paid claims. Over these 30 months, there has been little to no upward or downward trend in the monthly count of Medicaid recipients with paid claims.

Figure 7: Number of Recipients with Paid Medicaid Claims, July 2022 – December 2024*

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Based on date of payment.

Since monthly spending on Medicaid claims did increase between July 2022 and December 2024 (Figure 6), but the number of Medicaid recipients receiving services each month did not increase over this period (Figure 7), the only explanation for the increase is that average spending per Medicaid recipient increased. As Figure 8 shows, this is indeed what happened. Over this period, average spending per recipient increased on average by 8.7 percent per year, which equates to approximately $300 per Medicaid recipient.

Figure 8: Average Spending Per Recipient by Month, July 2022 – December 2024*



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Based on date of payment.

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 the 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 – 1115 Behavioral Health Reform

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.

On March 26, 2024, Alaska received approval from CMS to extend the 1115 waiver demonstration through December 31, 2028. The extension authorizes the state to change the title of the demonstration from "Substance Use Disorder Treatment and Behavioral Health Program (SUD-BHP)" to "Behavioral Health Reform." The title change aligns mental health and substance use disorders under a broader behavioral health definition to reflect the state's commitment to program reform and system transformation. Beyond the title change, the state did not request any changes with this extension but rather sought to continue operations of the current demonstration.

With CMS's approval and extension of the 1115 Behavioral Health Reform demonstration waiver, Alaska now has an opportunity to apply to expand services through an amendment. The services identified for an amendment include:

- Increasing flexibilities for and expanding community-based crisis services; and
- Strengthening in-home and community-based health services to support youth who remain close to their home and family.

These prioritized services are a direct result of engagement with communities and stakeholders through the Behavioral Health Roadmap Project for Youth.

Behavioral Health Medicaid Claims Transition

Beginning in February 2024, DBH began its focus on the Behavioral Health Medicaid claims transition from the Administrative Services Organization (ASO) Optum to the Medicaid Management Information System (MMIS) within the Division of Health Care Services. DBH and

Health Care Services collaborated to develop and implement transition activities with all vendors and stakeholders involved. The transition occurred in two phases: the first consisted of independent psychologists, licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), and licensed marital and family therapists (LMFTs), who transitioned to MMIS by October 1, 2024. The second (and final) transition occurred November 1, 2024 and included all provider types and specialties including those listed above plus autism, mental health clinics, 1115 Waiver Services (1115), and the State Plan Community Behavioral Health Service (CBHS).

This work aligns with CMS expectations for the DOH to design and implement projects and programs that are cohesive and unified. This transition was designed to 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.

Behavioral Health Provider Support Organization

DBH published a Request for Proposal (RFP) for a Behavioral Health Provider Support Organization (BHPSO). This RFP was intended to replace the expired Optum contract by soliciting a vendor to fully implement and realize the services available under the 1115 Behavioral Health Reform demonstration waiver. Contract deliverables included 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.

Behavioral Health Medicaid Rates

DBH initiated a regulations package to review Medicaid coverage and payments for 1115 Behavioral Health Reform demonstration waiver services through a 4.5 percent increase to existing service reimbursements. A regulations package was also initiated to provide for an increase to state plan Medicaid payment rates for Community Behavioral Health & Mental Health Physician Clinic Services.

Crisis Continuum of Care

DBH commissioned Milliman, Inc. to analyze Alaska's behavioral health crisis continuum of care amidst rising suicide rates, overdoses, and increased mental health needs nationwide. The report[14] was finalized in June 2024 and provides an overview of the current state of behavioral health crisis service delivery in Alaska, highlighting areas of opportunity as the state looks to increase access to

[14] Milliman, Inc. 2024. *Assessment of Alaska's Behavioral Health Crisis Services Continuum of Care*. Prepared for the Alaska Division of Public Health, Division of Behavioral Health. https://health.alaska.gov/dbh/SiteAssets/Pages/Resources/publications/Assessment%20of%20Alaska%e2%80%99s%20Behavioral%20Health%20Crisis%20Services%20Continuum%20of%20Care_202406.pdf

behavioral health crisis care in communities across the state. The report focuses on mobile crisis response and crisis stabilization facilities. Five areas of opportunity emerged as options for Alaska to consider:

1. Enhancing the crisis services array
2. Streamlining documentation
3. Providing additional support for providers and community partners
4. Improving sustainable financing
5. Facilitating collaboration

DBH will utilize information from the report as well as a recently released 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care[15] to create a robust crisis services continuum through an amendment to the 1115 Behavioral Health Reform demonstration waiver.

Certified Community Behavioral Health Center Grant

On December 30, 2024, DBH received a notification of award for a federal Certified Community Behavioral Health Center (CCBHC) demonstration grant. Alaska previously received a planning grant in 2016 but did not pursue a demonstration grant. Because the behavioral health landscape had changed considerably since 2016, DBH has applied for another CCBHC planning grant. If awarded the grant, DBH will engage with existing Substance Abuse and Mental Health Services (SAMHSA) CCBHC grantees, in addition to other stakeholders, to develop policy for state certification of CCBHCs as well as identify a Prospective Payment System (PPS) to enhance reimbursement to CCBHC providers. CCBHCs will be reimbursed under this PPS, like the system used by Federal Qualified Health Centers.

A CCBHC model is designed to ensure access to coordinated comprehensive behavioral health care. Organizations that meet the CCBHC criteria would be required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age—including developmentally appropriate care for children and youth. CCBHCs must provide 24/7 crisis services and meet standards for the range of services they offer. CCBHCs would also provide care coordination to help individuals navigate behavioral health care, physical health care, social services, and other systems.

[15] Substance Abuse and Mental Health Services Administration. 2025. *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care*. https://library.samhsa.gov/sites/default/files/national-guidelines-crisis-care-pep24-01-037.pdf

1.2.2 Healthcare and Tribal Health Services Reforms

Telehealth Services

Telehealth Cost Trends: Medicaid paid $71.8 million in reimbursements to providers of medical and behavioral health services in FY2024, down from just over $75 million in FY2023. This follows a similar decrease in reimbursements between FY2022 and FY2023, though this marks a flattening of the substantial drop between FY2021 and FY2022, signaling stabilization in post-pandemic service utilization.

Telehealth Growth: The continued use of telehealth for behavioral and mental health services accounted for 44 percent of all telehealth services, indicating sustained demand for remote care options. Telehealth remains a key strategy for improving healthcare access, especially in rural areas.

Covered Outpatient Drug Value-Based Purchasing (VBP) Arrangements

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.[16] The HCS Pharmacy Services Team has submitted a State Plan Amendment to CMS to allow for VBP participation and continues to evaluate current VBP opportunities, including participating in the CMS Cell and Gene Model, 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 Senate Bill (SB) 74,

[16] *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

DHSS (now the Department of Health) partnered with tribal health organizations to fully implement this revised federal policy. To date, more than 8,400 care coordination agreements have been signed between tribal and non-tribal providers that have resulted in state general fund savings exceeding $700 million.

Procurement of Provider Enrollment Module

In May of 2021, the DOH initiated steps to bifurcate the technical operations and maintenance of the Medicaid Management Information System (MMIS) from the fiscal management and support of the system. These steps were completed in April of 2023, affording the department flexibility in responding to the changing operational and administrative needs of the program. DOH has plans to procure a Provider Enrollment Module in FY2025 to modernize the system and create greater efficiencies with enrolling and maintaining providers through an approved capital project.

Care Management Services

The Care Management Program (CMP) was established by the DOH 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.[17] Historically, the CMP restricted a recipient to a primary care provider (PCP) and a pharmacy to reduce overuse and misuse of services, encourage continuity of care, and promote communication between the recipient's PCP and pharmacy. The CMP currently has 120 individuals/groups acting in a PCP role and 90 different pharmacies serving the CMP members; this represents a minimal decrease in the number of participating providers compared with FY2023 and FY2024.

The Alaska Medicaid Coordinated Care Initiative (AMCCI), which provides one-on-one case management services to Medicaid recipients, experienced a 26 percent decrease in utilization between FY2023 and FY2024 due to growth of individual case management programs within large non-tribal and tribal facilities.

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 FY2024:

- SDS smoothly transitioned its services and procedures from the flexibilities allowed under the COVID-19 public health emergency, with several of the flexibilities adopted permanently into practice because they increased efficiencies without jeopardizing safety or the quality of services.

[17] 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 completed two projects supported by the American Rescue Plan Act (ARPA) Section 9817 funding opportunity and approved by CMS. Under Section 9817, states are permitted to save 10 percent of their home and community-based services spending to fund projects that "enhance, expand, or strengthen" these services. The funding supported agencies employing direct support professionals who work with individuals with disabilities by providing incentives and trainings to enhance their recruitment, retention, and training, and, in collaboration with the University of Alaska Center for Human Development – Alaska Training Cooperative, established a new training and certification program for direct support professionals. In FY2024, SDS also received approval for new spending plans establishing initiatives to better serve individuals with complex needs and will be developing those initiatives in FY2025.
- SDS conducted several public webinars to introduce Alaskans to upcoming service changes, such as the implementation of a new Adult Host Home Care service, and to solicit public comment to inform regulations development in FY2025.
- The DOH received approval from CMS for eight home and community-based waiver amendments during FY2024. The amendments updated rates for long-term services and support and made the flexibilities adopted during the COVID-19 public health emergency permanent.
- SDS worked closely with the DOH's Office of Rate Review to update rates for Medicaid long-term services and support in response to a legislative appropriation of $5 million to increase rates, coupled with the annual inflationary adjustment for these rates. The new rates took effect on July 1, 2024.
- SDS continued its work 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 continued its efforts to design and implement services that will better 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

In partnership with the Alaska Native Tribal Health Consortium (ANTHC), the DOH co-leads the development and implementation of Alaska's state health improvement plan, Healthy Alaskans 2030 (HA2030). 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.

Beginning in FY2025, the DOH is launching a three-year pilot project to implement the Community Care Hub (CCH) model in Alaska. This model recognizes the vital role of community-based organizations (CBOs) in bridging social services with the health care system to improve access to care, particularly for chronic disease prevention and treatment and addressing health-related needs. In recent years, several CBO-based initiatives in Alaska have flourished, partly due to increased grant funding during the COVID-19 public health emergency. The DOH's CCH pilot project seeks to build on this momentum by establishing more sustainable funding for CBOs through reimbursement mechanisms under Medicare, Medicaid, and private payers. Initially focusing on the Anchorage area, the CCH will serve as a central administrative and operational hub and will enter into contractual relationships with multiple CBOs. CCH infrastructure will enable CBOs to seek reimbursement for services such as screening, referral, navigation, and alignment between clinical and community services. The CCH will support all provider types including but not limited to community health workers, who will be employed directly by CBOs to deliver services. The CCH will work with the Division of Public Health (DPH) and other partners to develop referral processes that connect priority populations with resources to improve health outcomes.

