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DEPARTMENT OF HUMAN SERVICES

November 2020 Forecast

Executive Summary and Trend Data

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Executive summary

The Minnesota Department of Human Services prepares a forecast of its expenditures in major programs twice annually. Forecasted programs include Medical Assistance (MA), MinnesotaCare, Minnesota Family Investment Program (MFIP), Child Care Assistance and others as described in the pages that follow. Projected expenditures are used in statewide budget forecasts that Minnesota Management and Budget releases in November and February each year. These forecasts are used to update fund balances and provide financial information to the Governor and the legislature as they work together to set budgets.

All November 2020 forecast highlights in this document represent changes from the End-of-Session 2020 forecast.

November 2020 forecast highlights

General Fund (GF)

Changes from the End-of-Session 2020 forecast

- Decrease of $919.4 million in 2020-2021 biennium (-7.6%)
- Decrease of $257.1 million in 2022-2023 biennium (-1.8%)
- Overall decrease of $1,176.5 million across the entire forecast horizon

Health Care Access Fund (HCAF)

Changes from the End-of-Session 2020 forecast

- Decrease of $95.5 million in 2020-2021 biennium (-7.1%)
- Decrease of $66.7 million in 2022-2023 biennium (-4.0%)
- Overall decrease of $162.2 million across the entire forecast horizon

Reasons: The November forecast produces a large projected General Fund reduction in both the current and the next biennium. Almost 90% of the General Fund reduction in the current biennium and essentially the entire reduction in the next biennium is the result of adjustments related to the global COVID-19 pandemic.

The first adjustment is an anticipated extension of the Public Health Emergency (PHE) from January 2021 through June 2021. This PHE extension provides additional federal funding through a 6.2 percentage point increase in the state's Federal Medical Assistance Percentage (FMAP), which directly replaces General Fund expenditures. These state savings are partially offset by the cost of continuous coverage policies, enacted by Executive Order, which are required to claim the additional federal funds. The enhanced federal share results in about $337 million in projected General Fund savings for this 6-month PHE extension period. The administrative changes to comply with this federal Maintenance of Effort (MOE) requirement leads to a projected cost of about $27 million in the current biennium with costs of about $58 million in the next biennium. Overall, the 6-month PHE extension results in a projected General Fund reduction of $310 million (34% of the total reduction) in the current biennium and a cost of $58 million in the next biennium.

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Who it serves

- Over 1.4 million people a year are served through DHS forecasted programs

How much it costs

- $15.0 billion total spending in DHS forecasted programs
- $6.0 billion state spending in DHS forecasted programs

Data for FY2020

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The second adjustment is due to lower than expected utilization of services within both medical and non-medical forecasted programs. When restrictions such as stay-at-home orders and closure of many services were put in place this spring, preventive and elective health care utilization practically ceased. Even with an easing of these restrictions during the summer months, actual health care utilization remained far below projected levels. In MA Fee-for-Service (FFS), low utilization has resulted in a much lower average cost of FFS claims, which is expected to remain low through FY2021 and not fully return to pre-COVID levels until FY2024. In managed care, reduced utilization generally results in savings to the health plans since the state pays fixed monthly capitations to the plans for enrollees' medical coverage. Due to the contractual requirement of the Minimum Medical Loss Ratio (MMLR) that health plans spend a minimum amount of capitations on medical services, it is expected that the state will take back a portion of the 2020 MA capitation payments. The forecast assumes that half of this rebate amount will be received in June 2021 with the remainder being received in June 2022. Outside MA, lower than expected utilization of chemical dependency services and sharply reduced demand for child-care result in forecast reductions in the Chemical Dependency Treatment Fund and Child Care Assistance Program (CCAP), primarily in the current biennium. Across all forecast programs, lower than expected utilization results in a projected General Fund reduction of $293 million (32%) in the current biennium and a reduction of $190 million (74%) in the next biennium.

The third adjustment is lower enrollment, primarily in MA. The primary reason for this decline is a base adjustment due to actual enrollment during the COVID-19 pandemic falling significantly short of enrollment projected in the May Interim Budget Projection. In May, large projected enrollment increases resulted from both the COVID recession and fiscal notes for the Executive Orders providing continuous coverage as a requirement to receive enhanced federal funding. Updated enrollment data indicates that the COVID recession impacts were reasonably accurate, but the fiscal notes overstated the impact of the Executive Orders on enrollment growth. The November forecast reflects downward adjustments to these fiscal notes, which reduces enrollment mainly in the current biennium. Much of the enrollment reduction in the next biennium is due to a projected economic scenario that is now more optimistic relative to the assumed economic scenario back in May. Overall, lower enrollment results in a projected General Fund reduction of $203 million (22%) in the current biennium and a reduction of $119 million (46%) in the next biennium.

The projected change in HCAF spending is the result of increased federal Basic Health Program (BHP) funding which, in turn, reduces the need for state HCAF funding. The increased federal BHP funding is due to the addition of the Premium Adjustment Factor (PAF) in the federal BHP Payment Methodology for CY2021 and CY2022. This adds approximately $155 million in federal BHP funding over the forecast horizon, which explains almost the entire projected HCAF reduction.

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Summary of forecast changes

The following is a list of the large and/or noteworthy changes in this forecast. Further detail for each change can be found on the specific budget activity pages noted below.

Forecast Decreases:

- Extension of the Public Health Emergency (PHE) from January through June 2021. (All budget activity pages)
- Low utilization of medical and child care services. (MA Elderly and Disabled Basic Care; MA Adults without Children Basic Care; MA Families with Children Basic Care; Chemical Dependency Treatment Fund; Child Care Assistance Program)
- Lower than expected enrollment. (MA Elderly and Disabled Basic Care; MA Adults without Children Basic Care; MA Families with Children Basic Care; Housing Support)
- Increased federal BHP funding due the addition of the Premium Adjustment Factor (PAF) in CY2021 and CY2022. (MinnesotaCare)
- Increased MA pharmacy rebates due to a one-time invoicing of additional historical pharmacy claims based on a federal audit. (MA Families with Children Basic Care)
- Increased federal funding due to statutory FMAP rate increase from 50.00% to 50.51%. (Medical Assistance: Total Program)

Forecast Increases:

- Disability waiver average cost increases. (MA Long-Term Care: Waivers and Home Care)
- Electronic Visit Verification (EVV) FMAP penalty and delay. (MA Long-Term Care: Waivers and Home Care)

FY2022 and FY2023 Forecasted Expenditures

	FY 2022		FY 2023	
Program	**Total Dollars**	**State Share**	**Total Dollars**	**State Share**
Medical Assistance (MA)	16,032,484,218	6,689,103,493	16,299,579,302	6,843,759,069
LTC Facilities	1,349,684,380	633,338,506	1,436,910,663	672,435,202
LTC Waivers	4,785,708,255	2,337,797,091	5,189,487,545	2,493,119,247
Elderly and Disabled Basic Care[1]	3,432,091,814	1,705,810,772	3,618,715,493	1,783,406,267
Adults without Children Basic Care	2,666,402,230	267,203,783	2,414,041,444	242,028,565
Families with Children Basic Care[2]	3,798,597,538	1,744,953,340	3,640,424,158	1,652,769,788
MinnesotaCare	616,462,996	198,837,908	619,932,025	179,268,686
Chemical Dependency Treatment Fund	220,447,825	106,796,993	250,680,316	123,468,007
Minnesota Family Investment Program (MFIP)[3]	319,197,447	95,108,910	303,871,680	93,702,923
MFIP/TY Child Care Assistance	205,898,238	103,588,719	212,330,395	110,618,876
Northstar Care for Children	267,908,491	113,028,934	290,084,935	121,196,464
General Assistance	52,866,546	52,866,546	52,819,271	52,819,271
Housing Support	184,536,398	182,536,398	191,610,573	189,610,573
Minnesota Supplemental Aid	51,581,687	51,581,687	52,515,278	52,515,278
Total	17,951,383,846	7,593,449,589	18,273,423,776	7,766,959,147

1 Includes Elderly Waiver managed care

2 Includes family planning, breast and cervical cancer coverage, pharmacy rebates, special funding items and adjustments

3 Includes cash and food assistance

Medical Assistance

Medical Assistance (MA), Minnesota's Medicaid program, provides preventive and primary health care coverage for low-income Minnesotans. MA has lower income eligibility guidelines and has no premiums, which differentiates it from the state's other health care program, MinnesotaCare. Additionally, MA can pay for nursing facility care for older adults and intermediate care facilities for people with developmental disabilities. It can also cover long-term care services and supports for people with disabilities and older adults so that they can continue living in the community.

Minnesota receives federal matching funds for MA. By accepting matching funds, states are subject to federal Medicaid regulations. States have some flexibility in determining what services are covered, what groups are covered and payment rates to providers. The Minnesota Department of Human Services partners with all 87 Minnesota counties to administer the MA program and contracts with health plans and health care providers across the state to deliver basic health care to MA enrollees.

Medical Assistance is forecasted in five segments: Long-Term Care Facilities, Long-Term Care Waivers, Elderly and Disabled Basic Care, Adults without Children Basic Care and Families with Children Basic Care. Each of these segments is discussed in the following pages.

Who it serves

- 1.1 million average monthly enrollees

How much it costs

- $13.4 billion total spending
- $5.3 billion state funds

Data for FY2020

November 2020 forecast highlights

General Fund

Changes from the End-of-Session 2020 forecast

- Decrease of $848.2 million in 2020-2021 biennium (-7.2%)
- Decrease of $223.0 million in 2022-2023 biennium (-1.6%)

Health Care Access Fund

Changes from the End-of-Session 2020 forecast

- There are no changes to the HCAF share of MA in the November forecast.

Reasons: The General Fund MA forecast reduction is primarily the result of three downward adjustments due to the COVID-19 pandemic.

The first is an extension of the PHE from January 2021 through June 2021. This PHE extension provides additional federal funding through a 6.2 percentage point increase in the state's FMAP, which directly replaces General Fund expenditures. These state savings are partially offset by the cost of continuous coverage policies, enacted by Executive Order, which are required to claim the additional federal funds. The enhanced federal share results in about $332 million in projected MA savings for this 6-month PHE extension period. The administrative changes to comply with this federal MOE requirement leads to a projected cost of about $21 million in the current biennium with lagging costs of about $58 million in the next biennium. Overall, the 6-month PHE extension results in a projected MA General Fund reduction of $311 million (37%) in the current biennium and a cost of $58 million in the next biennium.

