DIRECT CARE AND TREATMENT

Priority Admissions Review Panel

Report and Recommendations to the Minnesota Legislature

September 8, 2026

Cost to Produce this Report

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Dear Chairs, Co-Chairs, Co-Vice Chairs and Ranking Minority Members,

As directed by Laws of Minnesota 2025, Chapter 9, article 5, section 11, subdivision7, we submit for your review the second and final report and recommendations of the Priority Admissions Review Panel (Review Panel).

After submitting its initial report in 2025, the Review Panel was directed by the Legislature to study and evaluate seven specific items, including the priority admissions timeline, access to Direct Care and Treatment (DCT) programs, existing mobile crisis and intensive residential treatment services, local fiscal impacts, and quarterly data measuring the impacts of changes to state-operated treatment programs.

The recommendations contained in this report represent months of discussion about how to improve services across Minnesota's entire behavioral health continuum of care, not just state-operated treatment facilities. While there are many areas of agreement among all Review Panel members – and a majority endorsed this final report – we must note that support for the recommendations was not unanimous.

Review Panel members representing the Association of Minnesota Counties, the Minnesota Association of County Social Service Administrators, the Minnesota County Attorneys Association and the Minnesota

Sheriffs' Association did not endorse this report. In their view, the recommendations do not adequately address the urgent need to increase treatment capacity, especially in DCT's Forensic Mental Health Program. A letter outlining the concerns raised by these members is included as Appendix 4 in this report.

The Legislature empaneled the Task Force on Priority Admissions to State-Operated Treatment Programs in 2023 to review and evaluate the impact of the state's Priority Admissions Law. The Task Force provided its report and recommendations in 2024. At the Legislature's request, members continued to meet as the Review Panel. From the beginning, state investment in treatment capacity – whether in communities, DCT programs, or in jails – has been at the center of the debate. How much investment is necessary and where it's most urgently needed has been a persistent area of disagreement and will continue to be so in the future. Different stakeholders simply see the problems and solutions differently.

We point this out not to diminish the issues raised by some Review Panel members. The difficulties that all stakeholders face are real and their underlying concerns are valid. That's not in question. Nor do we suggest that there's nowhere else to find common ground. However, the differences of opinion among stakeholders are a reality that the Legislature must understand clearly as it works to improve access to care for patients; balance the often competing interests of counties, law enforcement, courts, community hospitals, advocates and the state-operated behavioral health care system; and do it all with limited resources.

For four years, this body, in one form or another, has identified and discussed at great length and breadth the most pressing issues surrounding Minnesota's behavioral health continuum of care. Every member has taken this duty seriously – and all have been zealous advocates for people in need of care. Members have given generously of their time and considerable professional expertise with one goal in mind: to improve the lives of Minnesotans with mental illnesses and other behavioral health challenges. We're grateful for the unique insights they each brought to this important and highly complex discussion. We hope their work and these recommendations provide useful guidance for state legislators in the policy and funding debates and decisions that lie ahead.

With the submission of this report and recommendations, the work of the Priority Admissions Review Panel is concluded.

Sincerely,

Laura Sayles
Co-Chair, Priority Admissions Review Panel

Teresa Steinmetz
Co-Chair, Priority Admissions Review Panel

Executive Summary

Introduction

The Priority Admissions Review Panel (Review Panel) was established by the Minnesota Legislature in 2024 to review and evaluate the priority admissions timeline to minimize litigation costs, maximize capacity in and access to state-operated treatment programs, and address issues related to individuals in jails and correctional institutions awaiting admission to state-operated treatment programs. The Review Panel was also directed to advise the Commissioner of the Minnesota Department of Human Services on the effectiveness of the priority admissions framework and priority admissions generally and review de-identified data quarterly for one year following the implementation of the framework to ensure equitable implementation and application. The Review Panel submitted its first report and recommendations to the Legislature on Feb. 1, 2025.

After submission of the 2025 report, the Legislature directed the Review Panel to study and evaluate seven specific items, including the priority admissions timeline, access to Direct Care and Treatment programs, existing mobile crisis and intensive residential treatment services, local fiscal impacts, and quarterly data measuring the impacts of changes to state-operated treatment programs.

The Priority Admissions Review Panel has convened several times to examine opportunities for strengthening Minnesota's behavioral health system and improving responses for Minnesotans experiencing a mental health crisis. While the panel reached consensus at time of this report, Minnesota's behavioral health system is composed of numerous independent entities, organizations, and service providers. In addition, every state, county, city, and local jurisdiction faces its own operational realities and constraints.

Given this complexity, the Legislature should anticipate that cities, counties, stakeholders, state agencies, the Attorney General's Office, and the Governor's Office may offer differing perspectives and propose varying legislative approaches to the recommendations outlined in this report.

The Review Panel submits this 2026 report addressing the results of its study and evaluations and provides legislative proposals to carry out the panel's recommendations.

Priority Admissions Statute

The current "Priority Admissions" statute in Minn. Stat. sec. 253B.10, sub. 1 directs the Minnesota Direct Care and Treatment (DCT) agency to give priority admission to civilly committed individuals waiting in jail or a correctional institution or who are referred to a state-operated treatment facility for competency attainment or a competency examination under sections 611.40 to 611.59, provided there is a medically appropriate bed in a state-operated treatment program. Admission is based on the decisions of physicians in DCT's executive medical director's office, using a priority admissions framework. These patients must be admitted within the timelines specified in Minn. Stat. Sec. 253B.1005.

In 2023, the Minnesota Legislature amended the Priority Admissions statute to clarify that patients subject to the priority admission law must be admitted to a state-operated treatment program within 48 hours of a

determination that a *medically appropriate bed* is available. The 2023 amendment was made effective May 25, 2023, but the clause was set to expire on June 30, 2025. During the 2025 session, the Legislature extended the provision for another two years. It is now set to expire on June 30, 2027.

Recommendations

The Review Panel supports key recommendations highlighted below. Detailed explanations for each recommendation appear later in this report.

Recommendations to Expand Capacity and Access (Highlights)

- **Recommendation 1:** Appropriate funding in the 2027 legislative session to build out additional intensive residential treatment services (IRTS), programs; release an RFP by January 1, 2028; and create in statute a new, extended residential treatment service.
- **Recommendation 2:** The Legislature should authorize and fund the Minnesota Department of Human Services (DHS) to commission an independent, comprehensive assessment of Minnesota's behavioral health system and continuum of care.
- **Recommendation 3:** Reinstitute and expand access to care in jail by re-appropriating the Long-acting Injectable Pilot program.
- **Recommendation 4:** Expand access to care in jails by expanding the DCT Jail Consultation Services Pilot.
- **Recommendation 5:** Reinvest more state resources in community based mental health resources.
- **Recommendation 6:** Updates to payment models and reimbursement.
- **Recommendation 7:** Allow counties to reinvest DNMC funding to build community capacity through Adult Mental Health Initiatives.

Recommendations that Support or Endorse Existing Work or Plans (Highlights)

- **Recommendation 8:** Renew the exception allowing up to 10 patients per year from community hospitals to be prioritized for admission to a DCT program for the next biennium.
- **Recommendation 9:** Support the work of the DHS Case Management Redesign Project
- **Recommendation 10:** Support implementation and future statewide expansion of 1115 Reentry Waiver, including pretrial access.

Acknowledgements

The members of the Review Panel wish to thank the Minnesota Legislature for directing the panel's work. This assignment has allowed for a close examination of the issues and provided an opportunity for stakeholders to collaborate on proposed solutions to these complex matters.

Review Panel Members

The Review Panel was instructed to appoint all members of the Priority Admissions Task Force, plus one member who has an active role as a union representative for DCT staff. The Review Panel members are:

- **Teresa Steinmetz**, Assistant Commissioner, Behavioral Health Administration, Minnesota Department of Human Services, Co-Chair.
- **Laura Sayles**, Director of Government Relations, Minnesota Attorney General's Office, Co-Chair.
- **Dr. KyleeAnn Stevens**, Executive Medical Director, Minnesota Direct Care and Treatment, a representative of Direct Care and Treatment, who has experience with civil commitments.
- **Tarryl Clark**, Stearns County Commissioner, a county representative, appointed by the Association of Minnesota Counties.
- **Bryan Welk**, Cass County Sheriff, appointed by the Minnesota Sheriffs' Association.
- **Angela Youngerberg**, Consultant and former county human services leader, a county social services representative, appointed by the Minnesota Association of County Social Service Administrators.
- **Kevin Magnuson**, Washington County Attorney, appointed by the Minnesota County Attorneys Association.
- **Chris Beamish**, Executive for Mental Health and Addiction Care, M Health Fairview, a hospital representative, appointed by the Minnesota Hospital Association.
- **Marcus Schmit**, Executive Director, Minnesota Chapter of the National Alliance on Mental Illness (NAMI Minnesota), a member appointed by the National Alliance on Mental Illness Minnesota.
- **Lauren Pockl**, Attorney, Hennepin County Adult Representation Services, a member appointed by the Minnesota Civil Commitment Defense Panel.
- **Jinny Palen**, Executive Director, Minnesota Association of Community Mental Health Programs. (MACHMP), a member appointed by the Minnesota Association of Community Mental Health Programs.
- **Dr. Eduardo Colón-Navarro**, Retired Chief of Psychiatry, Hennepin County Medical Center, a member appointed by the Minnesota Psychiatric Society.
- **Lisa Harrison-Hadler**, Ombudsman, Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities.
- **Miranda Rich,** a member appointed by the Commissioner of Corrections from an organization that represents racial and ethnic groups that are overrepresented in the criminal justice system.
- **Dr. Dionne Hart**, a member appointed by the Commissioner of Corrections from an organization that represents racial and ethnic groups that are overrepresented in the criminal justice system.

Members including those with lived experience and labor representation were invited to participate but were not formally appointed. Though not formally appointed, **Nicholas Rasmussen** participated as a member of the public and provided valuable insight.

Essential Background

Current Priority Admissions Statute and Scope

The current "Priority Admissions" statute in Minn. Stat. sec. 253B.10, sub. 1(b) directs the Minnesota Direct Care and Treatment (DCT) agency to give priority admission to civilly committed individuals waiting in jail or a correctional institution or who are referred to a state-operated treatment facility for competency attainment or a competency examination under sections 611.40 to 611.59, provided there is a medically appropriate bed in a state-operated treatment program. Admission is based on the decisions of physicians in DCT's executive medical director's office, using a priority admissions framework. These patients must be admitted within the timelines specified in Minn. Stat. Sec. 253B.1005. The framework must account for a range of factors for priority admission, including but not limited to:

> (1) the length of time the person has been on a waiting list for admission to a state-operated direct care and treatment program since the date of the order under paragraph (a), or the date of an order issued under sections 611.40 to 611.59;
>
> (2) the intensity of the treatment the person needs, based on medical acuity;
>
> (3) the person's revoked provisional discharge status;
>
> (4) the person's safety and safety of others in the person's current environment;
>
> (5) whether the person has access to necessary or court-ordered treatment;
>
> (6) distinct and articulable negative impacts of an admission delay on the facility referring the individual for treatment; and
>
> (7) any relevant federal prioritization requirements.

DCT implemented the framework in 2024 with broad stakeholder input and feedback. It has been working as intended and no modifications are needed.

During the 2023 regular session, the Legislature amended the Priority Admissions Law to clarify that patients subject to the statute shall be admitted to a state-operated treatment program within 48 hours of the availability of a medically appropriate bed. The 2023 amendment was effective May 25, 2023, but was scheduled to expire on June 30, 2025. The Legislature has extended the amendment until June 30, 2027.

Challenges Posed by the Priority Admission Law

Minnesota Statutes Chapter 253B addresses the civil commitment process in Minnesota and allows a person to be civilly committed to the care of the Executive Board of Direct Care and Treatment (formerly the

Commissioner of the Department of Human Services) for the purpose of receiving needed mental health treatment and care. The statutory process for civil commitment is lengthy and extensive, often involving multiple licensed mental health professionals, court-appointed counsel, and judicial oversight.

The original Priority Admission statute required the Commissioner to prioritize for admission patients being admitted from jail or a correctional institution who were:

- Ordered confined in a state-operated treatment program for an examination;
- Under civil commitment for competency treatment and continuing supervision;
- Found not guilty by reason of mental illness; or
- Committed to the Commissioner after dismissal of the patient's criminal charges.

At the time the law was being considered, the average time of 30 days from the commitment order to placement in a state-operated psychiatric hospital was unacceptably long. Among those most affected by the delay were people with mental illnesses being held in jails, even though they had not been convicted of a crime. Proponents hoped that the Priority Admission statute would spur significant investment in both DCT and community-based treatment capacity as well as investment in measures to reduce the number of people needing mental health care and treatment in jail. When passed in 2013, the law was intended to speed admissions for people waiting in jails for treatment. DCT was able to meet demand for a few years, but the number of people referred under the statute increased dramatically in the 10-year period since the law was enacted and admissions waiting lists resulted. The Priority Admission law did not solve the problem of lack of access to mental health care and treatment for people in jail.

At the same time, the law had numerous unintended consequences, including increased injuries for DCT staff due to higher concentrations of clients with significant symptoms; decreased access to care and treatment at DCT for people in the community; pressure to admit people in conflict with sound medical judgment; and numerous lawsuits.

In response, during the 2023 session, the Legislature appointed the Task Force on Priority Admissions to State-Operated Treatment Programs to review the priority admissions law.

Task Force Begins its Work in 2023

The Task Force on Priority Admissions to State-Operated Treatment Programs met over several months to review and evaluate the impact of Minnesota's Priority Admissions law on the state's ability to serve all individuals in need of care from state-operated services. Its charge was to analyze the impact of priority admissions on the mental health system in Minnesota; provide recommendations for improvements or alternatives to priority-admissions requirements; and identify and make recommendations for providing treatment to individuals referred under the priority admissions requirements as well as other individuals in the community who require treatment at a state-operated treatment program. The task force submitted its final report and recommendations to the Legislature on Feb. 9, 2024, and concluded its work.

