Long-term Forecast of Medicaid Enrollment and Spending in Alaska:

Supplement 2012–2032

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Introduction

Medicaid is an entitlement program created in 1965 by the federal government, but administered by the states, to provide payment for healthcare services for low-income citizens. People qualify for Medicaid by meeting federal income and asset standards and meeting specified eligibility requirements. Medicaid covers the aged, blind, or disabled persons and single parent families. In addition, Medicaid expanded coverage in 1998 through the Children's Health Insurance Program (CHIP) to children whose family income is too high to qualify for regular Medicaid, but too low to afford private health insurance. In Alaska, the CHIP program is administered through the Division of Health Care Services. The Division of Public Assistance manages enrollment for regular Medicaid and CHIP.

Alaska Medicaid History

Medicaid is jointly funded by the federal government and by the individual states, with each state managing its own program. Participation in the Medicaid program is optional, but all states choosing to participate in the program must follow certain federal guidelines pertaining to eligibility and services to be provided. An individual state is permitted to make a Medicaid state plan amendment (SPA) in order to modify how Medicaid is operated within the state. However, the Center for Medicare and Medicaid Services (CMS) must review and approve the SPA for consistency with federal laws and regulations before the state is allowed to implement a Medicaid program modification.

The website for the Alaska Division of Public Assistance contains the following information about Alaska's Medicaid program: [1]

> "Medicaid was established by Title XIX of the Social Security Act in 1965 to provide medical assistance to certain low-income needy individuals and families. Medicaid is basically intended to provide coverage for needy children, pregnant women, and aged, blind and disabled persons.
>
> The Alaska Department of Health and Social Services administers the Medicaid program in accordance with federal and state laws and regulations. The Medicaid program is authorized under Title XIX and Title XXI of the Social Security Act and the Code of Federal Regulations, Title 42 Part 435 and Title 45 Part 233.
>
> Alaska joined the Medicaid program in September 1972. New services and eligible groups have been added to the program since that time by the Legislature. The Medicaid

[1] http://dpaweb.hss.state.ak.us/manuals/fam-med/5000/5000-1_introduction_to_medicaid.htm
http://dpaweb.hss.state.ak.us/manuals/fam-med/5300/5300_denalikidcare.htm

program in Alaska is authorized under Alaska Statutes 47.07.010 - 47.07.900 and the Alaska Administrative Code, Title 7 Chapter 43 and Chapter 100.

Persons receiving Adult Public Assistance (APA) and Supplemental Security Income (SSI) are automatically eligible for Medicaid. There are eligibility categories for pregnant women and children based on having income below a percentage of the federal poverty level for Alaska. There are number of narrow eligibility categories that follow SSI or APA eligibility policy, but are for the elderly or disabled who are not recipients of those cash programs. Alaska also purchases Part B Medicare for Medicaid-eligible recipients, and provides payment for long term care services for persons whose income is within 300% of the SSI Supplemental Security Income payment level.

Before July 1, 1997, individuals and families who were eligible for and/or received Aid to Families with Dependent Children [AFDC] were automatically eligible for Medicaid. This entitlement was removed by the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. As a result of this major welfare reform legislation, families who are receiving cash assistance through the Alaska Temporary Assistance Program (ATAP), generally referred to as "Temporary Assistance" (TA), are not automatically eligible for Medicaid. This legislation eliminated the program, but required that Medicaid continue to be available to those who would have qualified for AFDC. This category of Medicaid is now called Family Medicaid.

The Balanced Budget Act of 1997 established the Child Health Insurance Program (CHIP) in Title 21 of the Social Security Act. This program provides Alaska with enhanced federal matching money to expand Medicaid eligibility to more children. At the same time, eligibility was also expanded for pregnant women.

Beginning March 1, 1999, children under age 19 and pregnant women qualified for health care coverage if their household income was at or below 200 percent of the federal poverty guideline (FPG) for Alaska."

On September 1, 2003, the eligibility standard for children without insurance and pregnant women was reduced from 200 percent to 175 percent of the 2003 federal poverty guideline (FPG) for Alaska. This 175 percent FPG standard was frozen at the 2003 level and did not increase each year as it had historically.

Effective July 1, 2007, the eligibility standard for children without insurance and pregnant women was increased to 175 percent of the 2007 federal poverty guideline for Alaska due to a change in law. This standard will increase each year along with the annual increases in the FPG.

Denali KidCare is an expansion of Medicaid, using the same basic infrastructure and benefit package. The Denali KidCare name encompasses the Medicaid eligibility subtypes of pregnant and postpartum women (PB, PC, PR, and PX), CHIP children (CP, H2, and S2), as well as other

children (H1, S1, HC, and SU).[2] Application intake and processing occur in the specialized Denali KidCare office.[3]

Alaska Medicaid Is a Fee for Service Program

Alaska Medicaid reimburses hospitals, physicians, and other healthcare providers for providing healthcare services to Medicaid enrollees. Alaska runs its program as fee-for-service program, meaning that it reimburses providers as payments per unit of service rendered according to an established payment rate. This is in contrast to managed care, where a healthcare organization receives a monthly payment for each Medicaid recipient enrolled in the plan. In a managed care arrangement, the health care organization is responsible for ensuring that the enrollees have access to a comprehensive range of medical services.

Origins of the Long-term Medicaid Forecast

In April 2005 the Alaska Department of Health and Social Services (HSS) contracted with the Lewin Group and ECONorthwest to develop a long-term forecasting model of Medicaid spending for the State of Alaska. In February 2006 a report, based on the results of the forecasting model, was submitted to the Alaska Legislature to inform policy makers of the projected growth in total spending on Alaska's Medicaid program over the 20-year period ending in 2025.

The purpose of the Long-term Medicaid forecast (assigned the acronym MESA—**M**edicaid **E**nrollment and **S**pending in **A**laska—by HSS in 2007) is to provide a long-term view of future enrollment and spending in the Alaska Medicaid program under the current mix of Medicaid services and the current eligibility criteria for enrollment in the Medicaid program. MESA provides department executives and the Alaska State Legislature with information on the direction and approximate magnitude of growth in enrollment and state matching fund spending for the Medicaid program.

[2] Pregnant and Postpartum Women: PR = Pregnant with income < 133% FPG; PX = Pregnant with income > 133% FPG =< 175% FPG; PB = Postpartum income < 133% FPG; PC = Postpartum income > 133% FPG =< 175% FPG

CHIP Children: CP = > 150% & <= 175% (age 0-8); H2 = > 133% & <= 150% (age 0-8); S2 = > 100% & <= 133% (age 6-18);

Other Children: H1 = > 133% & <= 150% (age 0-8); S1 = > 100% & <= 133% (age 6-18); HC = > 100% & <= 133% (age 0-5); SU <= 100% FPG (age 6-18)

[3] Appendix B contains a list of descriptions for Denali KidCare eligibility subtypes, as well as the other eligibility subtypes.

The Medicaid expenses for children who are eligible for the Medicaid program because of the Children's Health Insurance Program (CHIP) are eligible to be reimbursed by the federal government at the Enhanced Federal Medical Assistance Percentage (Enhanced FMAP). The Enhanced FMAP reduces the state's share of spending by 30 percent. If the regular FMAP for a state is 50 percent, the Enhanced FMAP is 65 percent.

In each successive year since the original forecast, the Medicaid Budget Group, at first with consultation from ECONorthwest and now with Evergreen Economics, has updated the underlying enrollment and claims data on which the MESA forecasting model depends, and has re-estimated the model to project enrollment and spending over the successive 20-year period. By integrating a successive year of data into the MESA model, we update the Medicaid program's status quo with respect to eligibility, enrollment trends, and spending. Thus, as changes are made to the Medicaid program by HSS or the Legislature, MESA provides estimates of the long-term impact of the changes.

Chapter 1 – MESA Projections Results 2012-2032

This chapter covers projections for claims on services provided to individual.[4] The analysis combines historical Alaska Medicaid enrollment and claims data, based on date of service, for fiscal years 1997 through 2011,[5] with U.S. Census data and population projections from the Alaska Department of Labor and Workforce Development (ADLWD) to develop forecasts of enrollment in the Medicaid program and utilization of and spending on Medicaid services. The projections are based on the Medicaid program as it currently exists.

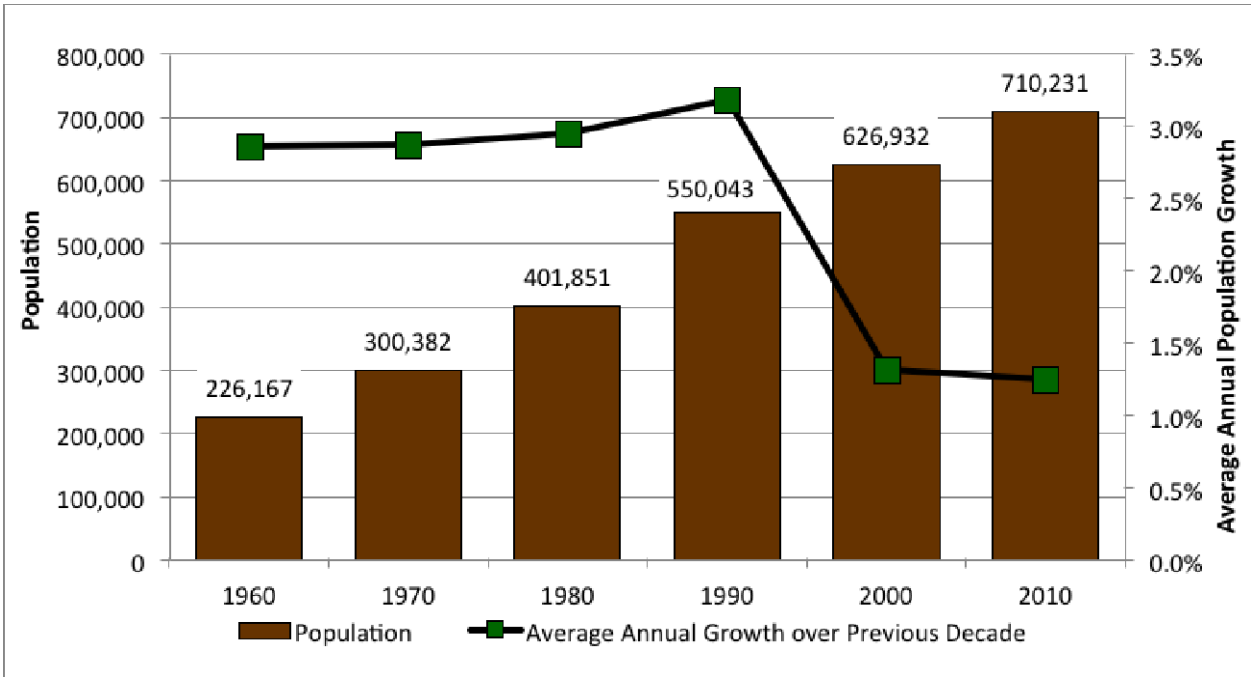
Population

The population of Alaska has changed substantially in the years since statehood. In 1960, one year after Alaska became a state, the population was 226,167 and about one-fifth (44,237) of all Alaskans lived in Anchorage.[6] By the time Alaska started its Medicaid program in 1972, the population of the state had increased to 329,800, for an average annual growth of 3.2 percent.[7] Population continued to grow quickly through the 1970s and 1980s, partly influenced by the construction of the Trans-Alaska Pipeline from 1975 to 1977 and other jobs related to the oil industry.[8] By 1990, the State's population had risen to 550,043 and the population of Anchorage had grown to 226,338 residents, or just over two-fifths of the state population.[9]