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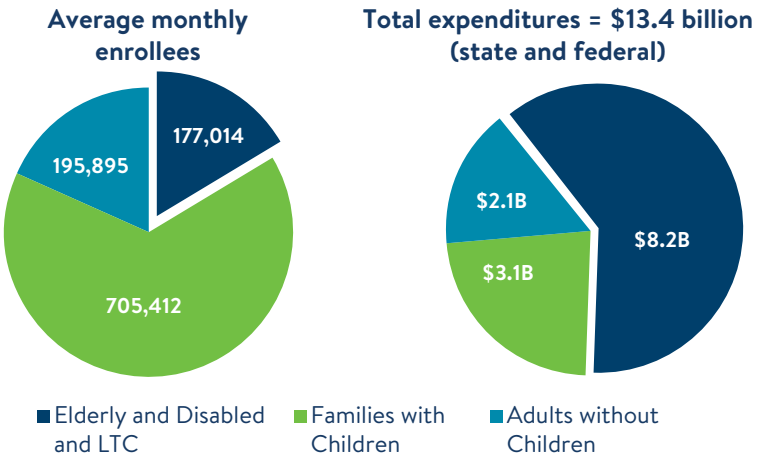
The second is due to lower than expected utilization of MA services. When COVID-19 led to massive restrictions this spring, preventive and elective care essentially ceased. Even with an easing of these restrictions during the summer months, actual health care utilization remained far below projected levels. In MA FFS, the utilization drop has resulted in significantly lower average claims cost because the reduction in health care utilization more than outweighed any increased costs incurred for COVID testing and treatment. The November forecast recognizes the current low FFS utilization levels, assumes this low utilization persists through FY2021, and projects average costs to slowly phase back up to pre-COVID levels over the next two years. In managed care, reduced utilization generally results in savings to the health plans since the state pays fixed monthly capitations to the plans for enrollees' medical coverage. Included in annual health plan contracts is a Minimum Medical Loss Ratio (MMLR) provision requiring health plans to spend a minimum percentage of capitations on medical services. If the plan fails to meet this minimum percentage, then it must rebate a portion of the capitations back to the state. Based on preliminary 2020 health plan financial data, the November forecast projects the state will take-back a portion of 2020 MA capitation payments under the MMLR. The forecast assumes that half of this rebate amount will be received in June 2021 with the remainder being received in June 2022. Lower than expected utilization of medical services accounts for about $217 million (26%) of the MA General Fund reduction in the current biennium and about $169 million (76%) in the next biennium.

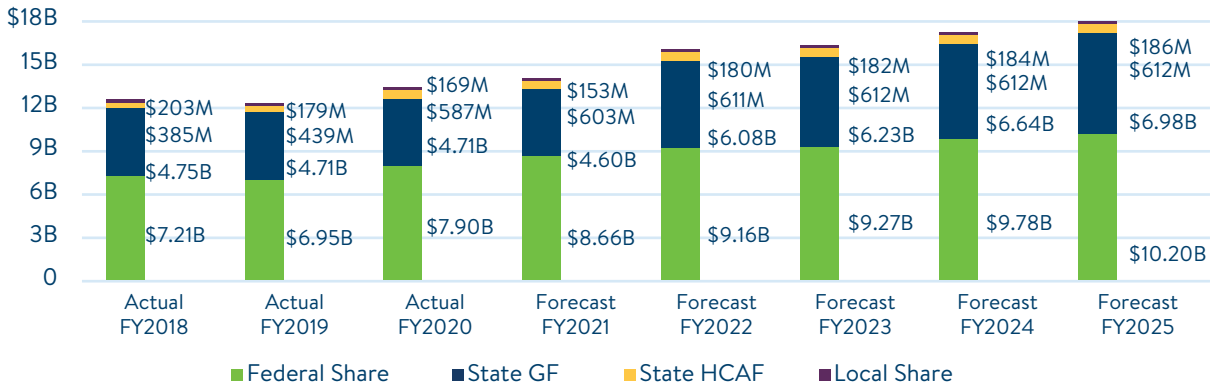
The third adjustment is lower enrollment. The May Interim Budget Update projected large enrollment increases from both the COVID recession and fiscal notes for the Executive Orders providing continuous coverage as a requirement to receive enhanced federal funding. Updated enrollment data now indicate the COVID recession impacts were reasonably accurate, but the fiscal notes overstated the impact of the Executive Orders on enrollment growth. The November forecast reflects downward adjustments to these fiscal notes, which reduces enrollment projections mainly in the current biennium. Much of the enrollment reduction in the next biennium is due to a projected economic scenario that is now more optimistic relative to the assumed economic scenario back in May. Lower enrollment accounts for about $188 million (22%) of the MA General Fund reduction in the current biennium and about $114 million (51%) in the next biennium.

Another noteworthy forecast change is that, effective October 2021, the statutory FMAP rate for MA will increase from 50.00% to 50.51%. The FMAP is the share of MA costs paid by the federal government and is determined based on state per capita income relative to the national average. The increase in FMAP produces a forecast reduction by directly replacing General Fund spending with federal funding. This statutory FMAP increase is separate from the enhanced 6.2 percentage point increase due to the PHE (discussed above). The forecast assumes the statutory FMAP increase is permanent, and this change is projected to reduce overall MA General Fund spending by $114 million in the next biennium.

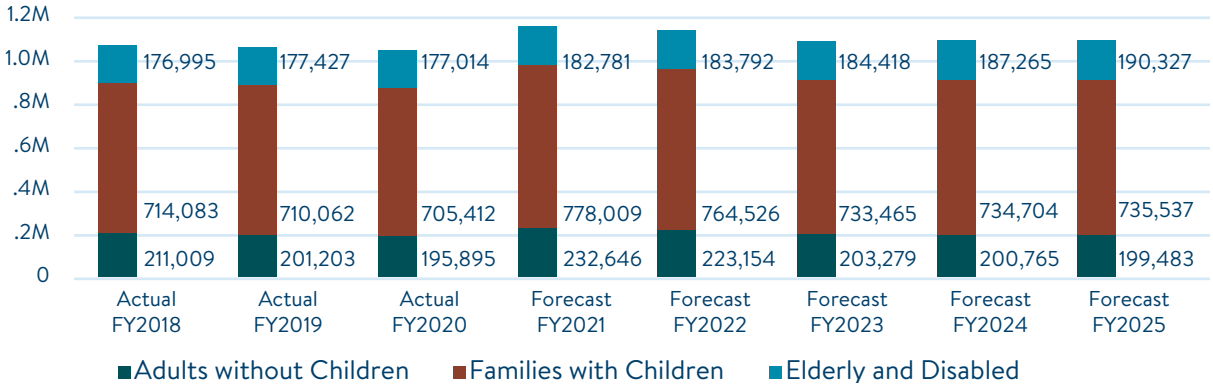
Medical Assistance Enrollment and Expenditures: FY2020



Total MA expenditures by fund



MA enrollment by eligibility category



Historical table

	Medical Assistance Program: Total Expenditures (All Funds)	
FY	Total $	% Change
2010	$7,235,667,652	
2011	7,530,059,117	4.07%
2012	8,241,120,196	9.44%
2013	8,045,603,494	(2.37%)
2014	9,265,114,945	15.16%
2015	10,584,571,411	14.24%
2016	11,225,214,682	6.05%
2017	10,888,487,327	(3.00%)
2018	12,548,729,798	15.25%
2019	12,280,201,965	(2.14%)
2020	13,370,645,488	8.88%
2021*	14,009,122,291	4.78%
2022*	16,032,484,218	14.44%
2023*	16,299,579,302	1.67%
2024*	17,220,198,522	5.65%
2025*	17,974,462,972	4.38%
Avg. Annual Increase 2010-2020		6.04%

**Projected*

Beginning in FY2011 there are managed care payment delays from odd years to even years which impact the annual percent change.

Medical Assistance Long-Term Care: Facilities

Medical Assistance pays for long-term care services for people who live in facilities that provide 24-hour care and supervision. Nursing facilities across Minnesota provide all-inclusive packages of services including nursing care, help with activities of daily living, medication administration, meals and housing. Care provided under this segment of MA also includes intermediate care facilities and day training and habilitation for people with developmental disabilities.

Alternative Care

The Alternative Care (AC) waiver provides home and community based services for people age 65 and older at risk of Nursing Facility placement who do not currently meet financial eligibility requirements for MA, but would be expected to spend down to MA eligibility within 135 days after entering a Nursing Facility. The state share of AC is financed through a fixed appropriation with unspent funds canceling to MA.

Who it serves

- 15,000 average monthly recipients

How much it costs

- $1.2 billion total spending
- $528 million state funds

Data for FY2020

November 2020 forecast highlights

General Fund

Changes from the End-of-Session 2020 forecast

- Decrease of $91.1 million in 2020-2021 biennium (-8.5%)
- Decrease of $41.8 million in 2022-2023 biennium (-3.2%)

Reasons: The May Interim Budget Projections recognized significant increases in payments to nursing facilities in the current and next biennium due to COVID-19 related costs. This forecast adjusts those impacts for the low take-up of requests for immediate reimbursement of pandemic costs under Minnesota Statutes section 12A, accounting for a 4% reduction of the nursing facility forecast in this biennium. The forecast still assumes that nursing facilities are incurring pandemic related costs that will result in higher MA rates in the future, but reduces the level of those reportable costs while also assuming they will occur for a longer time period. Compared to the previous forecast, this results in a net decrease of 2% in the next biennium. In addition, Intermediate Care Facilities (ICF)'s caseloads are adjusted downward about 5% due to data trends that appear to have been in place before the pandemic and have continued through early FY2021. Increased federal funding from enhanced FMAP during the PHE extension and the ongoing statutory FMAP increase to 50.51% in October 2021 results in further decreases in the General Fund forecast in the current and the next biennium. Extending the PHE accounts for about $33 million (36%) of the MA Long-Term Care: Facilities forecast reduction.

Medical Assistance Long-Term Care: Waivers and Home Care

Medical Assistance also pays for people to receive long-term care waivers, long-term care services and supports, or home care services in their homes and communities. Long-Term Care waivers, also known as Home and Community-Based Services (HCBS) waivers, are an alternative for people who need long-term care services but who do not choose to live in a nursing facility, intermediate care facility or hospital. The federal government allows states to apply for long-term care waivers, which provide a variety of services that help people live in the community instead of in a facility or institution. Waivers include the Elderly Waiver (EW) and the four disability waivers: Developmental Disabilities (DD), Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC) and Brain Injury (BI). Care provided under this segment of MA also includes Personal Care Assistance (PCA), Home Care Nursing, Housing Stabilization Services and Home Health Agency.

