National Association
for Behavioral Healthcare

Access. Care. Recovery.

2026 ADVOCACY PRIORITIES

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NABH's advocacy priorities for 2026 reflect the organization's mission to advance responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental health (MH) and substance use disorders (SUD).

Demand for our services across all age groups nationwide has never been higher, as the country continues to face intense access challenges for both MH and SUD patients.

NABH members face significant uncertainty as states navigate HR.1 (the *One Big Beautiful Bill Act*) implementation. Significant cuts to Medicaid in the form of cutting provider taxes, limits on state directed payments, and unclear community engagement requirements will stretch an already burdened system.

We will also continue to prioritize securing sufficient funding to expand the behavioral healthcare information technology (BHIT) infrastructure. We discuss these and other critical NABH issues below.

Top Association Priorities

H.R. 1 (*One Big Beautiful Bill Act*) Implementation

In Summer 2025, Congress passed a funding bill that included significant cuts to Medicaid. Of the measures enacted in the bill, NABH members are most concerned about community engagement requirements, limiting provider taxes, and state-directed payments. These are potentially devastating to behavioral healthcare service delivery, as Medicaid is the largest payor for these services.

NABH Advocacy Steps

- H.R. 1 explicitly exempted people with SUD and a "disabling mental disorder" from needing to meet Medicaid's new community engagement requirements. NABH staff is working with the Centers for Medicare & Medicaid Services (CMS) and members to clarify community engagement requirements and advocate for broad exemptions for people with substance use disorder and serious mental illness, while also limiting the burden to patients, providers, and states. NABH supports legislation to provide civil monetary penalty authority and increased appropriations to the U.S. Labor Department to improve enforcing parity requirements.

- For the limits to State-Directed Payments and Provider Taxes, NABH recommends eliminating or modifying both provisions, as they would inhibit efforts to address systematic underpayment to behavioral healthcare providers perpetuating access challenges. If retained, technical modifications should be made to prevent disruptions during implementation. Specifically, while these provisions allow for provider taxes and state-directed payments approved prior to enactment to continue, language should ensure that they would still be permissible (1) upon renewal (in the case of state-directed payments), and (2) if states make changes to comply with evolving federal requirements (e.g., statutory changes, new regulations, new agency guidance).

New Quality Outcome Measures

Twenty years ago, NABH was instrumental in developing the Hospital-Based Inpatient Psychiatric Services measures, some of which were included in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program. NABH is again taking a proactive approach to quality measurement, leading an initiative to develop a core set of quality measures (QMs) that behavioral healthcare (BH) organizations can implement across mental health, substance use, and the care continuum. NABH seeks to use these measures to partner with stakeholder organizations to establish a national benchmarking opportunity so similar organizations can compare outcomes, driving quality improvement by sharing how they have achieved a better percentile ranking. The QMs will also serve as the basis for establishing value-based care initiatives that align payment with improved patient outcomes.

NABH Advocacy Steps

- NABH established a working group of NABH member experts to develop a core set of validated quality measures. We will vet these quality measures with stakeholder partners prior to publication. Once published, NABH will disseminate and support implementation of the core set with NABH members, payors, and government regulators.

Payor Pressures

NABH members increasingly encounter problematic insurer practices, resulting in inappropriate delays and denials that harm patients. Issues are widespread and transcend managed care organizations, including increases in administrative denials, use of coverage guidelines that do not reflect generally accepted standards of care, excessive use of prior authorization and treatment audits, parity violations, degrading customer service quality, and insurers shifting more costs to patients. These practices threaten the access to and affordability of behavioral healthcare services for many individuals in need.

Congress is also concerned about abusive insurer practices. A majority of Members of Congress supported the *Improving Seniors' Timely Access to Care Act*, reflecting bipartisan impatience with insurers' abusive prior-authorization practices that have spread across plan types. Congressional oversight hearings on healthcare affordability with the CEOs of the largest U.S. health insurers also focused on prior authorization and ghost networks, among other practices.

NABH continues to gather data and engage congressional partners about legislative options to mitigate insurers' abusive practices that delay patients' access to care, create more red tape for providers, and drive-up costs for all Americans.

NABH Advocacy Steps

- NABH advocates for Congress to pass S. 1816/H.R. 3514 *Improving Seniors' Timely Access to Care Act* of 2025 to streamline the prior authorization process for seniors enrolled in Medicare Advantage (MA) plans.