Alaska's population growth has slowed in recent years. From 1990 to 2012, the population increased on average by 1.3 percent per year, reaching 732,298 in 2012. Of these residents, 298,842 lived in Anchorage (41 percent).[10] While the ratio of males to females has moved toward the national average over the past decades, in 2012, there were still about 108 males in Alaska for every 100 females.[11]

[4] Chapter 2 deals with other Medicaid payments and offsetting recoveries, which are not directly tied to a particular claim.
[5] Since the forecast is based on date of service and providers have up to a year to submit claims, many of the medical claims for services that were provided during fiscal year 2012 have not yet entered the claims system.
[6] http://www2.census.gov/prod2/decennial/documents/15611103.pdf
[7] See the Alaska Department of Labor and Workforce Development's report Alaska Population Overview 2009 Estimates, page 13, available at http://labor.alaska.gov/research/pop/estimates/pub/popover.pdf
[8] Population grew at an average annual rate of 2.9 percent over this period.
For more information on the impact of the Trans-Alaska Pipeline see http://www.alyeska-pipe.com/pipelinefacts.html
[9] See http://www.census.gov/prod/cen1990/cph2/cph-2-3.pdf
[10] See http://laborstats.alaska.gov/pop/popest.htm
[11] See http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf

Figure 1: Alaska's population growth has slowed in recent decades
ALASKA'S POPULATION AND ANNUAL GROWTH RATES FROM 1960 – 2010



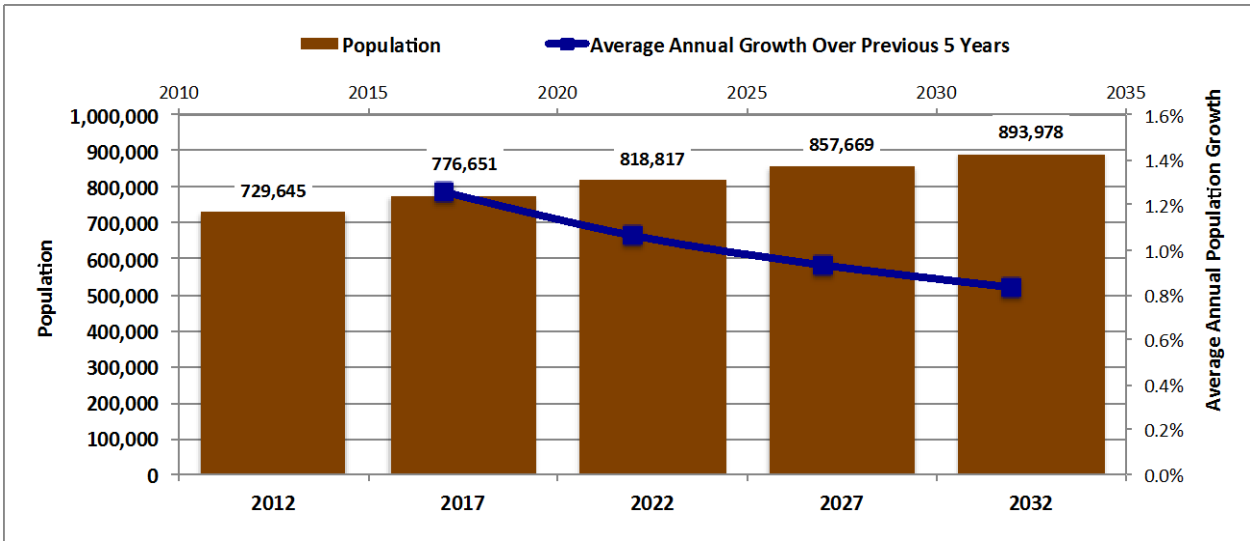
Source: U.S. Census Bureau

Even though Alaska's population has grown substantially over the past 50 years, it is important to keep in mind that there have been significant fluctuations in the year-to-year growth rates, and there have been some years when the population has decreased.[12] An extremely strong or extremely weak economic climate—relative to the rest of the nation—could lead to similar swings in growth in future years.

Based on analysis by the ADLWD, the population of Alaska is projected to grow at an average rate of 1.02 percent per year over the next 20 years, reaching 893,978 residents in 2032.[13] Population growth is expected to lead to growth in Medicaid enrollment and in turn more spending by the state on Medicaid services.

[12] See the Alaska Department of Labor and Workforce Development's report Alaska Population Overview 2009 Estimates, page 13, available at http://labor.alaska.gov/research/pop/estimates/pub/popover.pdf for details about the Alaska population estimates from 1945 to 2009.
[13] See Table 12 in Appendix D.
Population projections are derived from the growth rates within the ADLWD's report Alaska Population Projections 2010 to 2034, available at http://labor.alaska.gov/research/pop/projected/pub/popproj.pdf.

Figure 2: Alaska's rate of population growth is projected to decline through the forecast period
ALASKA'S PROJECTED POPULATION AND GROWTH FROM 2012 TO 2032



Source: MESA model, December 2012, using data from the Alaska Department of Labor and Workforce Development and adjusting for 2010 Census data.

The ADLWD projects the distribution of residents by gender and age will change over the next two decades as the state adds more females than males and the overall population ages. We expect this to have an impact on the Medicaid program as females enroll in the Medicaid program at a greater rate and tend to incur higher costs on average than men.[14] The population will also grow older, with the highest percent growth in the state being those above age 75. The elderly population not only tends to enroll in Medicaid at a higher rate than working-age adults, but the costs associated with caring for the elderly are also significantly higher than they are for children or working-age adults.

Table 1: The elderly population is projected to grow faster than other age groups
ALASKA'S PROJECTED POPULATION BY AGE GROUP FOR SELECTED YEARS, 2012—2032

Age Group	2012	2017	2022	2027	2032	Average Annual Change
Children (0-19)	210,758	224,857	238,216	249,453	257,541	1.01%
Working Age Adults (20-64)	455,938	464,050	465,282	469,461	484,400	0.30%
Elderly (65+)	62,950	87,744	115,319	138,755	152,038	4.51%
Total Population	729,645	776,651	818,817	857,669	893,978	1.02%

Source: MESA model, using data from the Alaska Department of Labor and Workforce Development.

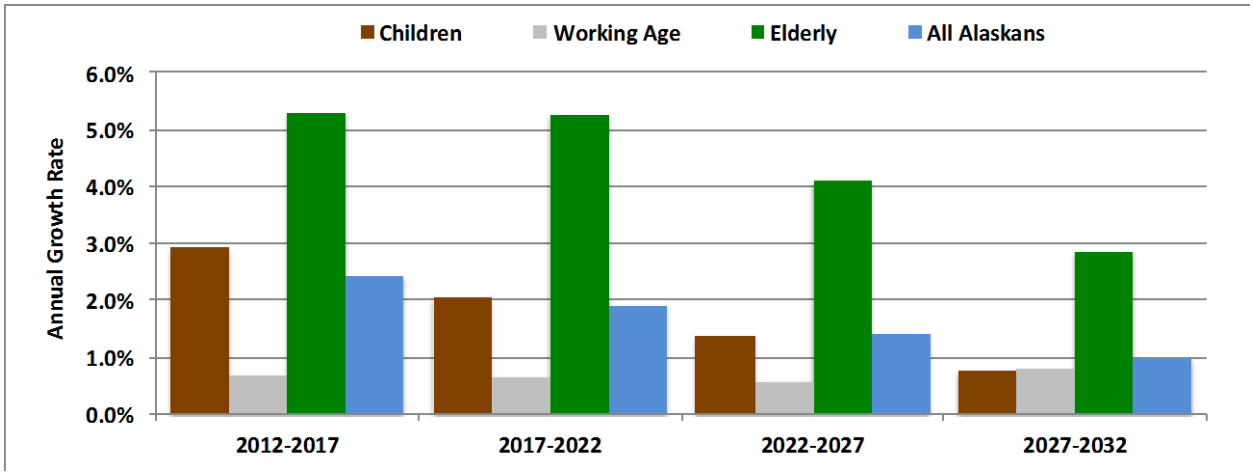
[14] More specifically, working-age females incur greater costs on average than working age males and elderly females incur greater costs on average than elderly males. Average Medicaid costs for male and female children are approximately equal.

Enrollment and Participation

The elderly population will continue to have a dramatic impact on the Medicaid program through 2032. The growth in enrollment among the elderly will average 4.37 percent per year through the forecast period, causing the elderly's share of enrollment to more than double by 2032, reaching 10 percent of total enrollment. During the same period, the annual growth rate in enrollment among children and working-age adults will be 1.76 percent and 0.68 percent, respectively.[15] The rate of growth in enrollment across the entire population will slow from .6 percent annually between 2012 and 2017 to 0.24 percent annually between 2027 and 2032.

Enrollment refers to the number of individuals who both meet the requirements and are registered to receive Medicaid services. Growth in enrollment is determined by two primary factors: (1) population growth and changes in the demographics of the population and (2) changes in eligibility requirements. For the purposes of this report, eligibility requirements are assumed to remain constant over the next two decades.[16]

Figure 3: Enrollment growth slows down over time. The elderly remain the fastest growing group.
YEAR-OVER-YEAR GROWTH IN ENROLLMENT BY AGE



Source: Medicaid Budget Group, MESA Model.

Figure 4 shows that, while the growth in Medicaid enrollment for the entire population will slow over time, the Medicaid program will experience substantial growth in the elderly (age 65 and older) population. The growth rate in enrollment for children (age 0-19) will be faster than that of working-age adults (age 20-64) for the first fifteen years of the forecast. After 2027 the growth rate in enrollment for working-age adults will exceed, albeit slightly, the growth rate for children.

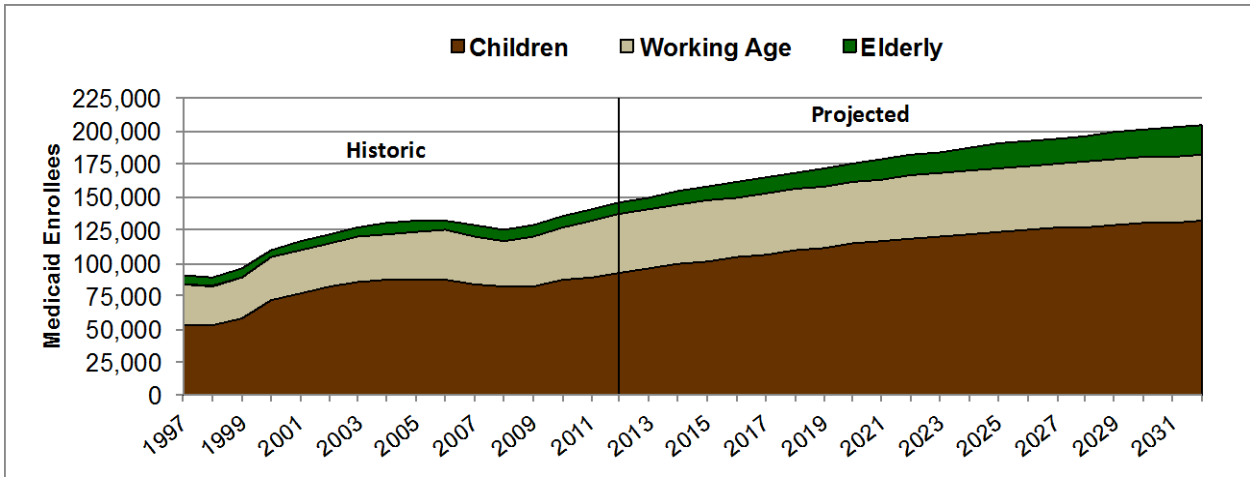
[15] See Table 3, page 11.
[16] We assume that the Modified Adjusted Gross Income (MAGI) methodology, which will take affect in January 2014, will not influence Medicaid enrollment in a materially significant way. We will revisit this assumption for the 2013-2033 MESA forecast.