Who it serves

- 74,700 average monthly recipients

How much it costs

- $4.0 billion total spending
- $1.9 billion state funds

Data for FY2020

November 2020 forecast highlights

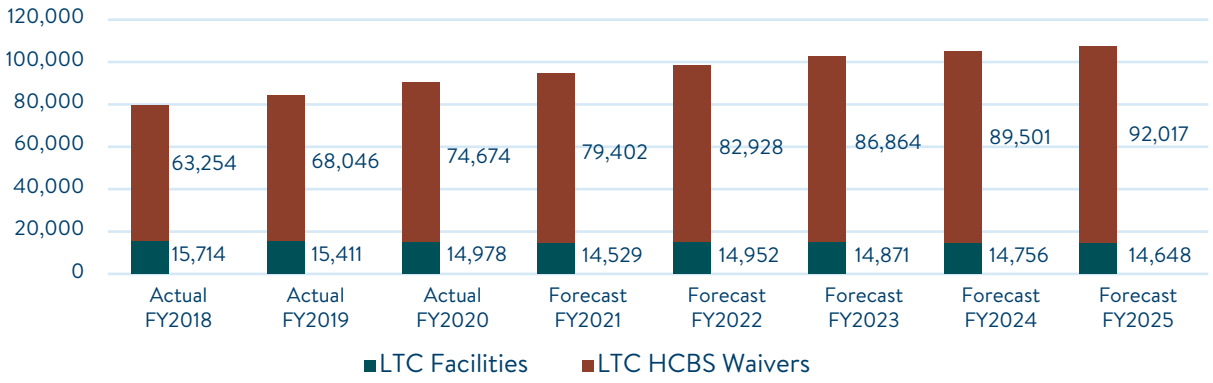
General Fund

Changes from the End-of-Session 2020 forecast

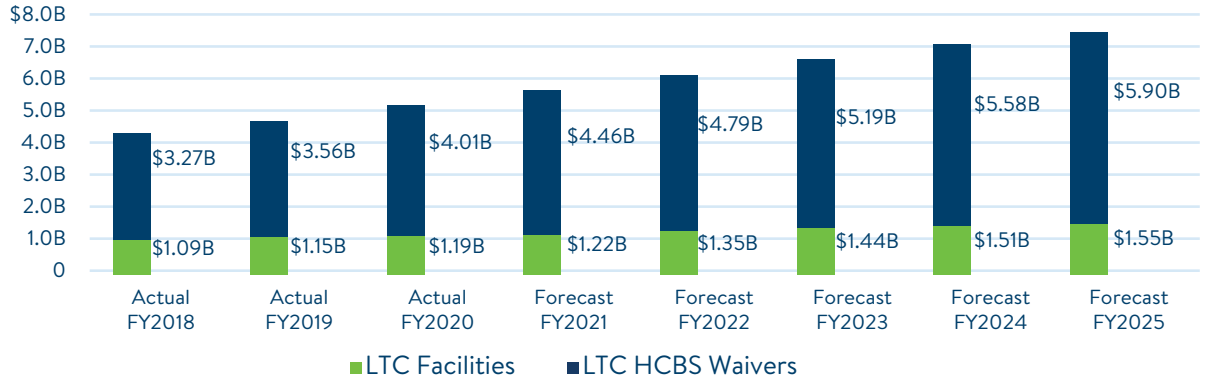
- Decrease of $142.8 million in 2020-2021 biennium (-3.5%)
- Increase of $73.0 million in 2022-2023 biennium (+1.5%)

Reasons: Increased federal funding from enhanced FMAP during the PHE extension is the primary driver of the forecast decrease this biennium. Extending the PHE results in a $155 million forecast reduction in MA Long-Term Care: Waivers and Home Care. Projected average payment increases in the CADI, CAC and BI waivers partially offset the forecast reduction this biennium and they are the largest driver of the forecast increase in the next biennium. CADI average payments are increased 5-7% based on data trends that were in place before the pandemic. The CADI caseload is also adjusted upward about 2.8% in the next biennium while other waivers have small decreases. The DD and PCA average payment forecasts are adjusted downward 1-2% based on recent data. This forecast also recognizes an expected FMAP penalty beginning January 1, 2021, because the state has not yet implemented Electronic Visit Verification (EVV) for PCA and similar services. The penalty is 0.5% in CY2021, increases to 0.75% in CY2022, and is expected to apply to only PCA and services for which EVV is required. This penalty is expected to be in effect until January 2023 due to an additional 9-month delay in EVV implementation.

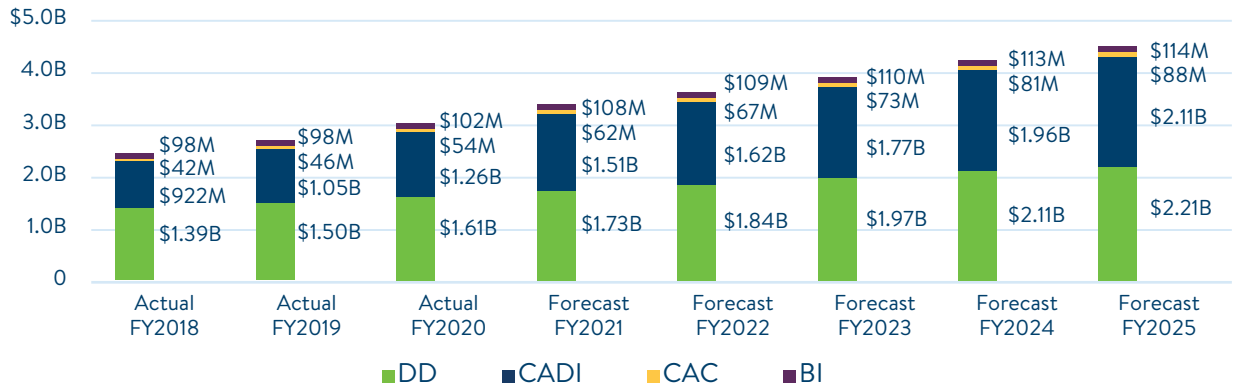
Long-term care facilities and waivers: Average monthly recipients



Long-term care facilities and waivers expenditures — all funds



Disability waivers expenditures — all funds



Historical Table

	A: Long Term Care (LTC) Facilities		B: LTC Waivers (Home & Community Based Services)		A + B = Total LTC	
FY	Total $	% Change	Total $	% Change	Total $	% Change
2010	$1,000,836,209		$2,053,318,327		$3,054,154,537	
2011	964,666,727	(3.61%)	2,179,651,151	6.15%	3,144,317,878	2.95%
2012	945,566,280	(1.98%)	2,223,655,096	2.02%	3,169,221,376	0.79%
2013	920,580,121	(2.64%)	2,260,064,090	1.64%	3,180,644,211	0.36%
2014	928,436,824	0.85%	2,446,905,605	8.27%	3,375,342,429	6.12%
2015	924,087,037	(0.47%)	2,797,274,346	14.32%	3,721,361,383	10.25%
2016	974,634,622	5.47%	2,878,037,420	2.89%	3,852,672,043	3.53%
2017	1,078,833,590	10.69%	3,040,609,756	5.65%	4,119,443,345	6.92%
2018	1,087,985,308	0.85%	3,270,556,814	7.56%	4,358,542,122	5.80%
2019	1,154,228,650	6.09%	3,558,835,259	8.81%	4,713,063,909	8.13%
2020	1,190,569,963	3.15%	4,009,994,313	12.68%	5,200,564,275	10.34%
2021*	1,221,478,151	2.60%	4,463,875,459	11.32%	5,685,353,610	9.32%
2022*	1,349,684,380	10.50%	4,785,708,255	7.21%	6,135,392,635	7.92%
2023*	1,436,910,663	6.46%	5,189,487,545	8.44%	6,626,398,208	8.00%
2024*	1,507,754,423	4.93%	5,582,544,073	7.57%	7,090,298,497	7.00%
2025*	1,554,477,522	3.10%	5,897,104,221	5.63%	7,451,581,744	5.10%
Avg. Annual Increase 2010-2020		1.75%		6.92%		5.47%

**Projected*

Medical Assistance Basic Care:
Elderly and Disabled

This program covers general medical care for elderly and disabled Medical Assistance enrollees. People eligible to receive basic care services are 65 years or older, blind or have a disability. Their income and assets must also fall below allowable limits. For almost all of the elderly and for about 50 percent of the disabled who have Medicare coverage, Medical Assistance acts as a Medicare supplement paying premiums and cost sharing. For those who are not eligible for Medicare, Medical Assistance pays for all their medical care. Also included in this segment are MA enrollees who are residents in an Institute for Mental Disease (IMD). Covered services for these individuals would be eligible for federally- matched MA if they did not reside in a facility which is designated by federal regulations as an IMD. Being a resident in an IMD makes covered services for these individuals ineligible for federal matching. Elderly Waiver managed care is also included in this section because it is paid as an add-on to the Elderly Basic Care capitation payment.

Who it serves

- 177,000 average monthly enrollees

How much it costs

- $3.0 billion total spending
- $1.4 billion state funds

Data for FY2020

November 2020 forecast highlights

General Fund

Changes from the End-of-Session 2020 forecast

- Decrease of $232.7 million in 2020-2021 biennium (-6.6%)
- Decrease of $116.1 million in 2022-2023 biennium (-2.8%)

Reasons: As described in the overall MA section, the forecast reduction for MA Elderly and Disabled Basic Care is primarily the result of three downward adjustments due to the COVID-19 pandemic.

The first is an extension of the PHE from January 2021 through June 2021. This PHE extension provides additional federal funding through a 6.2 percentage point increase in the state's FMAP, which directly replaces General Fund expenditures. These state savings are partially offset by the cost of continuous coverage policies, enacted by Executive Order, which are required to claim the additional federal funds. Increased federal funding is projected to exceed the cost of continuous coverage in the current biennium and accounts for about $62 million (27%) of the MA Elderly and Disabled reduction. In the next biennium, with no enhanced federal funding, the cost of continuous coverage for MA Elderly and Disabled is about $24 million.

The second is lower than expected utilization of medical services. This low utilization results in reduced average cost of FFS claims and, for enrollees on managed care, financial rebates from the health plans based on projected medical services spending below the required MMLR. Overall, lower than expected utilization of medical services accounts for about $78 million (34%) of the MA Elderly and Disabled reduction in the current biennium and about $63 million (54%) in the next biennium.

