POLICY BRIEF & LEGISLATIVE ROADMAP • NOVEMBER 2026

Bridging the Behavioral Health Divide After the 2026 Midterm Elections

Closing the Olmstead Gap, Reforming Medicaid's IMD Exclusion, and Ending Systemic Disparities Between Severe Mental Illness and Alzheimer's Disease

EXECUTIVE SUMMARY: A MANDATE FOR PRACTICAL STRUCTURAL REFORM

The November 3, 2026 midterm elections reshaped the balance of power in Washington, delivering Democratic majorities in both the U.S. House of Representatives and the U.S. Senate. Across party lines, voters registered a clear mandate for tangible governance: safe neighborhoods, affordable living, and functioning public systems.

For the millions of American families navigating severe mental illness (SMI), the defining challenge before the new Congress is structural rather than ideological. Decades of fragmented federal policy have produced an 'Olmstead gap'—a missing mid-tier of licensed residential care—reinforced by Medicaid's outdated Institution for Mental Diseases (IMD) exclusion. Meanwhile, individuals experiencing neurocognitive and psychotic symptoms due to schizophrenia or severe bipolar disorder are systematically denied the long-term residential protections routinely afforded to patients with Alzheimer's disease and related dementias.

01 The 2026 Midterm Landscape: Moving Beyond a False Political Binary

The November 3, 2026 midterm elections altered the legislative calculus on Capitol Hill, giving Democrats control of both chambers of Congress. Yet electoral shifts alone will not resolve America's behavioral health crisis unless lawmakers confront why previous reform efforts stalled. For decades, mental health policy has been trapped in a counterproductive political binary that pits civil liberties against public safety:

- **The Civil Rights & Deinstitutionalization Perspective:** Emphasizes community integration, individual autonomy, and vigilance against returning to the abusive, overcrowded state asylums of the mid-twentieth century.
- **The Public Safety & Crisis Response Perspective:** Focuses on visible street homelessness, untreated psychosis, emergency department boarding, and the growing use of county jails as de facto psychiatric facilities.

Both viewpoints capture genuine truths, yet treating them as mutually exclusive obscures the root problem: the United States has never built a complete, clinically graduated continuum of care. Advocacy organizations such as Healing Minds NOLA emphasize that families are not asking Congress for partisan talking points. They are asking for timely medical intervention, continuous care, legal due process, protection from abuse and neglect, and basic human dignity.

The Clinical Reality of Anosognosia

Policy debates frequently *assume* that every adult living with schizophrenia, schizoaffective disorder, or severe bipolar disorder can navigate voluntary outpatient clinics independently. In reality, approximately half of

individuals with severe psychotic disorders experience anosognosia—a neurological impairment caused by structural brain changes that prevents a person from recognizing that they are ill (Amador et al., 1994; Treatment Advocacy Center, 2023). Because no person voluntarily seeks treatment for an illness their brain insists they do not have, relying exclusively on outpatient appointments guarantees delayed care. Families exhaust every clinical avenue only to be turned away until an acute, catastrophic crisis forces emergency or law enforcement intervention.

02 Closing the "Olmstead Gap": Building the Missing Residential Tier

In its landmark 1999 Olmstead v. L.C. decision, the U.S. Supreme Court affirmed that individuals with disabilities have a civil right under the Americans with Disabilities Act to receive services in the most integrated community setting *appropriate to their clinical needs*. However, while Olmstead accelerated the closure of state psychiatric hospitals, federal and state governments failed to finance or construct the specialized community infrastructure necessary to support individuals with profound, persistent psychiatric disabilities.

This failure created what clinicians and families recognize as the 'Olmstead gap'—a dangerous void between short-term acute hospital beds and unsupported independent living. When a hospitalized patient stabilizes enough to leave an acute psychiatric unit, but remains too impaired to manage medications, finances, or personal safety alone, an appropriate step-down facility rarely exists. Discharging a vulnerable adult to a homeless shelter, an unstaffed boarding house, or the street is not meaningful community integration; it is systemic abandonment.