Table 2: Elderly enrollment is projected to grow faster than other age groups
MEDICAID ENROLLMENT BY AGE GROUP FOR SELECTED YEARS, 2012 – 2032

Age Group	2012	2016	2021	2026	2032	Average Annual Change
Children (0-19)	92,683	106,993	118,356	126,571	131,398	1.76%
Working Age Adults (20-64)	44,531	46,052	47,590	48,991	50,977	0.68%
Elderly (65+)	9,263	11,988	15,491	18,941	21,801	4.37%
Total Enrollment	146,476	165,033	181,436	194,504	204,176	1.67%

Source: Medicaid Budget Group, MESA Model.

Figure 4: Enrollment will continue to increase throughout the projection period
HISTORICAL & PROJECTED ENROLLMENT BY AGE GROUP



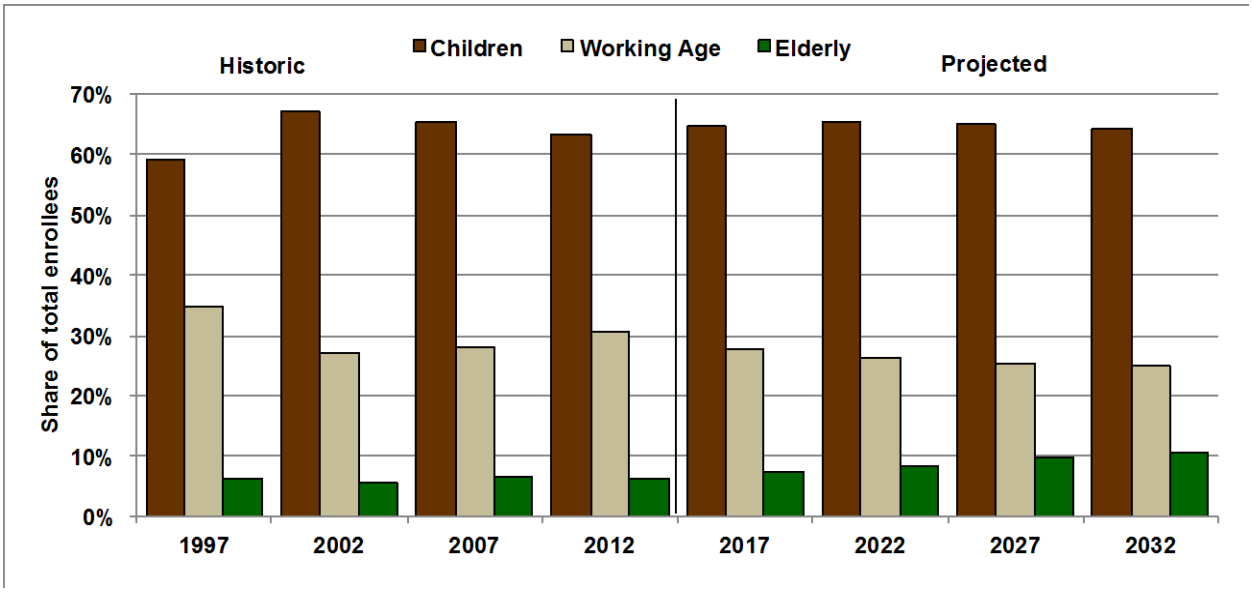
Source: Medicaid Budget Group, MESA Model

The demographic characteristics of Medicaid enrollees have changed and will continue to do so in the future. The share of children as a percent of all participants enrolled in Medicaid increased in the late 1990s and continued to increase until 2004, when they accounted for 67 percent of enrollees. This coincided with the introduction of Denali KidCare, which expanded Medicaid to more pregnant women and individuals. From 2004 to 2007, the household income eligibility requirements for Denali KidCare were locked into place instead of being adjusted for inflation, so some individuals fell off the rolls. The proportion of enrollees who are children has since dropped to 63 percent. With a projected 1.76 percent annual growth rate from 2012 to 2032, children's share of enrollment will remain largely unchanged; by 2032, enrollment is projected to include 131,398 children, accounting for 64 percent of enrollment.

The proportion of Medicaid enrollees who are working-age adults decreased from 35 percent of enrollment in 1997 to 27 percent of enrollment in 2002. Enrollment of working-age adults is projected to grow over the forecast period at 0.68 percent per year—slower than the projected rate for children and much slower than the projected rate for the elderly. The share of enrollees

who are working-aged adults is projected to decrease throughout the forecast period, from 30 percent in 2012 to 25 percent in 2032.

Figure 5: The percentage of enrollees who are elderly will increase over the next 20 years
SHARE OF TOTAL ENROLLEES BY AGE GROUP



Source: Medicaid Budget Group, MESA Model

With ever more people in the Baby Boom Generation reaching retirement age, the elderly will account for a larger share of Medicaid enrollees over the forecast period, increasing from 6 percent of enrollment to 11 percent in 2032. Enrollment of elderly is expected to grow at an annual rate of 4.37 percent over the next 20 years, from 9,200 in 2012 to 22,000 in 2032.

The proportion of enrollees by gender is projected to remain stable throughout the forecast period at approximately 55 percent female and 45 percent male.[17] The Native/Non-Native ratio of enrollees will also remain stable throughout the forecast period; Alaska Natives currently make up a little more than 36 percent of Medicaid enrollees, and that figure will remain roughly the same in 2032.

The forecast projects an increase in enrollment levels for each eligibility group,[18] with the greatest growth tending to be in eligibility categories that have a larger share of the disabled and the elderly. These groups include Other Disabled, Long Term Care Non-Cash, and SSI/APA/LTC Cash,[19] which we project will experience average annual enrollment growth of 1.3 percent, 4.2 percent, and 2.9 percent, respectively. SSI/APA/LTC Cash is the eligibility group that we project will experience the greatest increase in enrollment between 2012 and 2032 (19,400 additional enrollees).

[17] See Table 12 in Appendix D
[18] See Table 13 in Appendix D
[19] SSI = Social Security income; APA = Adult Public Assistance; LTC Cash = long-term care cash assistance

Table 3: Enrollment in eligibility groups associated with the disabled and elderly will grow faster than other eligibility categories

MEDICAID ENROLLMENT FOR SELECTED ELIGIBILITY GROUPS

Eligibility group	2012	2017	2022	2027	2032	Annual Change
LTC Non-cash	2,596	3,227	4,049	5,011	5,953	4.2%
Medicare	552	601	634	651	664	0.9%
SSI/APA/LTC Cash	25,651	30,609	36,054	41,123	45,096	2.9%
All Other Eligibility Categories	117,677	130,596	140,699	147,719	152,462	1.3%

Source: Medicaid Budget Group, MESA Model

Utilization

In the above sections of this report we presented information pertaining to projected population growth in Alaska and projected Medicaid enrollment growth. In this section, we present information pertaining to the utilization of Medicaid services.

The term "utilization" has multiple meanings in healthcare economics. For our purposes, we define utilization as the annual unduplicated count of Medicaid enrollees who received a particular Medicaid service during a fiscal year. These enrollees are referred to as "recipients" or "beneficiaries." Recipients are counted as utilizing a Medicaid service category if they used a Medicaid service during the fiscal year that resulted in a paid claim greater than zero dollars. Recipients are counted only once per fiscal year for any given service category, whether they used a service category once or used it multiple times during the fiscal year. To summarize, for the purposes of the MESA analysis, "utilization" measures the number of individuals who used a Medicaid service during a fiscal year, but it does not measure the quantity (or "intensity") of the service that an individual used. The quantity of use of a Medicaid service is considered in the forecast of spending on Medicaid services.

Table 4: Service category designations in the MESA forecast

Dental	Inpatient Hospital	Pharmacy
DME[20] / Supplies	Inpatient Psychiatric	Physician / Practitioner
EPSDT[21]	Lab / X-Ray	Residential Psychiatric / BRC[22]
Family Planning	Nursing Home	Therapy / Rehabilitation
HCB[23] Waiver	Outpatient Hospital	Transportation
Health Clinic	Outpatient Mental Health	Vision
Home Health / Hospice	Personal Care	

Currently, the service category with the highest utilization is Physician / Practitioner services, which had an estimated 108,800 users during 2012. We project that it will remain the service category with the highest utilization throughout the forecast period. This does not mean,

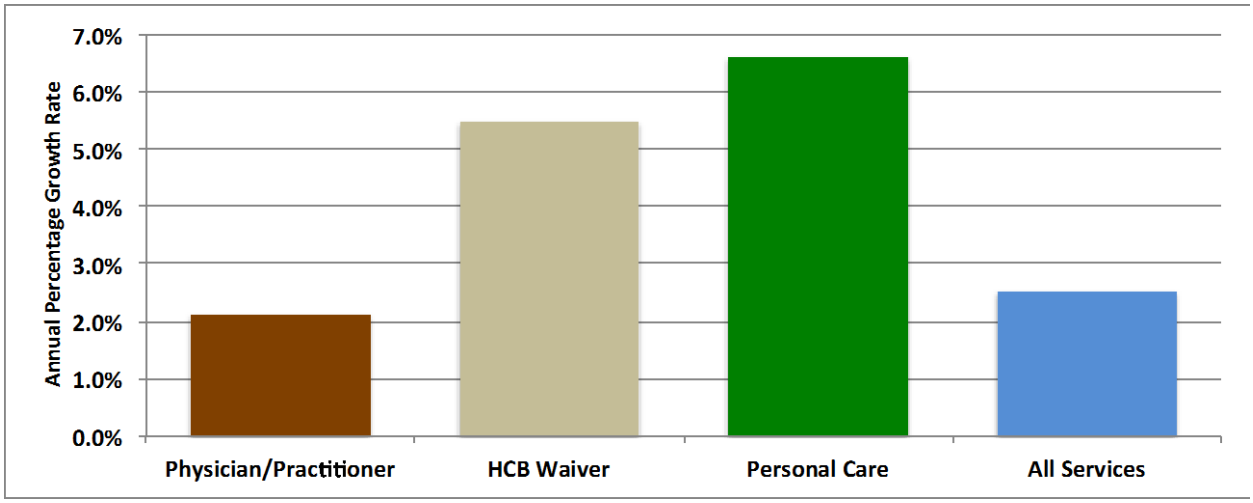
[20] Durable Medical Equipment
[21] Early and Periodic Screening, Diagnosis, and Treatment
[22] Behavioral Rehabilitation Centers
[23] Home and Community Based Waiver

however, that it is the fastest growing service category. In fact, with a growth rate in utilization averaging 2.1 percent per year, the Physician / Practitioner service category is one of the slower growing Medicaid service categories. It is projected that in 2032, approximately 165,000 Alaskans will receive Physician / Practitioner services through the Medicaid program.

The two service categories that are expected to see the highest percentage growth in utilization over the next twenty years are Personal Care, with an average annual growth of 6.6 percent, and Home and Community Based (HCB) Waiver (5.5 percent). The increasing number of the elderly in the Medicaid program will drive the increased utilization of these services. In spite of the high growth rates in utilization for services related to the elderly, Personal Care and HCB Waiver will continue to have low utilization relative to many other service categories.

Figure 6: HCB Waiver and Personal Care are projected to experience growth in utilization in excess of 5 percent per year

AVERAGE ANNUAL PERCENT GROWTH IN UTILIZATION FOR SELECTED SERVICE CATEGORIES



Source: Medicaid Budget Group, MESA model

Spending

We project that total Medicaid spending will increase by 7.6 percent annually between 2012 and 2032. This projection is based on the Medicaid program as it currently exists and does not consider policy changes that may occur during the forecast period. Service categories that primarily serve the elderly are projected to experience the highest growth in spending during the forecast period.[24] These services also tend to have the highest average per capita costs.

