VIA ELECTRONIC SUBMISSION

July 2, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue SW,
Washington, DC 20201

Docket No. 2026-11602

RE: HHS Request for Information on the Chronic Disease of Addiction

Dear Secretary Kennedy,

Thank you for the opportunity to provide information on the Department of Health and Human Services' (HHS) Request for Information (RFI), *Chronic Disease of Addiction [2026-11602]*.[1]

The Global Health Advocacy Incubator (GHAI), Overdose Prevention Initiative works to identify and advance federal policy solutions that make it easier for people with substance use disorder (SUD) to stay safe, access effective treatment and achieve long-term recovery.

Executive Order (EO) 14379 recognizes addiction as a chronic, treatable disease and notes that the nation's recovery efforts remain fragmented and do not always keep pace with scientific advancements.[2] We strongly support the Administration's commitment to addressing addiction and expanding opportunities for recovery. As HHS implements the Great American Recovery Initiative, the Department has an opportunity to strengthen access to evidence-based treatment, protect continuity of care and sustain the data systems needed to measure progress.

The need remains substantial. EO 14379 notes that 48.4 million Americans (16.8 percent of the United States population) have SUD, yet fewer than 20 percent of those who needed substance use treatment actually received it.[3] Recent progress is real, but it remains fragile. According to the latest data from the Centers for Disease Control and Prevention (CDC), 69,384 people died from a drug overdose in the United States in 2025. While this represents a significant decline from the prior year (14.7 percent), nearly 70,000 lives were still lost to a drug overdose.[4]

The decline does not mean every community is experiencing the same relief. Some communities continue to face higher overdose risk, fewer treatment options and greater

barriers to sustained recovery. HHS should use the Great American Recovery Initiative to sustain what is working, close gaps in treatment access and focus federal action where overdose risk remains highest.

The recent decline in overdose deaths reflects the impact of sustained federal, state and local investments in prevention, treatment, recovery supports, surveillance and overdose response. Maintaining and accelerating this progress will require continued attention to the programs and services that have helped drive these gains. The information below highlights opportunities for HHS to strengthen the nation's response to addiction, address remaining gaps in care and support the goals of the Great American Recovery Initiative.

Thank you for your consideration of these comments. Should you have any questions, please contact Daniel Diana, Research Manager, Overdose Prevention Initiative, at ddiana@advocacyincubator.org.

Sincerely,

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Associate Vice President,
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Background

The nation's response to the overdose crisis depends on sustained federal commitment to prevention, treatment and recovery services. Though it is the only active public health emergency, it is increasingly informed by modeling studies that estimate how overdose deaths change when specific interventions are scaled (e.g., access to and engagement in treatment and improved continuity of care).[5,6] This evidence base underscores the importance of sustained federal capacity for prevention, treatment and recovery services.[7]

The announcement of the Great American Recovery Initiative and related HHS actions reaffirm the Administration's commitment to addressing addiction through coordinated federal leadership.[8] To date, HHS has identified several priorities under the Great American Recovery Initiative, including strengthening agency collaboration, engaging faith-based providers, expanding access to medications for opioid use disorder (MOUD), integrating behavioral health information, advancing non-opioid pain treatment and strengthening recovery supports. The Department has also highlighted investments in recovery housing, health technology (Behavioral Health IT initiative), Safety Through Recovery, Engagement, and Evidence-based Treatment and Supports (STREETS) Initiative, Rural Communities Opioid Response (RCORP), Certified Community Behavioral Health Clinics (CCBHCs), Assisted Outpatient Treatment (AOT) program and the Hepatitis C Elimination Initiative Pilot (Hep C Free).[9,10,11,12,13]

While these represent meaningful commitments, the long-term success of the Great American Recovery Initiative hinges on alignment with the biennial National Drug Control Strategy (NDCS).[14] As the legally mandated framework for federal drug policy, the NDCS coordinates agency activities, ensures federal budget requests align with national priorities and measures progress against defined outcome goals.

As HHS considers future policies and programs, it should build on existing evidence-based efforts while preserving the full continuum of prevention, treatment, recovery and overdose response. The recommendations below identify opportunities to strengthen federal actions using existing authorities, improve access to treatment and protect the systems needed to measure progress. As new priorities emerge, Congress should provide the resources necessary to expand federal efforts and fund evaluations in alignment with the NDCS – without diminishing the capacity of existing programs.

GHAI's Response

Question #2: Using existing funding, what policies or changes to federal programs might improve outcomes in substance use prevention, treatment, and recovery; mental illness, prevention, treatment, and recovery; and care for co-occurring mental and chronic disease of addiction?