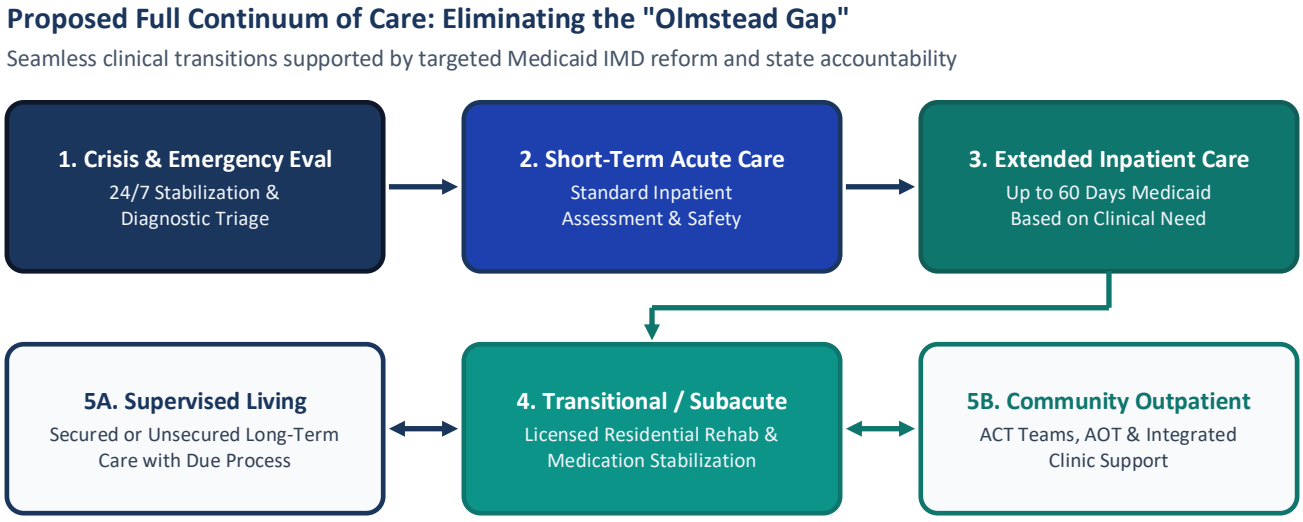


Figure 1: Proposed multi-tier behavioral health continuum bridging acute hospitalization and long-term community stability (built with native editable Word shapes).

Establishing Licensed Adult Psychiatric Residential Facilities

Closing the Olmstead gap does not mean returning to warehouse-style institutions. Instead, Congress and state Medicaid agencies should establish a dedicated, strictly regulated category of professionally operated adult psychiatric residential facilities encompassing two distinct levels of care:

- **Tier 1 — Transitional & Subacute Residential Treatment:** Structured, recovery-oriented programs for individuals stepping down from acute inpatient hospitalization who require 30 to 180 days of intensive medication stabilization, cognitive remediation, and life-skills rehabilitation before transitioning home.
- **Tier 2 — Long-Term / Permanent Supervised Residential Living:** Safe, homelike, clinically staffed residences for adults with enduring psychiatric disabilities or treatment-resistant psychosis who require ongoing supervision. Both unsecured and secured options must be available, with secured settings strictly governed by judicial due process, independent clinical review, regular state inspections, and enforceable resident rights.

03 Reforming Medicaid's IMD Exclusion: A Bipartisan Legislative Path

Enacted alongside Medicaid in 1965, the Institution for Mental Diseases (IMD) exclusion prohibits federal Medicaid matching funds for inpatient or residential care provided in psychiatric facilities with more than 16 beds serving adults aged 21 to 64. Originally intended to discourage states from shifting the cost of large state mental hospitals onto the federal government, the IMD exclusion has become the single largest financial barrier preventing states from building modern acute and residential treatment capacity.

In the 120th Congress, lawmakers have a prime bipartisan opportunity to modernize the IMD statute without sacrificing fiscal discipline or civil rights protections. Healing Minds NOLA outlines a targeted, two-part statutory reform:

- **1. Authorize Up to 60 Days of Medicaid Coverage for Acute Inpatient Care:** Replace arbitrary 15-day managed care caps with flexible federal matching funds for up to 60 days of acute inpatient psychiatric care when certified as medically necessary. Extending coverage gives clinicians adequate time to establish accurate diagnoses, titrate complex antipsychotic regimens, and execute safe discharge plans—dramatically reducing revolving-door readmissions.
- **2. Create a Dedicated Medicaid Residential Care Pathway:** Lift the 16-bed IMD restriction specifically for licensed, non-hospital adult psychiatric residential facilities (both transitional and long-term). Congress can model this statutory framework on existing Medicaid provisions for Psychiatric Residential Treatment Facilities (PRTFs) serving youth under age 21, tailoring clinical staffing and accreditation standards to adult needs.