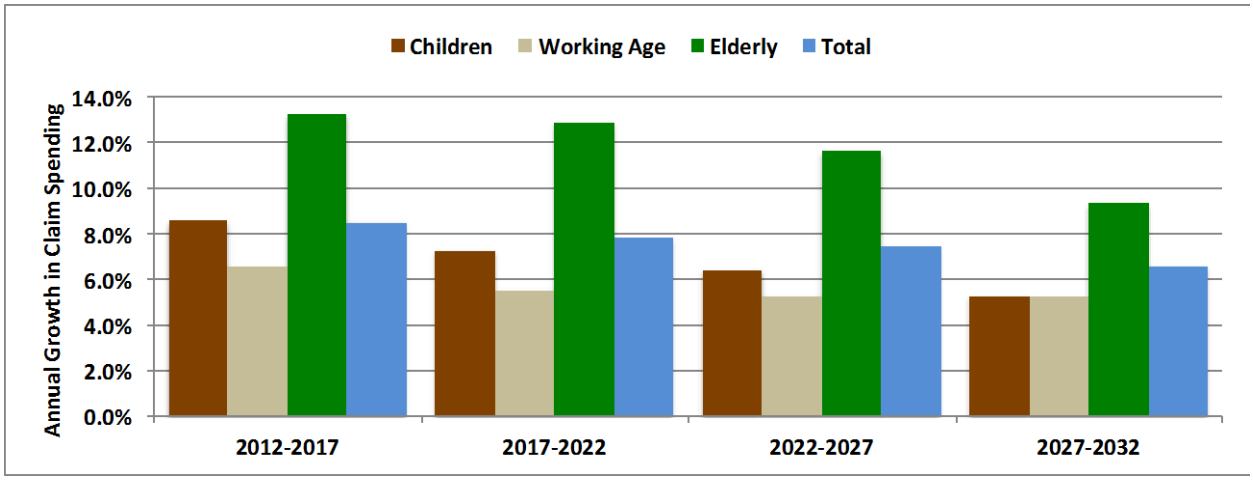
[24] See Appendix Table 14

Table 5: Spending on the elderly will grow nearly twice as fast as spending on other age groups
MEDICAID SPENDING BY AGE GROUP FOR SELECTED YEARS, 2012 – 2032 (IN MILLIONS)

Age Group	2012	2017	2022	2027	2032	Annual Growth
Children (0-19)	$524.3	$789.9	$1,121.0	$1,529.0	$1,977.4	6.9%
Working Age Adults (20-64)	$631.5	$868.3	$1,137.7	$1,470.9	$1,895.5	5.7%
Elderly (65+)	$228.5	$425.9	$779.7	$1,352.2	$2,112.4	11.8%
Total	$1,384.3	$2,084.0	$3,038.4	$4,352.0	$5,985.3	7.6%

Source: Medicaid Budget Group: MESA Model

Figure 7: Growth in Medicaid spending on the elderly will accelerate between 2012 & 2017 and then slow throughout the forecast period
ANNUAL GROWTH IN TOTAL CLAIMS SPENDING BY AGE GROUP

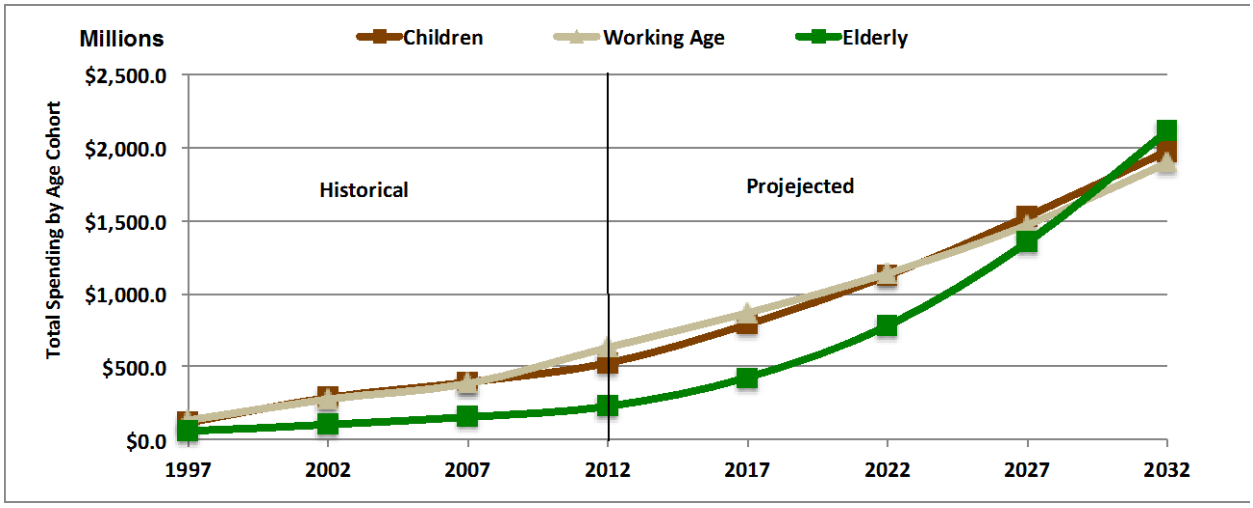


Source: Medicaid Budget Group, MESA Model

We project the average annual growth rate in spending for the elderly will be 11.76 percent through 2032. In comparison, we project average annual growth rates of 6.9 percent for children and 5.7 percent for working-age adults. Claims spending for all groups will grow from $1.4 billion in 2012 to $6.0 billion in 2032, for an annual growth rate of 7.6 percent. The higher projected growth rates in spending on the elderly, relative to children and working-age adults, is due in large part to the higher projected growth rate in enrollment of the elderly, relative to the younger age groups.

Figure 8: Claims spending for the elderly will converge with and then surpass spending on working-age adults and children

TOTAL CLAIMS SPENDING BY AGE GROUP

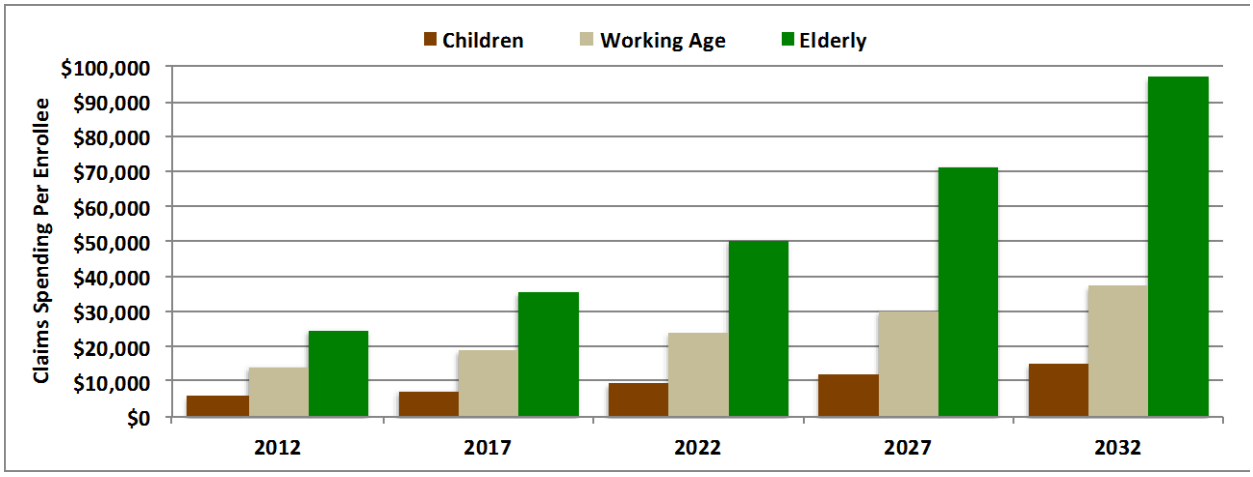


Source: Medicaid Budget Group: MESA Model

The higher costs of caring for the elderly will increase the total share of spending on elderly care. By 2032, we project spending for the elderly will account for 35 percent of total spending, even though the elderly will account for only 11 percent of Medicaid enrollees.

Figure 9: Spending on each elderly enrollee will continue to outpace spending per enrollee on children and working-age adults

AVERAGE TOTAL CLAIMS SPENDING PER ENROLLEE BY AGE CATEGORY[25]

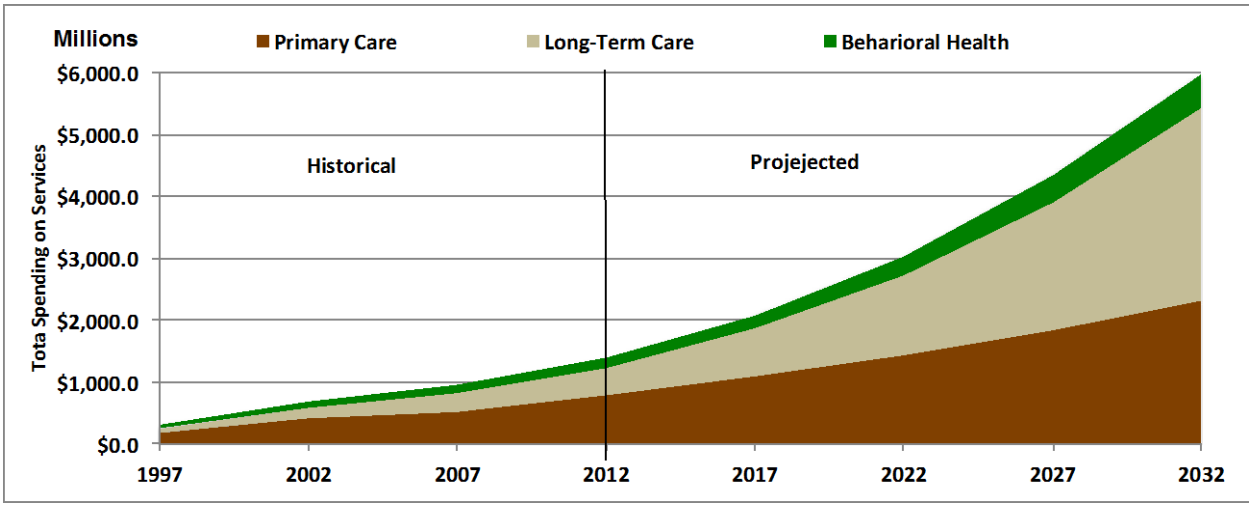


Source: Medicaid Budget Group: MESA Model

[25] For more in-depth information about average spending per enrollee by demographic group, see Table 15 in Appendix.