2024 Priority Admissions Task Force Report and Recommendations

The 2024 Priority Admissions Task Force report detailed previous efforts and studies on how to adequately build the mental health system in Minnesota, including a discussion of the Community Competency Restoration Task Force. The Priority Admissions Task Force report itself made nine different recommendations to improve access to mental health care and treatment in conjunction with the Priority Admissions law. Here are nine recommendations and resulting actions:

Recommendation: Immediately begin to increase capacity at Direct Care and Treatment. Specifically, the Task Force recommended an immediate increase of Forensic Mental Health Program (FMHP) beds by 10 % to 20% and a 20% increase in bed capacity at the Anoka Metro Regional Treatment Center (AMRTC) or DCT's six Community Behavioral Health Hospitals (CBHHs). This equated to a minimum immediate increase of 36 to 72 beds at the FMHP and 41 additional beds at AMRTC or the CBHHs.

Actions:

- DHS pursued and obtained legislative approval during the 2024 session to close a substance use disorder program in St. Peter and repurpose the facility to add 16 more beds to the FMHP. This resulted in 16 additional forensic beds.
- The FMHP's Ironwood Unit was re-opened, resulting in 14 additional beds becoming available. Although extremely helpful, these beds were already budgeted for and are not considered new.
- DCT's Community-Based Services (CBS) division has developed an Integrated Community Supports (ICS) program that will allow for at least 12 admissions to a less acute care setting. These should be considered community-based placement options.
- DHS submitted a bonding bill proposal during the 2024 session for $60 million to demolish an outdated building on the AMRTC campus and design, build, furnish, and equip a 50-bed expansion of the psychiatric hospital. The proposal was not included in the Governor's 2024 Capital Budget recommendations, and the Legislature did not pass a bonding bill. However, the Legislature provided funding to design the new facility.

Recommendation: Form joint incident collaboration to facilitate discharges for DCT patients.

Actions:

- DHS, county, community, and hospital providers accomplished this without legislative direction.
- Several efforts were undertaken to reduce the number of individuals not meeting hospital criteria at AMRTC from more than 40% of the patient population to 26% as of January 24, 2025.

Recommendation: Approve an exception to the Priority Admissions law.

Action:

- An exception allowing up to 10 priority admissions for patients in community hospitals was added to 253B.10 in 2024. As of 1/29/2025, five individuals from community hospitals had been admitted to DCT, with additional admissions planned.

Recommendation: Create and implement new priority admissions criteria for DCT facilities.

Actions:

- A new framework process was passed in 2024.
- DCT began implementing the new priority admissions framework on July 1, 2024. The framework is being reviewed internally and externally by stakeholders, including the Review Panel.
- The Legislature also required additional reporting requirements for program selection and admission notifications. DCT implemented these notifications by July 1, 2024.

Recommendation: Increase access to services provided in the community.

Actions:

- Legislation clarified that payments for assertive community treatment and intensive residential treatment services (IRTS) are based on medical necessity.
- Legislation established an engagement services pilot grant program at the Department of Human Services to provide grants to counties or certified community behavioral health clinics to intervene early to prevent people from experiencing a crisis and needing hospitalization or ending up in a jail.
- The Legislature slightly increased rates for mental health services after Jan. 1, 2025.

Recommendation: Administer medication in jails.

Actions:

- The 2024 Legislature appropriated funding for a pilot program to fund mental health medication for people in jail. This pilot program has been implemented by DHS.
- The 2024 Legislature also appropriated funding for a DCT jail consultation pilot to increase access to mental health medication for people in jail and assist jails in obtaining added resources. This pilot is currently underway.

Recommendation: Relieve counties of certain "Does Not Meet Criteria (DNMC)" costs.

Action:

- The 2024 Legislature passed revisions to relieve counties of the costs associated with individuals awaiting transfer to other DCT facilities.

Recommendation: Expedite Minnesota's Section 1115 Waiver application for individuals in custody.

Action:

- DHS plans to pilot the 1115 Waiver in four adult jails identified in coordination with county agencies through a competitive request for proposal process.

Recommendation: Increase access to forensic examiners.

Action:

- Payment rates for DCT forensic examiner services increased on March 1, 2025.

Review Panel Continues the Work in 2024 and 2025

In 2024, the Legislature established the Priority Admissions Review Panel to review and evaluate the priority admissions timeline to minimize litigation costs, maximize capacity in and access to state-operated treatment programs, and address issues related to individuals awaiting admission to state-operated treatment programs in jails and correctional institutions. The Legislature also directed the Review Panel to advise the Commissioner of Human Services on the effectiveness of the framework and priority admissions generally. Further, it directed the Review Panel to review de-identified data quarterly for one year following the implementation of the priority admissions framework to ensure that the framework is implemented and applied equitably. The Review Panel submitted its first report and recommendations to the Legislature on Feb. 1, 2025.

2025 Priority Admissions Review Panel Report and Recommendations

The 2025 Review Panel report included six different recommendations to improve access to mental health care and treatment in conjunction with the Priority Admissions law. The recommendations and resulting action are as follows:

Recommendation: Expand access to care.

Action:

- The Legislature provided funding for a $75 million, 50-bed expansion of AMRTC.

Recommendation: Extend the sunset of the “medically appropriate bed” provision for two years during which time the Legislature must develop DCT and community capacity.

Action:

- The Legislature extended the provision until 2027.

Recommendation: Increase data sharing and transparency.

Action:

- Statute passed in the 2025 session requires DCT to publish quarterly data on priority admission referrals on the agency's public website. DCT began publishing the data on Jan. 1, 2026.

Recommendation: Provide basic mental health care in jail.

Action:

- The 2024 Legislature established two pilot programs to help jails provide basic mental health care. The long-acting injectable pilot is intended to fund antipsychotic medications for jails. The DCT jail consultation pilot program helps jails navigate antipsychotic medication needs and processes, including pursuing Jarvis orders if necessary.

Recommendation: Continue DNMC payment relief to counties for clients in certain situations.

Action:

- The Legislature did not continue DNMC payment relief.

Recommendation: Renew the exception allowing up to 10 patients from community hospitals to be prioritized for admission to a DCT program.

Action

- The Legislature renewed the exception until June 30, 2027.

Requirements for the 2026 Report

The Legislature has directed the Review Panel to address the following for this report:

(1) Evaluate the 48-hour timeline for priority admissions and measure progress toward implementing the recommendations of the 2023 Task Force on Priority Admissions to State-Operated Treatment Programs;

(2) Develop policy and legislative proposals related to the priority admissions timeline that minimize litigation costs, maximize capacity in and access to direct care and treatment programs, and address issues related to individuals awaiting admission to direct care and treatment programs in jails and correctional institutions;

(3) Evaluate existing mobile crisis programs and funding and make recommendations to improve access to mobile crisis services in Minnesota;

(4) Evaluate the county correctional facility long-acting injectable medication pilot program and DCT's county correctional facility support pilot program and make recommendations related to the continuation of the pilot programs;

(5) Evaluate existing intensive residential treatment services (IRTS) and make recommendations to improve access to these services;

(6) Study local fiscal impacts and provide evaluation support of the limited capacity in and access to state-operated treatment programs, non-state-operated treatment programs, competency evaluation services, and competency attainment services; and

(7) Review quarterly data provided by the DCT Executive Board to measure the impact of changes, including priority admission waitlist data, data regarding engagement by the admissions team, priority notice data, and other similar data relating to admissions.

Current Trends and Statistics

The Review Panel reviewed data and trends related to admissions, waitlists, and referral sources. The most salient information is included here, with additional data included in Appendix Four.

The data dashboard is a snapshot of DCT's priority admissions to state-operated behavioral health programs from July 1, 2025, through March 30, 2026. Notable trends during this period include an increased number of priority referrals to DCT over the past year, at least in part due to the expanded criteria for who qualifies as a priority admission the Legislature passed in the 2024 session.

The data indicates that despite an increased number of new referrals, the wait time for admissions showed improvement. Although overall admission numbers during the quarter were slightly lower, wait times for admission show a significant decrease for the Mental Health and Substance Abuse Treatment Services (MHSATS) service line and a slight decrease for Forensic Services. Wait times for admissions to Anoka Metro Regional Treatment Center were down over the year and have averaged under 30 days, though they appear to be trending up due to the number of referrals. The longest wait time by far is for admission to the Forensic Mental Health Program at just under 300 days, though this number is trending down.

Discussion and Analysis

Progress Toward Implementing Task Force and Review Panel Recommendations

Following the 2023 Task Force Report, the Legislature amended the Priority Admission statute to require DCT's medical director to admit people using a framework that considers several factors. DCT has implemented this framework and shared information about it on the agency's public website. DCT has also provided quarterly admissions data to the Review Panel.

The Review Panel reviewed DCT's quarterly priority admission data from July 2025 through September 2025. Key findings included:

- A 22% increase in new priority referrals compared to the prior quarter. Additionally, calendar year 2025 showed a notable increase in the number of priority referrals compared to previous years. In part, this may reflect the expanded eligibility criteria for priority referrals implemented in 2024.
- Wait time (days) for priority admissions in DCT's MHSATS service line (which includes AMRTC and the community behavioral health hospitals) averaged 18 days or fewer for the quarter.

- The number of priority referrals on the active wait list remained stable but showed a slight decrease in time on the wait list.
- Average wait time (days) for priority admissions to the Forensic Mental Health Program (FMHP) was on the rise at 362.9 days on average. Of all DCT programs, the FMHP also had the largest number of people meeting high priority criteria waiting for admission.

The data indicated that despite an increased number of new referrals, the wait time for admissions showed improvement. Although overall admission numbers during the quarter were slightly lower, wait times for admission showed a decrease in the MHSATS service line and a slight decrease in Forensic Services. Demand for DCT services continues to outpace capacity.

The Legislature has taken action on numerous past Task Force and Review Panel recommendations. Expansion of AMRTC by 50 beds is planned to begin in summer of 2026.

Mobile Crisis Programs and Funding

The mental health continuum diagram above reflects the range of clinical mental health services available, from community-based supports through residential and inpatient care.

Mental health reimbursement rates in Medical Assistance range from 10 percent to more than 40 percent below the costs of delivering the care. A 2024 study commissioned by the Department of Human Services made several recommendations for updates to the current Medical Assistance rate structures. The Legislature took steps in passing major reforms and updates to our Medicaid mental health fee-for-service rates during the 2025 session. Unfortunately, the Centers for Medicare and Medicaid Services and Congress' actions removed Minnesota's funding mechanism. The Review Panel recommends that the Legislature implement two provisions of the 2025 law with general funds:

- Ensure reimbursement rates for psychological testing will be paid at least 100 percent of the Medicare fee schedule.
- Ensure masters-level educated service providers are reimbursed for the same amount as other independently licensed clinicians.

Additional service models that respond to individuals' needs while they are in the community include crisis response and Emergency Psychiatric Assessment Treatment and Health (EmPATH). Mobile crisis services and

Certified Community Behavioral Health Clinic (CCBHC) mobile crisis urgent care services are a first line of care in the community when someone is having a mental health crisis. The Review Panel recommends increased investments to build these services to increase access to the right care at the right time and address crises before they escalate to the point of requiring inpatient treatment or resulting in an arrest. EmPATH is a novel psychiatric service offered in hospital emergency departments for same-day psychiatric emergencies. This service decreases emergency department boarding and ensures that inpatient beds are accessible for high-acuity patients. Currently, there is no CPT / Facility code to bill for the EmPATH service accurately. Instead, hospitals are forced to use a combination of other codes, including psychiatric evaluation, crisis psychotherapy, and observation. These do not necessarily reflect the service provided. As a result, current Medicare / Medicaid reimbursement models incentivize inpatient admission and prohibit widespread growth of EmPATH. The Review Panel recommends creation of a new CPT / Facility code so hospitals can accurately and fairly bill for this valuable service.

County Correctional Long-Acting Injectable Antipsychotic Medication Pilot Program

The 2024 Legislature funded a pilot for the Department of Human Services (DHS) to reimburse jails for antipsychotic medications, including injectables, to individuals in custody. This pilot provides better outcomes for individuals and helps create safer environments in jails. The DHS team operating the pilot program reported that some, but not all, of the pilot funds had been spent, due to the launch time for program and restrictive language that considerably limited the circumstances under which reimbursement could be provided.

The pilot's primary objective is to enhance access to long-acting injectable antipsychotics (LAIs) for individuals with schizophrenia and other severe mental illnesses (SMIs). Research and guidelines from the American Psychiatric Association (APA) suggest that LAIs are more effective than oral-only regimens in reducing relapse, hospitalizations, symptom exacerbation, and involvement in the criminal legal system. In correctional settings, where factors like transfers, court dates, and staffing constraints frequently disrupt daily medication administration, LAIs offer sustained therapeutic coverage and minimize the risk of psychiatric crises that can result in emergency hospitalizations, referrals to restricted housing units, or the use of force, including the deployment of less lethal weapons. When administered with appropriate clinical assessments, informed consent, and legal safeguards, LAIs support recovery-oriented, least-restrictive care.

DCT's County Correctional Facility Support Pilot Program

The County Correctional Facility Support Pilot Program is a legislatively authorized, evidence-based initiative aimed at addressing systemic gaps in mental health care within Minnesota's county jails. This pilot program was developed in response to findings from the Task Force on Priority Admissions to State-Operated Treatment Programs and addresses persistent barriers in psychiatric assessment, medication continuity, lawful involuntary treatment processes, and interagency coordination for individuals with SMI in correctional custody.