The Fresh Start campaign, led by DPH, is transforming chronic disease prevention by empowering Alaskans with tools to manage their health. At the forefront of this effort are evidence-based programs such as the Diabetes Prevention Program, Diabetes Self-Management Education and Support, and Self-Measured Blood Pressure monitoring. These programs offer health education combined with counseling to empower Alaskans with the tools needed to adopt healthier lifestyles, reduce complications, and mitigate risks associated with chronic disease illnesses such as diabetes and cardiovascular disease.

Collaboration is the foundation of Fresh Start's success. Partnerships with healthcare providers, community organizations, and culturally specific stakeholders ensure the delivery of locally led, culturally tailored interventions that resonate with Alaska's diverse populations. DPH works to increase the resources available behind the Fresh Start campaign to address barriers identified such as fostering community-driven support that reflects the unique traditions and needs of Alaska Native communities and other priority groups.

Since the inception of Fresh Start, Alaskans have lost a combined 35,000+ pounds. By integrating innovative delivery models, culturally grounded approaches, and robust partnerships, the Fresh Start campaign is leading the charge in chronic disease prevention and management. Between 2023 and 2024, more than 70 percent of Alaskans participating in the online diabetes management program met their goal for reducing their A1C levels. In addition, over 70 percent of Alaskans whose blood pressure met the criteria for Stage 1 hypertension at the time of enrollment in the online blood pressure management program and almost 50 percent of Alaskans whose blood pressure met the criteria for Stage 2 hypertension now have controlled blood pressure.

These efforts are paving the way for healthier individuals and stronger, more resilient communities across Alaska.

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 utilize 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 288 subpopulations based on age (12 categories), gender (2 categories), AI/AN status (2 categories), and region of the state (6 categories). We then develop estimates of future Medicaid enrollment for each geo-demographic group based on historical enrollment trends and projected population estimates. For each geo-demographic group, we project future utilization of each of 20 different Medicaid service categories and the intensity of use of each service category. Finally, we project growth in Medicaid reimbursement rates based on the historical relationship between reimbursement rates and medical price inflation in Alaska.[18]

The following factors 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.[19] 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[20] for each of the 288 subpopulations for each year of historical data (FY1998 – FY2024). While enrollment has increased substantially since FY1998, rates of Medicaid enrollment differ by age, gender, region, and AI/AN status. Enrollment rates have also accelerated at times for certain groups (e.g., for individuals aged 18 to 64 in response to Medicaid

[18] To project medical price inflation in Alaska, we first use regression analysis to estimate the historical relationship between Alaska medical price inflation and the US All Urban Consumer Price Index (CPI). We then use a national forecast of the CPI from Standard and Poor's to project Alaska's rate of medical price inflation through 2045.
[19] Alaska Department of Labor and Workforce Development, Research and Analysis. 2024. *Alaska Population Projections 2023 to 2050.* http://live.laborstats.alaska.gov/pop/projections.cfm
[20] Medicaid enrollment ÷ population = rate of Medicaid enrollment

expansion), and enrollment rates at times do decline—as has occurred due to Medicaid unwinding.

- **Trends in Utilization and Intensity of Medicaid Services**: Changes in Medicaid utilization is a function of numerous factors—including aging of the population; increases in the prevalence of chronic conditions, which lead to greater morbidity; and changes in medical technology and practices—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 US. 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.
- **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 Forthcoming Changes in Policy or the Regulatory Environment**: Forthcoming 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-term trends in socioeconomic factors such as poverty rates, changes in personal income, and workforce participation are *implicitly* represented in the forecast based on enduring historical trends in Medicaid enrollment for each of the 288 subpopulations.

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,[21] by region of the state, 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 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

Total spending on Medicaid services grew slowly between FY2012 and FY2015, increasing on an average annual basis by 2.9 percent (see Figure 9). Spending jumped by 15.1 percent in FY2016 and by 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 the COVID-19 public health disaster emergency in March 2020. Spending began to increase again in FY2021 and through FY2024, it grew by 7.1 percent per year.

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 was mostly flat through FY2023 and even decreased in FY2020 due to additional funding by the federal government as part of the Families First Coronavirus Response Act (FFCRA).[22] Between FY2012 and FY2023, general fund spending grew by only 7.9 percent (0.7 percent per year); in FY2024, it grew by 16.2 percent due in part to overall growth in spending, but more critically due to the phasing out of the additional COVID-19-related funding provided by the federal government.

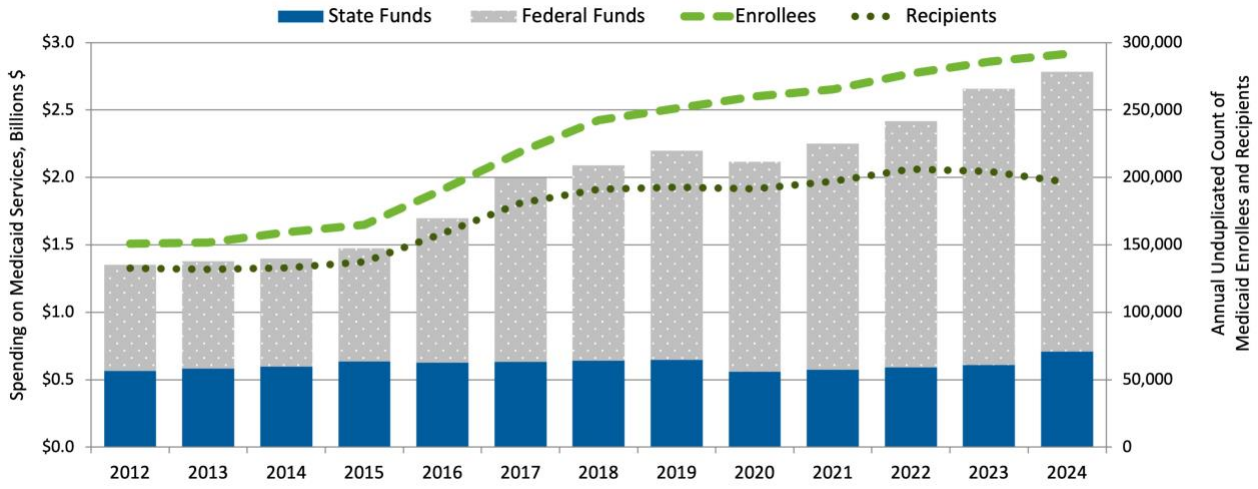
Figure 9 shows total spending on Medicaid services for FY2012 through FY2024, split by state general fund (blue bars) and federal funding (gray bars), and the trend in Medicaid enrollment

[21] Alaska Native, American Indian, and other race categories are based on self-identification by Medicaid enrollees. In FY2024, 90,968 Medicaid enrollees reported their race as either Alaska Native or American Indian.

[22] 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."

(green dashed line) and number of recipients (dark green dotted line) over this same period.[23] Between FY2012 and FY2024, enrollment increased by 93 percent, while the number of recipients grew by only 48 percent. In FY2012, nearly 90 percent of Medicaid enrollees were also recipients (i.e., received Medicaid services). The proportion of Medicaid enrollees that are recipients has declined since FY2012, dropping below 80 percent in FY2018 and below 70 percent in FY2024.

Figure 9: Spending on Medicaid Services, Enrollment in the Medicaid Program, and the Number of Recipients of Medicaid Services, Based on Date of Service, FY2012 – FY2024



Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group; 2024 estimated.

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 FY2024, the proportion had grown to 40 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 10). Data from KFF and the US Census indicate that the proportion of uninsured Alaskans decreased from 20.5 percent in calendar year (CY) 2010 to 10.5 percent in CY2023.[24] We estimate that the proportion of Alaskans without health insurance coverage further decreased slightly in FY2024 to 10.3 percent and will fall below 10 percent in FY2026.[25] The proportion of Alaskans receiving health insurance through an employer decreased from 51.1 percent in CY2010 to 43.8

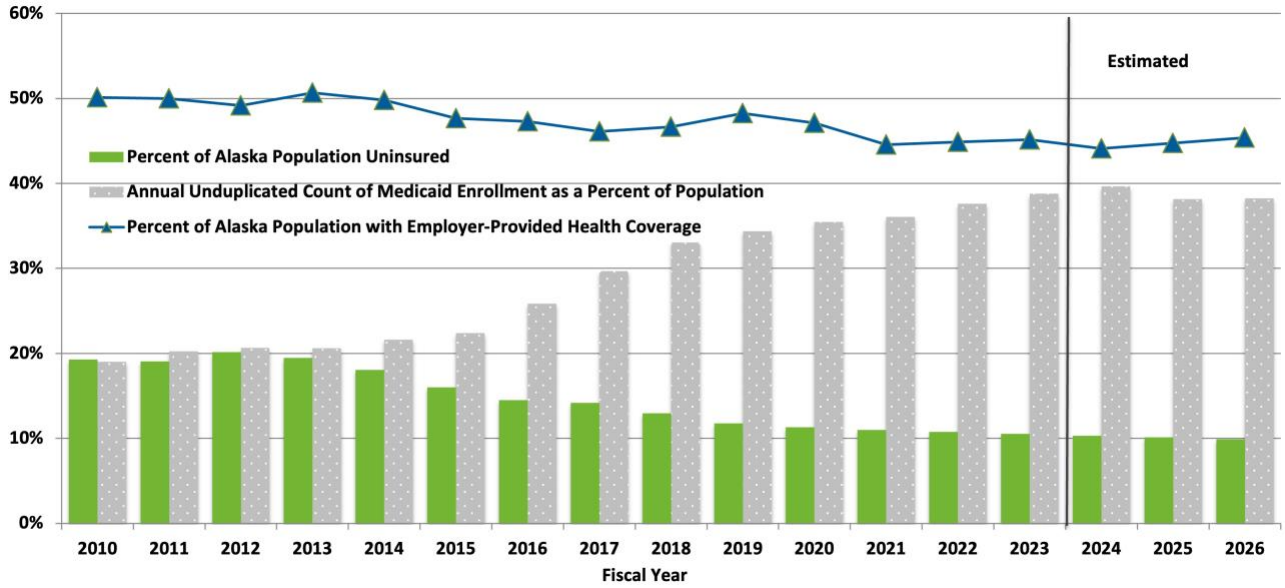
[23] State spending includes Unrestricted General Fund, Designated General Fund, and Other.

[24] 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.: US Census Bureau, published September 15, 2020. https://www.census.gov/library/publications/2020/demo/p60-271.html

[25] 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.

percent in CY2023.[26] We estimate the proportion of Alaskans enrolled in an employer-sponsored insurance plan will increase slightly over the next few years, reaching nearly 46 percent in CY2026.