Figure 10: Due in large part to rapid growth in spending on long-term care services, total spending on Medicaid will quadruple between 2012 and 2032

TOTAL CLAIMS SPENDING BY TYPE OF HEALTHCARE SERVICE

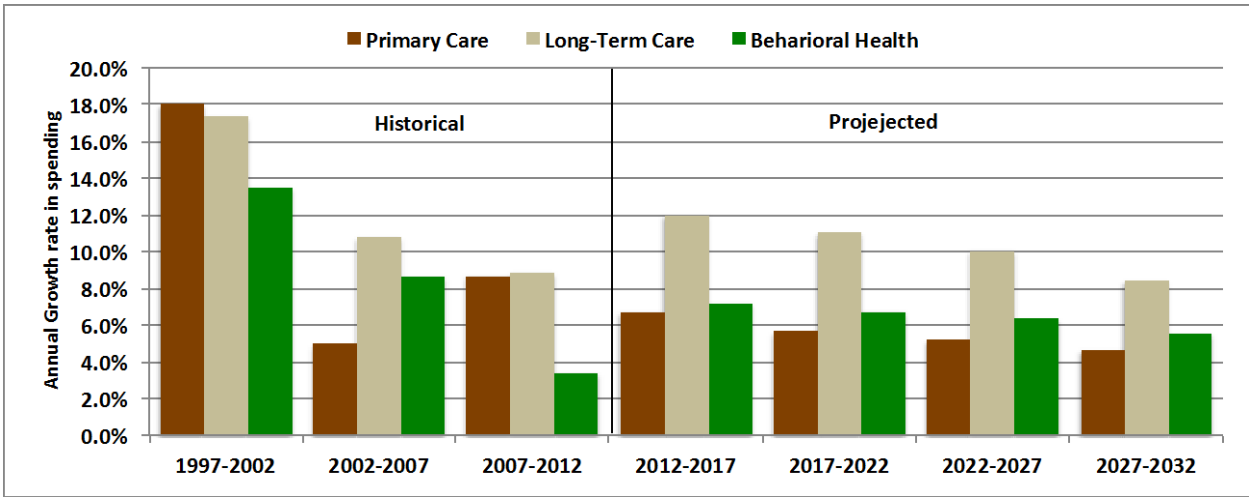


Source: Medicaid Budget Group: MESA Model

Note: All spending on Medicaid services is categorized into one and only one of these three types of healthcare services

Figure 11: Growth in total spending has slowed dramatically in recent years

ANNUAL GROWTH IN SPENDING BY SERVICE GROUP



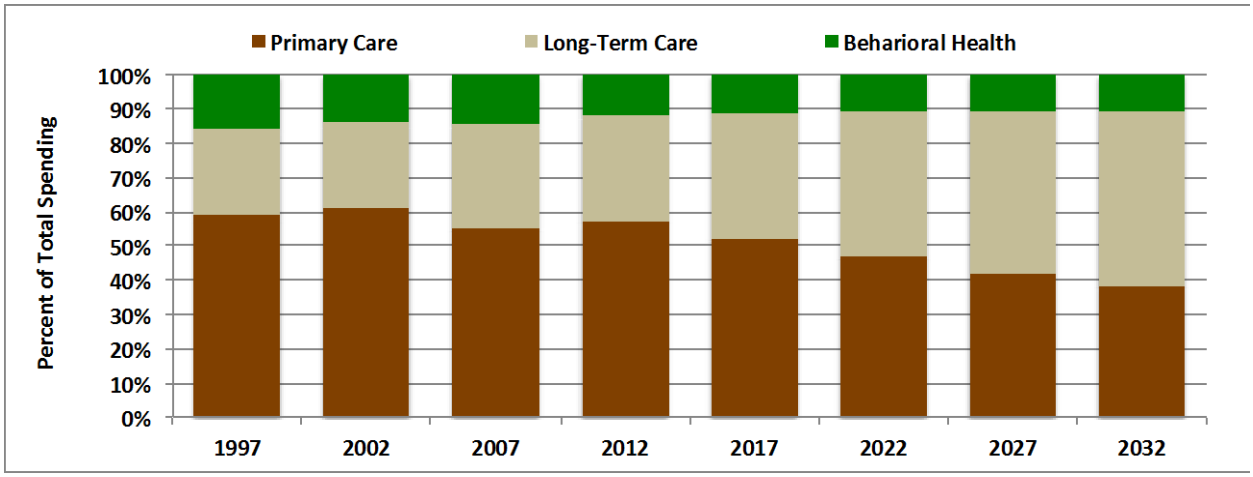
Source: Medicaid Budget Group: MESA Model

Figure 11 shows the growth rate in Alaska's historical and projected Medicaid spending. Spending on Medicaid increased rapidly from 1997 to 2002; annual growth rates never dropped below 10 percent in any year and averaged 16 percent annually for the period. The large spending increases of the late 1990s and early 2000s were brought under control from 2006 through 2008. The slowing down of the growth in spending from 2006 to 2008 was due at least in part to program changes put in place by the Legislature and Department following the release of the *Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025* in January 2006. However, with the severe economic recession that hit the country in 2008, enrollment in and spending on Medicaid increased in 2009 and 2010. Medicaid claims spending

in 2010 increased by 13.7 percent over 2009. Medicaid spending is projected to average a 7.6 percent annual growth over the forecast period.

Spending on long-term care services, such as Home and Community Based (HCB) Waiver and Personal Care,[26] is projected to grow faster than spending on Primary Care and Behavioral Health. Long-term Care, which is expected to grow from 31 percent to 51 percent of total spending, has a larger share of recipients over the age of 65 than either Primary Care or Behavioral Health.

Figure 12: Spending on long-term care services will increase as a share of total Medicaid spending
PERCENT OF TOTAL CLAIMS SPENDING BY SERVICE GROUP



Source: Medicaid Budget Group: MESA Model

Table 6: Long-term care is projected to be the fastest growing service category
MEDICAID SPENDING ON ***CLAIM PAYMENTS*** BY SERVICE GROUP FOR SELECTED YEARS (IN MILLIONS)

Service	2012	2017	2022	2027	2032	Annual Growth
Behavioral Health	$162.41	$230.67	$325.23	$456.36	$626.59	6.98%
Long-Term Care	$432.66	$761.77	$1,282.49	$2,064.75	$3,075.07	10.30%
Primary Care	$789.27	$1,091.61	$1,430.65	$1,830.85	$2,283.65	5.46%
Total	$1,384.33	$2,084.04	$3,038.37	$4,351.97	$5,985.31	7.60%

Source: Medicaid Budget Group, MESA model.

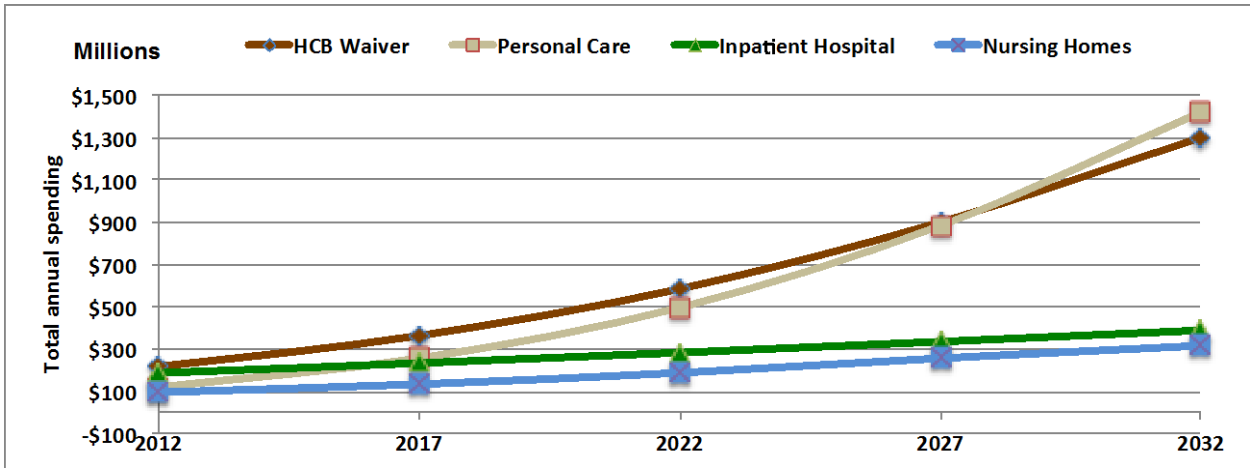
While total Medicaid spending is projected to grow at an average annual rate of 7.6 percent through the forecast period, there is significant variation in the growth rates of the individual services. Spending on HCB Waiver is projected to grow by an average of 9.5 percent per year. Personal Care is projected to grow by 13.1 percent per year. By 2032, HCB Waiver will account

[26] The HCB Waiver program allows people who would otherwise need an institutional level of care to live in their home or community and receive the care they need. These "waivers" are approved by the federal government and allow Alaska Medicaid to provide expanded services to people who meet the eligibility criteria for the specific waiver. Home and Community Based Waiver programs help the elderly and disabled, mentally retarded, developmentally disabled, and certain other disabled adults.

for $1.3 billion or 38 percent of Medicaid claims spending, up from the current 35 percent.[27] Personal Care will also make large gains, with an increase from 20 percent of total claims spending ($120 million) in 2012 to 41 percent of spending ($1.4 billion) in 2032. Spending in both of these programs is driven largely by growth in enrollment of the elderly.

Figure 13: Home and Community Based Waivers and Personal Care are the fastest growing service categories

TOTAL CLAIMS SPENDING FOR SELECTED SERVICE CATEGORIES



Source: Medicaid Budget Group, MESA model

Conversely, Inpatient Hospital is currently one of the largest categories of spending in 2012, second only to HCB Waiver, and is not as heavily influenced by growth in the enrollment of the elderly. Inpatient Hospital spending is projected to grow by 3.8 percent annually, resulting in a decrease in share of Medicaid spending from 30 percent in 2012 to 11 percent in 2032.[28]

Despite the relatively high rate of growth in the elderly population, the rate of spending growth for Nursing Homes is projected to be slower than the growth in spending for Medicaid as a whole. As a result, the Nursing Home category will drop from 16 percent of total Medicaid spending in 2012 to 9 percent by 2032. The data suggests that recipients may be shifting from Nursing Homes, where services are received in an institutional setting, to Personal Care and Home and Community Based Waivers, where care is received in one's own home.

Figure 14 shows the growth in total spending by components that affect spending growth. The components of spending growth are as follows:

Status Quo refers to what would happen if there were no health cost inflation, no growth in population, and no growth in the use and intensity of services provided. The status quo assumes that everything in future years remains exactly the same as in 2012.

[27] See Table 16 in Appendix
[28] IBID

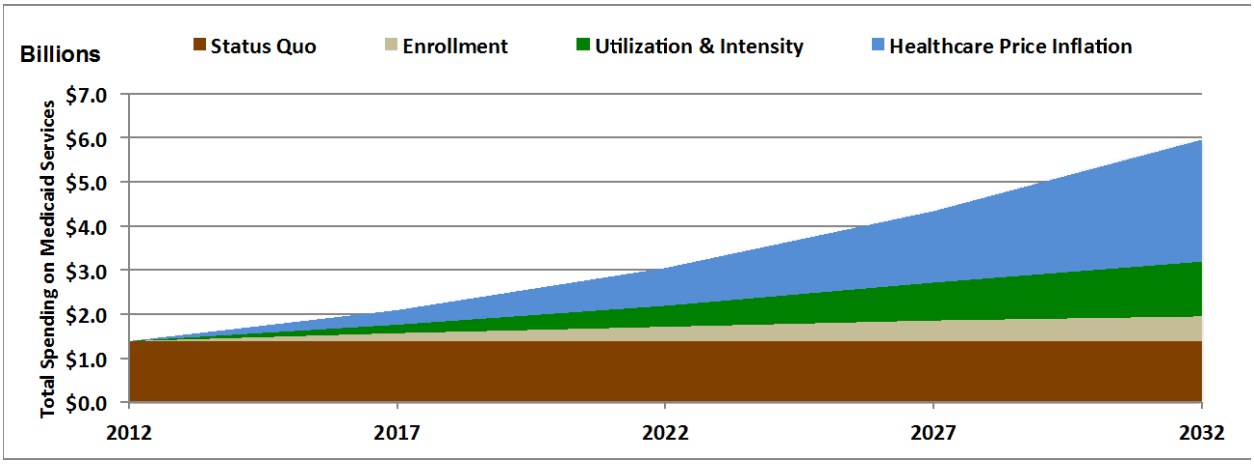
Enrollment Growth is the additional cost on top of the status quo resulting from growth in enrollment. Only the increase in total enrollment is taken into account and not demographic changes such as an aging population.