Correctional systems are constitutionally obligated to provide adequate medical and psychiatric care. Bowring v. Godwin established that incarcerated individuals have a right to psychiatric or psychological treatment, not just for SMI, but any condition that if left untreated would cause unnecessary pain or

suffering. Therefore, delays in psychiatric evaluations, interruptions of essential psychotropic medications, and the absence of lawful treatment pathways increases the risk of decompensation, self-harm, use of force, prolonged incarceration, and legal liability for counties and the State of Minnesota

A two-year pilot program, funded at $2.387 million for FY2025, offers education, technical assistance, and on-site consultation to county jails to improve access to psychiatric treatment. A multidisciplinary team composed of psychiatry, nursing, pharmacy, and quality improvement professionals supports the following key objectives:

- Timely psychiatric assessments
- Continuity of psychotropic medications
- Use of long-acting injectable antipsychotics when clinically indicated
- Legally compliant involuntary treatment processes

The initial implementation of the pilot involved conducting a statewide survey of 436 county stakeholders, resulting in responses from all 87 counties, with 35 counties expressing interest in the program. Ultimately, more than 10 counties were selected for the program. Selection prioritized geographic equity, limited access to community mental health infrastructure, jail size, and opportunities to evaluate diverse operational models. Early experiences highlight the significance of cross-sector collaboration among jail administration, clinical staff, county attorneys, and human services staff, as well as persistent challenges such as staffing shortages, limited mental health expertise, and discomfort with involuntary treatment processes.

Currently, the Jail Consultation Pilot team is working with the counties of Blue Earth, Carlton, Cass, Crow Wing, Itasca, Kandiyohi, Nicollet, St. Louis, Stearns, Tri-County and Wright County. Many more counties are eager to participate as resources are made available. Additionally, tribal leaders have approached DCT to request that jails operated by tribes be added to the list of eligible jails under the pilot.

The Jail Consultation Pilot represents a successful, proactive and constitutionally grounded strategy to enhance psychiatric care in Minnesota jails. By strengthening clinical capacity, promoting medication continuity, and aligning correctional practice with professional standards, the pilot improves patient safety, reduces liability, and supports public safety through treatment and stabilization rather than crisis response.

Minnesota's 1115 Reentry Services Demonstration

Minnesota's application to the Centers for Medicare and Medicaid Services (CMS) for an 1115 reentry waiver was submitted on Jan. 15, 2025. A Section 1115 Medicaid waiver would authorize Minnesota to use Medicaid funds to cover specific health and care coordination services for incarcerated individuals up to 90 days prior to release. A waiver is necessary because federal Medicaid law generally excludes coverage during incarceration, leaving individuals vulnerable during a time in which mental health treatment is of greatest need. Covered services typically include case management, medication-assisted treatment (MAT) for substance use disorders, and a 30-day supply of prescribed medications at release. These services are designed to support continuity of care during a high-risk period for serious health issues, such as overdose, suicidal behaviors, hospitalization, and poor management of chronic disease.

By enabling pre-release coverage and care planning funded through Medicaid, the waiver aims to reduce adverse outcomes, including death, while assisting individuals in accessing critical services. Continuity in mental health treatment, including substance use disorder, has been shown to decrease recidivism, the incidence of reoffending, and improve overall reentry success.

As of February 12, 2026, the waiver application was still pending.

Access to Intensive Residential Treatment Services (IRTS)

A Review Panel workgroup explored community-based locked intensive residential treatment facilities capable of admitting patients waiting for court-ordered treatment in jails, hospitals, and the community. The workgroup reviewed Minnesota's IRTS benefit, with a specific focus on understanding how the current IRTS model meets the needs of individuals across the behavioral health continuum of care and to explore the potential role of a locked IRTS or analogous benefit.

The workgroup's review focused on IRTS's role within the behavioral health continuum of care, with particular emphasis on the locked IRTS benefit and how it may support individuals whose needs exceed the capacity of unlocked IRTS settings but do not meet criteria for continued inpatient hospitalization. The purpose of this review was not to develop final policy or implementation details, but to identify key areas for consideration, system impact, and future recommendations, including concepts not available in current legislation.

The workgroup examined where IRTS fit within the broader systems of care, including needs that stretch or fall outside of existing conceptions of IRTS, services and supports necessary prior to IRTS placement, and services and supports necessary after discharge to ensure continuity, stability, and recovery. Particular attention was given to gaps that contribute to inappropriate placement, service delays, and cycling between hospitals, residential settings, and the justice system. One significant gap exists between hospital level of care and the current IRTS program. The review found many instances where individuals were no longer meeting hospital level of care and were awaiting discharge to the community. However, IRTS programs in the state are limited to 90 days of treatment and it is clear the individuals needed residential level of care more than 90 days. For these individuals, the disability services continuum of care is often utilized through community residential services, which provide the longer-term residential options but lack the onsite intense mental health treatment services that the individuals need.

Minnesota continues to face a significant shortage of state and community-based mental health resources, creating gaps that leave individuals without timely access to appropriate care and place pressure on hospitals, jails, and families. Limited availability of residential treatment, supportive housing, and step-down services has contributed to the overall lack of capacity for court-ordered mental health treatment, resulting in long waitlists, delayed discharges, and the use of settings that are more restrictive or less therapeutic than clinically necessary. As a result, people with serious mental illness are often forced to cycle between crisis services, emergency departments, or correctional facilities rather than receiving consistent, recovery-oriented care in the community. Expanding the availability and range of community-based mental health resources is critical to building a balanced continuum of care in Minnesota, reducing system bottlenecks, and ensuring individuals receive the right level of support at the right time.

Local Fiscal Impacts

The Review Panel studied local fiscal impacts related to state-operated treatment programs. Minnesota's payment model for state-operated services relies heavily on state and local (county) funding. Counties invested $232.3 million in mental health programming in calendar year 2025. This includes all expenses paid by county property tax funding for any mental health related programming cost within the continuum of care, whether community or hospital based, or through private, state or county providers. Of that total, $81.6 million was attributable to the cost of care at state-operated inpatient facilities for adults with mental illness.

	2024	2025	Percentage Change
Total County Investment in Mental Health Services	$221,276,581	$232,316,640	4.99% increase
County payments for cost of care to state-operated inpatient facilities (% of total county investment)	$64,083,875 (28.96%)	$81,611,881 (35.13%)	27.35% increase

Since many state-operated hospitals exceed the 16-bed Institute of Mental Disease federal threshold, federal sources of reimbursement are not available and are funded through public investment at state and local levels.

Counties are responsible for paying the cost of care in certain situations, as outlined in an annually published bulletin:

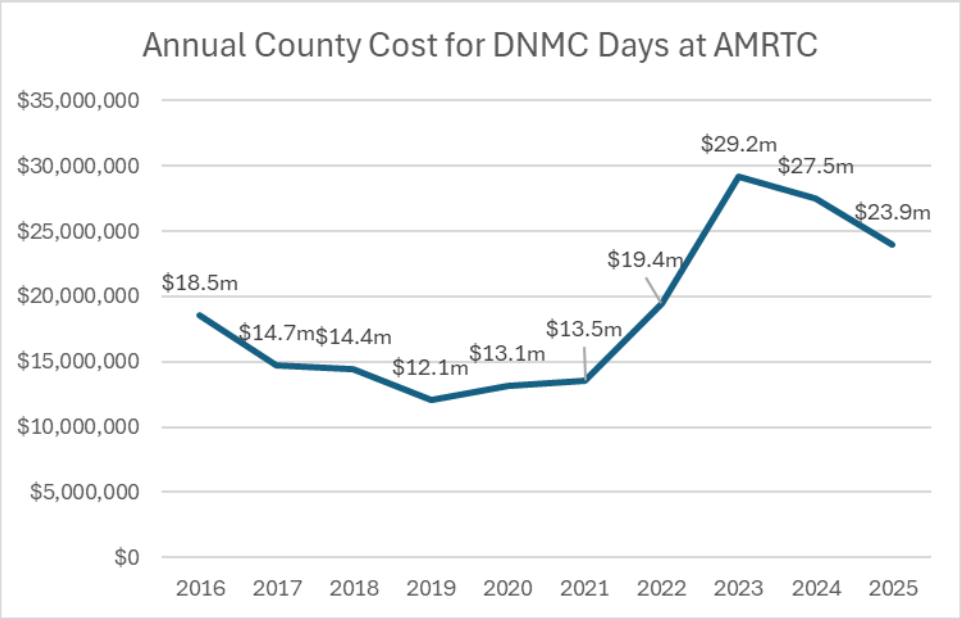
- At AMRTC, counties are financially responsible for 20% of the daily cost of care for days 31 and over, provided the patient meets hospital level of care criteria.
- At AMRTC and CBHHs, counties are financially responsible for 100% of the cost of care when a person no longer meets the medical criteria to remain hospitalized.
- At the FMHP, counties are financially responsible for 10% of the cost of care for each day in the program.
- At Forensic Transition Services (FMHP), counties are financially responsible for 50% of the cost of care for each day in the program.

The 100% cost share at AMRTC and the CBHHs was originally intended to expedite the discharge process and to minimize unnecessary hospital days. Bottlenecks in the process, including a lack of adequate community-based service options, are often the cause of the delay. Additionally, counties must pay the cost of care when a person does not meet medical criteria (DNMC) but is awaiting transfer to another state facility. The total amount paid by counties for DNMC days for AMRTC and the CBHHs continues to rise and is exacerbated by the increasing waiting times for admission to the FMHP and lack of appropriate community resources.

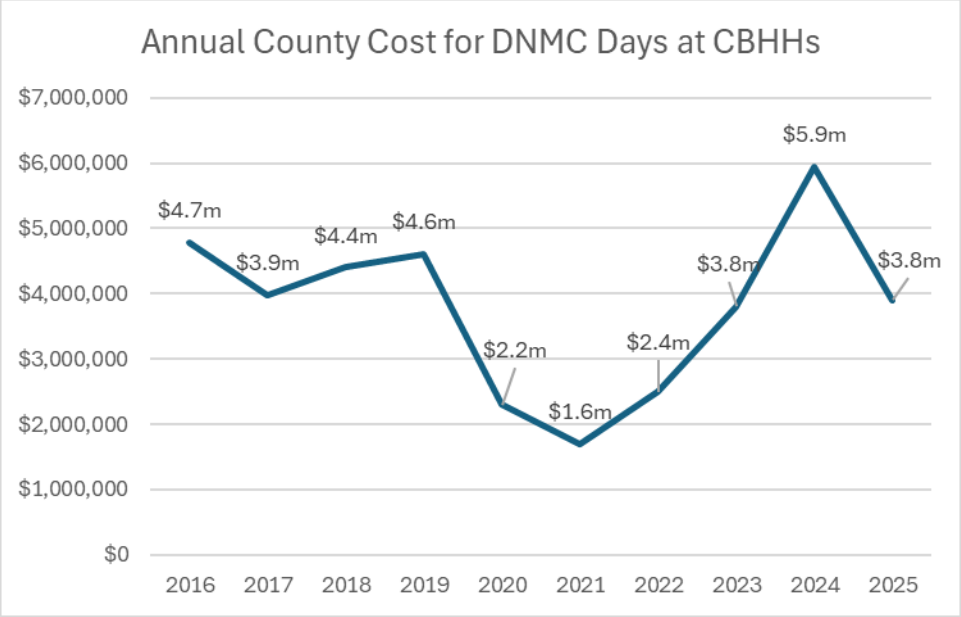
Previous legislation has supported cost relief to counties when situations exist where counties have no authority or ability to influence the timeline surrounding discharge of the person from the hospital. Critical statutory language sunset on June 30, 2025, reinstating this charge to counties.

There is lack of consensus regarding the intention, value and need for this charge to counties. From one perspective, holding counties financially responsible for the cost of care when a person no longer meets medical criteria provides an incentive for counties to expedite the discharge from the hospital to the community for individuals. From another perspective, there are many instances in which the county has no control over influencing the timely discharge of an individual from AMRTC or a CBHH. The acute behavioral needs of some patients combined with an overall lack of adequate community-based treatment options for

a person to discharge to is one type of barrier. Counties are also financially responsible yet unable to influence the discharge date when a person is at AMRTC and is DNMC but must wait for a bed at FMHP, which the data shows can take hundreds of days.



Graph: County cost for non-acute days at AMRTC from 2016-2025 totaled $186,732,000.



Graph: County cost for non-acute days at CBHHs from 2016-2025 totaled $37,899,000.

The 10-year county cost for non-actute days at DCT's AMRTC and CBHHs total $224,631,000 paid to the state's General Fund.

Despite lack of consensus on the intention of the cost assignment, one item that Review Panel members could agree upon is the desire for DNMC payments from counties to be reinvested into building community-based treatment developments rather than being returned to the state's General Fund. This would allow a mechanism for reinvestment of funds into solutions that directly influence these costs and provide much needed care and treatment to Minnesotans.

Status and Discussion of the 48-Hour Period in the Priority Admission Statute: No Recommendation

Beginning in 2023, the Legislature included language in the priority admission statute that only requires DCT to admit someone when there is a medically appropriate bed available for that person. This language has been extended twice, and is currently set to expire, or sunset, in June 2027. Over the past three years, the Priority Admission Task Force and then Review Panel have reviewed this language and the concept of inclusion of specific deadlines in the priority admission statute. In the 2024 and 2025 reports, the Task Force and Review Panel recommended inclusion of the "medically appropriate bed" language to reflect the critical need to ensure that state facilities are not required to admit more people than can safely and therapeutically be served. These reports, however, did not recommend including the "medically appropriate bed" language in statute indefinitely, and the duration of the language was accordingly limited to two years. The 2025 Report further specifically conditioned the recommendation to include "medically appropriate bed" language on resources to expand DCT capacity.