Figure 10: 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).

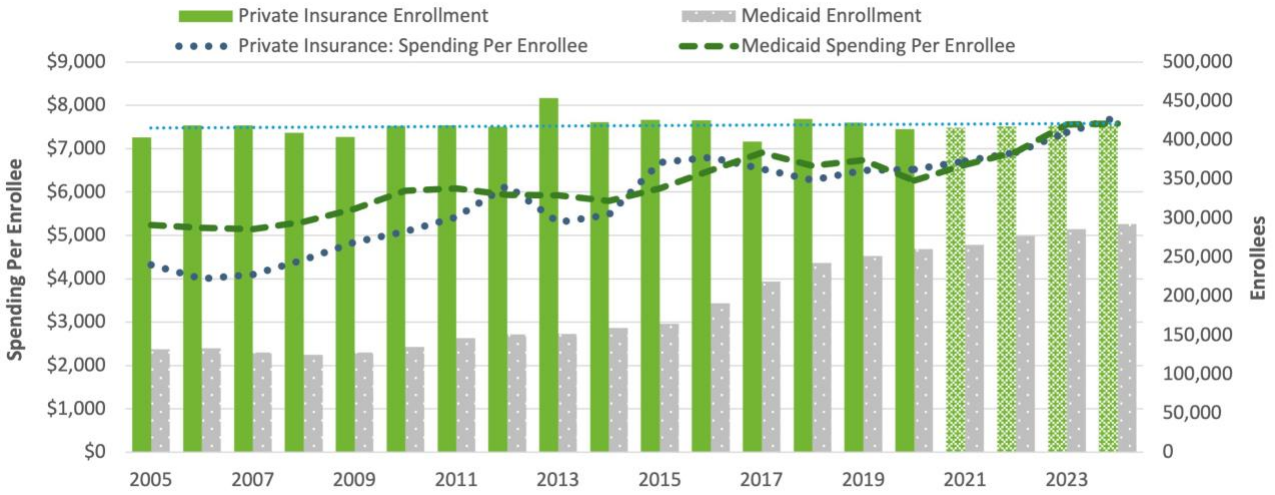
Figure 11 shows enrollment in Medicaid and private insurance in Alaska and spending per enrollee for the years 2005 through 2024.[27] As private insurance does not typically cover long-term care services (e.g., nursing home care, home-based personal care), spending per Medicaid enrollee as shown in Figure 11 excludes spending on long-term care services. Since 2005, enrollment in private insurance has moved up and down year-to-year but has remained flat overall. In comparison, Medicaid enrollment has more than doubled, increasing from 132,000 in 2005 to 292,390 in 2024.

In 2005, spending per enrollee for Medicaid was 21 percent greater than for private insurance ($5,242 versus $4,324). Since then, the difference in spending per enrollee has shrunk, and in 2020—the last year of data available from CMS on enrollment in and spending on private insurance in Alaska—spending per enrollee for Medicaid was 4 percent less than for private insurance ($6,523 versus $6,270). For FY2021 through FY2024, we estimate that spending per enrollee was virtually the same for Medicaid and private insurance.

[26] 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/

[27] Enrollment and spending per enrollment for private insurance are by calendar year.

Figure 11: Annual Enrollment and Per-Enrollee Spending for Medicaid and Private Insurance in Alaska, FY2005 - FY2024*



*Private insurance includes employer-provided health insurance and health insurance purchased directly by an individual or family. Enrollment in and per-enrollee spending for private insurance were estimated by Evergreen Economics for FY2021 – FY2024.

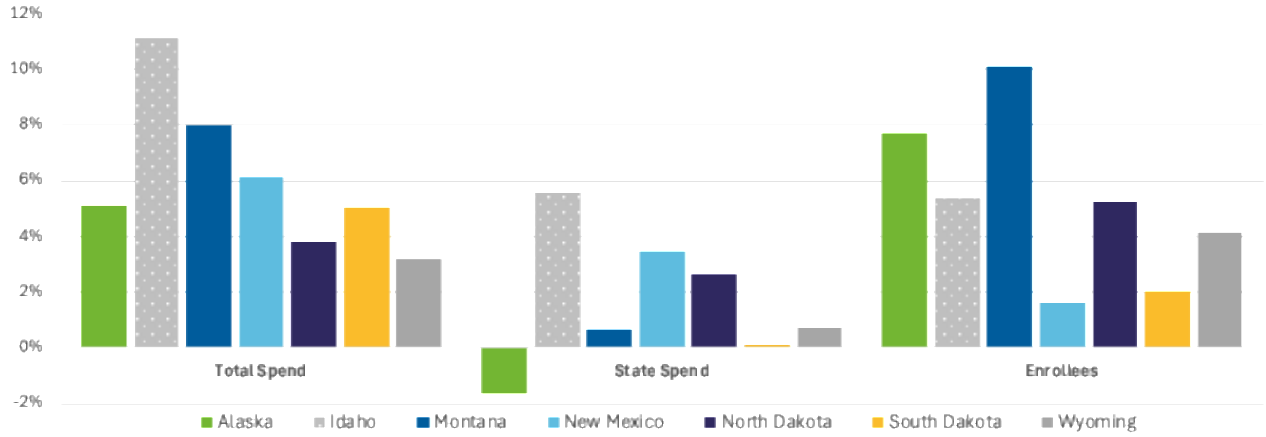
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group and CMF. https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-residence

1.4.3 Comparison to the Medicaid Programs of Other States

Figure 12 shows average annual growth in Medicaid spending and enrollment data from FY2016 through FY2023 for Alaska and six comparison states (Idaho, Montana, New Mexico, North Dakota, South Dakota, and Wyoming). Over this period, all seven states experienced growth in total spending on Medicaid of more than 3 percent per year, with growth being greatest in Idaho (11.1% annual growth) and Montana (8% annual growth). Montana and Alaska initiated Medicaid expansion during FY2016, and Idaho initiated Medicaid expansion in FY2021. Growth in total spending was lowest for Wyoming, which has not undergone Medicaid expansion.

Over this same period, while all comparison states experienced at least a modest increase in state spending on Medicaid, in Alaska, state general fund spending decreased. This decrease in state spending occurred even as Alaska's Medicaid enrollment increased substantially. Montana is the only comparison state to experience a greater percentage increase in Medicaid enrollment between FY2016 and FY2023.

Figure 12: Average Annual Growth in Medicaid Spending in Alaska and Comparison States Between FY2016 and FY2023



Source: Analysis by Evergreen Economics of data from *The Medicaid and CHIP Payment and Access Commission (MACPAC)*. https://www.macpac.gov/publication/macstats-archive/. Data were not available for FY2024.

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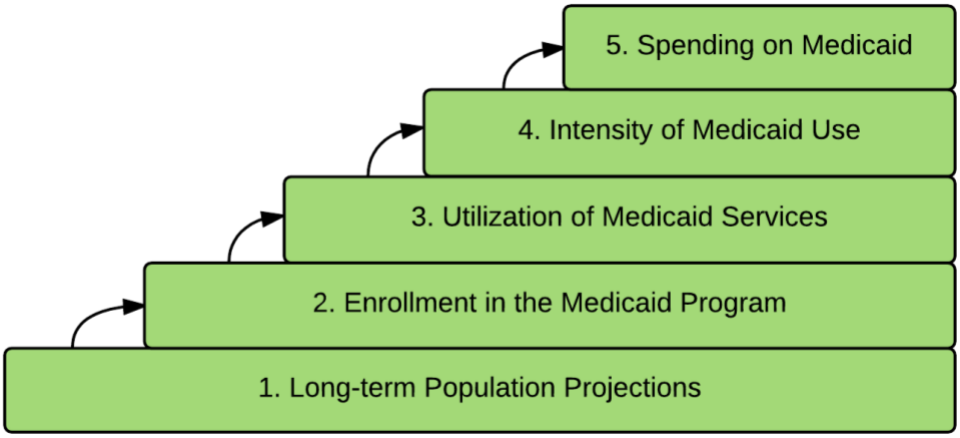
2 Overview of Projections: FY2025-FY2045

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 13 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 13: 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. 2024. *Alaska Population Projections 2023 to 2050.* http://live.laborstats.alaska.gov/pop/projections.cfm

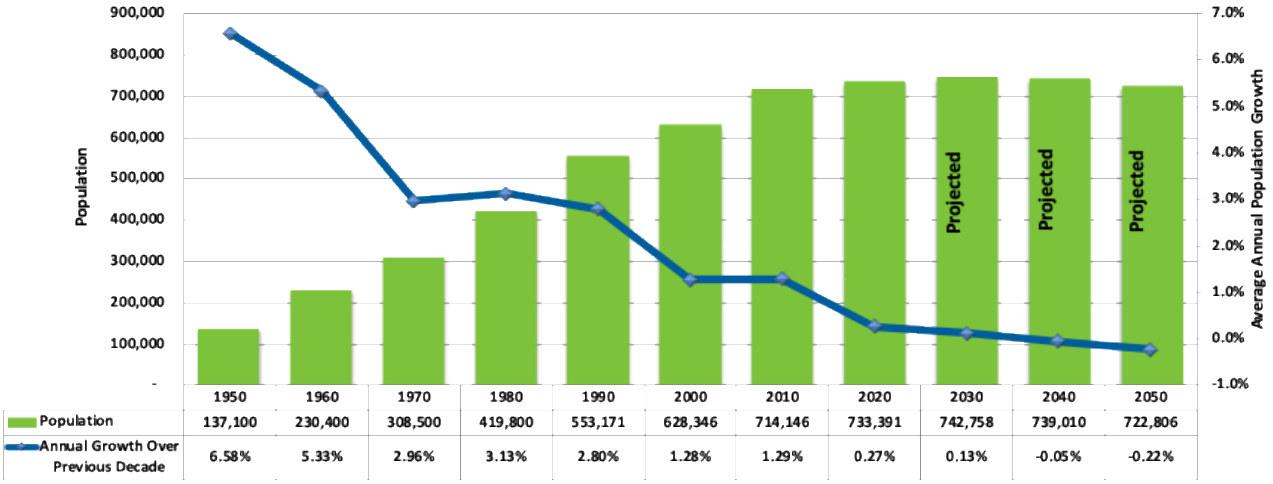
[29] Alaska Department of Labor and Workforce Development, *Alaska Population Overview: 2010 Census and 2011 Estimates*, October 2012. http://live.laborstats.alaska.gov/pop/estimates/pub/1011popover.pdf

