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**Major health care payment systems  
in Alaska.**

Insurance – private employers  
Insurance – public employers  
Individual insurance  
Veterans Administration  
Department of Defense  
Indian Health Service – tribal compact funding  
Medicare  
Medicaid/Denali KidCare

**Who pays**

Business and employees  
State taxpayers and employees  
The individual  
Federal taxpayers  
Federal taxpayers  
Federal taxpayers  
Federal taxpayers and state funds

**Who provides the services**

Thousands of independent practitioners  
25 hospitals  
15 nursing homes  
Numerous assisted living or congregate care facilities  
Numerous out of state providers  
Numerous tribal, rural, community health centers and public health clinics

## TITLE 19 Services

### **SERVICES mandatory**

Inpatient/Outpatient/Physician  
Family Planning  
Nursing home services  
Lab and X-ray services  
Early Periodic Screening Diagnosis and Treatment (EPSDT)  
Skilled nursing care services  
Rural health clinic services  
Medical transportation  
Federally Qualified Health Center services  
Medical and surgical services of dentists  
Ambulance services for emergency/non-emergency care  
Nurse midwife/nurse practitioner  
Indian Health Clinics  
Home health services  
Durable medical equipment (DME)  
Nursing Facilities

### **SERVICES optional for adults**

Dental  
Chiropractic services  
Podiatry services  
Freestanding ambulatory surgical centers  
Specialty hospitals  
Prosthetic devices  
Personal care services  
Organ transplants  
Direct entry midwifery  
Acupuncturist  
Naturopathic  
Vision exams, eyeglasses  
Prescription drugs  
Hearing aids  
Hospice  
Private duty nursing  
Home infusion therapy  
Certified registered nurse anesthetist services  
Medical supplies  
Occupational therapy  
Physical therapy  
Occupational therapy  
Speech therapy  
Targeted case management  
ICF/MR  
Mental health, A&D, SBHC, BRS rehabilitation services

# Economic Impact of the Medicaid Program on Alaska's Economy, FY 2001

## Summary of Findings

Although there is a tremendous amount of information about the Medicaid program services, providers, and recipients, the economic impact of the program on Alaska's economy is not well known. A study recently completed for the Department of Health and Social Services by a rural health care economist estimated the economic impact of the program for FY 2001. The economist used a widely-accepted input-output model known as "IMPLAN" to estimate the direct, indirect, and induced effects.

In FY 2001, total Medicaid expenditures in Alaska equaled \$574.5 million of which 74 percent was federal funds and 26 percent, or \$150.1 million, was State General Funds. Ninety-six percent of the \$574.5 million or \$553.2 million was spent on direct health care services in Alaska's economy.

As a result of the Medicaid expenditures for direct health care services, 5,158 health sector jobs were created in Alaska and \$219.8 million in income was generated in the health sector. As these health sector workers purchased goods and services in the economy, their spending generated 3,559 jobs in other businesses in Alaska's economy and created \$114.3 million in income. The total employment and income created as a result of the Medicaid program's health care services expenditures was 8,717 jobs and \$334.1 million in income in FY 2001.

Similarly, 191 division and contract employees worked directly for the Medicaid program and earned \$9.9 million in income in FY 2001. As these employees purchased goods and services in the economy, they generated 94 additional jobs and \$2.2 in income for a total employment impact of 285 jobs and a total income impact of \$12.1 million.

Combining the health care sector jobs and state/contract jobs, the total employment impact of the Medicaid program on Alaska's economy was 9,002 jobs. Combining the health care workers income and the state/contract employee income, the total income impact of the Medicaid program on Alaska's economy was \$346.2 million.

Although the focus of this report is the impact on jobs and income generated in Alaska's economy as a result of the Medicaid program, the total economic impact on Alaska's economy was estimated using an output multiplier for Alaska. The total impact of Medicaid expenditures on the health businesses purchases of goods, services, and labor was \$1,011.2 million (or \$1.0 billion).

In conclusion, Alaska's investment of \$150.1 million in State General Fund expenditures in FY 2001 for the Medicaid program created over 9,000 jobs and generated more than \$346.2 million income for Alaskans.

## Questions about Medicaid & Indian Health Services

1.. If a person is eligible for Indian Health Services, are they also eligible for Medicaid? Does Medicaid receive any reimbursement from the IHS provider? *They are eligible for IHS services based on their ethnicity. They can be eligible for Medicaid as long as they meet the income and resource requirements and fit into a Medicaid category. They could also be eligible for Medicare and have private insurance. No, Medicaid doesn't receive reimbursement from IHS providers. Instead, when an Alaska Native receives services through a tribal facility the reimbursement that Medicaid pays to that provider is 100% federal funds. When an Alaska Native receives services from a non-tribal provider Medicaid only receives the usual program match rate, now about 57%.*

2.. Does DHSS track Medicaid recipients by ethnicity? *We don't exactly track ethnicity. When a person applies for Medicaid they can indicate on the form their ethnicity. That information is carried in the claims processing system and used to determine the federal Medicaid match percentage described in #1. We also occasionally do a records check with IHS to determine if any additional Medicaid clients are recognized in their system. If a positive match is found we update our claims payment system. We assume that a person has been properly vetted by the tribe before the tribe agrees to take on the health care responsibility.*

3.. What is the proof of ethnicity required to receive IHS services (percentage of Ak. Native blood?)? Does this have any impact on the population covered under Medicaid? *Tribes have their own process for verifying blood quantum in Alaska and each organization requires something different. DHSS takes applicants at their word and verifies through the data match with IHS. Some lower 48 tribes do use blood quantum to establish tribal membership. In some places that has become contentious because tribal membership is sought for the benefits from gambling, not for health care*

4.. Is there any difference in the relationship between Medicaid and IHS in Alaska and in states that have reservation systems? For example, does a Native American living on a reservation in Arizona or Minnesota receive Medicaid or IHS services, or both? Does it matter if a person is living on or off a reservation? *Yes, Medicaid is based on income and IHS is based on blood quantum. Native beneficiaries can receive both Medicaid and IHS if they prove income eligibility and blood quantum. They may also receive just IHS. Reservation status does not make any difference on whether they receive one or the other, Medicaid is income based.*

5.. If a person is covered by other insurance (such as Denali Kid Care), how are payments for services split between that coverage and IHS? *It is the same method as used in Medicaid since DKC is an option of Medicaid. IHS is the payer of last resort, after Medicaid. Medicare, private insurance, all others pay before Medicaid. Also keep in mind that IHS does not operate as an insurance company. In Alaska the IHS annual funding grant is divided between the various tribal 638 health corporations. That is their budget for the year along with whatever 3<sup>rd</sup> party insurance, such as Medicaid, Medicare, or CHAMPUS they might receive for services provided. The IHS grant has not kept pace with native population growth and medical inflation, only increasing about 1-2% annually. National estimates suggest the IHS grant is only sufficient to meet about 60% of the need, thus contributing to the continuing health care disparities of AI/AN.*

**Recommended Reports**  
*(will be posted on Health Care Strategies Planning Council website)*