This year's Priority Admission Review Panel continued the discussion of inclusion of specific deadlines in the statute, and the utility of the "medically appropriate bed" language. On the one hand, the "medically appropriate bed" language ensures that state facilities are not over capacity and individuals can be treated safely. As history in Minnesota shows and as discussed in the 2025 Review Panel report, admission of more acutely ill people with significant criminal involvement than available bed capacity jeopardizes the safety of all patients and staff. This in turn threatens licensure of the facilities and their ongoing ability to operate, as well as negatively impacts the retention of qualified professionals.

On the other hand, some stakeholders remain concerned that removing the timeline entirely would eliminate the urgency with which DCT and the Legislature expand access to services. Similarly, the 48-hour timeline in statute and resulting significant number of lawsuits creates pressure on the State to allocate meaningful resources to increased capacity. Given that this Report continues to recommend expansion of critical community capacity, the Review Panel could not agree on relieving the pressure on the State that the sunset provision creates.

Ultimately, Review Panel members did agree that this is a critical issue for Minnesota. There is a common desire and goal among all stakeholders that people deserve the right level of treatment at the time they most need it. Any person in need of treatment at a DCT facility deserves timely access to the essential healthcare services it provides. As this Report and previous Reports have detailed, this requires increasing the overall capacity of mental health care in Minnesota. Due to the unmet capacity needs at this time, the Review Panel could not agree on a recommendation on the current status of the sunset provision of the "medically appropriate bed" language.

Complexities Associated with Forensic Capacity

The Review Panel discussed the population of individuals committed as Mentally Ill and Dangerous as it relates to the wait time experienced for those who are seeking admission and those who are unable to discharge. Mentally Ill and Dangerous commitment processes currently present the largest challenge in terms of access to the DCT Forensic Mental Health Program, as demonstrated by lengthy wait times for access to that program. The issues surrounding this commitment type are complex, and the Review Panel, as well as the Mentally Ill and Dangerous Task Force, have examined the subject extensively. However, stakeholders have not been able to agree on a path forward that will both help ensure community safety and efficient utilization of resources. Therefore, the Review Panel recommends that an independent third-party consultant be identified to assess barriers to access at FMHP, through examination of state and national trends, barriers to admission and discharge from FMHP, and an assessment of capacity needs in FMHP and in the community to meet the needs of the population requiring secure treatment.

Recommendations

Review Panel members unanimously agree that no one should experience a serious mental illness in jail or a correctional institution without appropriate care. Lack of access negatively impacts people and strains local resources. The Review Panel members also agree that there is no simple solution. As indicated in the last two reports, the state needs to increase access to all levels of care while addressing the treatment needs of people who currently are held in jails and correctional institutions without a conviction. We need to ensure that people living with mental illnesses in jails have access to the appropriate level of care, whether it's medication, outpatient level of care, residential care, or the level of care provided at DCT. *And* we must look at how to prevent people with mental illnesses from becoming involved in the criminal justice system by increasing access to care in the community, including crisis services, earlier intervention, outpatient care, residential, or the level of care provided at DCT.

While progress has been made, the recommendations in the previous reports remain necessary. This report also makes new recommendations. All are necessary jointly, not in isolation. Recommendations are grouped by topic areas they support.

Recommendations that Support Expanded Capacity and Access (Detail)

Recommendation 1: Appropriate funding in 2027 session to build out additional IRTS programs, including locked, acute and step-down IRTS; release an RFP by January 1, 2028; and create in statute a new, extended residential treatment service.

The Review Panel encourages the Legislature to appropriate funding to support the Minnesota Department of Human Services (DHS) to immediately prioritize finalizing policy to expand Intensive Residential Treatment Services (IRTS) programs to include locked IRTS programs, acute and step-down IRTS, and the creation of a new, extended residential treatment service focused on individuals whose illness requires treatment far longer than the 90-day limit that exists within an IRTS program. This would include:

- Extending previously unused grant funding for locked IRTS and for the new extended residential treatment service,
- Addressing the policy, licensing and certification concerns in statute to reduce risk, which resulted in previously unutilized grant funding for locked IRTS.
- Implementing a cross-agency systems of care workgroup to explore continuity of care and expand capacity strategically.
- Developing a new type of Medicaid-reimbursed residential treatment program to meet the needs of individuals who are not in need of hospital level of care yet need longer term intensive cares than the time limited nature of an IRTS may provide. This would require the Legislature to direct DHS to seek approval from the Centers for Medicare and Medicaid Services (CMS) for a Medicaid waiver or state plan amendment.

Recommendation 2: The Legislature should authorize and fund the Minnesota Department of Human Services (DHS) to commission an independent, comprehensive assessment of Minnesota's behavioral health system and continuum of care.

The assessment should examine the capacity, roles, and responsibilities of DHS, DCT, Tribes, counties, jails, health systems, and community-based providers across the full behavioral health continuum.

An independent, highly skilled consultant, working with Minnesota behavioral health professionals and stakeholders, should:

- Review existing Minnesota behavioral health studies, reports, and assessments from the past 10 years;
- Review court commitments and provide a current and projected trends of behavioral health related court fillings and court commitments.
- Provide a comprehensive overview of the state's current and projected behavioral health capacity and continuum of care, including hospitals and jails;
- Identify statutory, regulatory, and operational barriers affecting access, admission, treatment, transition, and discharge;
- Assess the appropriate balance of secure treatment, step-down services, Tribal care, and community-based care;
- Develop phased, short-term and long-term recommendations for statewide capacity, service development, and investment, including building and on-going operating costs; and
- The consultants will host and present their findings at a Minnesota Behavioral Health Symposium.

An initial report would review short-term options and provide recommendations to the Legislature by January 1, 2028. The final assessment and recommendations should be submitted to the Legislature by January 1, 2029, following the Minnesota Mental Health Symposium.

Recommendation 3: Reinstitute and expand access to care in jail by re-appropriating the Long-Acting Injectable Pilot Program.

The 2024 Legislature funded a pilot for DHS to reimburse jails for antipsychotic medications, including injectables, to individuals in custody. This pilot helps ensure that medications reach those who most need them, which not only provides better outcomes for individuals, but it also helps create safer environments in jails. The DHS team operating the pilot program reported that not all of the pilot funds had been spent due to the launch time of the pilot program and restrictive language which considerably limited the circumstances under which reimbursement could be provided. The lack of complete expenditure is not indicative of need or value. This pilot sunset as of June 30, 2026, leaving jails without this access to funding for these important and medically necessary medications. Members share concern this sunset will result in delays in access to appropriate medications, increased safety concerns within jails, and increased need for hospitalizations that are avoidable. The Review Panel recommends that the Legislature:

- Reappropriate funding to reinstate the Long-acting Injectable Pilot program with less restrictive language permitting ongoing use of the funds.
- Expand funding under the DCT pilot so that more individuals may benefit with minimal burden on jails.
- Establish and encourage collaboration between community mental health centers and CCBHCs to provide outpatient level of mental health care in the jails and correctional institutions, which will require a mechanism for reimbursement.

Recommendation 4: Expand access to care in jails by expanding the DCT Jail Consultation Services Pilot.

The 2024 Legislature funded a pilot program for Minnesota Direct Care and Treatment (DCT) to create a jail consultation service to survey jails about access to psychotropic medications, study resources available, provide best practice guidance, and provide direct consultation about individuals in need of antipsychotic medications, including *Jarvis* processes. DCT pilot team leaders presented to the Review Panel on their efforts, which included a scaled version of the service to approximately 10 jails across the state. Based on the positive feedback and widespread interest in participation, the Review Panel strongly endorses continuation of this pilot program so more jails in the state can benefit from the service. The pilot program currently serves a small sample of Minnesota counties, and both the leaders of the program and the Review Panel hopes to see this service expand statewide.

The Review Panel recommends that the Legislature provide necessary funding to:

- Continue DCT's Jail Consultation Service program so that the service can benefit more jails and Minnesotans into the future.
- Extend the pilot to permit Tribal correctional facilities to participate.

Recommendation 5: Reinvest more state resources in community-based mental health resources.

The Review Panel recommends that the Legislature increase funding – through reimbursement rates and grant appropriations – for expanded community-based services to free up space at AMRTC and the FMHP. These community-based services include:

- Peer support services (mental health peer specialists, family peers, SUD recovery peers)
- Skills-based services (ARMHS, CTSS)
- Mental health housing supports (Housing with Supports for Adults with Serious Mental Illness – HSASMI)

These services must be delivered with the appropriate regulatory oversight to ensure program integrity and support.

Recommendation 6: Updates to payment models and reimbursement.

Mental health reimbursement rates in Medical Assistance range from 10 percent to more than 40 percent below the costs of delivering the care. A 2024 study commissioned by the Department of Human Services made several recommendations for updates to the current Medical Assistance rates structures. The Legislature took steps in passing major reforms and updates to our Medicaid mental health fee-for-service rates during the 2025 session. Unfortunately, CMS and Congress removed Minnesota's funding mechanism for them. The Review Panel recommends that the Legislature implement two provisions of the 2025 law with general funds:

- Ensuring reimbursement rates for psychological testing will be paid at least 100 percent of the Medicare fee schedule
- Ensuring masters-level educated service providers are reimbursed the same amount as other independently licensed clinicians.

Additional service models that respond to individuals' needs while they are in the community include crisis response and Emergency Psychiatric Assessment Treatment and Health (EmPATH). Mobile crisis services and Certified Community Behavioral Health Clinic (CCBHC) mobile crisis urgent care services are a first line of care when an individual is having a mental health crisis in the community. The Review Panel recommends increased investments to build out these services to increase access to the right care at the right time and address the crisis before it escalates to the point of needing inpatient treatment or resulting in an arrest. EmPATH is a novel psychiatric service offered in emergency departments for same-day psychiatric emergencies. This service decreases emergency department boarding and ensures that inpatient beds are accessible for high-acuity patients. Currently, there is no CPT / Facility code to bill for the EmPATH service accurately. Hospitals are forced to use a combination of other codes including psychiatric evaluation, crisis psychotherapy, and observation, that do not necessarily reflect the service provided. As a result, current Medicare/Medicaid reimbursement models incentivize inpatient admission and prohibit widespread growth of EmPATH. The Review Panel recommends creation of a new CPT/Facility code so hospitals can accurately and fairly bill for this valuable service.

Recommendation 7: Allow counties to reinvest DNMC funding to build community capacity through Adult Mental Health Initiatives.

The Review Panel supports reinvestment of county-paid DNMC funds to expand the adult mental health continuum of care through expansion of Adult Mental Health Initiative (AMHI) funds. Originally created to incentivize expedient discharge from a state-operated facility, DNMC charges are often unavoidable due to

the lack of available community-based resources such as crisis stabilization units, mobile crisis teams, locked IRTS, voluntary engagement, and mental health housing supports.

County-paid DNMC dollars should be returned to the counties through a reinvestment in Adult Mental Health Initiative funding for counties or AMHIs that desire to use the funds for community-based service capacity building. This will require an expansion of the allowable expenses under the AMHI, including the use of capital purchases, and investments in renovations, planning, personnel and training resources

Recommendations that Support or Endorse Existing Work or Plans (Detail)

Recommendation 8: Renew the exception allowing up to 10 patients per year from community hospitals to be prioritized for admission to a DCT program for the next biennium.

In 2024, the Minnesota Legislature approved a Task Force recommendation to allow a one-time exception for up to 10 hospitalized patients to receive priority admission. This measure was intended to relieve the significant pressures community hospitals face when caring for individuals with complex symptoms and challenging behaviors. The exception has helped community hospitals support more people in the community while ensuring that some of our most vulnerable patients gain access to the level of care most appropriate to their needs. The Review Panel supports the following:

- Continue this exception annually for the next biennium, with a follow-up evaluation at that time to assess ongoing needs.

Recommendation 9: Support the work of the DHS Case Management Redesign Project

Review Panel members support the DHS Case Management Redesign initiative to assure the sustainability of this critical Medicaid-funded service and urge the legislature to adopt the recommendations formulated by this work to improve quality, access, outcomes, and financial sustainability of Targeted Case Management services.

Recommendation 10: Support implementation and future statewide expansion of 1115 Reentry Waiver, including pretrial access.

The 2024 Minnesota Legislature instructed DHS to apply to CMS for a 1115 Reentry Waiver with the intention of expanding Minnesota's Medicaid benefit to certain incarcerated individuals. The Review Panel:

- Acknowledges the significance of this request and investment the state plans to make in treating behavioral health and chronic medical conditions for people who are incarcerated.
- Supports the work of DHS and the Department of Corrections (DOC) as they work with CMS to seek approval of the waiver.
- Encourages DHS and DOC to complete readiness work with the Phase I facilities to expedite implementation once the waiver is approved and implore the Legislature to resource Phase II with the goal of statewide implementation.

Appendices

Appendix 1: Expansion of Section 1115 Waiver

Under federal law, Medicaid generally cannot pay for health care services while someone is in custody, except for inpatient hospital care. As a result, many eligible individuals lose access to Medicaid-reimbursable services during incarceration and often immediately upon release. A Section 1115 waiver is an approval of a state's request to implement innovative strategies within its Medicaid program to improve health outcomes, expand access, or enhance efficiency. These strategies must align with Medicaid's objectives and be financially neutral to the federal government. If approved, a Section 1115 waiver would enable Minnesota to extend Medicaid coverage to certain services before release, helping close a long-standing gap in healthcare for individuals in correctional settings.

A Section 1115 Medicaid waiver would authorize Minnesota to use Medicaid funds to cover specific health and care coordination services for incarcerated individuals up to 90 days before release. These services typically include case management, medication-assisted treatment (MAT) for substance use disorders, and a 30-day supply of prescribed medications at release. These services are designed to support continuity of care during a critically high-risk period for serious health issues, such as overdose, suicidal behaviors, hospitalization, and poor management of chronic disease. Continuity in mental treatment, including substance use disorder, has been shown to decrease recidivism, the incidence of reoffending, and improve overall reentry success. By enabling pre-release coverage and care planning funded through Medicaid, the waiver aims to reduce adverse outcomes, including death, while assisting individuals in accessing critical services. Section 1115 waivers will free resources and reinvest savings into expanding and enhancing reentry and treatment programs for justice-involved individuals and decreasing mortality, ultimately supporting successful reentry, an initiative that is both fiscally responsible and focused on public health.