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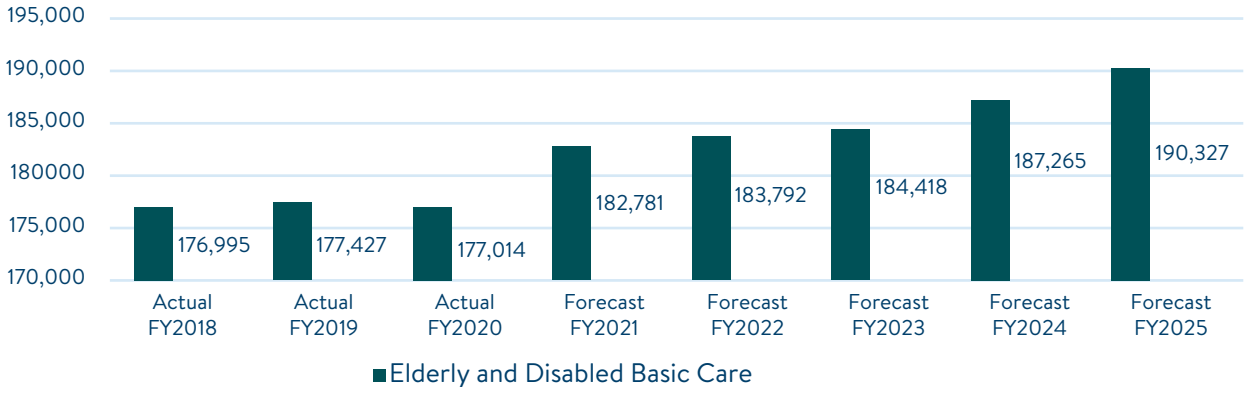
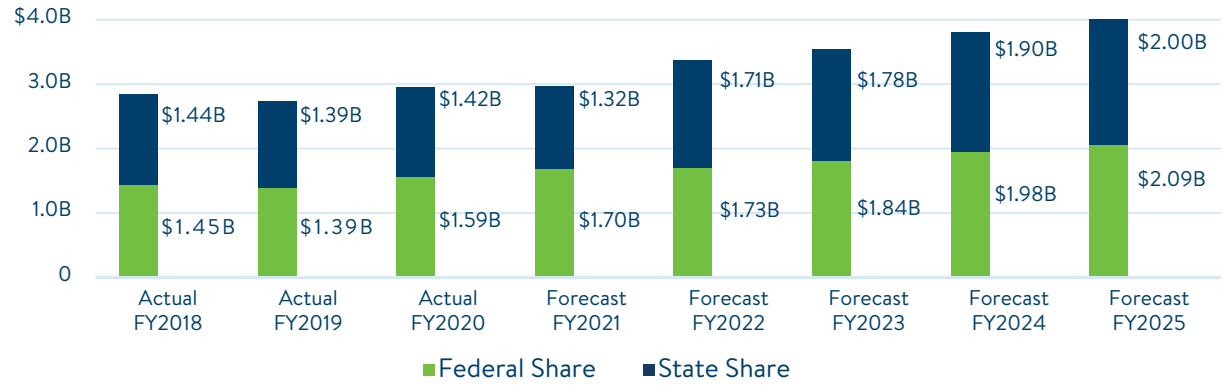
The third adjustment is lower enrollment. The November forecast reflects downward adjustments to prior fiscal notes projecting enrollment growth due to continuous coverage provisions during the pandemic. This reduces enrollment mainly in the current biennium. An improving labor market does not impact MA Elderly and Disabled enrollment as much as the other two basic care eligibility populations. This leads to a relatively small enrollment reduction in the next biennium. Lower enrollment accounts for about $56 million (24%) of the MA Elderly and Disabled reduction in the current biennium and about $14 million (12%) in the next biennium.

Another significant factor in the MA Elderly and Disabled forecast reduction in the current biennium is lower projected federal Part D clawback payments. Beginning in 2006, the Medicare benefit set expanded to include prescription drug coverage. For dual eligibles (i.e. elderly or disabled individuals enrolled in both Medicaid and Medicare), prescription drug coverage had previously been provided through Medicaid with federal and state shares. To help pay for this expanded Medicare coverage, the federal government bills each state an amount roughly equal to what the state would have paid if prescription drug coverage were still provided through Medicaid for dual eligibles. These payments from states to the federal government are known as Part D clawback payments. The PHE extension in the November forecast provides additional quarters of enhanced FMAP. The enhanced FMAP reduces the per-person Part D clawback charge rate which, in turn, results in a reduction in federal clawback payments. Lower clawback payments accounts for about $36 million (16%) of the MA Elderly and Disabled reduction in the current biennium.

Elderly and Disabled Basic Care: Average monthly enrollees



Elderly and Disabled Basic Care expenditures



Historical table

	Elderly & Disabled Basic Care	
FY	Total $	% Change
2010	$2,002,677,746	
2011	2,010,217,822	0.38%
2012	2,118,181,376	5.37%
2013	2,087,793,116	(1.43%)
2014	2,500,339,126	19.76%
2015	2,343,980,418	(6.25%)
2016	2,580,811,749	10.10%
2017	2,525,666,619	(2.14%)
2018	2,894,549,433	14.61%
2019	2,780,093,762	(3.95%)
2020	3,011,306,799	8.32%
2021*	3,026,493,812	0.50%
2022*	3,432,091,814	13.40%
2023*	3,618,715,493	5.44%
2024*	3,885,520,844	7.37%
2025*	4,083,941,590	5.11%
Avg. Annual Increase 2010-2020		3.97%

**Projected*

Beginning in FY2011 there are managed care payment delays from odd years to even years which impact the annual percent change.

Medical Assistance Basic Care:
Adults without Children

In March 2011, Minnesota elected to implement the early expansion of MA eligibility for Adults without Children with income up to 75% of the federal poverty level under the Affordable Care Act. In January 2014, Minnesota implemented full expansion of MA eligibility up to 138% of the federal poverty level for this population. Currently, at 138% federal poverty levels, the income eligibility limit for a single adult to be covered under this program is $17,609 per year.

As Minnesota's newly eligible expansion population under the Affordable Care Act, this segment of MA received 100% federal match from Calendar Year (CY) 2014 through CY2016. Beginning in CY2017, the federal match rate stepped down each year until it hit 90% in CY2020. This now becomes the ongoing fixed federal match rate for this expansion population.

Who it serves

- 196, 000 average monthly enrollees

How much it costs

- $2.1 billion total spending
- $166 million state funds

Data for FY2020

November 2020 forecast highlights

General Fund

Changes from the End-of-Session 2020 forecast

- Decrease of $48.1 million in 2020-2021 biennium (-11.3%)
- Decrease of $8.5 million in 2022-2023 biennium (-1.7%)

Reasons: The forecast reduction for MA Adults without Children Basic Care is primarily the result of two downward adjustments due to the COVID-19 pandemic. Since federal funding for this expansion population is fixed at 90%, there is no additional federal funding due to the PHE. As a result, the PHE extension in the November forecast only results in relatively small costs for continuous coverage of Adults without Children. These costs are about $3 million in the current biennium and about $6 million in the next biennium.

As described in the overall MA section, lower than expected utilization of medical services reduces projected spending on MA Adults without Children. This low utilization results in reduced average cost of FFS claims and, for enrollees on managed care, financial rebates from the health plans based on projected medical services spending below the required MMLR. Overall, lower than expected utilization of medical services accounts for about $26 million (54%) of the MA Adults without Children reduction in the current biennium and about $21 million in the next biennium.

Lower enrollment also reduces projected spending on MA Adults without Children. The November forecast reflects downward adjustments to prior fiscal notes projecting enrollment growth due to continuous coverage provisions during the pandemic. This reduces enrollment mainly in the current biennium. Much of the enrollment reduction in the next biennium is due to a

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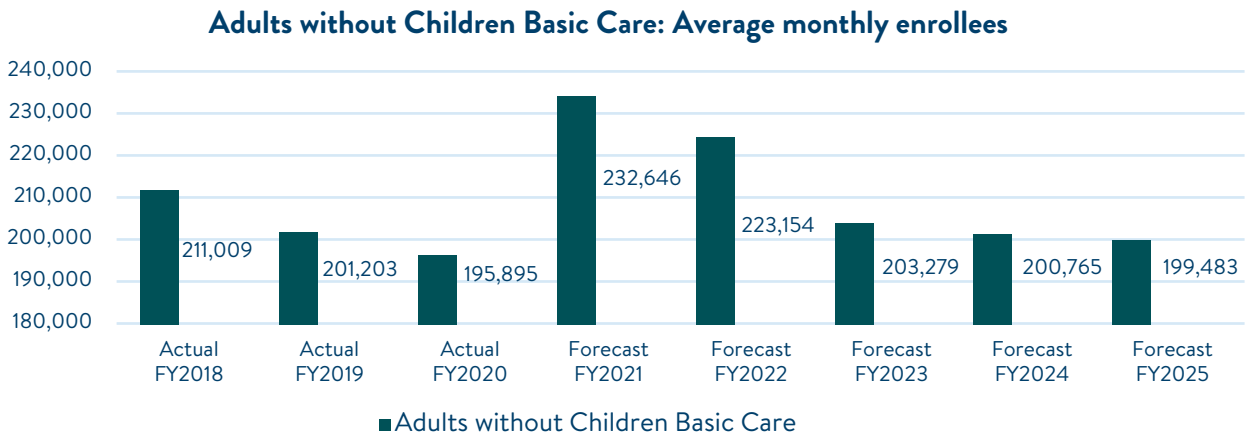
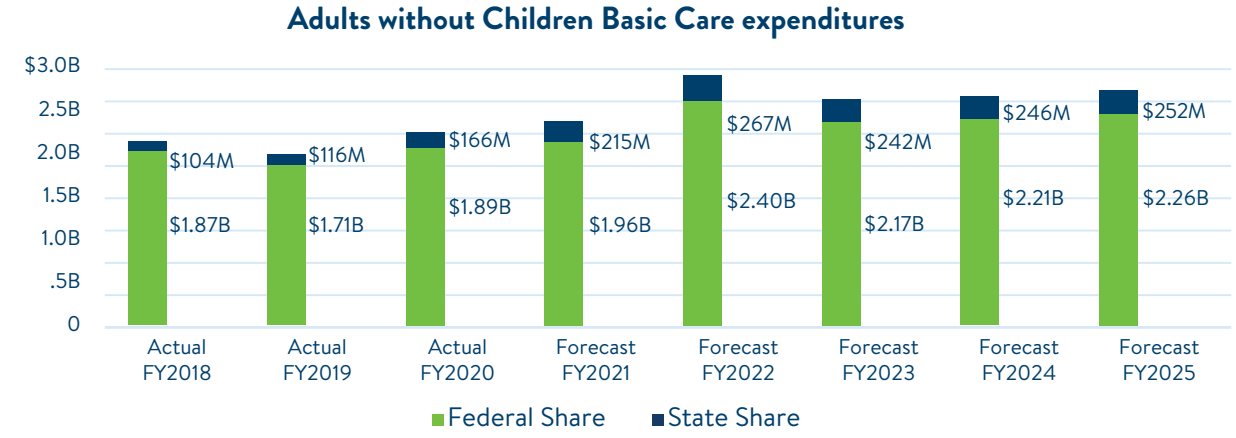
projected economic scenario that is now more optimistic relative to the assumed economic scenario back in May. Lower enrollment accounts for about $30 million (63%) of the MA Adults without Children reduction in the current biennium and about $22 million in the next biennium.

Offsetting these projected reductions are CY2021 managed care rates that are higher than expected. Actual CY2021 rates are about 10.4% higher than CY2020 rates while the assumed trend for these annual rate changes is 3%. The relatively high rates are the result of higher than expected pre-COVID trends, higher than expected actual health plan costs in 2019, and a continually high pharmacy trend. While the unexpected 2019 costs and trend appear to be a nationwide phenomenon, their causes are not yet completely known. The higher managed care rates cost about $5 million in current biennium and about $30 million in the next biennium.





Historical Table

	Adults without Children Basic Care	
FY	Total $	% Change
2011	$106,865,468	
2012	819,539,240	666.89%
2013	792,232,465	(3.33%)
2014[1]	1,063,752,126	34.27%
2015	1,694,519,567	59.30%
2016	1,658,897,539	(2.10%)
2017	1,756,135,556	5.86%
2018	1,970,490,317	12.21%
2019	1,823,780,554	(7.45%)
2020	2,060,499,313	12.98%
2021*	2,174,501,198	5.53%
2022*	2,666,402,230	22.62%
2023*	2,414,041,444	(9.46%)
2024*	2,454,069,885	1.66%
2025*	2,514,063,681	2.44%
Avg. Annual Increase 2012-2020		11.36%

**Projected*

1 2014 and 2015 reflect increases due to implementation of full expansion for this population

Beginning in FY2011 there are managed care payment delays from odd years to even years which impact the annual percent change.