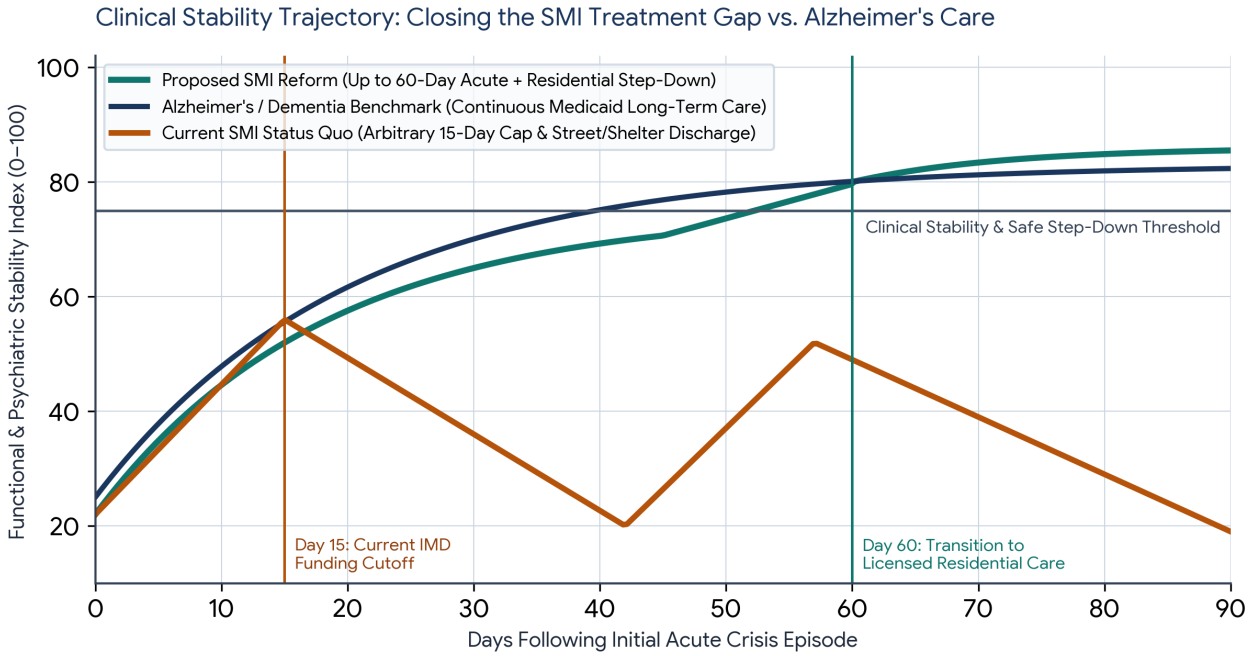


Figure 2: Modeled recovery and stability trajectories comparing current 15-day acute caps against a 60-day clinical need and step-down standard.

Balancing Federal Flexibility with Strict State Accountability

Expanding federal Medicaid reimbursement without enforceable state obligations would risk subsidizing incomplete systems. Any statutory IMD reform must condition federal matching funds on binding state commitments: expanding Assertive Community Treatment (ACT) teams and Assisted Outpatient Treatment (AOT), guaranteeing warm medication hand-offs at discharge, and publicly reporting metrics on housing stability, emergency room wait times, readmissions, and incarceration rates.