Appendix 2: IRTS Workgroup Report

Executive Summary and Overview

A Review Panel workgroup convened to explore community-based locked intensive residential treatment facilities capable of admitting patients waiting for court-ordered treatment in jails, hospitals, and the community. The workgroup reviewed Minnesota's Intensive Residential Treatment Services (IRTS) benefit, with a specific focus on understanding how the current IRTS model meets the needs of individuals across the behavioral health continuum of care and to explore the potential role of a locked IRTS or analogous benefit. The workgroup's review focused on the role IRTS play within the behavioral health continuum of care, with particular emphasis on how a locked IRTS may support individuals whose needs exceed the capacity of unlocked IRTS settings but do not meet criteria for continued inpatient hospitalization. The purpose of this review was not to develop final policy or implementation details, but to identify key areas for consideration, system impact, and future recommendations, including concepts not available in current legislation.

The workgroup examined where IRTS fit within the broader systems of care, including needs that stretch or fall outside of the existing IRTS structure, necessary services and supports before IRTS placement, and

necessary services and supports after discharge to ensure continuity, stability, and recovery. Particular attention was given to gaps that contribute to inappropriate placement, service delays, and cycling between hospitals, residential settings, and the justice system.

Minnesota continues to face a significant shortage of state and community-based mental health resources, creating gaps that leave individuals without timely access to appropriate care and place pressure on hospitals, jails, and families. Limited availability of residential treatment, supportive housing, and step-down services has contributed to the overall lack of capacity for court-ordered mental health treatment, resulting in long waitlists, delayed discharges, and the use of settings that are more restrictive or less therapeutic than clinically necessary. As a result, people with serious mental illness are often forced to cycle between crisis services, emergency departments, or correctional facilities rather than receiving consistent, recovery-oriented care in the community. Expanding the availability and range of community-based mental health resources is critical to building a balanced continuum of care in Minnesota, reducing system bottlenecks, and ensuring individuals receive the right level of support at the right time.

Overview of Intensive Residential Treatment Services (IRTS)

IRTS emerged as a structured, community-based alternative to hospitalization, focused on stabilization and recovery. IRTS initially fell under Rule 36 which was originally identified in the early 1980s to regulate Adult Mental Health (AMH) following statewide deinstitutionalization. Variances were created to fill gaps in recovery-focused and time-limited care. IRTS is a community-based, medically monitored level of care for an adult client that uses established rehabilitative principles to promote a client's recovery and to develop and achieve psychiatric stability, personal and emotional adjustment, self-sufficiency, and other skills that help a client transition to a more independent setting.

Below are the IRTS eligibility requirements under Minn. Stat. 245I.23, sub. 15 & 256B.0622:

- Age 18 or older
- Diagnosed with a mental illness
- Because of a mental illness, has a substantial disability and functional impairment in three or more areas listed within the functional assessment that markedly reduce the individual's self-sufficiency
- Has one or more of the following: a history of recurring or prolonged inpatient hospitalizations during the past year; significant independent living instability, homelessness, or very frequent use of mental health and related services with poor outcomes for the individual
- In the written opinion of a mental health professional (defined in Minn. Stat. 245I.04, subd. 2), needs mental health services that available community-based services cannot provide, or is likely to experience a mental health crisis or require a more restrictive setting if the individual does not receive intensive rehabilitative mental health services.

IRTS within the Current Continuum of Care

DCT currently operates three 16-bed IRTS facilities, formally known as the Minnesota Specialty Health System (MSHS). These facilities are licensed by the Minnesota Department of Health as supervised living facilities and licensed and certified by the Minnesota Department of Human Services (DHS) as IRTS

programs. DHS also establishes reimbursement rates for DCT services. All MSHS facilities are accredited by The Joint Commission. Although DCT is funded through a legislative appropriation, for any collections services provided are returned to the state's general fund; DCT does not retain revenue or collections.

DCT's MSHS facilities located in Willmar, Wadena, and Brainerd. As specified in the service delivery plan approved by DHS, the Brainerd facility is designed to provide specialty care for individuals with a traumatic brain injury (TBI). Because of the narrow eligibility criterion, it is rare—but does occasionally occur—that the Brainerd location will admit a voluntary client with a TBI when no committed individual meeting that diagnostic criterion is on the waitlist.

MSHS primarily serves individuals who are difficult to place or engage in other community-based IRTS settings, rather than focusing on commitment status. While some MSHS clients are transferred directly from the hospital under full commitment, the majority have been provisionally discharged from their commitment.

Many individuals served by DCT have pending criminal charges and are subject to conditions of release (commonly referred to as bail conditions) that require treatment to occur in a locked or secure setting. MSHS facilities are flex-locked, not fully locked. This means that unless a client presents an immediate risk to themselves or others, staff are required to open doors upon request. While an IRTS setting is often clinically appropriate and effective in supporting treatment goals, the physical limitations of a flex-locked environment may render it unacceptable to criminal or civil commitment courts that require a locked or secure setting.

For individuals subject to court-ordered placement at MSHS but who do not successfully complete treatment and instead leave prematurely, DCT notifies law enforcement of the individual's departure. The individual then faces the legal consequences associated with violating conditions of release. Law enforcement response varies, and it is important to note that MSHS facilities are typically located outside the person's county of commitment and/or the county in which the criminal charges are pending.

The prevention and management of disruptive behavior is also a significant concern for DCT staff working within MSHS facilities. Licensing regulations prohibit the use of restraint or seclusion, even in situations where limited physical intervention may be clinically necessary to help a client regain behavioral control and maintain safety. The absence of these therapeutic tools constrains DCT's ability to safely serve some individuals whose behavioral needs exceed what can be managed in this setting.

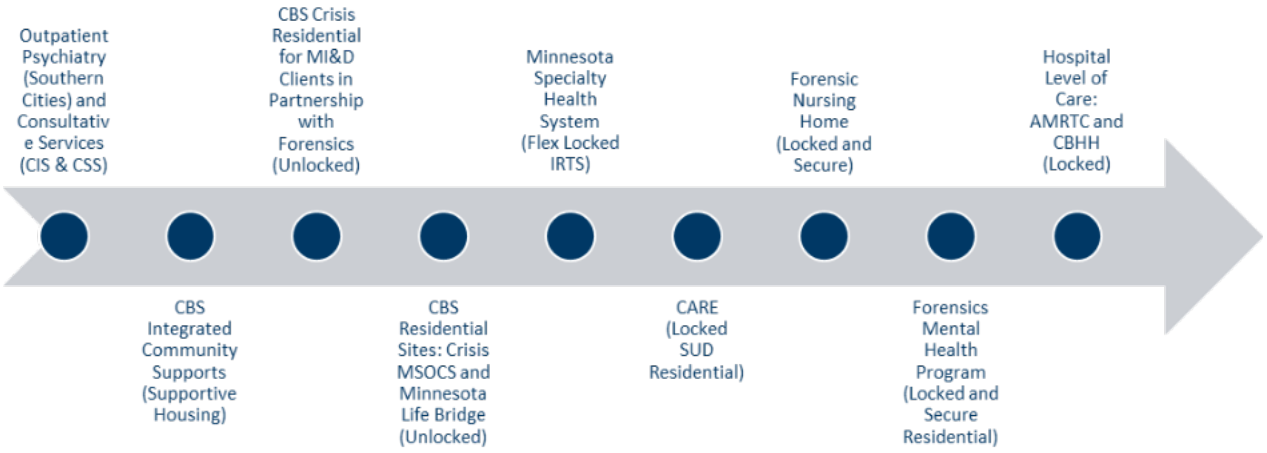
While MSHS, as a state-operated, flex-locked IRTS program, is a viable and effective solution for many individuals who no longer meet hospital-level criteria but continue to require structured treatment, it is not appropriate for everyone. In particular, individuals with serious criminal charges and court-ordered conditions requiring a secure environment may not be suitable for placement in a facility that must open its doors absent an imminent safety risk. Beyond physical limitations, the inability to employ hands-on therapeutic interventions when clinically necessary further restricts who can be served.

IRTS treatment is limited to 90 days without prior authorization. Individuals with long-standing, deeply reinforced behavioral patterns may require longer treatment durations to establish and sustain more adaptive behaviors. The time-limited nature of IRTS, combined with the absence of an appropriate step-

down option following discharge—especially when criminal court conditions remain a barrier—creates additional challenges.

What remains unmet is the need for a locked and/or secure treatment setting that allows for longer-term care and includes appropriate therapeutic tools to safely prevent and manage disruptive behaviors. Such a setting would fill a critical gap in the current continuum of care.

DCT and DHS Service Continuums



The mental health continuum diagrams above reflects the range of available clinical mental health services, from community-based supports through residential and inpatient care. In practice, the continuum should be understood as multidimensional, intersecting with housing, disability, and long-term support systems. People with serious mental illness may move from intensive mental health treatment into group homes, customized living arrangements, supported housing, or disability waiver services, not because their mental health needs have resolved, but because these settings are better equipped to provide daily structure, supervision, or long-term supports. Recognizing this reality is critical for system planning, as outcomes are shaped not only by mental health services, but by how effectively the continuum connects with adjacent systems that sustain stability and quality of life over time.

Exploration of a Locked IRTS

Community-based resources are essential to effectively addressing mental illness because they provide treatment and supports in settings that promote stability, recovery, and integration into everyday life. A strong mental health system relies on a full continuum of community-based options that can respond to varying levels of acuity and support needs, reduce reliance on hospitals and jails, and allow individuals to receive care in the least-restrictive setting appropriate to their needs. Within this continuum, locked IRTS play a critical role in filling the gap between inpatient hospitalization and open residential programs. Locked IRTS offer a treatment-focused, community-based option for individuals who require structured care and controlled egress due to safety or legal considerations, while still emphasizing recovery and transitioning to less restrictive settings. By expanding this level of care, Minnesota can strengthen its mental health continuum, improve access to timely treatment, and better align services with individuals' clinical and functional needs.

Currently, many patients are court-ordered to receive treatment in a locked facility due to serious safety concerns if the patient were to elope. Locked treatment is currently unavailable outside of hospital-level care and DCT's Community Addiction Recovery Enterprise program. This means many patients who are ready for a lower level of care wait in hospitals for weeks or months longer than is needed, violating their right to treatment in the least restrictive environment for their needs and wasting finite resources that other patients could use. A locked IRTS model could function as a more integrated treatment alternative consistent with the state's *Olmstead* obligations, reduce the time people spend in jails ill-equipped to meet their treatment needs, preserve admission to AMRTC for those who truly need that level of care, and reduce pressure and financial strain on community hospitals.

Appendix 3: Long-Acting Injectable Pilot and the Larry R. Hill Medical Reform Act

Constitutional Duty	APA/NAMI Principle	Pilot Activity
Provide adequate psychiatric care (*Estelle v. Gamble*)	APA: Correctional psychiatric care must meet community standards	Onsite jail assessments; psychiatric consultation
Avoid deliberate indifference (*Farmer v. Brennan*)	NAMI: Ignoring serious mental illness causes harm and rights violations	Identification of treatment gaps; targeted technical assistance

Ensure medication continuity	APA: Continuity of psychotropic medication is essential	Expansion of access to oral and LAI antipsychotics
Use evidence-based treatment	APA: Use evidence-based psychopharmacology	LAI education, pharmacy consultation, protocols
Prevent foreseeable psychiatric deterioration	NAMI: Untreated psychosis increases risk of harm and recidivism	LAIs to reduce relapse, crisis, and emergency intervention
Ensure lawful involuntary treatment	APA Ethics: Legal and ethical safeguards required	Training on commitment and Jarvis procedures
Reduce punitive responses to mental illness	NAMI: Promote treatment-oriented justice responses	De-escalation and engagement training
Reduce litigation and federal oversight	APA/NAMI: Systemic reform preferable to court orders	Legislative reporting and oversight mechanisms

The County Correctional Facility Support Pilot Program

The County Correctional Facility Support Pilot Program ("Jail Consultation Pilot") administered by DCT represents a clinically evidence-based response to systemic deficiencies in mental health care within Minnesota's county jails. Authorized by the Minnesota Legislature in 2023, the pilot was developed following findings of the Task Force on Priority Admissions to State-Operated Treatment Programs. The Task Force identified persistent barriers to psychiatric assessment, medication continuity, lawful involuntary treatment, and interagency coordination for individuals living with serious mental illness confined to correctional facilities. These failures not only violate constitutional standards governing correctional health care but also align with longstanding advocacy concerns raised by multiple stakeholders, including corrections staff, members of law enforcement, the American Psychiatric Association (APA), the state branch of the APA, the Minnesota Psychiatric Society, and the National Alliance on Mental Illness (NAMI).

Constitutional Standards of Care

The Eighth Amendment imposes an affirmative duty on correctional systems to provide adequate medical and psychiatric care. In *Estelle v. Gamble*, 429 U.S. 97, 104–05 (1976), the U.S. Supreme Court determined that deliberate indifference to serious medical needs constitutes cruel and unusual punishment. The Supreme Court further clarified in *Farmer v. Brennan*, 511 U.S. 825, 837 (1994), that deliberate indifference

exists when officials know of and disregard an excessive risk to inmate health or safety. Failures to provide timely psychiatric evaluation, continuity of antipsychotic medication, or lawful involuntary treatment mechanisms create foreseeable risks of decompensation, self-harm, use of force, and prolonged incarceration, exposing counties and the state to significant liability. Inadequate psychiatric assessments, interruptions of necessary psychotropic medications, or failures to provide lawful involuntary treatment mechanisms can expose correctional systems to constitutional liability under this standard.