[30] US 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 553,171, 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 14). 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 0.13 percent annually through 2030, but then will decline by 0.05 percent per year between 2030 and 2040 and by 0.22 percent per year between 2040 and 2050.[33]

Figure 14: 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	742,758	739,010	722,806
Annual Growth Over Previous Decade	6.58%	5.33%	2.96%	3.13%	2.80%	1.28%	1.29%	0.27%	0.13%	-0.05%	-0.22%

Source: US 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. 2024. *Alaska Population Projections 2023 to 2050*. 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 (0.37% per year for seniors versus a decrease of .04 percent for the total population) and that the number of children in Alaska will decrease (by 0.56% per year).[36] (Table 2)

Table 2: Alaska's Projected Population by Age Cohort for Selected Calendar Years 2025–2045

Age Group	2025	2030	2035	2040	2045	Avg. Annual Change
Children (0-19)	194,004	186,583	179,781	175,505	173,243	-0.56%
Adults (20-64)	425,636	423,674	428,171	431,913	430,720	0.06%
Seniors (65+)	118,725	132,501	134,849	131,592	127,886	0.37%
Total Population	738,365	742,758	742,801	739,010	731,849	-0.04%

Source: Analysis by Evergreen Economics of data from Alaska Department of Labor and Workforce Development, 2024. Research and Analysis, *Alaska Population Projections 2023 to 2050*. 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]

Approximately 59 percent of Alaska children were enrolled in the Medicaid program during all or some portion of FY2024, 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 Alaska Medicaid program covers more adults 20-64 years of age than children. Between FY2025 and FY2045, we expect the proportion of children enrolled in Medicaid to increase from 58

[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.

percent to 64 percent and the proportion of seniors to increase from 16 percent to 22 percent, while the proportion of adults 20-64 years of age enrolled in Medicaid will remain steady at 35 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 Affordable Care Act (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 a moderate decline in Medicaid enrollment in FY2025 and then slow growth through the projection period. In FY2045, we project that Medicaid enrollment will be 290,265 (see Table 3), which is still 2,100 fewer Medicaid enrollees than in FY2024, and that Medicaid will provide medical coverage to 40 percent of Alaska's projected 2045 population. This would represent an increase of two percentage point over FY2025, but would be equal to the proportion of Alaskans covered by Medicaid in FY2024.[40] Given the uncertainty associated with any long-term population forecast, actual Medicaid enrollment could be substantially different. Nevertheless, barring any substantive changes in Medicaid eligibility requirements (such as a continuous enrollment mandate), we believe it is

[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.

unlikely that the proportion of Alaskans covered by Medicaid will substantially exceed 40 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). We project that 222,328 Medicaid enrollees will utilize services in FY2045, which represents 77 percent of projected enrollees that year. 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	2025	2030	2035	2040	2045	*Percent Change**
Children (0-19)	Enrollees	94,532	112,273	113,395	111,242	109,323	110,051	-0.10%
	Recipients	79,540	83,916	86,601	86,678	86,878	89,090	0.30%
Adults (20-64)	Enrollees	58,884	150,916	149,330	151,210	151,103	152,706	0.06%
	Recipients	48,134	98,190	98,920	102,199	104,359	107,817	0.47%
Seniors (65+)	Enrollees	11,209	18,431	24,031	26,120	26,863	27,507	2.02%
	Recipients	9,779	15,583	20,772	23,092	24,302	25,421	2.48%
All Ages**	**Enrollees**	**164,947**	**281,621**	**286,756**	**288,573**	**287,289**	**290,265**	**0.15%**
	Recipients	**137,453**	**197,689**	**206,293**	**211,969**	**215,539**	**222,328**	**0.59%**

Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.
* Average annual percent change between FY2025 and FY2045.
** Due to rounding, some totals may not precisely match the sum of components shown in the table.

In FY2015, 22.3 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 35.5 percent of adults (ages 20-64) will be enrolled in Medicaid in all or part of FY2025. 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 remain constant.

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

Age Cohort	Measure	2015	2025	2030	2035	2040	2045
Children (0-19)	Enrollees	45.9%	57.9%	60.8%	61.9%	62.3%	63.5%
	Recipients	38.6%	43.3%	46.4%	48.2%	49.5%	51.4%
Adults (20-64)	Enrollees	12.9%	35.5%	35.2%	35.3%	35.0%	35.5%
	Recipients	10.6%	23.1%	23.3%	23.9%	24.2%	25.0%
Seniors (65+)	Enrollees	15.0%	15.5%	18.1%	19.4%	20.4%	21.5%
	Recipients	13.1%	13.1%	15.7%	17.1%	18.5%	19.9%
All Ages	**Enrollees**	**22.3%**	**38.1%**	**38.6%**	**38.8%**	**38.9%**	**39.7%**
	Recipients	**18.7%**	**26.8%**	**27.8%**	**28.5%**	**29.2%**	**30.4%**

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, FY2025 – FY2045

Eligibility Group	Measure	2025	2030	2035	2040	2045	Annual Growth
Aged or Disabled	Enrollees	32,993	38,750	40,112	40,930	42,428	1.27%
	Recipients	27,264	31,940	33,147	33,881	35,114	1.27%
Medicaid Expansion*	Enrollees	75,088	67,873	74,188	76,362	76,458	0.09%
	Recipients	47,092	43,221	48,211	50,600	51,561	0.45%
All Other Eligibilities	Enrollees	173,540	180,133	174,273	169,997	171,379	-0.06%
	Recipients	123,332	131,131	130,611	131,058	135,653	0.48%
Total**	**Enrollees**	**281,621**	**286,756**	**288,573**	**287,289**	**290,265**	**0.15%**
	Recipients	**197,689**	**206,293**	**211,969**	**215,539**	**222,328**	**0.59%**

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 paid claims totaling at least $10 during the fiscal year. In FY2010, 89 percent of Medicaid enrollees were recipients. In FY2015, the year before Medicaid expansion was initiated in Alaska, the proportion of Medicaid enrollees who were also recipients had decreased to 84 percent, and in FY2024, only 67 percent of Medicaid enrollees were recipients. We project the proportion of enrollees who are recipients will increase over the next 20 years, reaching 77 percent by FY2045.

[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 FY2024, fewer than three in four enrollees utilized 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 FY2024, Medicaid recipients with no diagnosed chronic conditions utilized on average 2.8 Medicaid service categories (Table 7). In comparison, Medicaid recipients with one diagnosed chronic condition utilized on average 4.3 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 6.4 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 2.7.

Table 7: Number of Medicaid Service Categories Utilized in FY2024

Number of Diagnosed Chronic Conditions	Number of Service Categories Utilized
No Diagnosed Chronic Conditions	2.8
One Diagnosed Chronic Condition	4.3
Two to Four Diagnosed Chronic Conditions	5.2
Five or More Diagnosed Chronic Conditions	6.4
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 recipient for each of the 20 service categories for each fiscal year from FY2016 through FY2024. 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.[50] With effects of rate increases 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 reimbursement rate-adjusted estimates of spending per recipient to estimate statistical models to explain intensity of use of Medicaid services 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 FY2045. On a weighted average basis across the 20 service categories, we project that intensity of use will increase on average by only about 0.41 percent per year through FY2045.

2.5 Growth in Medicaid Reimbursement Rates Paid to Providers

Evergreen Economics analyzed the per-unit rates of growth in reimbursement rates paid to Medicaid service providers from FY2016 to FY2024 and compared them to the rates of medical

[50] Our annual estimates of changes in Medicaid reimbursement rates are discussed in Section 2.5. 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.

price inflation in Alaska over the same period.[51] We found Medicaid reimbursement rates grew at a much slower rate than medical price inflation each year from FY2016 through FY2020 (Figure 15), but reimbursement rates increased at a slightly faster pace than medical price inflation in FY2021, by one percentage point on average in FY2022 and FY2023, and by one-half percentage point in FY2024.

Figure 15: Annual Percent Change in Medicaid Reimbursement Rates and Medical Price Inflation in Alaska, FY2016 – FY2024

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

We project Medicaid reimbursement rates will continue to increase over the projection period, but at a slower rate than we estimated for fiscal years 2021 through 2024. While there will likely be years in which the rate of growth of the Medicaid reimbursement rate will outpace medical price inflation in Alaska (as we estimated for FY2022 through FY2024), we expect the long-term growth in reimbursement rates to average 3.05 percent per year, while we expect the annual rate of medical price inflation to average 3.48 percent per year.

Each Medicaid reimbursement rate is reviewed either annually, biennially, or triennially, and periodically updated based on these reviews.[52]

[51] Medical price inflation is a measure of the change in "out of pocket" prices paid by consumers for medical services and health insurance premiums. We relied on the *Consumer Price Index for All Urban Consumers: Medical Care in Urban Alaska* index as the measure of historical medical price inflation. by consumers for medical care and health insurance premiums. US Bureau of Labor Statistics, https://www.bls.gov//data.htm.
Alaska Medicaid fee schedules and covered codes are available at https://extranet-sp.dhss.alaska.gov/hcs/medicaidalaska/Provider/Sites/ArchivedFeeSchedule.html

[52] 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.

2.6 Total Spending on Medicaid Services

The final step of the long-term forecast is to project spending on Medicaid services, which incorporate the forecasts of Medicaid enrollment, utilization and intensity of use of Medicaid services, and reimbursement rates described above.

Table 8 shows projected spending by Medicaid service group. We project that total Medicaid spending on Medicaid services will increase on average by 4.7 percent per year between FY2025 and FY2045, reaching more than $7.4 billion. Over this period, growth in spending on long-term care services will outpace other service groups—an average of 6.7 percent annually for long-term care services versus 5.8 percent for behavioral health services, 3.7 percent for healthcare services that are medical in nature (e.g., inpatient hospital, provider services, dental services), and 3.4 percent for healthcare services that are non-medical in nature (e.g., transportation services).