Growth in Services includes the additional spending associated with a greater use and intensity of services provided. Growth in services is the result of an aging population and other demographic changes, as well as the change in amount, duration, and scope of services provided from an increase of technology.

Inflation is the rate at which the price of a given medical service is expected to increase over time.

The component that will have the largest influence on growth in total spending is healthcare price inflation. Without inflation, Medicaid claims spending would increase from $1.3 billion to $3.2 billion in 2032, an average annual growth rate of 4.3 percent. Healthcare price inflation, however, increases the amount of spending in 2032 by an additional $2.8 billion for a total cost of $6.0 billion – a combined annual increase of 7.6 percent over the forecast period.

Figure 14: Healthcare price inflation accounts for the largest part of increased claims spending
PROJECTED SPENDING ON MEDICAID SERVICES BY INDIVIDUAL COMPONENTS OF GROWTH



Source: Medicaid Budget Group, MESA model

State Spending

State spending is projected to grow at 7.9 percent annually for the forecast period, compared to a projected 7.3 percent annual growth in federal spending.[29] The Federal Financial Participation (FFP) rate that applies to the majority of Medicaid spending is known as the Federal Medical Assistance Percentage (FMAP).[30] During the second half of calendar year 2011, the FMAP

[29] See Table 18 in Appendix
[30] Historically approximately 80 percent of Alaska Medicaid spending is reimbursed at the Regular FMAP rate. Alaska also has a substantial amount of Indian Health Services (IHS) spending, which is reimbursed at 100 percent. Family planning services are

leveled off at 50 percent and is expected to remain approximately at the same level throughout the forecast period. This projection, therefore, does not incorporate possible changes to the rate of federal financial participation in the future.

Federal financial participation rates are set at the federal level, and are largely outside of state control. The state's portion of Medicaid Service costs differs according to the recipient's Medicaid eligibility group, category of Medicaid service, provider of Medicaid-related service, and Native/Non-native status.

Table 7: State share of Medicaid funding increases throughout the forecast period
MEDICAID SPENDING BY FUND SOURCE AS A PERCENT OF TOTAL SPENDING, 2012 – 2032

Fund Source	2012	2017	2022	2027	2032
State and Other Match Funds (Percent of Total)	42.2%	42.8%	43.6%	44.4%	45.0%
Federal (Percent of Total)	57.8%	57.2%	56.4%	55.6%	55.0%

Source: Medicaid Budget Group, MESA model.

The FMAP is based on a three-year average of per capita personal income, ranked among states. While each state has its own FMAP, it can be no lower than 50 percent. Although the majority of Medicaid benefits are reimbursed at the regular FMAP rate, certain subgroups have higher reimbursement rates (*e.g.*, qualified Indian Health Services claims are reimbursed 100 percent). Where possible, the state contains costs by taking advantage of higher reimbursement rates.

reimbursed at 90 percent. Breast and Cervical Cancer services and Title XXI (CHIP) services are both reimbursed at what is called the "Enhanced FMAP", which is expected to be about 65 percent throughout the forecast period.

Chapter 2 – Other Medicaid Payments and Offsets

Chapter 2 deals with other ("special") Medicaid payments and offsetting recoveries, which are not tied to services provided to any individual Medicaid enrollee. The share of total spending attributed to the special payments and offsets varies from year to year. For example, in 2005 the special payments accounted for 13 percent of total Medicaid spending, compared to 5 percent during 2009.

These additional payments and offsets include Medicare premium payments, Medicare "clawback" payments, Disproportionate Share Hospital (DSH) payments, Continuing Care Agreement payments, and Tribal Encounter payments.[31]

Medicare Part A premium payments: Medicare Part A, or Hospital Insurance (HI), is a Medicaid program that helps pay for the costs of hospital stays, including meals, supplies, testing, and a semi-private room. The Medicaid Part A program also pays for home health care such as physical, occupational, and speech therapy that is provided on a part-time basis and deemed medically necessary. Care in a skilled nursing facility as well as certain medical equipment for the aged and disabled such as walkers and wheelchairs are also covered by Part A. Part A is generally available without having to pay a monthly premium, since payroll taxes are used to cover these costs.

Medicare Part B premium payments: Medicare Part B is also called Supplementary Medical Insurance (SMI). It helps pay for medically necessary physician visits, outpatient hospital visits, home health care costs, and other services for the aged and disabled.

Medicare Part D clawback: Medicare Part D is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006. Prior to Medicare Part D going into effect, the state's Medicaid program paid the drug costs for seniors in the Medicaid program. The federal government now pays the drug benefits for these individuals, but also requires that the state contribute payments on behalf of these individuals. These payments are called the Medicare Part D clawback.

Disproportionate Share Hospital (DSH) payments: DSH payments are designed to help hospitals that serve large numbers of Medicaid and uninsured patients. The Medicaid DSH

[31] Medicare is a federal program that provides health insurance to people age 65 or older, people under age 65 with certain disabilities, and people of all ages with End Stage Renal Disease. The program is voluntary and beneficiaries must pay monthly premiums. If Medicare beneficiaries have low-income, they may also be eligible for benefits under Medicaid. Because Medicaid is the payer of last resort, Medicare pays for 'dual-eligible' beneficiaries' claims before Medicaid does. Medicaid pays the premium for low-income Medicare Part A and Part B beneficiaries who cannot afford the insurance because it costs substantially less to pay the premium than to pay the claim.

payments are in addition to Medicaid payments paid to hospitals for services provided to individual Medicaid enrollees.

Continuing Care Agreement payments: These payments are paid to Tribal health care providers, which must provide particular services and perform certain administrative functions for children in the Medicaid program. Some of the medical services include the screening, diagnosis, treatment, and referral for follow-up services and physician's services needed by the recipient for acute, episodic, or chronic illnesses or conditions. Administrative functions include maintaining the recipient's consolidated health history and submitting any reports that the state Medicaid agency may reasonably require. Reimbursing Tribal continuing care providers for the cost of actually delivering the comprehensive range of health services offered at Tribal facilities helps ensure financial stability for the Tribal health care delivery system. It also avoids the costs (partially state funded) of transporting Medicaid clients elsewhere in the state to receive the health care services they need.

Encounter payments: These payments have been used for a quarter-century to pay Indian Health Services (IHS) and tribally operated facilities for services provided to Medicare and Medicaid enrollees. The encounter rate is a flat daily rate per visit that is published annually in the federal register. There are different inpatient and outpatient rates calculated for Alaska and the lower 48 states for Medicaid and Medicare Services.

Offsetting recoveries: "Offsetting recoveries" refers to credits used to reduce expenses and they include collections for third-party liability on claims and drug rebates. One of the tenants of Medicaid is that Medicaid is the payer of last resort; therefore, the department does not pay medical claims that are payable by a third party. The department contracts for the collection of medical expenses paid by Medicaid from potential third parties and does not pay medical claims that are payable by a third party.

There is uncertainty about the magnitude of the effect that special payments will have on Medicaid spending in the future. The Medicaid program is always changing, and payments that are acceptable one year may be disallowed by Centers for Medicare and Medicaid Services (CMS) in later years.[32] Because of this, we are unable to develop reasonable estimates of spending on special Medicaid payments and offsetting recoveries by type. However, on average total spending on these payments historically has been approximately 5 percent of total spending on Medicaid claims. Therefore, special payments are represented in this forecast by adding an additional 5 percent onto the forecast, based on claims data. In any given year, the forecast assumes that the share of total spending paid by the federal government will be the same for these special payments as it was for the claims payments.

[32] FairShare and ProShare are two examples of supplemental payment programs that have been discontinued in recent years.

Table 8: Other Medicaid payments will increase total Medicaid spending in 2032 to $6.3 billion
MEDICAID SPENDING BY FUND SOURCE FOR SELECTED YEARS, 2012 – 2032 (IN MILLIONS)

		2012	2017	2022	2027	2032
Claims payments	**Federal**	$800.5	$1,192.2	$1,715.0	$2,421.8	$3,291.3
	State Match	$583.9	$891.9	$1,323.4	$1,930.1	$2,694.0
	Total	$1,384.3	$2,084.0	$3,038.4	$4,352.0	$5,985.3
Other Payments	**Federal**	$40.0	$59.6	$85.8	$121.1	$164.6
	State Match	$29.2	$44.6	$66.2	$96.5	$134.7
	Total	$69.2	$104.2	$151.9	$217.6	$299.3
Total Payments	**Federal**	$840.5	$1,251.8	$1,800.8	$2,542.9	$3,455.9
	State Match	$613.1	$936.5	$1,389.5	$2,026.6	$2,828.7
	Total	$1,453.6	$2,188.3	$3,190.3	$4,569.6	$6,284.6

Source: Medicaid Budget Group: MESA Model. Estimates include only the costs for Medicaid services.

Chapter 3 – Summary

We project total spending on Alaska's Medicaid program to grow at an average annual rate of 7.6 percent over the next 20 years and to reach $6.3 billion by 2032 (see Table 8, page 22). Over this same period, State spending is expected to grow at 8.0 percent and reach $2.8 billion. In addition to healthcare price inflation, which is expected to average 3.3 percent per year, growth in spending on the Medicaid program through 2032 is the result of the following factors:

Growth in Alaska's Population – expected to average 1.0 percent per year
Growth in Medicaid Enrollment – expected to average 0.7 percent per year
Growth in the Utilization of Medicaid Services – expected to average 0.9 percent per year
Growth in Intensity of Service Provided – expected to average 1.7 percent per year

The population forecast includes assumptions about the changing demographic profile of Alaska. The average annual growth rate in enrollment of the elderly (65 and older) is expected to be 4.5 percent, which is higher than the growth rate for other age groups. As a result, the overall focus of the Medicaid program will shift from a child-based program to programs more evenly distributed between the elderly, working-age adults, and children. This demographic change affects spending, because spending on the elderly is growing at a rate over double that of children and working-age adults; this growth is likely to continue. A shift in spending towards the elderly is still expected to occur, but the timing will be delayed compared to earlier forecasts.

Services used more heavily by the elderly, such as Personal Care and Home and Community Based Waivers, will experience the highest spending growth throughout the forecast period.

The purpose of this forecast is to enable policy makers and the Department of Health and Social Services to see where Medicaid is headed, based on key growth components. By looking farther into the future, policy can be based more on proactive rather than reactive measures.