Constitutional, Clinical, and Policy Framework for the Jail Consultation Pilot

The Jail Consultation Pilot is a two-year pilot funded at $2.387 million for fiscal year 2025. The pilot offers education, technical assistance, and onsite consultation to county jails. The focus is on psychiatric assessment, the administration of psychotropic medications (including long-acting injectables), and legally compliant involuntary treatment processes. In October 2024, a multidisciplinary team composed of psychiatry, nursing education, pharmacy, quality improvement, and program leadership was established to operationalize these goals.

The initial implementation of the pilot involved conducting a statewide survey of 436 county stakeholders, resulting in responses from 87 counties and expressed interest from 35, leading to more than 10 contracted counties. The selection of partners prioritized geographic equity, limited access to community mental health infrastructure, jail size, and opportunities to evaluate diverse operational models. Early experiences highlight the significance of cross-sector collaboration among jail administration, clinical staff, county attorneys, and human services staff, as well as persistent challenges such as staffing shortages, limited mental health expertise, and discomfort with involuntary treatment processes.

Overall, the Jail Consultation Pilot represents a proactive initiative aimed at mitigating the risk of deliberate indifference, enhancing patient safety, and aligning county jail practices with nationally recognized professional and advocacy standards.

Alignment with APA and NAMI Advocacy

The pilot aligns with long-standing advocacy positions of the APA and NAMI. The APA has consistently affirmed that individuals in correctional settings are entitled to psychiatric care equivalent to community standards, including continuity of evidence-based pharmacologic treatment and adherence to professional ethical obligations (APA, *Position Statement on Psychiatric Services in Correctional Facilities*, 2015; APA, *Practice Guideline for the Treatment of Patients With Schizophrenia*, 3rd ed.). NAMI has similarly identified jails as de facto mental health institutions and has advocated for improved access to treatment, medication continuity, expanded access to treatment, medication continuity, and diversion-oriented approaches to reduce recidivism and human suffering.

Clinical Importance of Long-Acting Antipsychotics (LAIs)

These efforts align closely with community standards as established by APA policy, which emphasizes that individuals with serious mental illness in correctional settings are entitled to timely psychiatric evaluation, continuity of evidence-based medication treatment, and care consistent with professional ethical standards.

A core focus of the pilot is expanding access to long-acting injectable antipsychotics (LAIs). LAIs are given by injection and designed to release the medication slowly in the body over an extended period of time. This evidence-based treatment is for individuals living with schizophrenia and other serious mental illnesses, particularly those with histories of medication non-adherence, repeated hospitalization, or justice involvement. Peer-reviewed research and APA practice guidelines demonstrate that LAIs reduce relapse, rehospitalization, symptom exacerbation, and criminal justice contact when compared with oral-only regimens.

LAIs improve cognition, promote sustained symptom control, and long-term recovery. For many patients with schizophrenia and other serious, chronic mental health disorders, daily oral medication regimens are difficult to maintain due to cognitive symptoms, lack of insight during illness exacerbations, housing instability, or disruptions in access to care. LAIs address these barriers by providing consistent therapeutic levels of medication over weeks or months, reducing the burden on the patient to manage daily dosing and decreasing the likelihood of abrupt treatment interruption. From the patient's perspective, medication continuity is not merely a matter of convenience; it is essential to preserving dignity, safety, and autonomy. Interruptions in antipsychotic treatment are strongly associated with symptom exacerbation, psychiatric hospitalizations, increased risk of self-harm, and encounters with emergency, law enforcement, or carceral systems. LAIs reduce these risks by stabilizing symptoms over time, allowing individuals to engage more effectively in treatment planning, participate in court proceedings, and make informed decisions about their care.

Further, by decreasing relapse rates, LAIs reduce the need for coercive interventions such as involuntary emergency hospitalization and biological treatment, physical or chemical restraint, less lethal weapons, or outcomes that are often experienced by patients as frightening, stigmatizing, and harmful. There is published evidence linking LAI use to reduce criminal justice system encounters, including arrests and jail admissions, particularly among people with schizophrenia or schizoaffective disorder. In this way, LAIs support recovery-oriented care and align with ethical principles emphasizing least-restrictive treatment and respect for patient autonomy.

In correctional settings, the reliance on daily oral medications is often impractical due to staffing shortages, transfers, court appearances, and security disruptions. Interruptions in antipsychotic treatment are well-documented triggers for psychiatric crises, behavioral incidents, segregation placement, and emergency hospitalizations. Clinicians and administrators are aware of these risks but fail to implement clinically appropriate alternatives, which may even rise to the level of deliberate indifference under the principles of *Estelle* and *Farmer*. Moreover, the cost of medication remains a significant barrier because it is unpredictable and based on real-time population needs that fluctuate based on the incarcerated population. The Review Panel recognizes the importance of funding flexibility to carry forward unused funds from each quarter as a crucial change.

The benefits of sustained treatment adherence extend beyond the individual to their peers, correctional staff, and the broader community. While individuals living with mental health disorders are more likely to be a victim rather than a perpetrator of violence, stable psychiatric symptoms reduce the likelihood of behavioral crises that place patients and others at risk, including incidents of self-injury, victimization, unintentional harm, or violence against others. Consistent treatment of serious mental illness is associated

with lower rates of re-hospitalization and reduced contact with the criminal legal system, contributing to improved public safety through prevention rather than punishment. When people living with serious mental illnesses cycle between homelessness, psychiatric decompensation, and incarceration, LAIs may be a valuable tool to support continuity of treatment and broader social stability.

Importantly, the appropriate use of LAIs must always be guided by individualized clinical assessment, informed consent whenever possible, and adherence to legal and ethical safeguards. When implemented in this manner, LAIs represent a patient-centered intervention that promotes stability, recovery, and long-term well-being, while simultaneously advancing public safety and reducing preventable harm.

Larry R. Hill Medical Reform Act: Clinical, Constitutional, and Patient-Centered Considerations

The Larry R. Hill Reform Act was enacted to provide "improved medical care in licensed facilities" by increasing access to psychotropic medications for individuals living with serious mental illness in carceral settings while awaiting admission to state-operated treatment facilities. The Act reflects a critical civil rights objective. However, its implementation has revealed structural gaps that undermine patient wellness. A 2023 statewide health assessment also found that around 64 percent of adults experiencing homelessness have serious mental illness, and about 24 percent have substance use disorders, with half having more than one serious condition. Homeless populations in Minnesota have elevated rates of mental health challenges and substance use – factors strongly linked with high emergency department utilization. Frequent users are commonly defined as people with four or more emergency visits per year. Unhoused people who frequently use hospital emergency departments are more likely to have a serious mental illness, substance use disorders, interrupted medication access, and lack of outpatient care.

Given these facts, language that prevents physicians and other health care providers from using standard safety measures such as medication reconciliation to determine what medications should be continued may lead to more adverse consequences for patients. (*see* Minn. Stat. 241.021, subd. 4f. Provision of medications in correctional facilities. (a) Correctional facilities licensed by the commissioner shall administer to confined and incarcerated persons the same medications prescribed to those individuals prior to their confinement or incarceration.) Further, such proscriptive language could lead to continued treatment when there is a high risk of a medication interaction – dosing at the last documented dose after a period of non-adherence increases the risk of a serious complication such as when prescribing an antipsychotic like clozapine or a mood stabilizer like lamotrigine.

The Larry R. Hill Medical Reform Act also requires health care professionals to defer any medication changes until a physician or midlevel provider who prescribed the individual's medications is notified. This requirement is inappropriate given the high utilization of emergency room physicians by unhoused populations who are overrepresented in carceral settings. It is critical that a licensed health care professional at the correctional facility makes a reasonable effort to review available medical records, reconcile prescribed medications, review medication administration records, consult with a guardian and/or community supports, and determine treatment adherence using objective measures (such as drug levels) when feasible. These elements are consistent with well-established community standards.

A critical gap in the Act's implementation is the absence of explicit guidance or support for the use of evidence-based psychiatric treatments while in custody, leaving counties vulnerable to inconsistent practices and exposing individuals to avoidable harm. For example, the Act does not require access to psychiatrists, continuity of antipsychotic medication, or use of long-acting injectables while individuals await admission. In addition, there is no established accrediting or certifying organization such as the National Commission on Correctional Healthcare to assist a jail or prison in obtaining the standards and resources to meet established "minimal standards for these facilities with respect to their management, operation, physical condition, and the security, safety, health, treatment, and discipline of persons confined or incarcerated therein." Without parallel investment in jail-based psychiatric capacity, including medication continuity and lawful involuntary treatment mechanisms, jails face heightened exposure to constitutional violations, staff safety incidents, and litigation.

Counties report reluctance to pursue civil commitment or *Jarvis* procedures due to uncertainty about priority admission eligibility, fear of rejection, or concern that pursuing treatment may prolong custody. This hesitancy delays clinically indicated care, exacerbates psychiatric deterioration, and undermines both patient outcomes and public safety. Specifically, refinement of the Larry R. Hill Reform Act should include (1) explicit interim care standards for individuals awaiting admission; (2) authorization and support for evidence-based treatments such as long-acting antipsychotics in jail settings; and (3) sustained funding and reporting requirements tied to measurable outcomes. Centering patient stability, dignity, and recovery – particularly through continuity of biological treatment – protects individual rights while improving safety outcomes for communities and reducing avoidable litigation.

Conclusion

The Jail Consultation Pilot mitigates risks by supporting constitutionally adequate care during extended custody periods, including education and consultation on lawful, ethical, and patient-centered use of long-acting antipsychotics. However, pilot-based interventions alone are insufficient to address a statewide statutory gap in access to the most appropriate placement.

The Review Panel cautions that untreated serious mental illness in county jails poses substantial risks to constitutional compliance, public safety, and patient welfare. Continuity of evidence-based psychiatric treatment, including long-acting injectable antipsychotics when clinically indicated, reduces relapse, behavioral crises, and recidivism. Sustained treatment adherence supports improved functional outcomes, including enhanced capacity for informed decision-making, engagement in legal proceedings, and participation in recovery-oriented planning. Importantly, when individuals receive consistent and appropriate psychiatric treatment, the risk of behavioral crises that endanger themselves or others is significantly reduced. In this way, patient-centered treatment continuity advances public safety through prevention rather than punishment.

Ongoing legislative oversight is crucial to ensure consistent implementation, prevent constitutional violations, and mitigate costly litigation impacting individuals, counties, and the state. While the Larry R. Hill Medical Reform Act signifies a commitment to reform, its success hinges on realistic implementation, robust clinical infrastructure, and sustained oversight. When combined with the Jail Consultation Pilot, evidence-based medication strategies, and legislative accountability, the Act can progress towards its objective of

safeguarding individual civil rights while enhancing safety and outcomes. However, without these supportive measures, it inevitably leads to predictable constitutional and clinical failures that adversely affect individuals, staff, counties, and the state.

Appendix 4: Letter from Select Review Panel Members

To: Laura Sayles, Director of Government Relations, MN Attorney General's Office Teresa Steinmetz, Deputy Commissioner, Department of Human Services

From: Association of Minnesota Counties: Tarryl Clark, Stearns County Commissioner
Minnesota Association of County Social Service Administrators: Angela Youngerberg, Consultant
Minnesota County Attorney's Association: Kevin Magnuson, Washington County Attorney
Minnesota Sheriffs' Association: Bryan Welk, Cass County Sheriff

Re: Priority Admissions Review Panel – August 18, 2026, vote

Date: August 28, 2026

As dedicated members of the Priority Admissions Review Panel, we believe it is important to provide the rationale for the county members' difficult decision to vote against supporting the Priority Admissions Review Panel report. The dissenting votes were cast only after careful consideration and serious deliberation. County members supported each of the specific recommendations included in the report, often with the expectation that other recommendations would be stronger or more concrete. In the end, the fact that we collectively voted to oppose the report as a whole reflects our view that the report falls materially short of the Panel's legislative charge. Taken together, the recommendations do not provide the substantive, concrete, and timely solutions needed to address the urgent needs of Minnesotans.

The Legislature charged the Priority Admissions Review Panel with preparing a 2026 report addressing multiple requirements. Although the final report fulfilled many of those requirements, county members believe two core issues were not sufficiently addressed in the report or its final recommendations:

- "develop policy and legislative proposals related to the priority admissions timeline that minimize litigation costs, maximize capacity in and access to direct care and treatment programs, and address issues related to individuals awaiting admission to direct care and treatment programs in jails and correctional institutions."

- "review quarterly data provided by the DCT Executive Board to measure the impact of changes, including priority admission waitlist data, data regarding engagement by the admissions team, priority notice data and other similar data relating to admissions."

County members have repeatedly expressed concern about the lack of movement for individuals who are being held in jails, unconstitutionally, while awaiting a hospital bed at a state facility. DCT has made

significant strides to maximize capacity within existing resources; however, it remains unable to meet the current demand for services. Last quarter alone, 35 individuals were referred to the state's Forensic Mental Health Program (FMHP), and only seven were admitted. The data indicates that this pattern has remained consistent over the past four quarters. Of the seven individuals admitted last quarter, one person waited—likely in jail—for 821 days before admission to the state hospital, despite having a court order. This is not an isolated occurrence; in the three preceding quarters, the longest wait times ranged from 517 to 679 days. Counties are grateful to the Legislature for the funding to support the needed 50-bed expansion at AMRTC, however it is essential to know these new beds will not provide relief to the growing population awaiting placement at FMHP.

The Priority Admissions Review Panel only reviewed this data during its final meeting, and only after county members urged the panel to devote time to examine it. The data was not reviewed on a quarterly basis as directed by the Legislature. As a result, county members are concerned that the urgency of the situation is understated in the report's recommendations.

