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# The Proof Standard for Behavioral Health Growth

A 2026 Operator's Playbook for Scaling  
Behavioral Health

**kipu.**



**The operators scaling behavioral health successfully into today’s record demand are working from a playbook that’s been fundamentally rewritten in the last 24 months.**

Behavioral health crossed a remarkable threshold in 2024 when visits among commercially insured patients passed primary-care visits for the first time in U.S. history, 66.4 million to 62.8 million. Utilization is up 62.6% since 2018, anxiety-disorder visits alone have grown 89%, and PwC actuaries now name behavioral health a top-three medical-cost inflator for 2026.

Demand is the strongest behavioral health has ever experienced, while the operating environment underneath has rarely been stranger. Through 2025, Acadia Healthcare paused multiple de novo projects, closed five facilities, laid off 400 staff, and watched its share price drop roughly 70%. Newport Healthcare closed nine residential facilities, addiction-treatment M&A hit a six-year low, the One Big Beautiful Bill Act removed roughly \$1 trillion of federal Medicaid spending from the next decade, federal MHPAEA parity enforcement paused, and SAMHSA was cut by more than half.

The demand is real and rising. The question reaching the C-suite has become whether the organization can be built to grow on terms that capital, payers, and regulators will reward. Industry observers are calling this the proof standard, and meeting it has become the defining work of behavioral health leadership in 2026.

# Seven shifts that have **reshaped** the behavioral health growth playbook

Demand has held at record levels through every disruption of the past 24 months, but the operating environment has shifted dramatically. The seven shifts that follow form the new playbook behavioral health leadership has to navigate to scale defensibly in 2026.



01

**The policy floor moved.** The One Big Beautiful Bill Act takes roughly \$1 trillion of federal Medicaid spending out over a decade and requires states to redetermine eligibility every six months by end of 2026. With Medicaid funding roughly a quarter of national behavioral health spend, the ripple is broad. Federal MHPAEA parity enforcement also paused in May 2025, shifting commercial parity battles back to the states.

02

**The capital story is shifting.** Behavioral health M&A volume rose 42% in 2025 to 104 deals, the most active year since 2022. Outpatient mental health, counseling, and psychiatric-care deals nearly tripled, with strategic acquirers in healthcare services up 105% year over year, evidence that buyer appetite is concentrating sharply in outpatient and integrated care.

# 03

**Service-line preferences shifted.** Residential treatment had a hard year, with Newport Healthcare, Vista Maria, Buena Vista, and Acadia all closing multiple locations. The operators winning the M&A and de novo conversation were almost universally running partial hospitalization and intensive outpatient programs, which are payer-preferred, faster to break even, and easier to staff.

# 04

**AI documentation became standard infrastructure.** Every major behavioral health EHR has shipped an AI documentation product in the last 12 months. Kipu Intelligence, the AI-native layer inside the Kipu EMR, is delivering 50% documentation-time reductions across customer deployments and surfaces ASAM and LOCUS level-of-care recommendations directly from patient charts. Other behavioral health technology platforms are also building capabilities in notes processing, automation, and compliance auditing. The differentiation question for operators has moved past whether they use AI to how deeply they've integrated it into clinical workflow.

# 05

**CCBHCs and the IBH Model became the real federal tailwinds.** Certified Community Behavioral Health Clinics became a permanent Medicaid state plan option in 2024, with service areas now reaching roughly 55% of the U.S. population. CMS's Innovation in Behavioral Health Model has selected three Cohort I states and opened Cohort II for up to five more, with awards of up to \$7.5 million per state.



# 06

**Workforce moved from HR problem to financial strategy.** Behavioral health nurse turnover hit 22.8% in 2024 against a 16.4% national RN average, and 40% of the U.S. population lives in a Mental Health Professional Shortage Area. The operators successfully scaling now treat retention as a financial KPI because every percentage point of turnover shows up as measurable cost in the P&L.

# 07

**Value-based care matured into stepping stones.** Roughly 10% of behavioral health providers now derive meaningful revenue from at-risk contracts, and 38 state Medicaid programs reimburse Collaborative Care Model codes. The trajectory is incremental, but the pathway from fee-for-service to value-based care is navigable for the first time. Operators building outcomes infrastructure today are positioning for contracts that didn't exist 24 months ago.

*“After the Big Beautiful Bill passed, we built two outlooks for 2026: a full-disaster plan based on 50 to 60% of ACA patients losing coverage, or a 20% reduction. The 20% scenario hit, and on December 31, 2025, our growth plans got scrapped and rebuilt for January 1. That had never happened to us before.”*

— Riley Osborne, Chief Growth Officer, Recovery Unplugged

## WHAT TO FOCUS ON NOW

- ▶ Build a scenario plan that accounts for at least 20% Medicaid reduction in any market you operate in
- ▶ Map which service-line best align with M&A-active subsegments (partial hospitalization and intensive outpatient programs) and which sit in depressed ones (residential SUD)
- ▶ Engage CCBHC certification and IBH Model participation as real growth tailwinds

# The Proof Standard

What Behavioral Health Business named “from growth to proof” in late 2025 has become shorthand for what operators have been feeling all year. Capital, payers, and regulators are converging on the same demand: prove it before you grow it.