Appendix A: Medicaid Eligibility Classification Descriptions

Eligibility Class	Description
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 DHSS
LTC Non-cash	Elderly 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

Appendix B: Federal Financial Participation (FFP) Rates

FFP Type	Rate of Federal Financial Participation
Regular Medicaid "FMAP"	Not Less than 50 Percent
CHIP "Enhanced FMAP"	Regular FMAP + ≈15 percentage points ≈ 65 Percent
Breast and Cervical Cancer "Enhanced FMAP"	Regular FMAP + ≈15 percentage points ≈ 65 Percent
Indian Health Services	100 Percent
Family Planning (always 90% federal)	90 Percent
State Only	0 Percent

Appendix C: Medicaid Service Category Descriptions

Service Group	Service Category	Description
Behavioral Health	**Inpatient Psychiatric Hospital**	Inpatient psychiatric hospital services
Behavioral Health	**Outpatient Mental Health**	Outpatient mental health services, psychology services, and drug abuse centers
Behavioral Health	**Residential Psychiatric/Behavioral Rehabilitation Services**	Residential psychiatric treatment centers and behavioral rehabilitation services (BRS)
Long-term Care	**Home & Community Based Waiver**	Home and community based long-term care services offered through Medicaid Waivers including Alaska Pioneer Homes, assisted living homes, respite care, adult day care, chore services, residential and day habilitation, nutrition, and meals.
Long-term Care	**Home Health/Hospice**	Home health services, hospice care, nutrition services, and private duty nursing
Long-term Care	**Nursing Home**	Skilled nursing and intermediate care facilities including intermediate-care facilities for the mentally retarded; and temporary long-term care services
Long-term Care	**Personal Care**	Personal care attendant services including agency-based and consumer-directed programs
Primary Care	**Dental**	Dental services for children and adults
Primary Care	**Durable Medical Equipment/Supplies**	Durable medical equipment (DME), medical supplies, prosthetics, and orthotics
Primary Care	**Early & Periodic Screening, Diagnosis & Testing**	Early, periodic screening, diagnosis and treatment (EPSDT) including preventive health checkups, health screenings and immunizations
Primary Care	**Health Clinic**	Health clinic services including rural health clinics, federally-qualified health clinics and tribal health clinics
Primary Care	**Inpatient Hospital**	Inpatient hospital services
Primary Care	**Laboratory/X-Ray**	Laboratory, x-ray and diagnostic services
Primary Care	**Other Services**	Other services not classified elsewhere
Primary Care	**Outpatient Hospital**	Outpatient hospital services, outpatient surgery services, and end-stage renal disease services
Primary Care	**Pharmacy**	Prescription drugs
Primary Care	**Physician/Practitioner Services**	Physician, podiatrist, advanced nurse practitioner, and midwifery services
Primary Care	**Therapy/Rehabilitation**	Outpatient rehabilitation, physical therapy, occupational therapy, speech therapy, audiology, and chiropractic services
Primary Care	**Transportation**	Emergency and non-emergency medically necessary transportation and accommodation
Primary Care	**Vision**	Optometrist services and eyeglasses

Appendix D: Detailed Tables of 2012-2032 MESA Forecast

Table 9: Forecast of Population by Subpopulations

	Calendar Year					Annual %
	2012	2017	2022	2027	2032	Change
State	729,645	776,651	818,817	857,669	893,978	1.02%
Gender						
Male	378,978	402,145	422,509	441,057	458,239	0.95%
Female	350,667	374,506	396,308	416,611	435,739	1.09%
Native Status						
Native	122,873	130,154	136,682	142,780	148,289	0.94%
Non-Native	606,772	646,498	682,135	714,888	745,689	1.04%
Region						
Northern	123,415	131,341	138,465	145,253	152,160	1.05%
Western	43,156	45,883	48,489	50,903	53,108	1.04%
South Central	97,093	100,273	102,847	104,670	105,732	0.43%
Anchorage / Mat-Su	394,286	425,896	456,413	485,379	513,070	1.33%
Southeast	71,695	73,258	72,603	71,464	69,908	-0.13%
Age Group						
0-4	56,137	60,613	61,575	62,202	64,230	0.68%
5-9	52,573	58,400	62,530	63,606	64,337	1.01%
10-14	51,584	54,683	60,052	64,270	65,427	1.20%
15-19	50,463	51,161	54,059	59,375	63,547	1.16%
20-24	54,025	50,330	49,614	52,307	57,427	0.31%
25-34	109,517	114,971	112,101	109,280	112,009	0.11%
35-44	92,854	101,922	115,429	122,455	120,218	1.30%
45-54	106,361	96,545	92,400	99,738	113,069	0.31%
55-64	93,181	100,282	95,738	85,681	81,676	-0.66%
65-74	41,532	60,378	77,074	84,340	80,234	3.35%
75+	21,417	27,367	38,245	54,415	71,803	6.24%

Table 10: Forecast of Enrollment by Subpopulations

	Calendar Year					Annual %
	2012	2017	2022	2027	2032	Change
State	146,476	165,033	181,436	194,504	204,176	1.7%
Gender						
Male	66,582	74,791	82,491	88,443	92,563	1.7%
Female	79,894	90,242	98,945	106,061	111,612	1.7%
Native Status						
Native	53,719	59,945	64,851	68,760	71,615	1.4%
Non-Native	92,757	105,088	116,585	125,744	132,560	1.8%
Region						
Northern	18,366	20,988	23,174	24,910	26,222	1.8%
Western	20,947	23,647	25,943	27,831	29,304	1.7%
South Central	19,320	21,374	23,004	24,153	24,770	1.3%
Anchorage / Mat-Su	74,023	84,023	93,844	102,005	108,443	1.9%
Southeast	13,820	15,001	15,471	15,606	15,437	0.6%
Age Group						
0-4	32,152	37,104	39,229	40,606	42,272	1.4%
5-9	22,661	28,677	32,202	33,663	34,310	2.1%
10-14	19,835	22,978	26,560	29,249	29,974	2.1%
15-19	18,035	18,234	20,365	23,054	24,842	1.6%
20-24	8,704	7,383	7,496	8,079	8,978	0.2%
25-34	13,645	15,501	15,576	15,510	16,031	0.8%
35-44	8,574	9,759	11,372	12,334	12,254	1.8%
45-54	7,794	6,113	5,990	6,574	7,497	-0.2%
55-64	5,814	7,296	7,154	6,494	6,216	0.3%
65-74	4,874	6,370	8,147	9,344	9,277	3.3%
75+	4,389	5,619	7,343	9,598	12,524	5.4%

Table 11: Enrollment Rates by Subpopulations

	Calendar Year					Annual %
	2012	2017	2022	2027	2032	Change
State	20.1%	21.2%	22.2%	22.7%	22.8%	0.6%
Gender						
Male	17.6%	18.6%	19.5%	20.1%	20.2%	0.7%
Female	22.8%	24.1%	25.0%	25.5%	25.6%	0.6%
Native Status						
Native	43.7%	46.1%	47.4%	48.2%	48.3%	0.5%
Non-Native	15.3%	16.3%	17.1%	17.6%	17.8%	0.8%
Region						
Northern	14.9%	16.0%	16.7%	17.1%	17.2%	0.7%
Western	48.5%	51.5%	53.5%	54.7%	55.2%	0.6%
South Central	19.9%	21.3%	22.4%	23.1%	23.4%	0.8%
Anchorage / Mat-Su	18.8%	19.7%	20.6%	21.0%	21.1%	0.6%
Southeast	19.3%	20.5%	21.3%	21.8%	22.1%	0.7%
Age Group						
0-4	57.3%	61.2%	63.7%	65.3%	65.8%	0.7%
5-9	43.1%	49.1%	51.5%	52.9%	53.3%	1.1%
10-14	38.5%	42.0%	44.2%	45.5%	45.8%	0.9%
15-19	35.7%	35.6%	37.7%	38.8%	39.1%	0.4%
20-24	16.1%	14.7%	15.1%	15.4%	15.6%	-0.1%
25-34	12.5%	13.5%	13.9%	14.2%	14.3%	0.7%
35-44	9.2%	9.6%	9.9%	10.1%	10.2%	0.5%
45-54	7.3%	6.3%	6.5%	6.6%	6.6%	-0.5%
55-64	6.2%	7.3%	7.5%	7.6%	7.6%	1.0%
65-74	11.7%	10.5%	10.6%	11.1%	11.6%	-0.1%
75+	20.5%	20.5%	19.2%	17.6%	17.4%	-0.8%

Table 12: Enrollment Levels by Eligibility Groups

	Calendar Year					Annual %
	2012	2017	2022	2027	2032	Change
AFDC & Related	47,387	51,621	55,015	57,469	59,280	1.13%
Title XIX Kids	6,741	7,012	7,211	7,488	7,886	0.79%
Title XXI Kids	44,410	50,207	54,393	57,064	58,729	1.41%
Pregnancy/Post Partum	13,229	15,018	16,552	17,536	17,986	1.55%
Kids in Custody	4,585	5,146	5,624	5,942	6,096	1.43%
Alien (Foreign)	4	5	5	6	7	2.83%
SSI/APA/LTC Cash	25,651	30,609	36,054	41,123	45,096	2.86%
LTC Non-cash	2,596	3,227	4,049	5,011	5,953	4.24%
Other Disabled	476	635	809	961	1,058	4.08%
Medicare	552	601	634	651	664	0.93%
Exams	846	952	1,089	1,253	1,421	2.63%
Total (Undup. Count)	146,476	165,033	181,436	194,504	204,176	1.67%

Table 13: Total Spending on Medicaid Services by Subpopulations (in millions)

	Calendar Year					Annual %
	2012	2017	2022	2027	2032	Change
State	$1,384.3	$2,084.0	$3,038.4	$4,352.0	$5,985.3	7.6%
Gender						
Male	$605.7	$920.5	$1,348.8	$1,932.9	$2,649.6	7.7%
Female	$778.6	$1,163.6	$1,689.6	$2,419.1	$3,335.7	7.5%
Native Status						
Native	$464.0	$687.6	$984.1	$1,387.3	$1,883.5	7.3%
Non-Native	$920.3	$1,396.4	$2,054.3	$2,964.6	$4,101.8	7.8%
Region						
Northern	$146.1	$222.0	$326.4	$470.6	$651.4	7.8%
Western	$151.8	$228.3	$332.1	$474.7	$652.3	7.6%
South Central	$214.0	$314.9	$451.2	$635.5	$857.4	7.2%
Anchorage / Mat-Su	$716.5	$1,093.7	$1,619.8	$2,353.7	$3,281.1	7.9%
Southeast	$156.0	$225.2	$308.8	$417.5	$543.2	6.4%
Age Group						
0-4	$176.1	$266.1	$360.9	$472.4	$609.3	6.4%
5-9	$83.8	$131.9	$190.0	$251.2	$317.1	6.9%
10-14	$115.6	$175.0	$259.5	$361.3	$458.5	7.1%
15-19	$148.8	$216.9	$310.6	$444.1	$592.6	7.2%
20-24	$97.5	$123.5	$160.0	$216.9	$297.5	5.7%
25-34	$152.8	$217.7	$279.5	$350.5	$447.3	5.5%
35-44	$106.3	$158.4	$235.8	$322.3	$395.4	6.8%
45-54	$141.6	$173.0	$216.6	$299.7	$422.3	5.6%
55-64	$133.2	$195.8	$245.8	$281.4	$333.0	4.7%
65-74	$82.3	$167.8	$293.7	$432.5	$536.2	9.8%
75+	$146.2	$258.0	$485.9	$919.6	$1,576.1	12.6%

Table 14: Spending per Enrollee on Medicaid Services by Subpopulations

	Calendar Year					Annual %
	2012	2017	2022	2027	2032	Change
State	$9,451	$12,628	$16,746	$22,375	$29,315	5.8%
Gender						
Male	$9,097	$12,307	$16,350	$21,855	$28,625	5.9%
Female	$9,746	$12,894	$17,076	$22,808	$29,886	5.8%
Native Status						
Native	$8,638	$11,471	$15,175	$20,177	$26,300	5.7%
Non-Native	$9,922	$13,288	$17,620	$23,577	$30,943	5.9%
Region						
Northern	$7,954	$10,579	$14,084	$18,891	$24,841	5.9%
Western	$7,246	$9,653	$12,802	$17,055	$22,260	5.8%
South Central	$11,076	$14,731	$19,614	$26,312	$34,613	5.9%
Anchorage / Mat-Su	$9,679	$13,017	$17,261	$23,075	$30,256	5.9%
Southeast	$11,287	$15,010	$19,961	$26,754	$35,187	5.8%
Age Group						
0-4	$5,476	$7,172	$9,201	$11,634	$14,413	5.0%
5-9	$3,697	$4,599	$5,901	$7,461	$9,242	4.7%
10-14	$5,828	$7,614	$9,768	$12,352	$15,297	4.9%
15-19	$8,253	$11,897	$15,250	$19,265	$23,854	5.5%
20-24	$11,207	$16,724	$21,338	$26,854	$33,139	5.6%
25-34	$11,199	$14,044	$17,942	$22,601	$27,900	4.7%
35-44	$12,401	$16,232	$20,736	$26,126	$32,266	4.9%
45-54	$18,170	$28,297	$36,166	$45,588	$56,327	5.8%
55-64	$22,915	$26,832	$34,363	$43,335	$53,573	4.3%
65-74	$16,890	$26,348	$36,055	$46,291	$57,800	6.3%
75+	$33,313	$45,924	$66,172	$95,817	$125,854	6.9%