Counties firmly believe that addressing this critical situation requires increased capacity both in the community and in hospital settings. Jails have become the de facto hospital system for individuals awaiting appropriate treatment, and Minnesotans are not well served when this becomes the default solution. The recommendations on which the panel reached consensus are, in our view, insufficient to meet the panel's charge and leave too many people who have not been convicted languishing in jails without the treatment they need. For this reason, county members opposed the final report.

We look forward to continuing this work and advocating on behalf of our associations to support meaningful legislation that improves the priority admissions system.

Signed:

Association of Minnesota Counties: Tarryl Clark, Stearns County Commissioner

Minnesota County Attorney's Association: Kevin Magnuson, Washington County Attorney

Minnesota Association of County Social Service Administrators: Angela Youngerberg, Consultant

Minnesota Sheriffs' Association: Bryan Welk, Cass County Sheriff

Cc: Priority Admissions Review Panel Membership

Appendix 5: Priority Admissions Framework Quarterly Dashboard Reports

DCT Priority Admissions Framework – Quarterly Data Dashboard 7/1/25 –9/30/25

DIRECT CARE AND TREATMENT

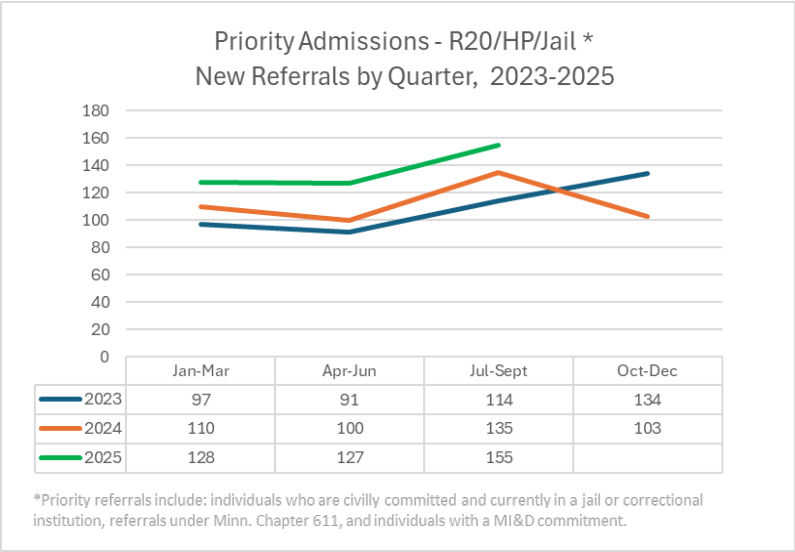
Executive Summary

This dashboard provides a snapshot of Direct Care and Treatment's priority admissions to state-operated behavioral health programs from July 1, 2025, through September 30, 2025. This period represents the first quarter of the state fiscal year 2026. Admissions are to programs in the agency's Community Based Services (CBS), Forensic Services (FS) and Mental Health and Substance Abuse Treatment Services (MHSATS) service lines.

Key findings include:

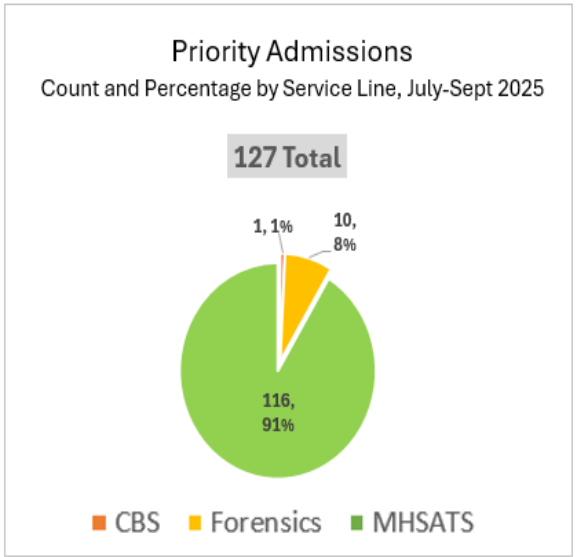
- A 22% increase in new priority referrals as compared to the prior quarter.
- Wait time (days) for priority admissions for MHSATS averaged 18 days or less for the quarter.
- Priority referrals on the active wait list counts have remained stable but show a slight decrease in time on the wait list.

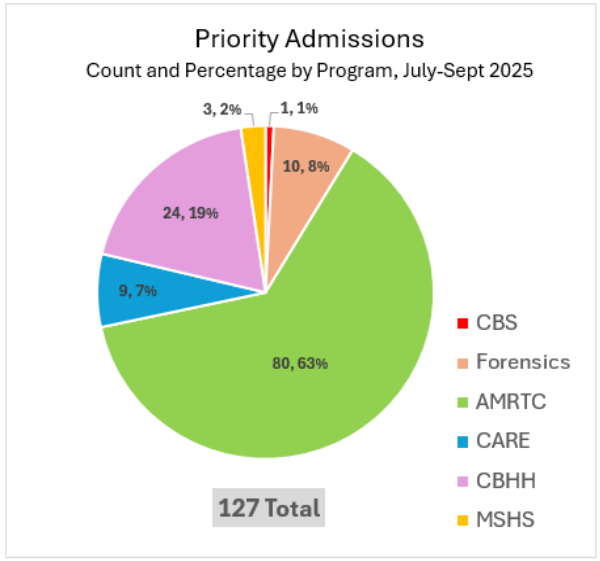
The data indicates that despite an increased number of new referrals, the wait time for admissions showed improvement. Although overall admission numbers during the quarter were slightly lower, wait times for admission show a significant decrease for the MHSATS service line and a slight decrease for Forensic Services.



	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec
2023	97	91	114	134
2024	110	100	135	103
2025	128	127	155	

*Priority referrals include: individuals who are civilly committed and currently in a jail or correctional institution, referrals under Minn. Chapter 611, and individuals with a MI&D commitment.

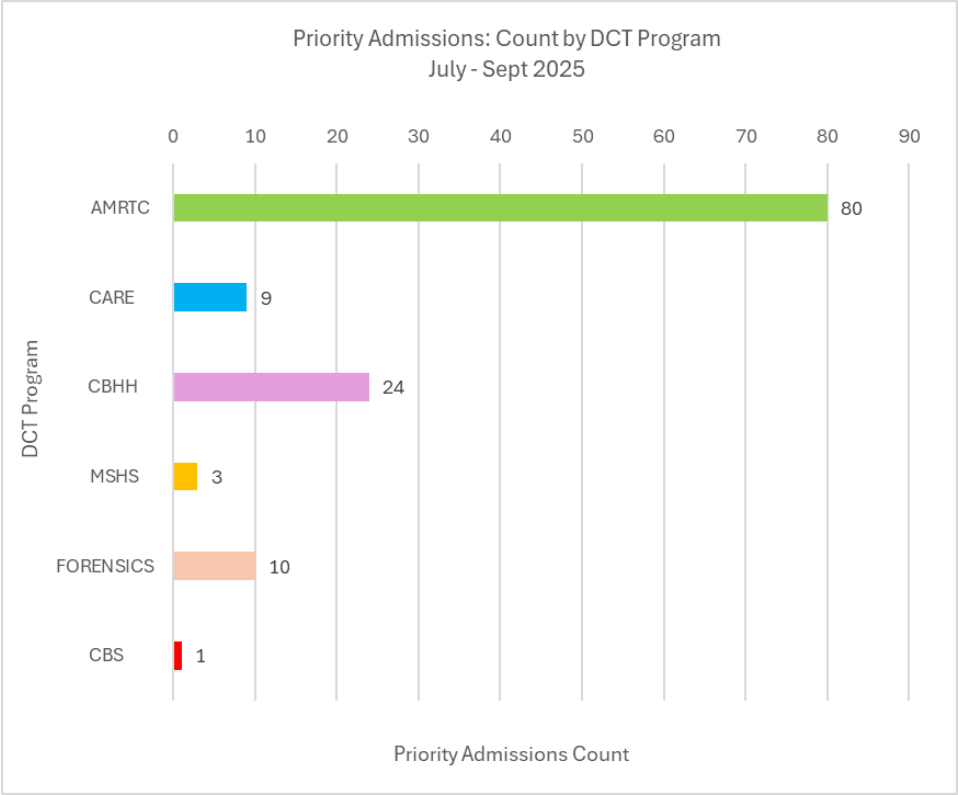


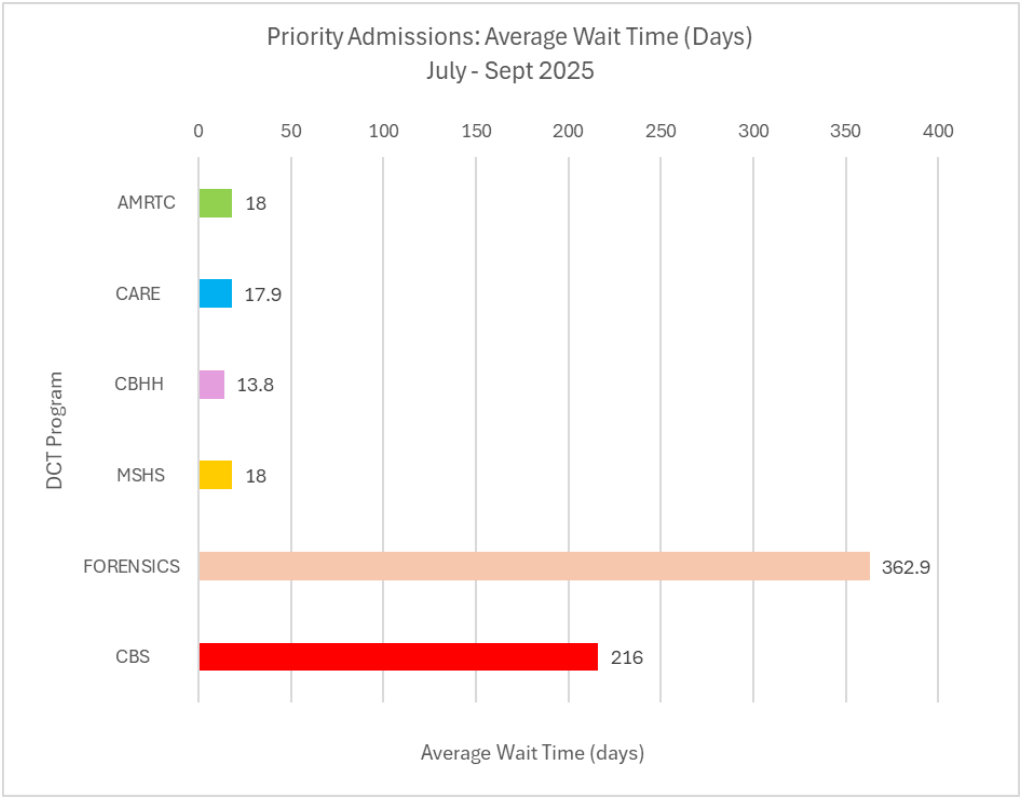


DCT Priority Admissions Framework – Quarterly Data Dashboard

7/1/25 –9/30/25

Priority Admissions (July -Sept 2025)						
Releasable Referrals	Summary			Source Location		
	Count	Avg *(days)*	Range *(days)*	Jail/Prison	Community	Hospital
AMRTC	80	18	6-104	80	-	-
CARE	9	17.9	12-32	9	-	-
CBHH	24	13.8	7-38	24	-	-
MSHS	3	18	43-98	3	-	-
Forensics	10	362.9	5-679	10	-	-
CBS	1	216	216	1	-	-
Total	**127**					
Transitions	9	57.5	4-245	8	-	1