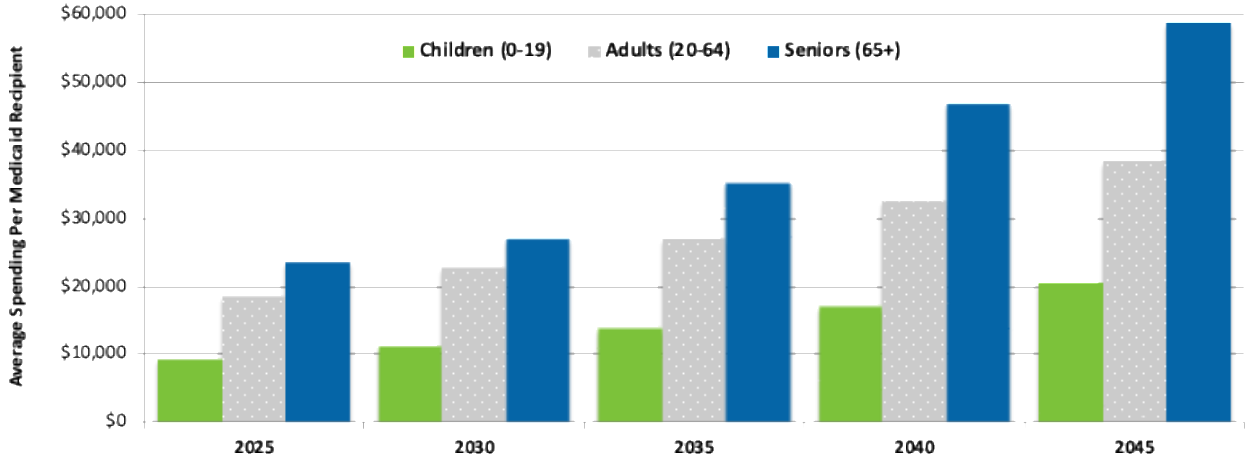
Table 8: Medicaid Spending by Medicaid Service Group, FY2025 – FY2045 (Millions $)

Service Group*	2025	2030	2035	2040	2045	Annual Growth
Behavioral Health	$513.9	$748.7	$992.4	$1,281.0	$1,592.5	5.8%
Long-Term Care	$192.9	$292.1	$402.7	$548.5	$707.0	6.7%
Long Term Services & Supports	$423.2	$1,235.7	$858.7	$1,117.3	$1,374.6	6.1%
Healthcare Direct Medical	$1,460.6	$1,691.1	$2,020.5	$2,472.5	$3,043.7	3.7%
Healthcare Other Services	$354.1	$398.0	$470.7	$570.9	$696.7	3.4%
Total	**$2,944.7**	**$4,365.7**	**$4,745.0**	**$5,990.2**	**$7,414.5**	**4.7%**

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

Figure 16 shows projected spending per recipient on Medicaid services. For FY2025, we estimate that for children, average spending per recipient will be about $9,100, while for adults and seniors, average spending per recipient will be about $18,500 and $23,400, respectively. By FY2045, we project that average spending per child recipient will be nearly $20,200, while average spending per adult recipient will be $38,250 and the average spending per senior recipient will be $58,700.

Figure 16: Average Spending Per Recipient on Medicaid Services by Age Cohort, FY2025 – FY2045



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;[53] in FY2015 the year before Medicaid expansion—the average age was 23 and the median age was 16. We project that by FY2045, the average age of a Medicaid enrollee will be 32 and the median age will be 26.

Figure 17 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 FY2025 to FY2045. Figure 17 then shows how the spending forecast builds off this base.

The components of spending growth are as follows:

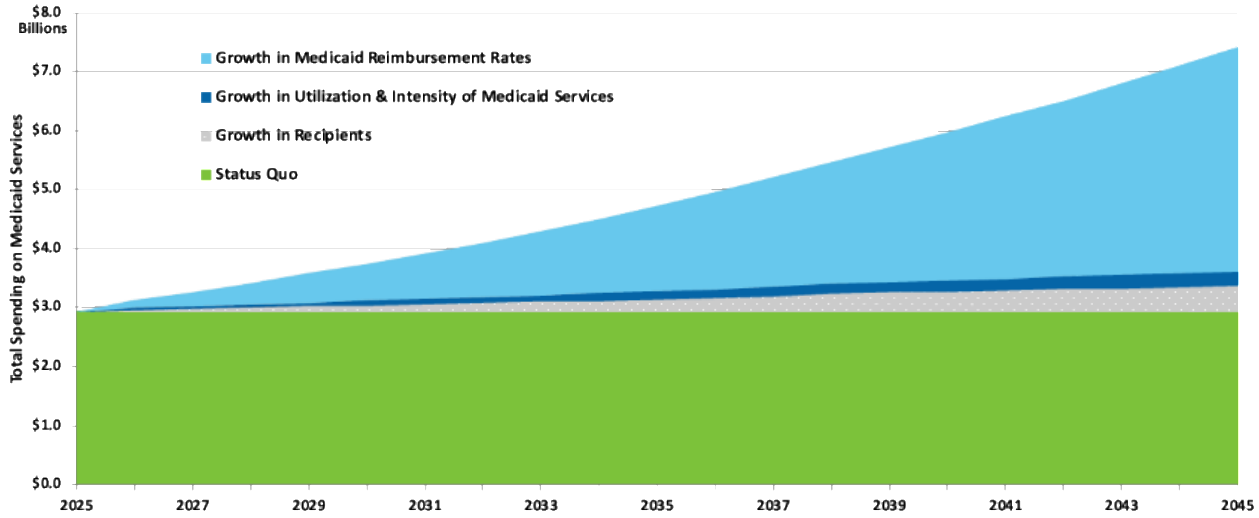
- ***Growth in Medicaid reimbursement rates*** represents increases in the schedule of fees paid to Medicaid service providers.
- ***Growth in Recipients*** represents the impact of growth in either the number of Medicaid enrollees utilizing Medicaid services due to increases in the number of Medicaid enrollees, the rate at which enrollees utilize Medicaid services, or both.

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

- ***Growth in Utilization & Intensity of Medicaid Services*** represents the incremental impact of growth in the number of Medicaid service categories used by a recipient and the greater use of a service category.[54]

As Figure 17 shows, we expect *growth in reimbursement rates* to be the primary driver of spending growth in Alaska's Medicaid program, representing 51 percent of total spending in FY2045 and 84 percent of the growth in spending between FY2025 and FY2045. Relative to growth in Medicaid reimbursement rates, the combined impact of all other factors that affect growth in Medicaid spending will be relatively modest.

Figure 17: Projected Spending on Medicaid Services by Component of Growth, FY2025-FY2045

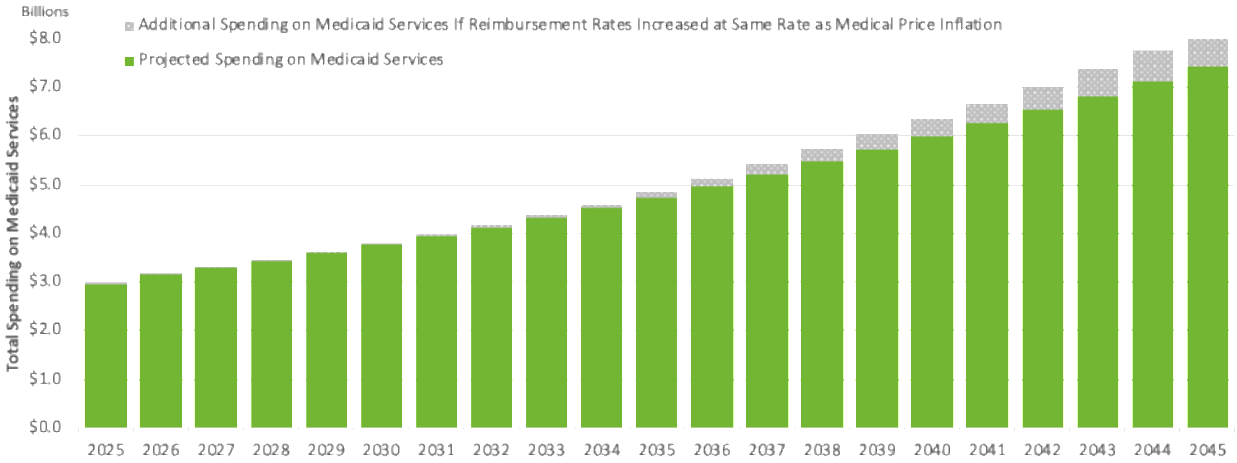


* All other factors include population growth, growth in enrollment rates, growth in utilization of Medicaid services, and growth in the intensity of use of Medicaid services.
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

Even with the substantial impact that growth in Medicaid reimbursement rates will have on Medicaid spending over the next two decades, it is worth reiterating that we expect Medicaid reimbursement rates to increase slower than medical price inflation in Alaska.[55] Figure 18 shows the projected forecast for total Medicaid spending through FY2045 (in green) and how much greater the forecast would be if Medicaid reimbursement rates grew at the projected rate of medical price inflation (in grey). We estimate that in FY2045, spending on Medicaid services would be $750 million more and that over the 20-year projection period, total spending would be $4.7 billion greater.

[54] Increases in the intensity of use of a Medicaid service category may be due to changes in medical technology or practices, an increase in the scope of services within a Medicaid service category, or another reason.
[55] Recall that medical price inflation is a measure of the change in "out of pocket" prices paid by consumers for medical services and health insurance premiums.

Figure 18: Impact of Reimbursement Rates Growing at the Same Rate as Medical Price Inflation



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

2.6.1 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]
  - 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 through September 30, 2025
  - 52.42 percent FFP beginning October 1, 2025
- 1915 (K) Community First Choice (CFC):

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

[57] The additional 6.2 percentage points of FFP is attributable to the declaration by the US 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

    - 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 through September 30, 2024
    - 57.54 percent FFP beginning October 1, 2024 through September 30, 2025
    - 58.42 percent FFP beginning October 1, 2025
- 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 through September 30, 2025
    - 66.69 percent FFP beginning October 1, 2025
- 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 through September 30, 2025
    - 66.69 percent FFP beginning October 1, 2025
- Family Planning: 90 percent FFP
- 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

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

receives the regular FMAP rate, which is currently 51.54 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 FY2045, 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 4.7 percent per year through FY2045, but the rate of growth in spending will be less for the State of Alaska (4.5%) than for the federal government (4.8%).[62]

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

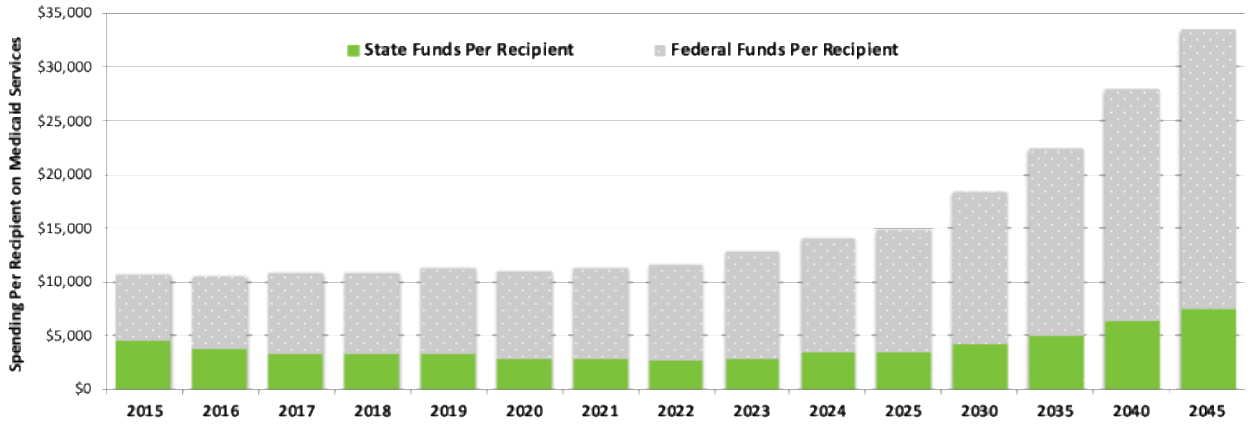
Fund Source	2025	2030	2035	2040	2045	Annual Growth
State GF and Other Matching Funds	$710.1	$909.4	$1,153.7	$1,438.4	$1,700.5	4.5%
Federal	$2,234.6	$2,859.5	$3,591.3	$4,551.9	$5,714.1	4.8%
Total Spending*	**$2,944.7**	**$3,768.9**	**$4,745.0**	**$5,990.2**	**$7,414.5**	**4.7%**

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 19 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 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.