Program/Policy #1: Ensure access to low-barrier buprenorphine

i. *Title:* The Substance Abuse and Mental Health Services Administration (SAMHSA) should use its regulatory and subregulatory authority to reduce barriers to Food and Drug Administration (FDA)-approved MOUD by maintaining its advisory on low-barrier models of care for SUD
ii. *Type of activity:* Regulatory and subregulatory guidance
iii. *Description:* Despite strong evidence that MOUD saves lives, fewer than one in ten people who need treatment receive it, in part because many programs maintain barriers that delay or discourage care.[15,16] SAMHSA's *Advisory on Low-barrier Models of Care* outlines evidence-based approaches – including same-day treatment, telehealth, integrated services and peer support – that improve treatment engagement and reduce hospitalizations.[17,18] SAMHSA should use its regulatory and subregulatory authority to reinforce this guidance and encourage providers to adopt low-barrier models of care. Maintaining and promoting the advisory would help expand timely access to FDA-approved forms of MOUD while supporting patient-centered, evidence-based treatment.[19,20]
iv. *Statutory authority:* Social Security Act (SSA) § 1905(a)(29) (42 U.S.C. § 1396d(a)(29)); SSA § 1927(d) (42 U.S.C. § 1396r-8(d)); 42 CFR § 438.210

Program/Policy #2: Strengthen Medicaid continuity at reentry for justice-involved individuals with SUD

i. *Title:* The Centers for Medicare & Medicaid Services (CMS) should continue approving and standardizing Section 1115 Waiver reentry demonstrations and provide technical assistance to states to support pre-release Medicaid services.
ii. *Type of activity:* Regulatory, subregulatory guidance and technical assistance
iii. *Description:* The weeks immediately following release from incarceration represent one of the highest-risk periods for overdose, with mortality nearly 40 times higher than in the general population during the first two weeks after release.[21] Continuity of treatment before and after release is one of the most effective opportunities to prevent deaths among people with SUD leaving incarceration, and providing MOUD before release can reduce overdose deaths by roughly 80 percent.[22] [1] CMS has

[1] Established under Social Security Act §1905(a)(A), the Medicaid Inmate Exclusion Policy (MIEP) prohibits federal Medicaid matching funds for medical services provided to incarcerated individuals, with a limited

already recognized this need through its Medicaid Reentry Section 1115 Demonstration Opportunity, which allows states to cover targeted pre-release services up to 90 days before an individual's expected release.[23] CMS should continue approving reentry demonstrations, streamline review timelines and provide model waiver language and technical assistance to help states implement benefit designs that include MOUD, case management, care coordination (including with community-based providers), prescription access and Medicaid enrollment assistance.

iv. *Statutory authority:* SSA § 1905(a)(31); SSA § 1115; Consolidated Appropriations Act, 2023 (P.L. 117-328), § 5121

Program/Policy #3: Strengthen parity enforcement and compliance in eligible plans to ensure equal coverage for substance use disorder treatment

i. *Title:* HHS should continue implementing and enforcing the Mental Health Parity and Addiction Equity Act (MHPAEA) statutory obligations and existing regulations in coordination with the Departments of Labor and Treasury, to identify and remedy coverage restrictions that limit access to SUD treatment.

ii. *Type of activity:* Regulatory oversight, compliance guidance and enforcement
Description: Addiction is a chronic, treatable disease. Coverage policy should reflect that principle. Coverage for SUD treatment remains inconsistent despite longstanding federal parity requirements.[24] MHPAEA requires coverage for behavioral health services to be comparable to coverage for other medical conditions, and CMS already has authority to oversee compliance in Medicaid managed care.[25,26] [2] Enforcing the Department of Labor's (DOL) 2024 parity rule to the greatest extent possible and promoting consistent compliance standards would improve access to treatment while reinforcing the Administration's recognition of addiction as a chronic disease.[27,28]

iii. *Statutory authority:* Mental Health Parity and Addiction Equity Act (MHPAEA) (P.L. 110-343); SSA § 1932(b)(8) (42 U.S.C. § 1396u-2(b)(8)); 42 CFR § 438.900 et seq.

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exception for inpatient hospitalizations. Modifying MIEP to allow Medicaid reimbursement in the 30 days preceding release would align federal policy with the reentry window where the evidence for MOUD's life-saving impact is strongest.

[2] 42 CFR § 438.900 establishes the federal regulatory framework requiring Medicaid MCOs to comply with MHPAEA's mental health and SUD parity requirements, including equivalence in treatment limitations, prior authorization standards and network adequacy compared to medical and surgical benefits. 42 CFR § 438.900 derives its authority from Social Security Act §1932, which grants CMS the power to establish requirements for Medicaid MCOs, including compliance with federal parity laws.