Stakeholder Concern	Statutory & Regulatory Policy Safeguard
Civil Rights & Risk of Institutional Abuse	Mandate rigorous state licensing, independent ombudsman inspections, judicial due process for secured settings, and enforceable resident-rights charters.
Fear of Returning to Massive Asylums	Target new residential Medicaid funding toward small-to-midsize structured community residences rather than open-ended expansion of large state hospitals.
Revolving-Door Crises & Untreated SMI	Pair up to 60 days of clinically driven inpatient stabilization with step-down transitional beds, ACT teams, and evidence-based AOT programs.
Exclusion & Burnout of Family Caregivers	Require structured family engagement in discharge planning, care coordination, care compensation, and legally compliant clinical communication.
Federal Spending Without Measurable Results	Condition enhanced Medicaid matching funds on verified state capacity benchmarks and transparent public outcome reporting.

04 The Parity Paradox: Severe Mental Illness vs. Alzheimer's Disease

Perhaps the clearest moral and legal indictment of current federal behavioral health policy emerges when comparing how Medicaid and Medicare treat severe mental illness versus Alzheimer's disease and related dementias. Clinically, late-stage neurocognitive disorders and severe, treatment-resistant psychiatric illnesses frequently present with remarkably similar neurological and behavioral symptoms:

- **Shared Anosognosia & Impaired Insight:** Both a patient with moderate-to-severe Alzheimer's disease and an adult with acute schizophrenia frequently lack neurological awareness of their deficits and resist medical assistance.
- **Psychosis, Paranoia & Cognitive Disorganization:** Delusions, hallucinations, severe agitation, and impaired executive functioning occur across both conditions, making independent self-care impossible.
- **Wandering & Vulnerability to Harm:** Without structured supervision, individuals in both populations face high risks of exposure, malnutrition, victimization, and accidental injury.

Despite these overlapping clinical realities, federal reimbursement law draws an arbitrary boundary based on diagnostic coding rather than functional need. Under federal Medicaid rules, nursing facilities and specialized memory care units serving individuals with Alzheimer's disease are classified as medical care facilities—exempt from the IMD exclusion—allowing Medicaid to finance continuous, dignified long-term residential care. Conversely, when identical symptoms stem from a primary psychiatric diagnosis in a 30-year-old adult, federal law labels the care setting an 'Institution for Mental Diseases,' stripping federal funding and pushing the patient toward homelessness or incarceration.

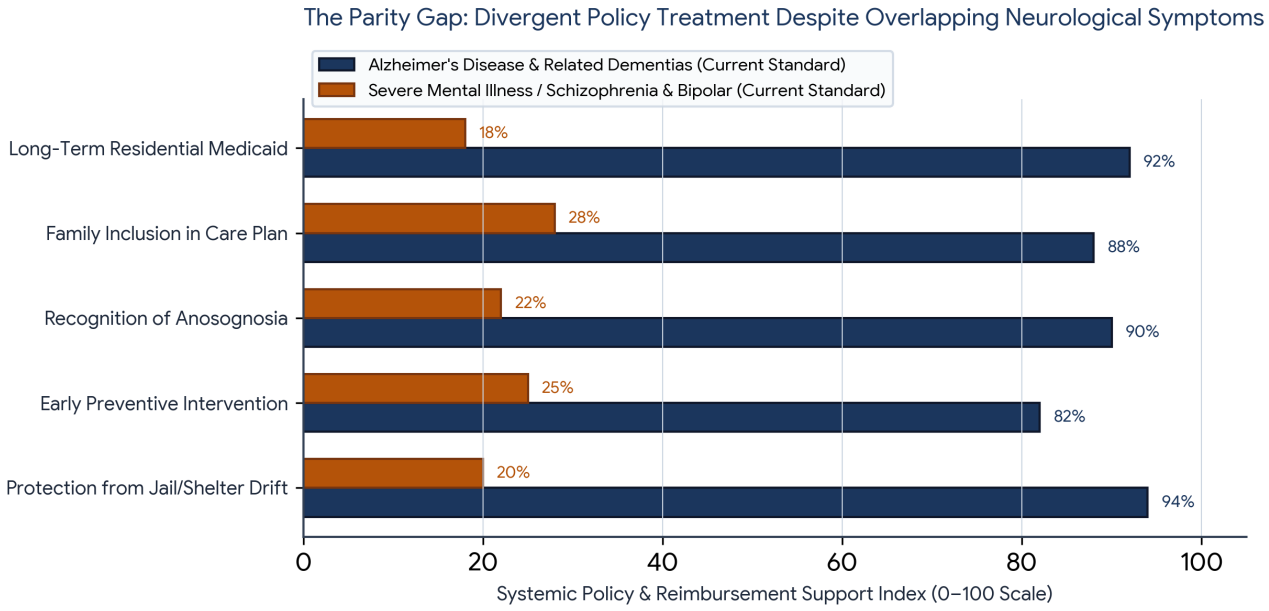


Figure 3: Structural disparity in federal reimbursement, residential access, and family integration between Alzheimer's disease and SMI.