- NABH advocates for passage of H.R. 5281, the *REAL Health Providers Act* to improve the accuracy of MA provider directories to combat "ghost networks."

Liability Reform

NABH members are increasingly challenged to access liability insurance that is reasonable and commensurate with the risk they incur. In many states, insurance premiums have risen at rates much higher than inflation and without settlement caps, many insurers are getting out of the market, limiting insurance coverage options and driving higher premiums.

NABH Advocacy Steps

- NABH is partnering with other organizations in the National Child & Family Services Liability Working Group to share data and monitor the national impact of limited and costly liability insurance options.

- Together with partners, we are monitoring federal and state legislation and member concerns to develop advocacy efforts.

Veteran and Military Healthcare

Active-duty military personnel, veterans, and their families made significant sacrifices to serve their country. They are entitled to appropriate and timely care.

The need for behavioral healthcare services continues to grow every year, but the U.S. Veterans Affairs Department (VA) does not have nearly enough residential treatment facilities to meet the need. *The MISSION Act* established access standards for veterans to receive care through providers in the community, but with very little transparency and accountability, members fear that veterans are not receiving adequate behavioral healthcare.

NABH Advocacy Steps

- NABH urges congress and the Defense Health Agency to hold TRICARE contractors accountable for timely and adequate payment for services provided to members and families of the military.

- NABH recommends that the VA hold its VA medical centers (VAMCs) accountable for ensuring veterans receive the right care, in the right setting, at the right time according to *MISSION Act* access standards by referring veterans out into the community when appropriate and not deny timely care.

- NABH calls for legislation that would provide more transparency from the VA on reasons for denying veterans care in the community, CCN budgets at the VAMC level, and quality data and service offerings.

Secure the Promise of Parity

The promise of parity remains unfulfilled. Although the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* became law more than17 years ago, Americans have yet to see full parity between behavioral and physical healthcare. As one example, the parity law does not apply to Medicare Advantage plans. NABH will continue to support policies that advance true parity in benefits, access and payment.

NABH Advocacy Steps

- NABH's Managed Care Committee is harnessing the nationwide footprint of NABH's membership to identify the scope of parity challenges, detail how the lack of true parity harms those most in need of treatment and develop practical solutions to remedy this unjustifiable crisis.

Expand Medicare to Include Coverage of Residential Treatment

Medicare does not have a benefit for residential behavioral healthcare, causing a major gap in the types of services available to beneficiaries. Adding coverage for residential settings would enable access to the full continuum of behavioral healthcare services and ensure that beneficiaries can obtain the appropriate level of care in accordance with national treatment standards.

NABH Advocacy Steps

- NABH supports legislation to expand Medicare coverage of residential services, including the reintroduction of the *Residential Recovery for Seniors Act*.

IMD Exclusion

The Medicaid program's Institution for Mental Diseases (IMD) Exclusion discriminates against adult Medicaid beneficiaries by denying them access to specialized acute behavioral healthcare in psychiatric hospitals and residential treatment facilities. This provision is inconsistent with the principles of parity, hinders care, and contributes to the criminalization of mental illness.

Rising rates of suicide and overdoses highlight the need for improved access to acute mental health and addiction treatment that is provided in psychiatric hospitals and residential treatment facilities. Addressing the IMD Exclusion would give states flexibility to fund a full continuum of care for Medicaid beneficiaries struggling with serious mental illnesses and/or addiction.

NABH Advocacy Steps

- NABH continues to advocate for Congress to repeal the IMD Exclusion and develop new champions for this key issue. At the same time, NABH is pursuing both legislative and regulatory solutions to reduce the burden of the IMD Exclusion. These include:
  - Supporting legislation to waive the IMD Exclusion for beneficiaries enrolled in Medicaid managed care plans.
  - Supporting legislation to allow state Medicaid programs to cover services in IMDs for MH treatment. We support legislation to authorize state plan amendments to permanently waive the federal IMD Exclusion for SMI services, similar to what has occurred for SUD services in the 118th Congress.
  - Supporting legislation and regulatory action to exempt qualified residential treatment programs from the IMD Exclusion.
  - Educating key Members of Congress and their staff about the urgent need to expand this under-resourced segment of the behavioral healthcare continuum.

190-day Lifetime Limit

Medicare beneficiaries are limited to 190 days of inpatient care in a psychiatric hospital in their lifetime. No other lifetime limits exist in Medicare for any other type of inpatient care. Eliminating this policy would expand beneficiary choice, increase access for those with more serious behavioral health conditions, improve continuity of care, create a more cost-effective Medicare program, and align Medicare with parity, the standard required for most other healthcare coverage programs.