Table 15: Spending on Medicaid Services by Service Category (in millions)

Service	Calendar Year 2012	2017	2022	2027	2032	Annual % Change
Dental	$61.4	$93.3	$132.0	$180.1	$236.2	7.0%
DME/Supplies	$19.4	$28.3	$39.8	$55.1	$73.7	6.9%
EPSDT	$0.0	$0.0	$0.0	$0.0	$0.0	0.2%
HCB Waiver	$212.5	$363.9	$586.8	$907.2	$1,318.5	9.6%
Health Clinic	$57.8	$89.3	$125.8	$169.4	$219.3	6.9%
Home Health/Hospice	$6.0	$8.7	$12.5	$17.9	$25.2	7.5%
Inpatient Hospital	$183.4	$233.8	$283.6	$337.1	$393.3	3.9%
Inpatient Psychiatric	$19.2	$31.4	$51.5	$78.6	$110.4	9.1%
Lab/X-ray	$2.4	$3.0	$3.7	$4.4	$5.2	4.0%
Nursing Home	$94.7	$133.3	$188.1	$258.1	$320.1	6.3%
Other Services	$0.1	$0.1	$0.1	$0.1	$0.1	0.9%
Outpatient Hospital	$144.2	$199.0	$260.6	$334.2	$418.9	5.5%
Outpatient Mental Health	$111.0	$148.0	$191.2	$244.4	$305.9	5.2%
Personal Care	$119.5	$256.4	$498.2	$890.9	$1,439.6	13.3%
Pharmacy	$89.7	$119.8	$154.3	$196.2	$244.3	5.1%
Physician/Practitioner	$133.2	$184.0	$241.9	$313.8	$399.4	5.6%
Residential Psych/BRC	$32.2	$50.3	$75.5	$109.4	$149.7	8.0%
Therapy/Rehabilitation	$24.2	$35.3	$48.5	$64.4	$81.9	6.3%
Transportation	$67.5	$96.8	$131.0	$172.4	$219.5	6.1%
Vision	$5.9	$9.3	$13.4	$18.4	$24.1	7.3%
Total Service Spending	$1,384.3	$2,084.0	$3,038.4	$4,352.0	$5,985.3	7.6%

Table 16: Average Spending per Recipient by Service Category (in dollars)

Service	Calendar Year 2012	2017	2022	2027	2032	Annual % Change
Dental	$1,049	$1,275	$1,539	$1,883	$2,296	4.0%
DME/Supplies	$1,454	$1,714	$2,009	$2,394	$2,869	3.5%
EPSDT	$162	$163	$165	$168	$170	0.2%
HCB Waiver	$34,560	$41,704	$49,794	$60,450	$73,723	3.9%
Health Clinic	$1,477	$1,711	$1,949	$2,249	$2,615	2.9%
Home Health/Hospice	$9,180	$11,220	$13,844	$17,588	$22,647	4.6%
Inpatient Hospital	$11,206	$13,110	$15,044	$17,321	$19,981	2.9%
Inpatient Psychiatric	$19,296	$26,818	$39,138	$55,096	$73,303	6.9%
Lab/X-ray	$150	$178	$208	$245	$290	3.4%
Nursing Home	$95,631	$123,337	$157,896	$200,284	$243,417	4.8%
Other Services	$446	$535	$637	$769	$923	3.7%
Outpatient Hospital	$2,009	$2,360	$2,732	$3,195	$3,750	3.2%
Outpatient Mental Health	$8,890	$11,080	$13,714	$17,189	$21,564	4.5%
Personal Care	$25,682	$35,830	$48,450	$65,112	$85,907	6.2%
Pharmacy	$1,143	$1,347	$1,577	$1,865	$2,209	3.3%
Physician/Practitioner	$1,273	$1,503	$1,759	$2,096	$2,514	3.5%
Residential Psychiatric/BRC	$49,289	$63,485	$82,983	$109,421	$141,011	5.4%
Therapy/Rehabilitation	$2,697	$3,204	$3,753	$4,426	$5,188	3.3%
Transportation	$2,588	$3,084	$3,603	$4,230	$4,961	3.3%
Vision	$199	$239	$281	$333	$394	3.5%
Total Service Spending	$2,826	$3,552	$4,504	$5,809	$7,422	4.9%

Table 17: Forecast of State Claims Spending by Service Category (in millions)

Service	Calendar Year 2012	2017	2022	2027	2032	Annual % Change
Dental	$23.6	$36.0	$51.0	$69.5	$90.9	7.0%
DME/Supplies	$9.7	$14.1	$19.9	$27.5	$36.7	6.9%
EPSDT	$0.0	$0.0	$0.0	$0.0	$0.0	0.0%
HCB Waiver	$104.2	$179.1	$289.4	$448.5	$651.5	9.6%
Health Clinic	$4.5	$7.0	$9.9	$13.4	$17.3	6.9%
Home Health/Hospice	$2.7	$3.9	$5.6	$8.0	$11.3	7.5%
Inpatient Hospital	$70.5	$90.2	$109.4	$130.0	$151.3	3.9%
Inpatient Psychiatric	$9.4	$14.7	$24.8	$39.5	$58.7	9.6%
Lab/X-ray	$1.2	$1.5	$1.8	$2.2	$2.6	4.0%
Nursing Home	$45.4	$65.6	$92.8	$127.6	$158.2	6.4%
Other Services	$0.1	$0.1	$0.1	$0.1	$0.1	0.9%
Outpatient Hospital	$48.2	$66.8	$87.5	$112.2	$140.3	5.5%
Outpatient Mental Health	$50.5	$69.6	$92.3	$122.9	$162.7	6.0%
Personal Care	$59.6	$126.2	$245.7	$440.5	$711.3	13.2%
Pharmacy	$37.4	$50.1	$64.6	$82.1	$102.0	5.1%
Physician/Practitioner	$55.7	$77.2	$101.6	$131.6	$167.1	5.6%
Residential Psych/BRC	$15.6	$23.6	$36.4	$55.0	$79.6	8.5%
Therapy/Rehabilitation	$11.3	$16.5	$22.7	$30.2	$38.3	6.3%
Transportation	$31.4	$45.2	$61.2	$80.5	$102.2	6.1%
Vision	$2.9	$4.5	$6.5	$8.9	$11.6	7.3%
Total Service Spending	$583.9	$891.9	$1,323.4	$1,930.1	$2,694.0	7.9%

Table 18: Historical Enrollment by Demographic Group

Year	Non-Native	Native	Female	Male	Children	Working Age	Elderly	Total
1997	59,803	30,327	52,149	37,981	53,098	31,290	5,742	90,130
1998	58,154	30,572	50,967	37,759	52,103	30,754	5,869	88,726
1999	62,994	32,840	54,381	41,453	58,296	31,444	6,094	95,834
2000	72,898	37,368	61,889	48,377	71,649	32,133	6,484	110,266
2001	76,732	39,524	64,603	51,653	77,477	32,038	6,741	116,256
2002	80,588	41,021	67,201	54,408	81,677	32,943	6,989	121,609
2003	84,045	42,621	69,828	56,838	85,171	34,116	7,379	126,666
2004	84,943	44,611	71,305	58,249	87,027	34,946	7,581	129,554
2005	85,450	46,569	72,742	59,277	87,485	36,619	7,915	132,019
2006	85,269	47,695	73,215	59,749	87,232	37,433	8,299	132,964
2007	81,048	47,027	70,580	57,495	83,930	35,829	8,316	128,075
2008	78,813	46,325	68,745	56,393	81,694	35,126	8,318	125,138
2009	80,670	47,274	70,193	57,751	82,930	36,578	8,436	127,944
2010	85,733	49,353	74,014	61,072	86,502	39,849	8,735	135,086

Appendix E: Glossary and Definition of Terms

ADLWD:	Alaska Department of Labor and Workforce Development
AFDC:	Aid to Families with Dependent Children
APA:	Adult Public Assistance
BCC:	Breast and Cervical Cancer
BEA:	Bureau of Economic Analysis
BRS:	Behavioral Rehabilitation Services
CHIP:	Children's Health Insurance Program
CMS:	Center for Medicare and Medicaid Services
CPI:	Consumer Price Index
CY:	Calendar Year
DME:	Durable Medical Equipment
DSH:	Disproportionate Share Hospital
EPSDT:	Early & Periodic Screening, Diagnosis and Treatment
FFP:	Federal Financial Participation
FFY:	Federal Fiscal Year
FMAP:	Federal Medical Assistance Percentage
FY:	Fiscal Year
GDP:	Gross Domestic Product
HCB:	Home and Community Based
IHS:	Indian Health Services
HSS:	Alaska Department of Health and Social Services
ISER:	Institute for Social and Economic Research
JUCE:	Juneau Claims and Eligibility System
LTC:	Long Term Care
MMIS:	Medicaid Management Information System
PCPI:	Per Capital Personal Income
PDL:	Preferred Drug List
SCHIP:	State Children's Health Insurance Program/Denali KidCare
SFY:	State Fiscal Year
SHP:	Supplemental Hospital Payments
SSI:	Supplemental Security Income
SURS	Surveillance and Utilization Review System
Title XIX:	Medicaid
Title XXI:	CHIP, which is an expansion to Alaska's Medicaid program that receives an enhanced FMAP
TPL:	Total Personal Income
TPL:	Third Party Liability

SPONSORED ALIEN: A sponsored alien is an alien admitted into the United States for permanent residence as defined in the immigration and Nationality Act and, as a condition of entry, was sponsored by a person who executed an affidavit of support for the alien. Sponsored Alien is ineligible for Supplemental Security Income/Adult Public assistance.

SSI "1619" ELIGIBLE: Section 1619(b) Blind or disabled individuals who have had their SSI eligibility maintained for Medicaid purposes by section 1619(b) of the Social Security Act.

SSI ELIGIBLE WHO HAVE NOT APPLIED FOR SSI: This phrase refers to those applicants who are ineligible for Supplemental Security Income/Adult Public assistance because of requirements that do not apply to Medicaid.

TITLE IV-E SUBSIDIZED ADOPTION: Title IV-E is created to prevent unnecessary placement of children from low-income families by offering state fiscal incentives for providing preventive services. Title IV-E subsidized adoption program is to ensure that "special needs" children who are difficult to place in adoptive homes do not remain in foster care solely for financial reasons.

TITLE XIX: Title XIX of the Social Security Act is the federal legislation that established Medicaid, a joint federal state program that provides Medical Assistance to low-income consumers of all ages who need care but cannot afford it.

TITLE XXI: Title XXI of the Social Security Act provides funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

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Long-term Forecast of

Medicaid Enrollment

and

Spending in Alaska:

Supplement 2012–2032

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