Medical Assistance Basic Care:
Families with Children

This activity funds general medical care for children, parents and pregnant women, including families receiving Minnesota Family Investment Program (MFIP) and those with transition coverage after exiting MFIP. This segment also includes funding for Family Planning Services and for Breast and Cervical Cancer coverage. This segment also includes non-citizens who are ineligible for federal Medicaid match, but almost all of whom are eligible for enhanced federal Children's Health Insurance Program (CHIP) funding.

Enhanced federal CHIP funding is also available for children with family income over 133% of the federal poverty level. This funding supplements the regular 50% Medicaid match with an additional enhanced federal match, within the limits of Minnesota's CHIP allocation from the federal government.

Who it serves

- 705,400 average monthly enrollees

How much it costs

- $3.1 billion total spending
- $1.3 billion state funds

Data for FY2020

November 2020 forecast highlights

General Fund

Changes from the End-of-Session 2020 forecast

- Decrease of $333.4 million in 2020-2021 biennium (-12.0%)
- Decrease of $129.7 million in 2022-2023 biennium (-3.8%)

Reasons: As described in the overall MA section, the forecast reduction for MA Families with Children Basic Care is primarily the result of three downward adjustments due to the COVID-19 pandemic.

The first is an extension of the PHE from January 2021 through June 2021. This PHE extension provides additional federal funding through a 6.2 percentage point increase in the state's FMAP, which directly replaces General Fund expenditures. These state savings are partially offset by the cost of continuous coverage policies, enacted by Executive Order, which are required to claim the additional federal funds. Increased federal funding is projected to exceed the cost of continuous coverage in the current biennium and accounts for about $64 million (19%) of the MA Families with Children reduction. In the next biennium, with no enhanced federal funding, the cost of continuous coverage for MA Families with Children is about $36 million.

The second is lower than expected utilization of medical services. This low utilization results in reduced average cost of FFS claims and, for enrollees on managed care, financial rebates from the health plans based on projected medical services spending below the required MMLR. Overall, lower than expected utilization of medical services accounts for about $113 million (34%) of the MA Families with Children reduction in the current biennium and about $84 million (65%) in the next biennium.

The third adjustment is lower enrollment. The November forecast reflects downward adjustments to prior fiscal notes projecting

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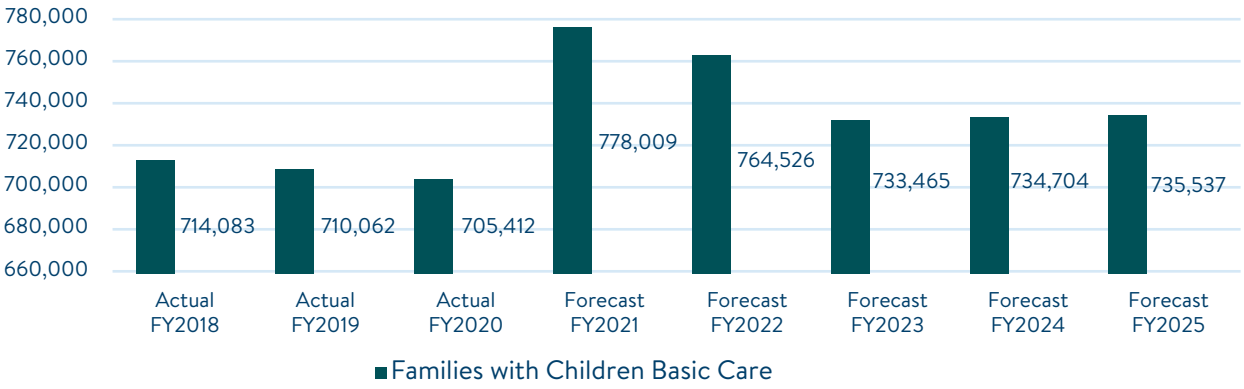
enrollment growth due to continuous coverage provisions during the pandemic. This reduces enrollment mainly in the current biennium. Much of the enrollment reduction in the next biennium is due to a projected economic scenario that is now more optimistic relative to the assumed economic scenario back in May. Lower enrollment accounts for about $101 million (30%) of the MA Families with Children reduction in the current biennium and about $78 million (60%) in the next biennium.

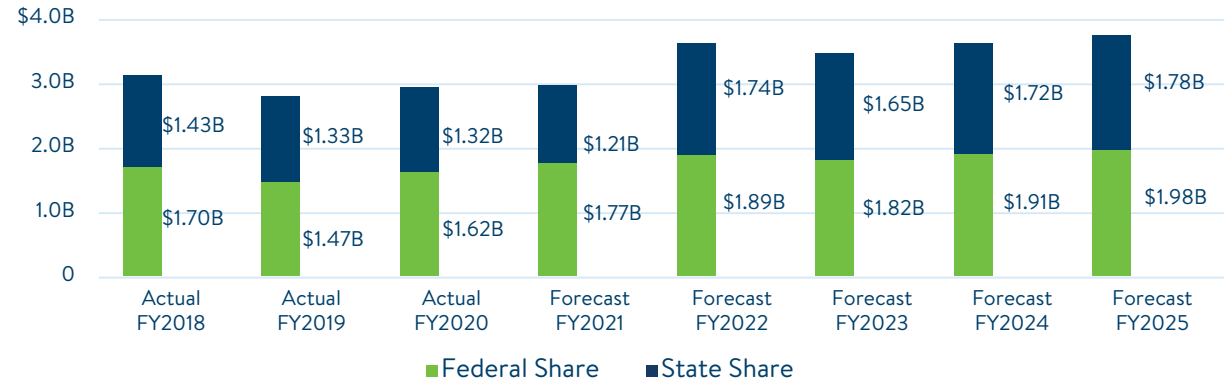
Another significant factor in the MA Families with Children forecast reduction in the current biennium is higher pharmacy rebates. In working with the federal Office of the Inspector General (OIG), the department identified a universe of claims that had not been billed to the drug manufacturers but were eligible for rebates. In the first half of FY2020, the department resolved the system issue that prevented these claims from going through the rebating process and invoiced the drug manufacturers for the outstanding drug rebates. The rebates on these additional claims were primarily received during the second half of FY2020 with some being collected during the first quarter of FY2021. The increased pharmacy rebates account for about $74 million (22%) of the MA Families with Children forecast reduction in the current biennium. These additional pharmacy rebates are a one-time occurrence.

Similar to MA Adults without Children, CY2021 managed care rates for MA Families with Children are higher than expected and partially offset the above forecast reductions. Actual CY2021 rates are about 5.2% higher than CY2020 rates while the assumed trend for these annual rate changes is 3%. The relatively high rates are the result of higher than expected pre-COVID trends, higher than expected actual health plan costs in 2019, and a continually high pharmacy trend. While the unexpected 2019 costs and trend appear to be a nationwide phenomenon, their causes are not yet completely known. The higher managed care rates for Families with Children cost about $10 million in current biennium and about $65 million in the next biennium.

Families with Children Basic Care: Average monthly enrollees



Families with Children Basic Care expenditures



Historical table

	Families with Children Basic Care	
FY	Total $	% Change
2010	$2,178,835,369	
2011	2,268,657,949	4.12%
2012	2,134,178,204	(5.93%)
2013	1,984,933,703	(6.99%)
2014	2,325,681,264	17.17%
2015	2,824,710,042	21.46%
2016	3,132,833,352	10.91%
2017	2,487,241,806	(20.61%)
2018	3,325,147,926	33.69%
2019	2,963,263,740	(10.88%)
2020	3,098,275,101	4.56%
2021*	3,122,773,672	0.79%
2022*	3,798,597,538	21.64%
2023*	3,640,424,158	(4.16%)
2024*	3,790,309,296	4.12%
2025*	3,924,875,957	3.55%
Avg. Annual Increase 2010-2020		2.95%

**Projected*

Includes family planning, breast and cervical cancer coverage, pharmacy rebates, special funding items and adjustments

Beginning in FY2011 there are managed care payment delays from odd years to even years which impact the annual percent change.

MinnesotaCare

MinnesotaCare provides health care coverage for low-income parents and adults without children who have higher income than those served on the Medical Assistance program as well as legal noncitizens who are ineligible for MA. Unlike MA, MinnesotaCare requires enrollee premiums and does not include coverage for long-term care services or supports.

Effective January 2015, MinnesotaCare operates as the state's Basic Health Program (BHP). As a BHP, MinnesotaCare no longer receives federal funding in the form of a percentage expenditure match. Instead, the state receives a per person subsidy equal to 95% of the premium tax credits each BHP enrollee would have received through MNsure had the state opted against running a BHP.

MinnesotaCare also provides state-only funded coverage for people with Deferred Action for Childhood Arrivals (DACA) status and certain elderly individuals who do not qualify for Medicare and are not MA or BHP eligible. Overall, MinnesotaCare is funded with a mix of enrollee premiums, Health Care Access Fund (HCAF) appropriations, and federal BHP funds (for the BHP eligible population).

Who it serves

- 78,000 average monthly enrollees

How much it costs

- $453 million total spending
- $26 million state funds

Data for FY2020

November 2020 forecast highlights

Health Care Access Fund

Changes from the End-of-Session 2020 forecast

- Decrease of $95.5 million in 2020-2021 biennium (-62.2%)
- Decrease of $66.7 million in 2022-2023 biennium (-15.0%)

Reasons: The HCAF forecast savings across both biennia primarily results from increased federal BHP funding which, in turn, reduces the need for state HCAF funding. The increased federal BHP funding is due to the addition of the Premium Adjustment Factor (PAF) in the federal funding formula for CY2021 and CY2022. The PAF resulted from a 2018 federal administrative order following a lawsuit over CMS' decision to stop funding the Cost Sharing Reduction (CSR) formula in the federal BHP Payment Methodology. At the time, this administrative order specifically did not address what factors would be included in the funding formula in future years. Due to ongoing uncertainty around this new factor, the BHP forecast has only assumed federal funding from the PAF once CMS has published a BHP Payment Methodology that includes the PAF in the funding formula. Since the previous forecast, both the final CY2021 and proposed CY2022 BHP Payment Methodologies have appeared in the Federal Register and both years contain the PAF. Two more years of this factor adds approximately $155 million in federal BHP funding over the forecast horizon, which explains almost the entire projected HCAF reduction.