The expert clinical judgment of a treating physician, not an arbitrary policy, should be the primary basis for determining the scope of services a patient needs. Eliminating this cap would help behavioral healthcare patients access the right care, in the right place, at the right time.

NABH Advocacy Steps

- NABH supports legislation to permanently repeal Medicare's 190-day lifetime limit. We urge Congress to pass H.R.4619, the *Medicare Inpatient Equity Act* of 2025.

Behavioral Healthcare Workforce

The existing demand for behavioral healthcare continues to greatly exceed the supply of qualified treatment professionals. Federal projections show the behavioral healthcare workforce will require millions of additional workers to meet current needs. People experiencing a MH crisis or drug overdose face life-threatening conditions that can be treated with appropriate behavioral healthcare; however, in many parts of the United States, treatment professionals are not available to provide that care.

NABH Advocacy Steps

- NABH calls for legislation to require increased Medicare reimbursement rates for behavioral healthcare providers to levels that are more consistent with their education and credentialing, comparable with how reimbursement rates are set for general medical providers.
- This would encourage more behavioral healthcare providers to participate in the program. Moreover, because Medicare rates tend to be key benchmarks for reimbursement in commercial insurance, improvements in Medicare reimbursement should lead to better reimbursement in commercial plans and potentially Medicaid programs as well.
- CMS should reexamine and require states to improve its Medicaid rates for behavioral healthcare providers to encourage greater participation in Medicaid.
- In addition, we appreciate the steps Congress and relevant federal agencies took in 2023 to expand the MH and SUD workforce by authorizing new behavioral healthcare practitioner types to bill Medicare. We support additional steps in the future to increase the behavioral healthcare workforce, including adding medical school physician training slots earmarked for students pursuing behavioral healthcare positions, additional loan repayment support, and similar efforts.

Behavioral Health Information Technology

The behavioral healthcare field's information technology (IT) continues to lag behind the IT capacity of its physical healthcare peers. This gap is largely due to behavioral healthcare providers' Exclusion from The *Health Information Technology for Economic and Clinical Health Act* (HITECH), which offered financial incentives to other healthcare providers for demonstrating "meaningful use" of electronic health records (EHRs). Unfortunately, today our field has much lower EHR adoption rates and a lack of EHR developers creating IT systems for the behavioral healthcare patient population.

This overdue investment would materially advance the goals of parity, improve overall quality and transitions of care across settings, and help provide greater safety for patients suffering under the nation's MH crisis

NABH Advocacy Steps

- NABH will push for legislation to fund BHIT providing financial incentives for the adoption of interoperable electronic health records.

Alternative Payment Models (APMs)

Various stakeholders, including CMS, are exploring value-based payment (VBP) arrangements for Medicaid behavioral healthcare services. The goal is to shift from systems that pay for volume of services to a model that rewards high-quality, cost-effective care.

NABH Advocacy Steps

- NABH is engaged in the national conversation about VBPs and APMs in behavioral healthcare settings and will continue working with CMS as the agency continues to develop these models.

Modernize Psychiatric Hospital Regulations

CMS regulations define conditions of participation (COP) applicable to all hospitals, including psychiatric facilities. However, psychiatric hospitals and units are also currently subject to an additional series of COP, the majority of which have not been updated since the 1980s. These outdated regulations impose large costs on providers without increasing treatment quality or patient safety.

NABH Advocacy Steps

- NABH recommends the administration reduce regulatory burden by revising the psychiatric hospital COP requirements. We continue to provide information to CMS on specific staffing and medical records conditions that can be amended through updates to COP regulations and interpretive guidance.

Expand SUD Treatment and Prevent Overdoses

The nation's addiction and overdose crises continue to escalate on multiple fronts, affecting tens of thousands of individuals and families with loss and grief, as well as posing difficult challenges to public health and the U.S. healthcare system.

In 2024, 48.4 million people aged 12 or older – 16.8% of this age group – are estimated to have had SUD in the past year. Among these people, 95.4%[1] did not receive treatment in the past year. In addition, the Centers for Disease Control and Prevention predicts that more than 68,962 people in the United States will have died from an overdose in the 12-month period ending in September 2025.

Overdose deaths involving fentanyl and stimulants dropped between 2023-2024 by 35.6%[2].