[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.

Figure 19: 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 – FY2023 are actual expenditures; FY2024 is estimated; FY2025 – FY2045 are projected.

In FY2024, the weighted average FFP rate for Medicaid services was 75.8 percent, and we estimate the average FFP rate for FY2025 will be about the same. For the remainder of the forecast period, barring any changes in individual FFP rates, we expect the weighted average FFP on Medicaid services to remain at 76 percent.[63]

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

[63] For FY2025, each percentage point of FFP equates to about $29 million (1% of the projected $2.94 billion in spending). 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.

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, FY2025–FY2045, in Millions

Spending Type		2025	2030	2035	2040	2045
Medicaid Services	Federal	$2,234.6	$2,859.5	$3,591.3	$4,551.9	$5,714.1
	State Match	$710.1	$909.4	$1,153.7	$1,438.4	$1,700.5
	Total	$2,944.7	$3,768.9	$4,745.0	$5,990.2	$7,414.5
Other Payments	Federal	$95.7	$122.5	$154.2	$194.7	$241.0
	State Match	$51.5	$66.0	$83.0	$104.8	$129.8
	Total	$147.2	$188.4	$237.3	$299.5	$370.7
Total Spending	**Federal**	$2,330.3	$2,982.0	$3,745.6	$4,746.5	$5,955.0
	State Match	$761.6	$975.3	$1,236.7	$1,543.2	$1,830.2
	Total*	$3,091.9	$3,957.4	$4,982.3	$6,289.8	$7,785.3

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.

2.7 Spending on Medicaid Enrollees with Chronic Conditions

Chronic conditions have a significant impact on healthcare spending in Alaska, the US, and globally. The US 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 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:

[65] National Health Council, "About Chronic Diseases." https://nationalhealthcouncil.org/wp-content/uploads/2019/12/AboutChronicDisease.pdf
[66] Centers for Disease Control and Prevention, "About Chronic Diseases." https://www.cdc.gov/chronic-disease/about/?CDC_AAref_Val=https://www.cdc.gov/chronicdisease/about/index.htm

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 conditions will increase over the next 20 years.

2.7.1 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 FY2024. There were about 6.5 million Medicaid claims and more than 10.7 million claim lines for services provided to recipients in FY2024. 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.[67] We examined up to four diagnosis codes for each Medicaid claim line in FY2024 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, 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

[67] In FY2024, 2.3 million claim lines (22%) did not include a diagnosis code. Of these, nearly all (96%) were either for pharmacy or dental services.

	Chronic Condition Group	Chronic Conditions
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.[68] 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.[69]

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 FY2024 with a diagnosis code specifying the chronic condition as defined in the CMS Chronic Conditions Data Warehouse.[70] In FY2024, the unduplicated count of Medicaid enrollees was 292,392, of which 196,667 were recipients of Medicaid services. Applying the criterion described above, we identified 84,007 Medicaid recipients as being diagnosed with one or more chronic conditions.

2.7.2 Characteristics of Recipients with Chronic Conditions

Figure 20 shows the distribution of Medicaid recipients by age and whether the recipient was diagnosed with one or more chronic conditions in FY2024. The prevalence of being diagnosed with

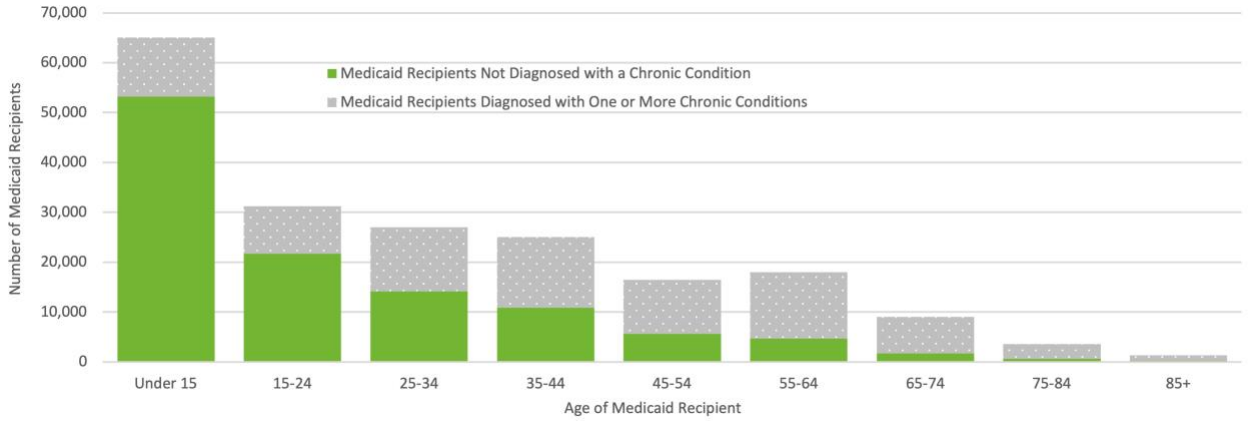
[68] Note: The full acronyms are ICD-9-CM and ICD-10-CM, where "CM" stands for Clinical Modification. It is a common practice to drop the "-CM." ICD-10 codes provide greater specificity about the medical encounter; there are approximately 68,000 ICD-10 codes.

[69] 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.

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

a chronic condition increases with age and/or is linked to the aging process.[71] While the number of Medicaid recipients has generally increased each year, the distribution shown in Figure 20 has not materially changed since we began analyzing chronic condition diagnoses in 2018.

Figure 20: Medicaid Recipients by Age and Diagnosis of One or More Chronic Conditions, FY2024



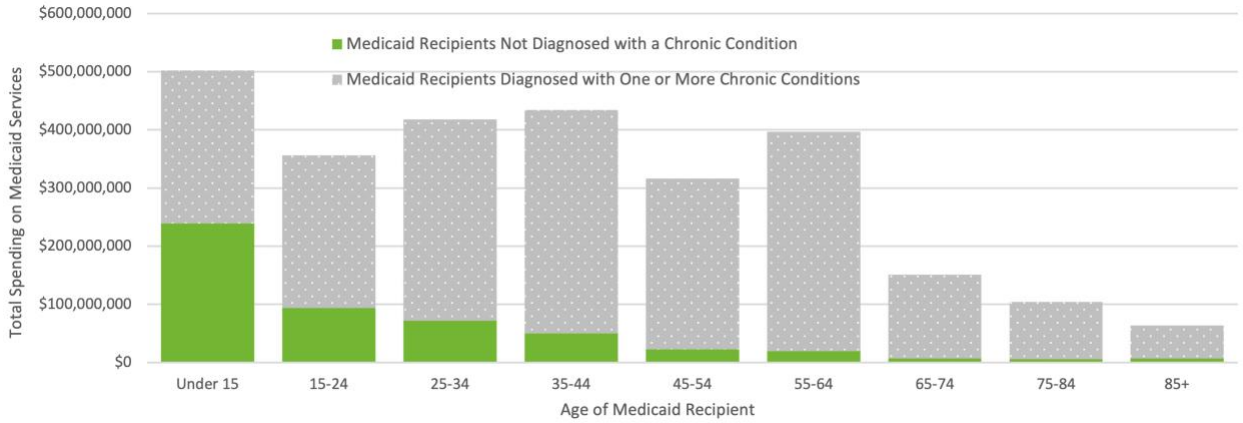
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

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, reaching 83 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 FY2024 and would not have been captured in the MMIS or ASO systems, which only contain Medicaid claims. 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.

Figure 21 shows total spending on Medicaid services by age and whether the recipient was diagnosed with a chronic condition. Comparing the distribution of spending by age in Figure 21 to the distribution of recipients by age in Figure 20 shows the substantial impact that chronic conditions have on Medicaid spending regardless of age.

[71] 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." US Department of Health and Human Services, Centers for Disease Control and Prevention, 2012. https://www.cdc.gov/nchs/products/databriefs/db100.htm

Figure 21: Total Spending by Age and Diagnoses of a Chronic Conditions



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

Table 12 shows average spending per recipient on Medicaid services in FY2024 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 $4,581 in FY2024, while average spending per recipient with *one or more chronic condition diagnoses* was nearly six times greater at $26,499.

Table 12: Spending Per Medicaid Recipient and Incremental Cost of Chronic Conditions, FY2024

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	$9,672	$6,102	$30,205	$24,103
05-09	$5,799	$3,438	$16,086	$12,648
10-14	$7,765	$3,894	$22,108	$18,214
15-19	$11,129	$4,226	$29,807	$25,581

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)
20-24	$11,817	$4,447	$25,098	$20,651
25-34	$15,492	$5,095	$26,894	$21,799
35-44	$17,352	$4,611	$27,088	$22,478
45-54	$19,188	$4,019	$26,984	$22,964
55-64	$22,025	$4,137	$28,244	$24,106
65-74	$16,782	$4,034	$19,793	$15,759
75-84	$29,077	$9,360	$33,048	$23,688
85+	$48,741	$29,672	$53,122	$23,450
All Recipients	$13,943	$4,581	$26,499	$21,917

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 FY2024, average spending per recipient, and total spending on all recipients. Most (57.3%) Medicaid recipients have no diagnosed chronic conditions.[72] These recipients account for 18.5 percent of total spending on Medicaid services. In comparison, 19.4 percent of recipients have one diagnosed chronic condition and account for 24.5 percent of spending, and 23.3 percent of recipients have two or more chronic conditions and account for 57 percent of total spending on Medicaid services.

[72] 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 FY2024. If a Medicaid recipient had a chronic condition in FY2024, but the diagnosis of that condition went unreported in the MMIS or ASO systems in FY2024, we would categorize that recipient as not having a chronic condition in FY2024.