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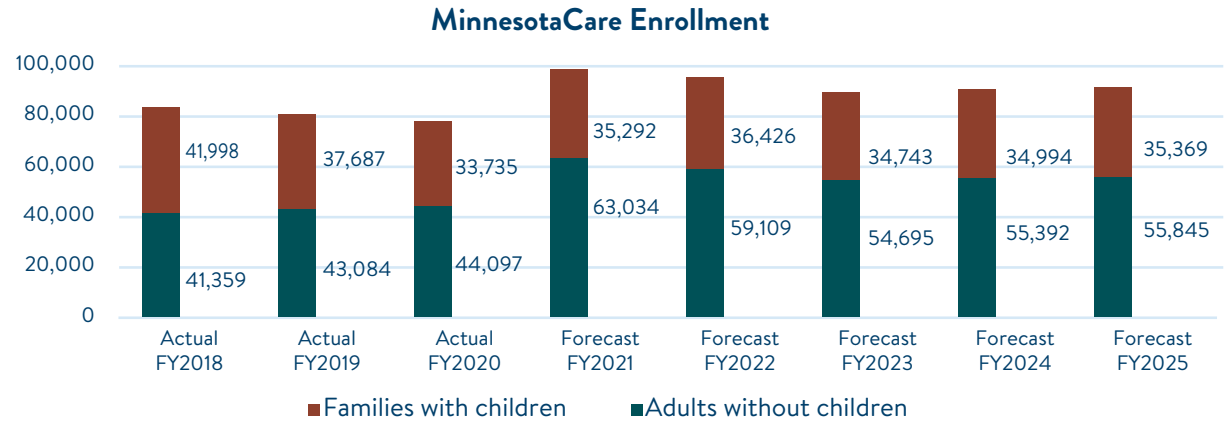
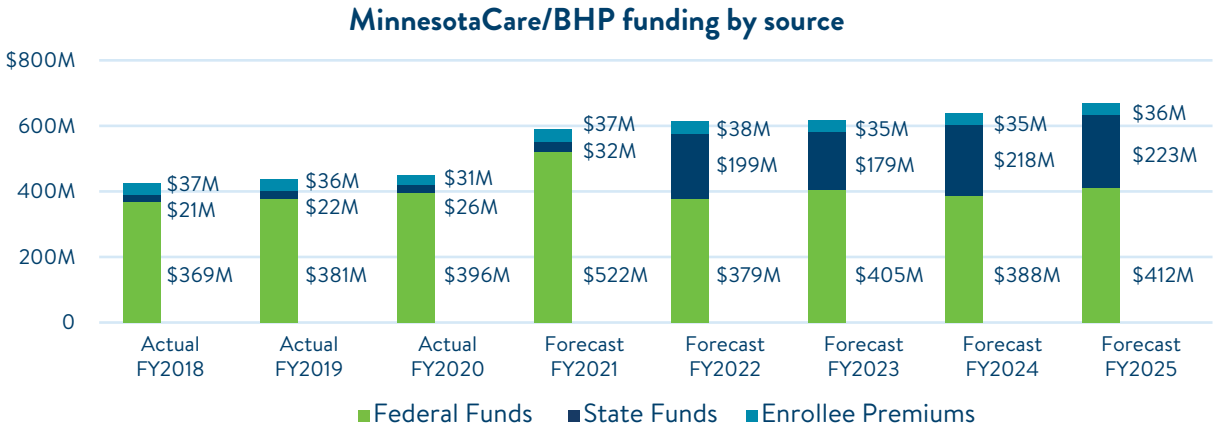
The remaining HCAF reduction is the result of lower than expected utilization of medical services. The low utilization produces expected financial rebates from the health plans based on projected medical services spending below the MMLR for MinnesotaCare enrollees. Projected rebates from the health plans account for about $15 million of the HCAF reduction in each of the current biennium and the next biennium.

Since federal BHP funding is a per-person amount based on the BHP Payment Methodology, there is no additional federal funding due to the PHE. As a result, the PHE extension in the November forecast only results in relatively small lagging HCAF costs for BHP enrollees of about $5 million in the next biennium.





Historical table

	MinnesotaCare Total Expenditures	
FY	Total $	% Change
2010	$665,498,191	
2011	737,952,071	10.89%
2012	551,090,615	(25.32%)
2013	569,928,239	3.42%
2014	520,005,344	(8.76%)
2015	509,709,341	(1.98%)
2016	479,909,046	(5.85%)
2017	397,211,084	(17.23%)
2018	426,581,871	7.39%
2019	438,234,552	2.73%
2020	452,643,878	3.29%
2021*	591,423,130	30.66%
2022*	616,462,996	4.23%
2023*	619,932,025	0.56%
2024*	641,523,155	3.48%
2025*	671,013,396	4.60%
Avg. Annual Decrease 2010-2020		(3.78%)

**Projected*

Chemical Dependency Treatment Fund

The Chemical Dependency (CD) Treatment Fund pays for residential and outpatient substance use disorder treatment services for eligible low-income Minnesotans. To access treatment services paid by the fund, individuals must first be assessed for treatment need and meet financial eligibility guidelines similar to those for Medical Assistance. As part of substance use disorder reform efforts passed in the 2017 legislature, the State is currently transitioning from the previous system of counties and tribes providing "Rule 25" assessments and authorizing treatment, to offering "direct access to treatment," where qualified treatment providers provide comprehensive assessments to determine medical necessity.

Who it serves

- 7,100 average monthly recipients

How much it costs

- $184 million total spending
- $108 million state funds

Data for FY2020

November 2020 forecast highlights

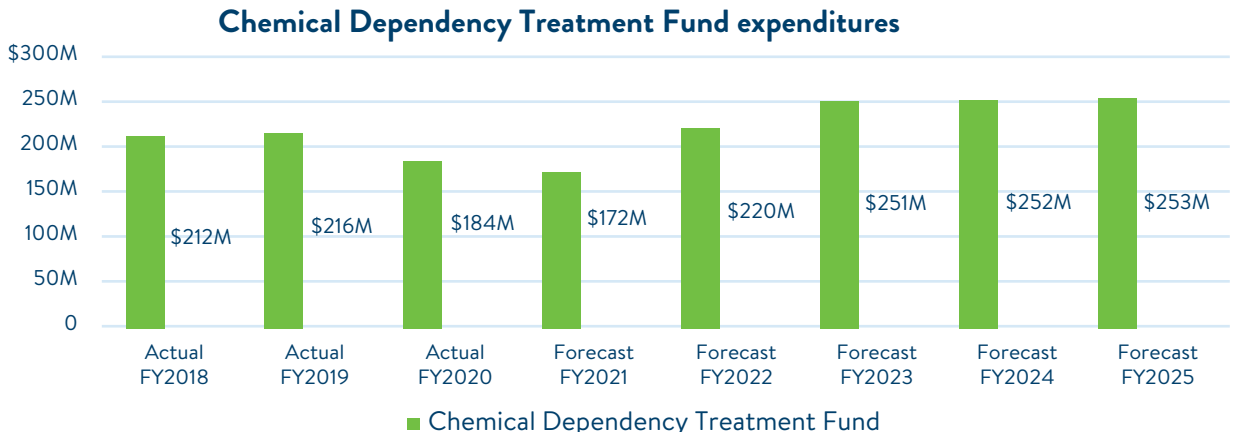
General Fund

Changes from the End-of-Session 2020 forecast

- Decrease of $55.4 million in 2020-2021 biennium (-23.0%)
- Decrease of $29.0 million in 2022-2023 biennium (-11.2%)

Reasons: The main reason for the forecast reductions is lower actual and projected utilization of services, mainly due to the effects of the COVID pandemic. Utilization of most services dropped dramatically this past spring and remained at levels markedly lower than expected through the summer months. The forecast assumes the lower levels of utilization will continue through March 2021 and then gradually return to levels which would have been expected pre-COVID by January 2022. Lower utilization accounts for $46 million (83%) of the forecast reduction in the current biennium and $17 million (60%) of the reduction in the next biennium.

The remainder of the forecast reduction results from reconciliation adjustments for FY2020 and technical adjustments in future fiscal years. The previous forecast anticipated future reductions of federal matching (and corresponding increased state costs) to result from corrections regarding the claiming of federal matching for services received by residents of facilities defined by the federal government as Institutions for the treatment of Mental Diseases (IMDs). Reconciliation of actual base data following the corrections to federal claiming results in the elimination of these future adjustments and lowers projected state costs.



Historical table

	Chemical Dependency Treatment Fund Total Expenditures	
FY	Total $	% Change
2011	$143,499,246	
2012	132,221,922	(7.86%)
2013	138,539,414	4.78%
2014	138,744,237	0.15%
2015	169,583,060	22.23%
2016	159,611,752	(5.88%)
2017	186,287,061	16.71%
2018	211,925,848	13.76%
2019	215,706,572	1.78%
2020	184,310,877	(14.55%)
2021*	172,441,779	(6.44%)
2022*	220,447,825	27.84%
2023*	250,680,316	13.71%
2024*	251,736,658	0.42%
2025*	253,415,355	0.67%
Avg. Annual Increase 2011-2020		2.82%

**Projected*

Minnesota Family Investment Program

The Minnesota Family Investment Program (MFIP) provides cash and food assistance for low-income families with children. MFIP operates as Minnesota's federal Temporary Assistance for Needy Families (TANF) program. As such, MFIP cash assistance is funded with a mixture of federal TANF Block Grant and state General Fund dollars determined primarily by the federally mandated Maintenance of Effort (MOE) requirement for state spending on its TANF program.

November 2020 forecast highlights

General Fund

Changes from the End-of-Session 2020 forecast

- Increase of $25.7 million in 2020-2021 biennium (+13.2%)
- Decrease of $0.5 million in 2022-2023 biennium (-0.3%)

Reasons: Overall, the MFIP program forecast is down about 0.1% in the current biennium and down about 3% in the next biennium. This reduction is primarily driven by a 1.3% base average payments reduction and a 1.7% reduction in average caseload. The average caseload reduction is due to a projected economic scenario that is now more optimistic relative to the assumed economic scenario back in May.

Despite the overall program forecast reduction, there is a projected General Fund increase in the current biennium due mostly to more cases being directed to Family Stabilization Services (FSS), a state-only funded part of MFIP. In order to implement executive orders during the PHE, FSS was used to classify new MFIP/DWP cases. This has resulted in a significant shift from federal to state funding within the MFIP program. The state is implementing new guidelines in early 2021 to direct most of these cases back to regularly-funded MFIP. Higher MOE requirements due to less state spending in the Child Care Assistance Program also contributed to the General Fund increase in this biennium.

This forecast continues to assume claiming of the Working Family Tax Credit for MOE despite the omission of the claiming authority in the 2019 session. It is anticipated that claiming authority will be re-established during the 2021 session.