Equally important for policymakers to address is the more pervasive but under-acknowledged problem of the number of deaths from excessive alcohol use that is responsible for about 178,000[3] deaths per year.

Consequently, America's addiction crisis reflects the lethality of synthetic opioids such as fentanyl, as well as the use of cocaine, methamphetamine, other drugs, and alcohol.

NABH Advocacy Steps

- NABH advocates for reimbursement and policy solutions to increase SUD treatment, including:
  - Improving Medicare and other coverage for substance use residential programs and other intermediate levels of care.
  - Permitting the use of federal funds for all types of evidence-based SUD treatment.
  - Permitting the use of federal workforce and treatment funds by for-profit treatment programs.
  - Broadening the use of evidence-based contingency management protocols for individuals with stimulant, opioid, and other SUDs.
  - Allowing telehealth treatment through state reciprocity and other measures.
  - Increasing rural treatment capacity.

Opioid Treatment Programs

Opioid Treatment Programs (OTPs) offer a range of services, including methadone, the most widely researched FDA-approved medication to treat opioid use

[1] *https://www.cdc.gov/nchs/products/databriefs/db549.htm*
[2] *https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm*
[3] *https://www.cdc.gov/alcohol/facts-stats/index.html*

disorder effectively. In addition, OTPs offer counseling, vocational, recovery support, and other services. OTP services are funded through Medicare Part B, Medicare Advantage, Medicaid, and some commercial plans.

NABH Advocacy Steps

- NABH will advocate for OTPs to remain the source of methadone treatment by opposing the Modernizing Opioid Treatment Access Act and support legislation that increases access to treatment while maintaining patient safety. Further, we appreciate the Substance Abuse and Mental Health Services Administration revising 42 CFR 8 to provide OTPs with additional flexibility to tailor treatment for each patient's unique needs.

- NABH will also urge CMS to offer payment rates that provide adequate and appropriate reimbursement for OTP services, including:
  - Assuring rates are competitive by using hospital market basket rates for the non-drug bundle.
  - Creating rates and billing protocols for contingency management.
  - Establishing a 17% add-on for rural services in high overdose areas.
  - Permitting admissions and treatment without a physician referral and preauthorization under Medicare Advantage.

Maintain Telehealth Coverage

Expanded coverage of MH and SUD services via telehealth technology during and following the COVID-19 pandemic has been critical for preserving access to treatment during these extremely challenging times.

This expanded coverage enabled behavioral healthcare providers to demonstrate how effectively telehealth is augmenting in-person care, as we report with Manatt in the issue brief Telehealth is Effectively Augmenting Partial Hospitalization and Intensive Outpatient Programs.

NABH Advocacy Steps

- NABH advocates to build upon and extend the telehealth flexibilities that Congress and the U.S. Department of Health and Human Services (HHS) made permanent during the COVID-19 pandemic.

- Coverage expansions are warranted from Medicare, Medicaid, and commercial insurance plans for MH and SUD treatment, including partial hospitalization and intensive outpatient programs and opioid treatment programs.

- This coverage should also include behavioral healthcare delivered via audio-only technology, which is critical for supporting treatment for people living in professional shortage areas, with limited technical literacy and without broadband services; access to transportation; and other vulnerable populations.

- NABH also advocates that reimbursement rates for behavioral healthcare services via telehealth be maintained at comparable levels with rates for in-person treatment. In addition to clinical services, providing care via telehealth requires assistance from administrative staff and other overhead costs. Without assurance of continued reimbursement that accounts for costs associated with providing telehealth services, we will lose the opportunity to maintain behavioral healthcare access now and expand access to this treatment in the future.

Telehealth for Controlled Substances

Since the COVID-19 pandemic, regulatory flexibilities have exempted clinicians from the general requirement to conduct an initial in-person medical evaluation prior to prescribing controlled substances. The Drug Enforcement Administration and HHS proposed a new rule in 2023 that would limit this practice going forward, but they have delayed issuing a final rule.

These flexibilities have facilitated clinically indicated controlled substance prescribing during and after

the pandemic, which has helped mitigate pervasive behavioral health workforce shortages, limited availability of in-network providers, and other access barriers.

NABH Advocacy Steps

- NABH supports policies that ensure patients can be prescribed controlled substances via telehealth with appropriate guardrails that maximize care quality and minimize undue burden on providers and patients.

Please visit www.nabh.org to learn more about NABH.

For questions or comments about NABH's 2026 advocacy priorities, please contact us at nabh@nabh.org.