Policy Dimension	Alzheimer's Disease / Dementia	Severe Mental Illness (SMI)
Clinical & Behavioral Presentation	Anosognosia, delusions, paranoia, cognitive decline, wandering, and inability to manage ADLs.	Anosognosia, psychosis/delusions, cognitive disorganization, safety risks, and inability to manage ADLs.
Medicaid Long-Term Residential Coverage	Covered under Medicaid nursing home and memory care waivers; exempt from the 16-bed IMD exclusion.	Barred from federal Medicaid matching in facilities >16 beds (ages 21–64) due to the IMD exclusion.
Secured / Supervised Environment Access	Secured memory care units are widely accepted as protective, compassionate medical environments.	Secured psychiatric residential beds are scarce; patients are routinely discharged to shelters or streets.
Role of Family Caregivers	Families are recognized as essential care partners, consulted on safety, guardianship, and discharge.	Families are frequently excluded from discharge planning due to rigid privacy interpretations.
Default System Response to Crisis	Geriatric medical evaluation, memory care placement, and continuous long-term care planning.	Short emergency stabilization, premature discharge, or criminal justice arrest and jail detention.

05 Legislative Action Plan for the 120th Congress

With the 2026 midterm elections behind them, members of the U.S. House and Senate have an immediate opportunity to deliver bipartisan structural reform that unites civil rights protections with clinical reality. Lawmakers should advance a comprehensive behavioral health package anchored by five core pillars:

- **Pillar 1 — Enact Flexible 60-Day Inpatient Medicaid Coverage:** Amend Title XIX of the Social Security Act to permit federal Medicaid matching funds for up to 60 days of acute inpatient psychiatric care when determined by treating clinicians to be medically necessary for stabilization and safe discharge.
- **Pillar 2 — Establish a Federal Residential Medicaid Pathway:** Create a dedicated statutory benefit authorizing Medicaid reimbursement for licensed, non-hospital adult psychiatric residential facilities—closing the Olmstead gap for both transitional subacute recovery and long-term supervised living.
- **Pillar 3 — Require Full Continuum Capacity from Participating States:** Mandate that states utilizing enhanced IMD flexibility demonstrate measurable investments across every tier of care, including crisis stabilization centers, ACT teams, AOT programs, and supportive housing.
- **Pillar 4 — Enforce Rigorous Oversight, Due Process & Parity Standards:** Require independent facility inspections, strict judicial due process for any secured residential setting, and functional parity with neurocognitive memory care standards so brain disorders are treated equitably.
- **Pillar 5 — Mandate Cross-System Coordination & Family Inclusion:** Require hospitals, residential providers, outpatient teams, courts, and families to execute documented warm hand-offs—ensuring medication continuity and transparent public tracking of housing, readmission, and diversion outcomes.

CONCLUSION: MEASURING SUCCESS BY HUMAN OUTCOMES

Voters in the November 2026 midterm elections sent a clear message that public institutions must be judged by real-world results rather than partisan rhetoric. True reform in severe mental health policy will not be measured by bills introduced or ideological victories claimed, but by whether a young adult experiencing anosognosia and acute psychosis receives timely clinical stabilization, a safe residential bridge to recovery, and a system that treats brain illness with the same compassion and continuity afforded to Alzheimer's disease.

06 Selected Clinical & Policy References

Amador, X. F., Flaum, M., Andreasen, N. C., Strauss, D. H., Yale, S. A., Clark, S. C., & Gorman, J. M. (1994). Awareness of illness in schizophrenia and schizoaffective and mood disorders. Archives of General Psychiatry, 51(10), 826–836.

Treatment Advocacy Center. (2023). Anosognosia [Research summary]. Office of Research and Public Affairs.