Table 13: Distribution of Medicaid Recipients and the Cost of Providing Medicaid Services by the Number of Diagnosed Chronic Conditions, FY2024

Diagnosed Chronic Conditions	Medicaid Recipients	Percent of Recipients	Average Spending Per Recipient	Total Spending	Percentage of Spending
0	112,660	57.3%	$4,581	$516,108,224	18.5%
1	38,249	19.4%	$16,774	$682,648,908	24.5%
2	19,272	9.8%	$26,698	$514,526,641	18.5%
3	11,782	6.0%	$31,580	$372,078,284	13.4%
4	7,129	3.6%	$38,157	$272,020,180	9.8%
5	3,835	1.9%	$48,139	$184,613,938	6.6%
6	2,041	1.0%	$56,547	$115,412,208	4.1%
7	997	0.5%	$66,877	$66,676,253	2.4%
8 or More	702	0.4%	$84,281	$59,165,245	2.1%
All Recipients	**196,667**	**100.0%**	**$13,943**	**$2,783,249,880**	**100.0%**

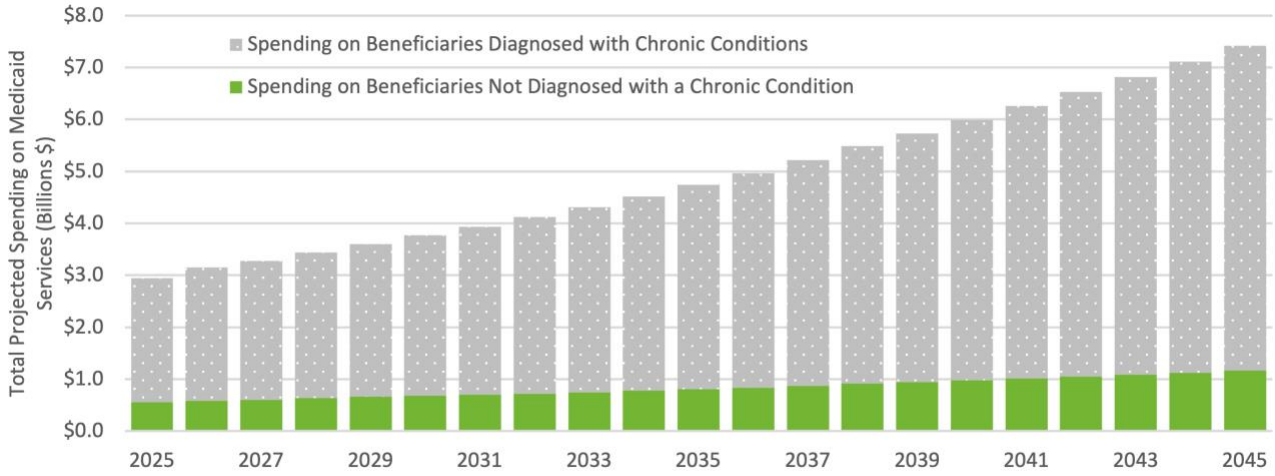
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

2.7.3 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 FY2045.[73] Figure 22 shows that over this period, we project that Medicaid spending on recipients diagnosed with one or more chronic conditions will grow from $2.4 billion (81% of total Medicaid spending) in FY2025 to $6.25 billion (84% of total Medicaid spending) in FY2045. Comparatively, we project that spending on recipients *not* diagnosed with a chronic condition will increase from $554 million to nearly $1.2 billion between FY2025 and FY2045, which, though increasing by $608 million over the 20-year period, will decrease as a proportion of total spending from 19 percent in FY2024 to 16 percent in FY2045.

[73] 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.

Figure 22: Projected Spending on Medicaid Services, FY2025–FY2045



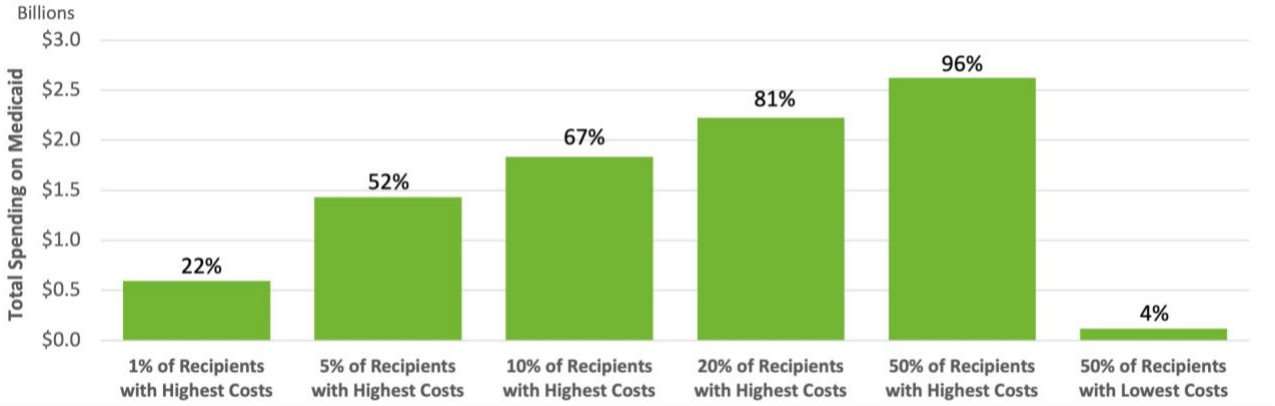
Source: Analysis by Evergreen Economics of data provided by the Medicaid Budget Group.

2.7.4 High Utilizers in Alaska's Medicaid Population

Evergreen examined the distribution of spending on Medicaid services for FY2024 and found that it is highly concentrated among a relatively small proportion of recipients. For example, we found that the 1 percent of recipients with the highest costs accounted for 22 percent of total spending on Medicaid services, and that the 5 percent and 10 percent of recipients with the highest costs accounted for 52 percent and 67 percent of spending, respectively (Figure 23). In comparison, the half of Medicaid recipients with the lowest costs accounted for only 4 percent of spending on Medicaid services.

The average spending per recipient on Medicaid services for the 1 percent of recipients with the highest costs was $303,000 in FY2024, while it was $145,000 and $93,000, respectively, for the 5 percent and 10 percent of recipients with the highest costs. For the half of recipients with the highest Medicaid costs, spending per recipient was $26,690, and for the half with the lowest Medicaid costs, spending per recipient was $1,193.

Figure 23: Distribution of Medicaid Spending by Recipient Cost of Services



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

The distribution of Medicaid spending shown in Figure 23 is very similar to findings reported by researchers at KFF in a January 2024 article.[74] They found nearly the exact distribution for the entire US population (not just Medicaid recipients) in calendar year 2021 as we found for the Alaska Medicaid population for FY2024:

- The 1 percent with the highest costs accounted for 24 percent of total US health spending.
- The 5 percent with the highest costs accounted for 51 percent of total US health spending.
- The 10 percent with the highest costs accounted for 67 percent of total US health spending.
- The 20 percent with the highest costs accounted for 82 percent of total US health spending.
- The 50 percent with the highest costs accounted for 97 percent of total US health spending.
- The 50 percent with the *lowest* costs accounted for 3 percent of total US health spending.

Unsurprisingly, the prevalence of chronic conditions is much greater among Medicaid recipients with the highest spending. For example, Figure 24 shows the proportion of Medicaid recipients with each of seven different chronic conditions in FY2024. The green bars represent the 10 percent of recipients with the highest Medicaid costs, and the gray bars represents all other Medicaid recipients. As many Medicaid recipients have been diagnosed with multiple chronic conditions, many recipients are represented in multiple bars in Figure 24.

[74] Ortaliza, Jared, Matthew McGough, Emma Wager Twitter, Gary Claxton, and Krutika Amin. *How do health expenditures vary across the population?*" Peterson Center on Healthcare and KFF, January 4, 2024. https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/

Perhaps most striking is the prevalence of a diagnosed mental health condition among the 10 percent of recipients with the highest costs (more than 45% versus less than 15% for all other Medicaid recipients). The proportion of recipients diagnosed with either cardiovascular disease or drug and alcohol abuse is similarly extremely high among the 10 percent of Medicaid recipients with the highest costs, relative to all other recipients (nearly 30 percent for each versus less than 10 percent for all other Medicaid recipients).

Figure 24: Proportion of Medicaid Recipients with Select Chronic Conditions

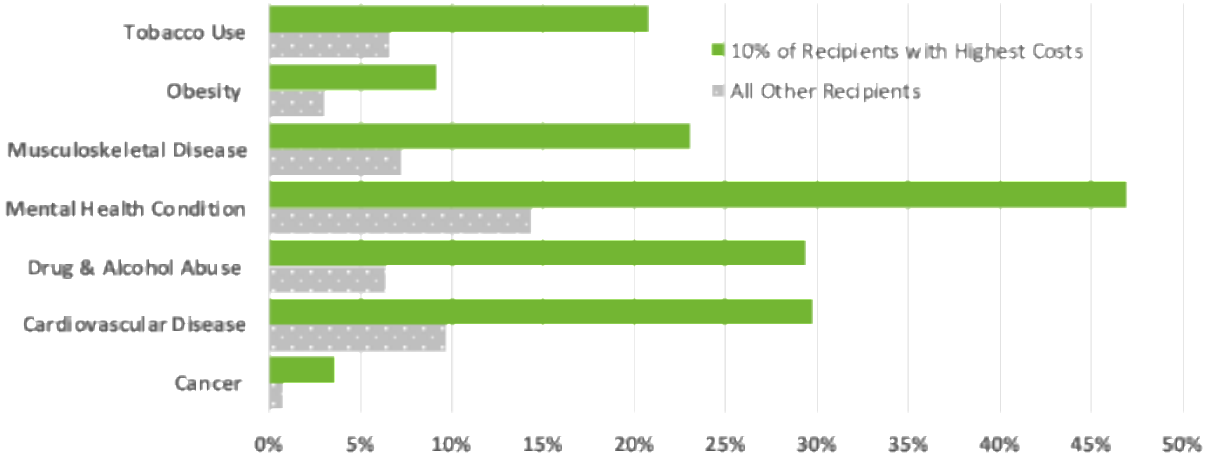


Table 14: Medicaid Service Category Descriptions for Long-Term Forecast

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

Service Group	Service Category	Description
	Outpatient Hospital	Outpatient hospital services, outpatient surgery services, and end-stage renal disease services
	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, FY2025-FY2045