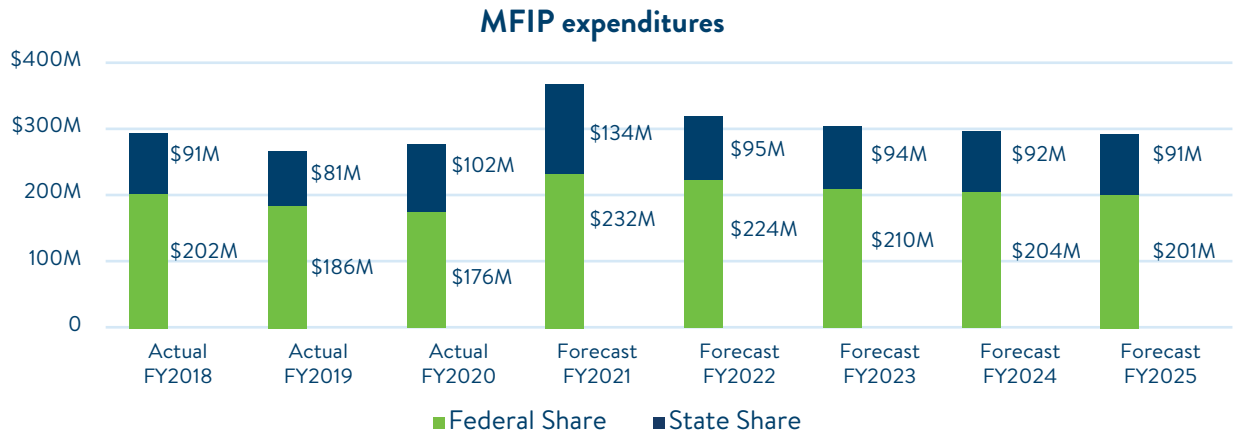
Who it serves

- 79,800 average monthly recipients

How much it costs

- $278 million total spending
- $102 million state funds

Data for FY2020



Historical table

	Minnesota Family Investment Program (MFIP)	
FY	Total $	% Change
2010	$329,544,523	
2011	340,792,915	3.41%
2012	333,591,354	(2.11%)
2013	322,457,424	(3.34%)
2014	297,431,102	(7.76%)
2015	279,723,824	(5.95%)
2016	301,750,210	7.87%
2017	312,674,443	3.62%
2018	293,095,053	(6.26%)
2019	266,620,941	(9.03%)
2020	277,577,083	4.11%
2021*	366,304,608	31.97%
2022*	319,197,447	(12.86%)
2023*	303,871,680	(4.80%)
2024*	296,456,147	(2.44%)
2025*	291,614,124	(1.63%)
Avg. Annual Decrease 2010-2020		(1.70%)

**Projected*

Child Care Assistance

This program provides child care assistance to MFIP families who are employed or are engaged in other work activities or education as part of their MFIP employment plan. This activity also provides transition year (TY) child care assistance for former MFIP families. As with the MFIP grant program, child care assistance is funded with a mixture of federal and state General Fund dollars. The federal child care funding comes from the Child Care Development Fund (CCDF). The forecast does not include the Basic Sliding Fee child care program.

November 2020 forecast highlights

General Fund

Changes from the End-of-Session 2020 forecast

- Decrease of $26.3 million in 2020-2021 biennium (-15.1%)
- Decrease of $2.6 million in 2022-2023 biennium (-1.2%)

Reasons: The Child Care Assistance forecast reduction in both the current and next biennium is fully explained by lower than expected utilization due to the COVID pandemic. Utilization of child care services is expected to revert back to normal levels in FY2022. This lower than expected utilization results in a $30 million forecast reduction in the current biennium and a $4 million reduction in the next biennium. This is somewhat offset by increased average payment projections and emergency measures taken to support child care providers and families.

Who it serves

MFIP/TY Child Care

- 7,300 average monthly families served

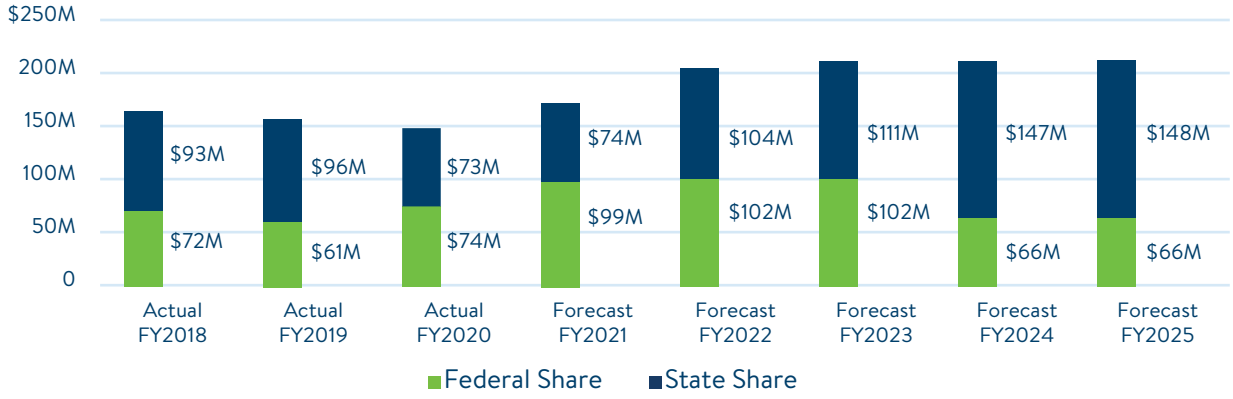
How much it costs

MFIP/TY Child Care

- $147 million in total spending
- $73 million state funds

Data for FY2020

MFIP/TY Child Care expenditures



Historical table

	MFIP/TY Child Care Assistance	
FY	Total $	% Change
2010	$113,435,302	
2011	118,621,823	4.57%
2012	116,728,218	(1.60%)
2013	118,035,920	1.12%
2014	128,982,296	9.27%
2015	141,994,040	10.09%
2016	150,602,122	6.06%
2017	161,122,098	6.99%
2018	165,175,205	2.52%
2019	157,475,004	(4.66%)
2020	146,909,847	(6.71%)
2021*	172,886,895	17.68%
2022*	205,898,238	19.09%
2023*	212,330,395	3.12%
2024*	212,579,060	0.12%
2025*	213,684,272	0.52%
Avg. Annual Increase 2010-2020		2.62%

**Projected*

Northstar Care for Children

Northstar Care for Children is designed to help children who are removed from their homes and supports permanency through adoption or transfer of custody to a relative if the child cannot be safely reunified with parents. Financial support is provided to adoptive and foster parents to encourage permanent placement of children in safe homes. Northstar Care for Children consolidates and simplifies administration of three existing programs: Family Foster Care, Kinship Assistance and Adoption Assistance.

Who it serves

- 18,900 average monthly recipients

How much it costs

- $224 million total spending
- $92 million state funds

Data for FY2020

November 2020 forecast highlights

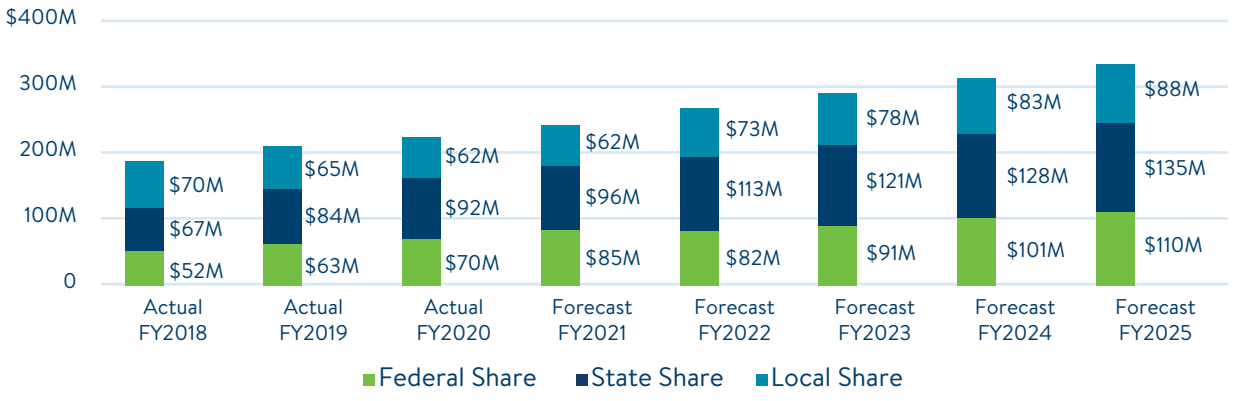
General Fund

Changes from the End-of-Session 2020 forecast

- Decrease of $6.8 million in 2020-2021 biennium (-3.5%)
- Decrease of $1.3 million in 2022-2023 biennium (-0.5%)

Reasons: The Northstar Care forecast reductions are driven by a lower program forecast and lower relative state share. The lower relative state share is the result of two factors. The first is higher enhanced FMAP during the 6-month PHE extension, which accounts for about $3 million (43%) of the forecast reduction in the current biennium. The second is a 1% reduction in state share due to a funding shift towards county share based on the fiscal reconciliation process. The lower program forecast is the result of a 2% reduction in Foster Care caseload and 0.5% reductions in Adoption Assistance caseload and average payment projections. These adjustments are offset by a slight increase in the Kinship Assistance caseload and Foster Care average payment forecasts. All these program adjustments are based on data from recent experience.

Northstar expenditures



Historical table

	Northstar Care for Children	
FY	Total $	% Change
2016	$132,201,226	
2017	155,510,705	17.63%
2018	187,750,651	20.73%
2019	211,165,176	12.47%
2020	223,705,208	5.94%
2021*	241,991,738	8.17%
2022*	267,908,491	10.71%
2023*	290,084,935	8.28%
2024*	312,449,222	7.71%
2025*	333,341,368	6.69%
Avg. Annual Increase 2016-2020		14.05%

**Projected*

The program began being forecasted in 2016.

General Assistance, Housing Support and Minnesota Supplemental Aid

General Assistance (GA) provides state-funded cash assistance for single adults and couples without children, provided they meet one of the specific GA eligibility criteria. The most common reason people are GA eligible is illness or incapacity. The program is the primary safety net for very low income people and helps meet some of their basic and emergency needs. Housing Support (HS) pays for housing and some services for individuals placed by the local agencies in a variety of residential settings. The program, formerly called Group Residential Housing, is a state-funded income supplement program that pays for room and board in approved locations. Two types of eligibility are distinguished: MSA-type recipients are elderly or disabled, with the same definitions as used for MA eligibility, while GA-type recipients include all other adults. Minnesota Supplemental Aid (MSA) supplements the incomes of Minnesotans who are eligible for the federal Supplemental Security Income program. MSA benefits cover basic daily or special needs.

November 2020 forecast highlights

General Assistance, General Fund

Changes from the End-of-Session 2020 forecast

- Decrease of $3.4 million in 2020-2021 biennium (-3.2%)
- Increase of $0.4 million in 2022-2023 biennium (+0.3%)

Reasons: The General Assistance forecast reduction in the current biennium is driven by decreased average payment projections and a lower caseload forecast. The average payment reductions are due to a higher share of facility recipients in the overall recipient mix and the reduced caseload is due to lower actual enrollment in the base data. This lower base is partially offset by added caseload due to the extension of the PHE through June 2021.