In practice, the proof standard resolves to five proof points operators are being asked to demonstrate:

01	Unit economics	Each level of care needs to demonstrate clear payback, with the timeline mapped and verifiable.
02	Payer relationships	Credentialing depth, days in A/R, denial rates, and payer-mix concentration all need to be visible and managed.
03	Clinical outcomes	Results need to be measurable, comparable, and defensible across populations and care modalities.
04	Workforce sustainability	Turnover, caseload discipline, and the retention drivers an operator can move all need to be tracked as core operating metrics.
05	Operational discipline	Admissions throughput, documentation compliance, and audit-readiness decide whether a growth plan survives execution.

The proof standard sharpens what defensible growth actually looks like. A new building filled with patients only reads as growth when it comes paired with a credentialed payer panel, a faster admissions process only reads as growth when it doesn't expose denial-rate problems the operator can't quantify, and a service-line expansion only reads as growth when retention discipline can hold the new volume. Growth that can prove itself is the growth that gets to keep growing.



Glenn Hadley, chief growth officer of JG Healthcare Solutions, frames it this way: “I think of it from an exit perspective first and work my way back.” The discipline that satisfies a buyer is the same discipline that builds a durably profitable business, and the proof standard turns that observation into a planning posture.

## WHAT TO FOCUS ON NOW

- Audit your organization against the five proofs and identify which one is weakest
- Put a 90-day plan against the weakest proof point
- Build the practice of running growth decisions through “what does this prove?”

# Where to grow: diversification as the new default

The 2024 playbook assumed enough policy and reimbursement stability to pick a state, validate the market, and open. The 2026 playbook assumes any state can change its rate schedule on December 31 and ask you to operate January 1.

Glenn Hadley's team at JG Healthcare runs 15 candidate states for expansion at any given time, scored across reimbursement clarity, regulatory environment, MCO posture, real estate, and service-line fit. They expect seven or eight of those 15 to remain viable as conditions move. "If a state decides they want to cut our rate in half on December 31 for us to operate January 1, we can weather that storm," he told us. The rest of the portfolio absorbs the shock.

The same logic applies inside a single state. An operator who can move clients across PHP, IOP, virtual, and residential keeps the clinical relationship that a single-modality operator hands off. A portfolio spanning VA contracts to commercial in-network absorbs Medicaid rate cuts that would have been existential for a single-payer operator.



The market selection scorecard worth running has gotten longer. The familiar inputs of reimbursement clarity, regulatory environment, and real estate now sit alongside CCBHC presence, IBH-state status, labor market depth, community receptivity, and what's worth calling the ghost-network advantage. HHS OIG found in 2025 that 55% of behavioral health providers listed as in-network on Medicare Advantage plans are inactive, and 28% on Medicaid managed care. In markets where credentialed, available providers are scarce, the operators with depth in both win without needing to discuss it.

Universal Health Services grew 13.4% in Q3 2025 while Acadia retrenched. Same sector, same year, very different operating decisions. Sector trends never substitute for the operating decisions any individual organization is making at the leadership table.



## WHAT TO FOCUS ON NOW

- Maintain a candidate state pipeline larger than your launch capacity
- Diversify payer mix deliberately so single-state actions become absorbable rather than existential
- Add ghost-network advantage and IBH-state status to your market selection scorecard

# What to grow: Service lines under the new economics



In 2025, the operators making news for closures were almost all residential. The operators making news for break-even-within-a-year were almost all running partial hospitalization and intensive outpatient. That contrast was the cleanest signal the year produced about where the next wave of growth capital is going.

Residential remains essential care, and many of the strongest behavioral health operators still build their practice around it. The new economics have raised the bar on residential growth: stronger step-down pathways into PHP and IOP, sharper utilization review and payer documentation, tighter census forecasting and AR visibility, and outcomes data that demonstrates clinical value. Operators investing in these disciplines are positioning for sustainable growth in 2026.

PHP and IOP are the unambiguous bright spot. A well-run de novo can hit break-even within a year, the clinical model fits where payers want care to happen, and the staffing model is more forgiving than residential. Behavioral Health Business reported in mid-2025 that 28% of SUD providers named de novo expansion as their top growth strategy, almost universally pointing at PHP or IOP.

Multi-state operators have started calling this the “listen to the state” pattern: ask each state Medicaid agency what they actually need before deciding which service line to launch. Alex Williams, founder of Spark Recovery and Brave Minds Academy, took exactly that approach after Kentucky Medicaid cut its rates 20% in October 2024. Spark went to the state, asked what it needed, and ended up launching a workforce and reentry vocational program that pulled in \$750,000 from the opioid abatement committee, sustaining the operation through a quarter when the original growth plan would have failed.



## WHAT TO FOCUS ON NOW

- Lean into PHP/IOP expansion as the lowest-risk service-line bet of 2026
- Ask your state Medicaid agency what they actually need before deciding what to launch
- Build a path from single-modality to multi-modality care under one operating roof

# Building the **engine**: workforce, technology, and RCM discipline

The growth plans that actually grow are the ones built on top of three operational disciplines that don't show up in pitch decks but decide whether a plan survives execution: workforce, technology, and revenue cycle.