	FY2025	FY2030	FY2035	FY2040	FY2045	Annual % Change
State	738,365	742,758	742,801	739,010	731,849	-0.04%
Gender						
Female	354,888	357,166	357,243	355,239	351,307	-0.1%
Male	383,477	385,592	385,558	383,771	380,542	0.0%
AI/AN Status						
AI/AN	166,149	170,808	174,704	178,085	180,572	0.4%
Not AI/AN	572,216	571,950	568,097	560,925	551,277	-0.2%
Region						
Northern	27,807	28,001	28,260	28,509	28,729	0.2%
Western	109,524	108,893	107,509	105,805	103,934	-0.3%
South Central	84,058	84,357	83,990	82,986	81,520	-0.2%
Anchorage/Mat-Su	404,235	409,479	412,305	412,590	410,422	0.1%
Southeast	70,863	69,155	67,019	64,587	61,920	-0.7%
Age Group						
0-4	44,611	44,966	44,156	43,571	42,308	-0.3%
5-9	48,067	44,794	45,154	44,350	43,768	-0.5%
10-14	50,591	47,504	44,232	44,596	43,798	-0.7%
15-19	50,735	49,319	46,239	42,988	43,369	-0.8%
20-24	48,247	49,553	48,148	45,099	41,902	-0.7%
25-34	104,203	100,307	99,830	99,768	95,359	-0.4%
35-44	108,133	109,366	106,404	102,730	102,367	-0.3%
45-54	82,511	91,968	101,819	103,151	100,424	1.0%
55-64	82,542	72,480	71,970	81,165	90,668	0.5%
65-74	76,131	74,051	63,231	54,641	54,557	-1.7%
75-84	34,353	46,682	54,201	52,610	44,417	1.3%
85+	8,241	11,768	17,417	24,341	28,912	6.5%

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

Table 17: Forecast of Enrollment by Demographic Group, FY2025-FY2045

	FY2025	FY2030	FY2035	FY2040	FY2045	Annual % Change
State	281,621	286,756	288,573	287,289	290,265	0.2%
Gender						
Female	142,179	145,614	146,669	146,091	147,434	0.2%
Male	139,441	141,142	141,904	141,198	142,831	0.1%
AI/AN Status						
AI/AN	95,930	104,268	106,574	108,045	111,226	0.7%
Not AI/AN	185,691	182,488	181,999	179,244	179,039	-0.2%
Region						
Northern	14,955	15,707	16,036	16,240	16,685	0.5%
Western	33,286	33,663	33,523	33,084	33,245	0.0%
South Central	32,441	32,350	32,397	32,042	32,151	0.0%
Anchorage/Mat-Su	147,602	149,706	150,924	150,252	151,731	0.1%
Southeast	25,299	24,790	24,131	23,307	22,806	-0.5%
Age Group						
0-4	27,084	30,513	30,557	30,327	30,043	0.5%
5-9	29,290	27,864	28,540	28,210	28,435	-0.1%
10-14	28,547	27,407	26,030	26,333	26,449	-0.4%
15-19	27,352	27,611	26,115	24,453	25,125	-0.4%
20-24	21,154	21,859	21,647	20,351	19,650	-0.4%
25-34	43,835	42,324	42,882	43,150	42,385	-0.2%
35-44	38,844	38,489	37,611	36,436	37,378	-0.2%
45-54	23,794	25,507	27,767	28,011	27,669	0.8%
55-64	23,290	21,151	21,305	23,155	25,624	0.5%
65-74	11,598	12,517	11,363	10,106	10,399	-0.5%
75-84	5,111	8,556	10,363	10,564	9,485	3.1%
85+	1,722	2,958	4,395	6,193	7,623	7.7%

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

Table 18: Forecast of Spending by Demographic Group (Millions $), FY2025-FY2045

	FY2025	FY2030	FY2035	FY2040	FY2045	Annual % Change
State	$2,944.7	$3,768.9	$4,745.0	$5,990.2	$7,414.5	4.7%
Gender						
Female	$1,555.9	$1,991.0	$2,497.0	$3,152.3	$3,892.2	4.7%
Male	$1,388.8	$1,777.9	$2,248.0	$2,837.9	$3,522.3	4.8%
AI/AN Status						
AI/AN	$1,288.7	$1,652.0	$2,069.8	$2,613.0	$3,242.9	4.7%
Not AI/AN	$1,656.0	$2,116.9	$2,675.2	$3,377.3	$4,171.7	4.7%
Region						
Northern	$180.5	$236.3	$304.5	$388.4	$482.5	5.0%
Western	$296.8	$388.5	$500.6	$641.0	$796.4	5.1%
South Central	$347.6	$457.3	$595.4	$767.5	$953.6	5.2%
Anchorage/Mat-Su	$1,493.8	$1,967.7	$2,562.0	$3,302.5	$4,137.3	5.2%
Southeast	$347.5	$454.9	$586.1	$747.5	$928.7	5.0%
Age Group						
0-4	$224.3	$285.4	$338.2	$402.9	$476.9	3.8%
5-9	$137.4	$156.1	$174.1	$195.6	$223.4	2.5%
10-14	$175.0	$225.9	$289.3	$379.5	$480.1	5.2%
15-19	$227.9	$297.8	$382.8	$488.2	$618.9	5.1%
20-24	$154.0	$181.4	$195.2	$206.8	$222.3	1.9%
25-34	$443.3	$560.0	$715.6	$918.5	$1,137.8	4.8%
35-44	$467.1	$593.5	$751.4	$948.6	$1,184.5	4.8%
45-54	$332.8	$399.6	$451.8	$490.8	$531.3	2.4%
55-64	$418.4	$508.9	$634.3	$822.4	$1,048.1	4.7%
65-74	$170.0	$236.0	$314.8	$418.7	$552.7	6.1%
75-84	$120.9	$200.6	$299.6	$415.5	$521.0	7.6%
85+	$73.5	$123.8	$198.0	$302.7	$417.4	9.1%

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

Table 19: Forecast of Total Spending on Medicaid (Millions $), FY2025-FY2045

Service Category	FY2025	FY2030	FY2035	FY2040	FY2045	Annual % Change
Inpatient Hospital	$447.2	$522.9	$627.8	$771.4	$950.6	3.8%
Outpatient Hospital	$328.1	$371.9	$440.2	$533.1	$650.7	3.5%
Family Planning	$0.2	$0.3	$0.3	$0.4	$0.5	4.0%
Health Clinic	$243.1	$285.8	$347.6	$431.7	$537.6	4.0%
Physician/Practitioner	$238.6	$268.1	$314.6	$378.9	$459.7	3.3%
Dental	$108.0	$127.4	$151.5	$185.2	$229.8	3.8%
Lab/X-ray	$8.6	$10.0	$12.1	$14.9	$18.5	3.9%
EPSDT	$22.0	$28.7	$35.5	$45.4	$57.9	5.0%
Therapy/Rehabilitation	$42.9	$48.5	$55.9	$66.4	$79.6	3.1%
Home Health/Hospice	$12.3	$16.9	$22.5	$30.4	$41.0	6.2%
Vision	$9.6	$10.7	$12.4	$14.8	$17.8	3.2%
Pharmacy	$232.3	$253.7	$298.6	$361.2	$440.4	3.2%
DME/Supplies	$27.5	$33.4	$41.2	$51.7	$64.4	4.4%
Transportation	$94.3	$110.9	$130.9	$158.1	$192.0	3.6%
Inpatient-Res Psych	$46.1	$51.8	$57.3	$65.6	$80.0	2.8%
Outpatient Mental Health	$149.0	$197.0	$261.9	$348.9	$461.6	5.8%
1115 Waver	$318.8	$499.9	$673.1	$866.6	$1,050.9	6.1%
Nursing Home	$192.9	$292.1	$402.7	$548.5	$707.0	6.7%
State Plan Personal Care Services	$24.9	$42.5	$61.4	$84.4	$107.8	7.6%
Community First Choice (1915(k) Services	$368.1	$544.9	$725.2	$939.1	$1,156.3	5.9%
HCB 1915(c) Waivers	$30.3	$51.5	$72.1	$93.8	$110.4	6.7%
Total Spending on Medicaid Services	$2,944.7	$3,768.9	$4,745.0	$5,990.2	$7,414.5	4.7%
Other Medicaid Payments*	$147.2	$188.4	$237.3	$299.5	$370.7	4.7%
Total Spending on Medicaid Program	$3,091.9	$3,957.4	$4,982.3	$6,289.8	$7,785.3	4.7%

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 $), FY2025-FY2045

Service Category	FY2025	FY2030	FY2035	FY2040	FY2045	Annual % Change
Inpatient Hospital	$96.1	$112.4	$135.9	$164.5	$193.3	3.6%
Outpatient Hospital	$54.8	$62.1	$74.0	$88.3	$102.8	3.2%
Family Planning	$0.2	$0.3	$0.3	$0.4	$0.5	3.7%
Health Clinic	$12.2	$14.4	$17.6	$21.6	$25.6	3.8%
Physician/Practitioner	$62.9	$70.7	$83.6	$99.2	$114.7	3.0%
Dental	$25.5	$30.0	$36.0	$43.3	$51.3	3.6%
Lab/X-ray	$2.3	$2.7	$3.3	$4.0	$4.8	3.6%
EPSDT	$4.0	$5.2	$6.5	$8.1	$9.9	4.7%
Therapy/Rehabilitation	$19.1	$21.5	$25.0	$29.3	$33.4	2.9%
Home Health/Hospice	$5.2	$7.1	$9.5	$12.7	$16.3	5.9%
Vision	$3.7	$4.1	$4.8	$5.6	$6.5	2.9%
Pharmacy	$58.2	$63.5	$75.3	$89.7	$104.3	3.0%
DME/Supplies	$10.6	$13.0	$16.1	$19.9	$23.6	4.1%
Transportation	$9.1	$10.8	$12.8	$15.2	$17.6	3.3%
Inpatient-Res Psych	$14.4	$16.2	$18.0	$20.3	$23.7	2.5%
Outpatient Mental Health	$28.1	$37.2	$49.8	$65.4	$82.4	5.5%
1115 Waver	$62.5	$73.4	$87.4	$103.9	$120.3	3.3%
Nursing Home	$66.2	$100.2	$139.1	$186.7	$229.4	6.4%
Personal Care	$12.6	$21.5	$31.2	$42.3	$51.5	7.3%
Community First Choice 1915(k) Services	$150.2	$222.3	$298.0	$380.3	$446.4	5.6%
HCB 1915(c) Waivers	$12.3	$20.9	$29.4	$37.7	$42.3	6.4%
Total Spending on Medicaid Services	$710.1	$909.4	$1,153.7	$1,438.4	$1,700.5	4.5%
Other Medicaid Payments*	$51.5	$66.0	$83.0	$104.8	$129.8	4.7%
Total Spending on Medicaid Program	$761.6	$975.3	$1,236.7	$1,543.2	$1,830.2	4.5%

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.