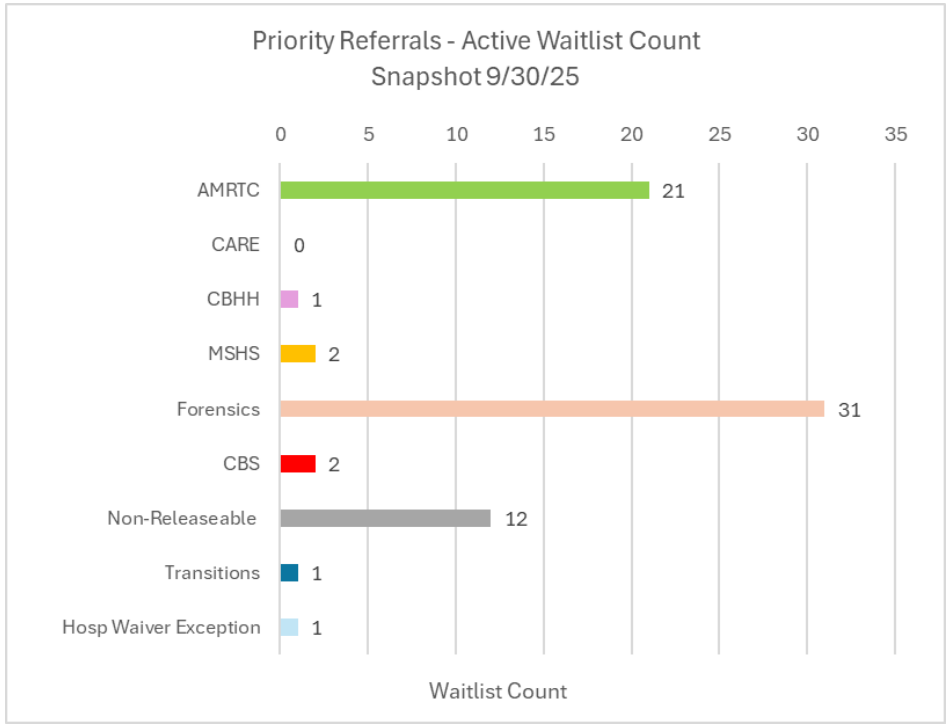


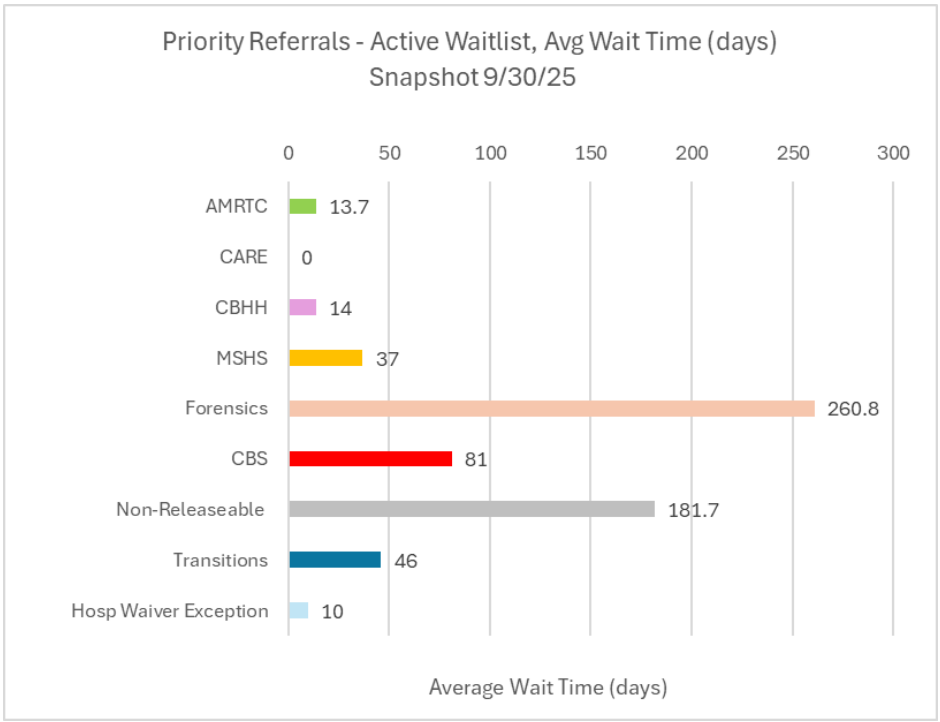
DCT Priority Admissions Framework – Quarterly Data Dashboard

7/1/25 –9/30/25

Priority Referrals - Active Waitlist (as of 9/30/2025)

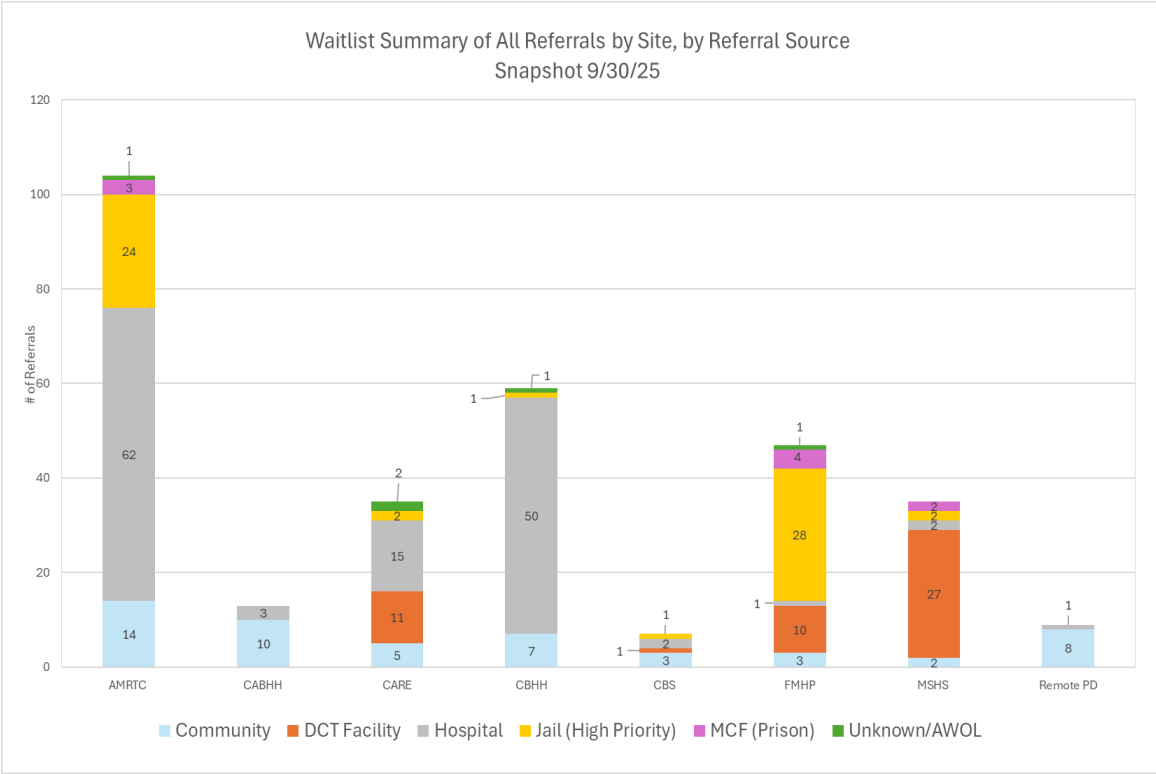
Releasable Referrals	Summary			Source Location		
	Count	Avg *(days)*	Range *(days)*	Jail/Prison	Community	Hospital
AMRTC	21	13.7	0-62	21		
CARE	0	-	-			
CBHH	1	14	14	1		
MSHS	2	37	26-48	2		
Forensics	31	260.8	16-574	28	2	1
CBS	2	81	1-161	2		
Total	**57**	**81.3**	**0-574**	**54**	**2**	**1**
Non-Releaseable	12	181.7	18-972	12		
Transitions	1	46	46	1		
Hosp Waiver Exception	1	10	10			1

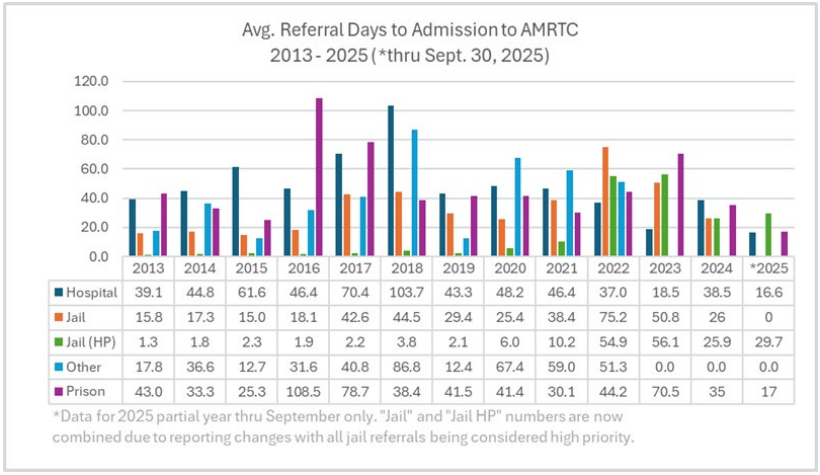




DCT Priority Admissions Framework – Quarterly Data Dashboard

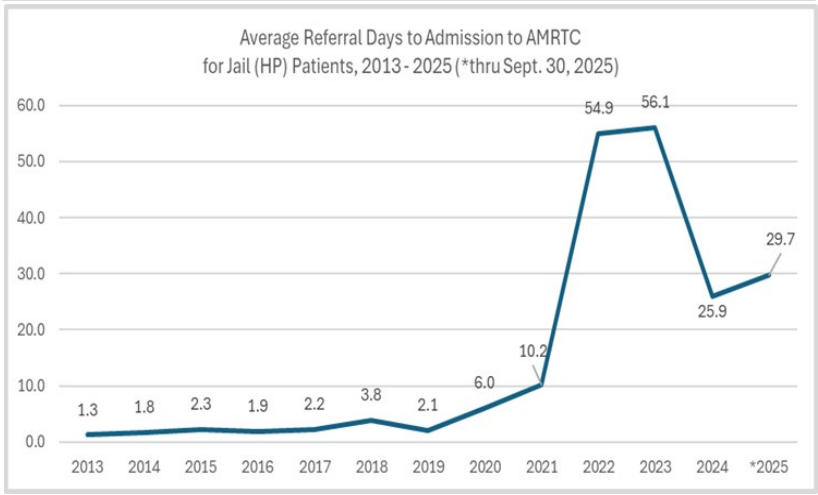
7/1/25 –9/30/25





	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	*2025
Hospital	39.1	44.8	61.6	46.4	70.4	103.7	43.3	48.2	46.4	37.0	18.5	38.5	16.6
Jail	15.8	17.3	15.0	18.1	42.6	44.5	29.4	25.4	38.4	75.2	50.8	26	0
Jail (HP)	1.3	1.8	2.3	1.9	2.2	3.8	2.1	6.0	10.2	54.9	56.1	25.9	29.7
Other	17.8	36.6	12.7	31.6	40.8	86.8	12.4	67.4	59.0	51.3	0.0	0.0	0.0
Prison	43.0	33.3	25.3	108.5	78.7	38.4	41.5	41.4	30.1	44.2	70.5	35	17

*Data for 2025 partial year thru September only. "Jail" and "Jail HP" numbers are now combined due to reporting changes with all jail referrals being considered high priority.



UPDATED FRAMEWORK FACTOR KEY (As of Jan. 1 2025)

Weighted Factors		MHSATS	Forensics	CBS	Scoring
Factor 1	Intensity of treatment needed due to clinical acuity	45%	5%	10%	0 = Stable, low acuity, or responsive to current treatment 1 = Urgent, high acuity, or unresponsive to current treatment
Factor 2	Current concerns for safety of the individual and/or others in the proximal environment	25%	20%	20%	0 = No risk or adequately mitigated/managed risk 1 = Imminent risk either unmanaged or ongoing risk present despite mitigation efforts
Factor 3	Access to/or lack thereof to essential or court ordered treatment in a non-DCT environment	20%	30%	30%	0 = Appropriate treatment available and adequate 1 = Appropriate treatment unavailable or insufficient
Factor 4	Other negative impacts to the referring facility, such as the number of beds unavailable because of caring for the referred individual.	10%	10%	30%	0 = Standard resources utilized 1 = Extraordinary resource allocation needed, or negative impacts are present
Factor 5	NGMI Finding	0%	35%	10%	0 = No 1 = Yes

ACRONYMS:

AMRTC – Anoka Metro Regional Treatment Center
CABHH – Child & Adolescent Behavioral Health Hospital
CARE – Community Addiction Recovery Enterprise
CBHH – Community Behavioral Health Hospital
CBS – Community Based Services
FMHP – Forensic Mental Health Program
MHSATS - Mental Health & Substance Abuse Treatment Services
MSHS – MN Specialty Health System
HP – High Priority (admission)
PD - Provisional Discharge

DIRECT CARE AND TREATMENT

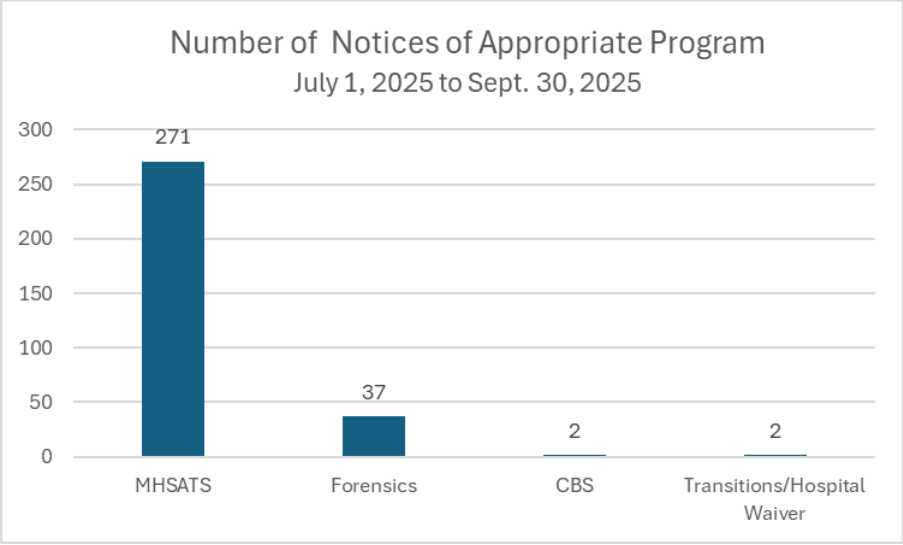
Executive Summary

The following data provides a snapshot of Direct Care and Treatment's Central Pre-Admissions (CPA) communications and engagement including priority referral notices for state-operated behavioral health programs and call volume. Referral data includes programs in the agency's Community Based Services (CBS), Forensic Services (FS) and Mental Health and Substance Abuse Treatment Services (MHSATS) service lines.

Key Points:

Notice of Appropriate Program - July 1, 2025, to Sept. 30, 2025

- This data reflects the number of notices sent out to referrals on the "priority" waitlist once the referral has been evaluated, framework scoring has been applied, and appropriate program has been determined. Non-priority referral notices have been excluded.
- All admits to DCT will receive a notice, although some referrals who are sent a notice, may ultimately not admit to a DCT facility or are placed in the community.
- Data presented includes both the *Initial Notice*, which is sent within 4 days of completing the framework scoring, and an *Update Notice*, which is issued within 60 days from the initial notice if still the person is still on the waitlist.



CPA Call Volume – Jan. 1, 2023, to Nov. 30, 2025

- Data reflects the monthly totals for incoming and outgoing phone calls for the DCT Central Pre-Admissions staff.
- This includes communications regarding *all* referrals for DCT (priority and non-priority) and does not include any communications handled via email.