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## Workforce as a financial strategy

Behavioral health nurse turnover hit 22.8% in 2024, the highest of any nursing specialty against a 16.4% national RN average. That gap is a financial number long before it's an HR number, with every percentage point of turnover landing in the budget through recruitment costs, ramp time, overtime, and quality risk.

Riley Osborne at Recovery Unplugged calls his operating answer transplanting culture: rather than building a new site's culture from scratch, take a leader who already lives the existing program and physically move them to the new site. "The piece I underestimated in the biggest way was investing in culture first, second, and third," he told us. The practice has shortened his ramp time by years rather than months.

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# Technology as the operating baseline

AI documentation is now broad operating reality across behavioral health. The differentiation question has shifted from whether operators use AI to how deeply they've integrated it into clinical workflow, and integration depth is what separates basic productivity gains from clinical-quality multipliers.

Recovery Unplugged's deployment of RVK AI shows what focused AI can deliver. Pre-deployment, the organization was receiving 13,000 to 15,000 first-time inbound calls a month and missing 18%. Post-deployment, Q1 2026 closed with zero missed calls, the most profitable Q1 in company history, and the highest census on record. Riley Osborne did not increase web spend, outreach team size, or alumni team size. "I don't want to replace humans," he told us. "I want to give them back the time to go do what they should be doing."

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# RCM as the growth lever

Margin discipline is the cleanest path to growth that doesn't require capital, market expansion, or new service lines. When Kentucky Medicaid cut its reimbursement schedule 20%, Alex Williams's team at Spark Recovery audited their billing against the state's fee schedule and found codes they had never been pulling. "We weren't billing biopsychosocials because in our mindset, they were only 50 or 60 bucks," he said. "We were leaving a lot on the table." Days in A/R, denial rate, and clean-claim rate are the three numbers that gate growth. Operators who can quote theirs from memory operate in a different reality from those who can't.

## WHAT TO FOCUS ON NOW

- Treat retention metrics as a financial KPI in monthly operating reviews
- Pick one specific bottleneck where AI integration produces visible operational lift, and execute against it
- Audit your billing against the full fee schedule for codes you're not capturing



# Capital and M&A in a **different** cycle

The capital market for behavioral health remains active and increasingly selective. The 42% year-over-year rise in M&A volume dominates the headlines, but the shift underneath is what operators actually need to plan against.

Outpatient mental health, counseling, and psychiatric-care platforms commanded premium multiples through 2025, with strategic acquirers aggressive across the year and private-equity add-on activity returning at a measured pace. Buyer appetite is concentrating in outpatient and integrated care, where unit economics read cleanest in diligence. Lenders have shifted into forensic diligence on insurance receivables that didn't exist as a serious category in 2022, and the operators who can answer those questions with current, defensible numbers have a meaningfully shorter path to a deal.

Diligence has changed in ways that change planning. Buyers and lenders look harder at workforce metrics, payer-mix concentration, credentialing depth, documentation compliance, and the underlying quality of revenue-cycle infrastructure. “I’m signing about one NDA a week,” Riley Osborne told us, “for programs that held a belief system that either A, if you have the most amazing clinical program on the planet you will succeed, or B, all I gotta do is put heads in beds. That just isn’t the world we live in today. You have to be a phenomenal operator and a phenomenal marketer to achieve that dream.” The 2026 buyer is looking for both.

Glenn Hadley’s recommendation is the same regardless of whether you plan to transact. Get the data room in order now. “We’re going to see a wave in a couple of years like we saw back in 2022 and 2023,” he told us. “Don’t wait until then to get your ducks in a row.” The discipline that satisfies a buyer is the discipline that builds a durably profitable business, which is exactly what the proof standard rewards.



## WHAT TO FOCUS ON NOW

- Get the data room in order now, whether or not you plan to transact
- Run workforce-metric reports monthly; buyers will ask for them on day one
- Operate with exit-first discipline as a planning posture, not just transaction prep



# Where mission and margin meet in 2026

The most counterintuitive fact about behavioral health in 2025 should give every operator confidence: U.S. drug overdose deaths fell roughly 27% in 2024 even as SUD treatment supply was contracting. The mortality trend and the supply trend moved in opposite directions. What that says about 2026 is that the need is real, the moment to step in is real, and the standard for stepping in is the proof standard.

“No money, no mission” has been the durable truth in behavioral health for decades. The 2026 update reads more like “no proof, no money.” Mission, margin, and the proof standard align in ways they didn’t two years ago. The operators who can demonstrate clinical outcomes, workforce stability, payer relationships, and unit economics are the operators capital wants to fund, payers want to contract with, and patients want to find.

The operators meeting the proof standard build careers and organizations with genuine durability. They earn capital that compounds, payer contracts that hold, and talent that stays. They keep delivering on the mission that brought them into this work, well past the next reimbursement cycle. Growth that can prove itself is the growth that gets to keep growing, and the operators choosing to scale on the proof standard are the ones likely to still be in this conversation a decade from now.

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## About the author

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