Housing Support, General Fund

Changes from the End-of-Session 2020 forecast

- Decrease of $7.8 million in 2020-2021 biennium (-2.1%)
- Decrease of $3.5 million in 2022-2023 biennium (-0.9%)

Reasons: The Housing Support forecast reduction in both biennia is due to lower than expected caseload growth. This is partially offset by a slightly higher average payment forecast in both biennia. The average payment forecast is higher in the current biennium due to delayed savings from the implementation of the MA Housing Stabilization Services and in the next biennium due to a higher than expected cost of living adjustments on the Housing Support base rate. Also partially offsetting the current biennium reduction is added caseload due to the extension of the PHE through June 2021.

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Who it serves

GA

- 23,400 average monthly cases

HS

- 21,000 average monthly recipients

MSA

- 32,400 average monthly recipients

How much it costs

GA

- $50 million total spending, all state funds

HS

- $185 million total spending
- $182 million state funds

MSA

- $44 million total spending, all state funds

Data for FY2020

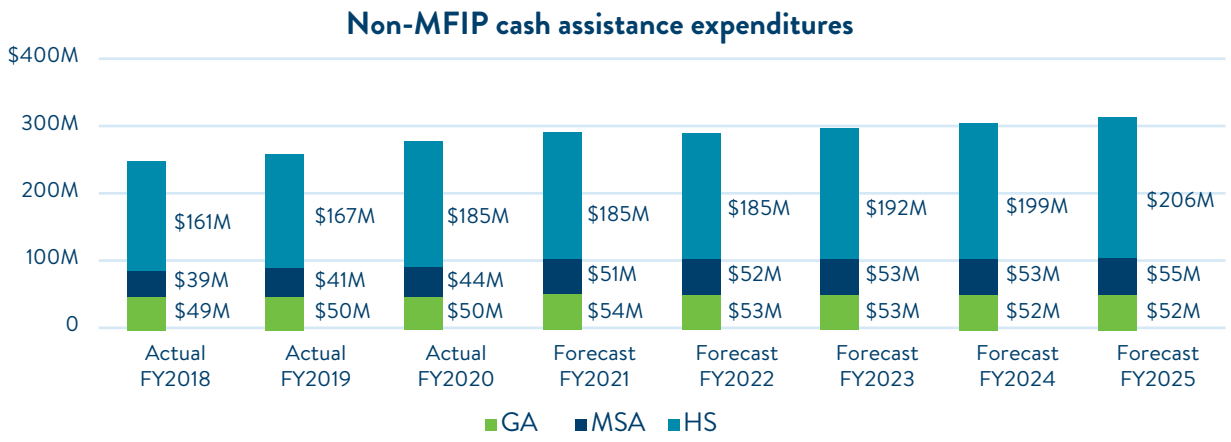
Continued from previous page

Minnesota Supplemental Aid, General Fund

Changes from the End-of-Session 2020 forecast

- Increase of $2.7 million in 2020-2021 biennium (+2.9%)
- Increase of $2.5 million in 2022-2023 biennium (+2.4%)

Reasons: The MSA forecast increases are driven by higher average payments due to the early implementation of higher MSA Housing Assistance standard and updated projections of special need and special diet costs for the MSA Housing Assistance program. Also contributing to the current biennium increase is added caseload due to the extension of the PHE through June 2021.



Historical table

	General Assistance (GA)		Minnesota Supplemental Aid (MSA)		Housing Support (HS)	
FY	Total $	% Change	Total $	% Change	Total $	% Change
2010	$42,712,048		$33,296,630		$112,922,066	
2011	48,045,075	12.49%	35,748,140	7.36%	117,140,667	3.74%
2012	49,552,612	3.14%	35,767,568	0.05%	121,678,773	3.87%
2013	51,620,198	4.17%	36,038,980	0.76%	130,187,929	6.99%
2014	51,124,719	(0.96%)	36,478,561	1.22%	138,708,619	6.54%
2015	51,435,727	0.61%	37,066,951	1.61%	141,396,622	1.94%
2016	50,443,730	(1.93%)	37,735,036	1.80%	149,460,915	5.70%
2017	49,556,022	(1.76%)	38,309,226	1.52%	159,456,706	6.69%
2018	48,883,093	(1.36%)	39,065,624	1.97%	160,535,838	0.68%
2019	50,301,759	2.90%	41,128,443	5.28%	166,972,636	4.01%
2020	49,778,343	(1.04%)	43,502,787	5.77%	184,631,491	10.58%
2021*	54,286,958	9.06%	51,469,175	18.31%	185,001,933	0.20%
2022*	52,866,546	(2.62%)	51,581,687	0.22%	184,536,398	(0.25%)
2023*	52,819,271	(0.09%)	52,515,278	1.81%	191,610,573	3.83%
2024*	52,476,286	(0.65%)	53,431,015	1.74%	198,551,619	3.62%
2025*	52,215,339	(0.50%)	54,922,896	2.79%	205,940,618	3.72%
Avg. Annual Increase 2010-2020		1.54%		2.71%		5.04%

**Projected*

November 2020 forecast changes: In a nutshell

Millions of dollars

	2020-2021 Biennium	2022-2023 Biennium
General Fund Total Change	($919.4)	($257.1)
General Fund Percent Change	(7.6%)	(1.8%)
Summary Changes Across All Budget Activities		
Extend Public Health Emergency (Jan thru Jun 2021)	($309.7)	$58.5
Reduced utilization due to COVID	($292.5)	($189.9)
Lower enrollment	($202.6)	($118.9)
Other changes	($114.6)	($6.7)
Detail Changes By Budget Activity		
MA LTC Facilities:	($91.1)	($41.8)
Extend Public Health Emergency (Jan thru Jun 2021)	($32.7)	($2.0)
Nursing Facilities: avg cost -4.6%, -2.2%	($46.1)	($27.5)
ICF: caseload -5%, -4.4%	($6.5)	($5.3)
Statutory FMAP increase (50.00% to 50.51%)	$0.0	($12.0)
Other changes	($5.8)	$5.0
MA LTC Waivers:	($142.8)	$73.0
Extend Public Health Emergency (Jan thru Jun 2021)	($154.5)	($5.3)
CADI,CAC,BI: avg cost +5.0%, +6.7%	$70.4	$115.8
DD: avg cost -1.5%, -2.2%	($25.0)	($42.6)
Disability waivers: caseload -0.5%, +1.5%	($21.0)	$38.0
PCA/CFSS: avg cost -1.3%	($11.6)	($9.3)
Statutory FMAP increase (50.00% to 50.51%)	$0.0	($44.1)
Electonic Visit Verification FFP penalty and delay	$3.0	$18.3
Other changes	($4.2)	$2.4
MA Elderly and Disabled Basic:	($232.7)	($116.1)
Extend Public Health Emergency (Jan thru Jun 2021)	($61.8)	$24.3
Reduced utilization due to COVID	($78.1)	($63.1)
Lower enrollment -1.5%, -0.2%	($56.3)	($13.5)
CY21 managed care rates	($4.3)	($30.1)
Statutory FMAP increase (50.00% to 50.51%)	$0.0	($28.1)
Federal clawback payments	($36.3)	$10.1
Other changes	$4.0	($15.6)
MA Adults with No Children	($48.1)	($8.5)
Extend Public Health Emergency (Jan thru Jun 2021)	$2.5	$5.7
Reduced utilization due to COVID	($26.2)	($21.4)
Lower enrollment -6.7%, -4.4%	($30.2)	($22.0)
CY21 managed care rates	$4.7	$29.5
Other changes	$1.1	($0.3)
MA Families with Children Basic:	($333.4)	($129.7)
Extend Public Health Emergency (Jan thru Jun 2021)	($64.1)	$35.7
Reduced utilization due to COVID	($112.8)	($84.3)
Lower enrollment -3.0%, -2.0%	($101.3)	($78.1)
CY21 managed care rates	$9.9	$65.3
Statutory FMAP increase (50.00% to 50.51%)	$0.0	($29.6)
CHIP enhanced match	$11.7	($5.9)
Pharmacy rebates	($74.2)	($3.7)
Other changes	($2.7)	($29.1)

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	2020-2021 Biennium	2022-2023 Biennium
November 2020 Forecast Changes		
Chemical Dependency Fund	($55.4)	($29.0)
Extend Public Health Emergency (Jan thru Jun 2021)	($0.4)	$0.0
Reduced utilization due to COVID	($45.9)	($17.3)
Technical adjustments	($9.7)	($11.5)
Other changes	$0.6	($0.2)
Minnesota Family Investment Program	$25.7	($0.5)
Extend Public Health Emergency (Jan thru Jun 2021)	$1.7	$0.0
NonMOE expenditures +11%	$24.0	($0.6)
Child Care Assistance	($26.3)	($2.6)
Reduced utilization due to COVID	($29.6)	($3.7)
Avg payment: +1.9%, +0.5%	$3.3	$1.1
Northstar Care for Children	($6.8)	($1.3)
Extend Public Health Emergency (Jan thru Jun 2021)	($2.9)	$0.0
Fiscal reconciliation -1.1%, -0.6%	($2.1)	($1.5)
State payments -0.9%	($1.8)	$0.2
General Assistance	($3.4)	$0.4
Extend Public Health Emergency (Jan thru Jun 2021)	$0.7	$0.0
Lower enrollment -1%, +1.7%	($1.0)	$1.7
Avg payment: -2%, -1%	($2.2)	($1.4)
EGA payments -1%	($0.8)	$0.0
Housing Support	($7.8)	($3.5)
Extend Public Health Emergency (Jan thru Jun 2021)	$1.2	$0.1
Lower enrollment -3.7%, -1.9%	($13.8)	($7.1)
Avg payment: +1.5%, +1%	$5.5	$3.6
Other changes	($0.7)	($0.0)
Minnesota Supplemental Aid	$2.7	$2.5
Extend Public Health Emergency (Jan thru Jun 2021)	$0.4	$0.0
Avg payment: +3.1%, +2.2%	$2.9	$2.3
Other changes	($0.6)	$0.2
Health Care Access Fund Total Change	($95.5)	($66.7)
Health Care Access Fund Percent Change	(7.1%)	(4.0%)
MinnesotaCare HCAF Funding	($95.5)	($66.7)
Extend Public Health Emergency (Jan thru Jun 2021)	$0.0	$5.4
Reduced utilization due to COVID	($15.4)	($15.4)
HCAF impact of changes in federal BHP funding	($79.6)	($61.5)
Other changes	($0.5)	$4.7
MA HCAF Funding	$0.0	$0.0
TANF Total Change	($31.7)	($10.7)
TANF Percentage Change	(19.4%)	(5.3%)
Minnesota Family Investment Program	($31.7)	($10.7)
Extend Public Health Emergency (Jan thru Jun 2021)	$6.9	$0.1
Higher GF for MOE & NonMOE expenditures	($38.6)	($10.8)

Note: Represents the change from the End-of-Session 2020 forecast.

Contacts and additional resources

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Resources

Minnesota Department of Human Services Reports and Forecasts Division
https://mn.gov/dhs/reports-and-forecasts/

Minnesota Department of Human Services current biennium budget activities
https://mn.gov/dhs/budget-activities/

State of Minnesota forecast
https://mn.gov/mmb/forecast/

DEPARTMENT OF HUMAN SERVICES