Question #4: E.O. 14379 calls for Federal efforts to, "help Americans receive the treatment they need" including "aligning relevant Federal programs" and "all necessary steps to coordinate the Federal Government's response to the addiction crisis." One problem in this area is the insufficient supply of addiction and mental health counselors (a shortfall estimated by HHS-HRSA at about 77,050 and 99,780 respectively). This means it is harder for Americans to find the help they need in their area and covered by their insurance, especially in rural or underserved areas. How can Federal policies and programs be improved to address this practitioner supply issue to better ensure that every American seeking addiction treatment can find affordable help covered by their insurance in their area?

Policy Idea #1: Reinforce telehealth pathways for buprenorphine access in rural and underserved communities

i. *Title:* HHS should coordinate with the Drug Enforcement Administration (DEA) to provide clear implementation guidance that supports durable telehealth access to buprenorphine, including audio-only access where clinically appropriate, specifically for rural and underserved communities.
ii. *Type of activity:* Regulatory, technical assistance and interagency coordination
iii. *Description:* Telehealth has expanded access to buprenorphine, particularly in rural communities where nearly all counties face behavioral health workforce shortages.[29,30,31] Although HHS and DEA have extended COVID-era flexibilities through 2026, providers continue to navigate multiple overlapping regulations governing virtual prescribing.[32,33,34] This uncertainty discourages provider participation and limits access for patients in underserved communities.[35] HHS should work with DEA to provide clear, durable guidance that supports long-term telehealth access to buprenorphine.
iv. *Statutory authority:* Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (21 U.S.C. § 829(e)); 21 U.S.C. § 802(54)(G); 42 U.S.C. § 247d

Question #5: How can HHS strengthen its ability to evaluate the effectiveness of substance use and mental health prevention, treatment, and recovery programs and initiatives? How can the Department leverage data modernization, advanced analytics, and emerging technologies such as artificial intelligence to enable performance measurement on a real time or continuing basis?

Policy/Operational Idea #1: Restore and sustain critical federal health and overdose surveillance systems

i. *Title:* HHS should restore the Drug Abuse Warning Network (DAWN), as well as sustain the Agency for Healthcare Research and Quality's (AHRQ) Medical

Expenditure Panel Survey (MEPS) and Healthcare Cost and Utilization Project (HCUP), as core national early-warning and health systems data infrastructure.

ii. *Type of activity:* Grant program

iii. *Description:* Timely data allow public health officials to identify emerging drug threats, evaluate programs and direct resources where they are needed most. The discontinuation of new data collection for DAWN, together with the proposed elimination of AHRQ's MEPS and HCUP, would significantly weaken that capacity.[36,37,38,39] Restoring DAWN and sustaining MEPS and HCUP would preserve the national data infrastructure needed to monitor overdose trends and measure program effectiveness.[3] These investments would directly support the data-driven accountability envisioned in EO 14379 §3(i).

iv. *Statutory authority:* PHS Act § 505(d)(1)(A) (42 U.S.C. § 290aa–4(d)(1)(A)); 42 U.S.C. §§ 299a(a)(3), 299b-2; 42 U.S.C. §§ 299a(a)(3), 299c-3(c)

Policy/Operational Idea #2: Secure the continuity and integrity of national overdose, treatment and public health data systems

i. *Title:* HHS should secure the continuity and integrity of national overdose, treatment and public health data systems (DAWN, the National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), Overdose Data to Action (OD2A), Transformed Medicaid Statistical Information System (T-MSIS), CDC Wide-ranging Online Data for Epidemiologic Research (WONDER), and coordinate with the Department of Transportation (DOT) on the National Emergency Medical Services Information System (NEMSIS) at the federal level.

ii. *Type of activity:* Grant program

iii. *Description:* HHS maintains multiple surveillance systems that track substance use, overdose deaths, treatment utilization and Medicaid enrollment, but these datasets remain fragmented and often operate on different reporting timelines. Integrating systems, such as NSDUH, TEDS, T-MSIS, OD2A and CDC WONDER - and coordinating with NEMSIS - would create a more complete picture of the overdose crisis.[40,41,42,43,44,45] A modernized, interoperable data infrastructure would help policymakers detect emerging threats more quickly, evaluate program performance and target resources where they can have the greatest impact.[46,47,48] [4]

[3] Effective June 13, 2025, SAMHSA's DAWN discontinued new data collection. The FY 2027 PBR proposes to eliminate SAMHSA's DAWN (-$10 million). The value of surveillance systems depends on methodological continuity and institutional independence from political influence (as required by OMB Statistical Policy Directive No. 1.) Disruptions to staffing continuity or oversight structure risk compromising data integrity and year-over-year comparability.

iv. *Statutory authority:* PHS Act § 301, § 306, § 505 (42 U.S.C. § 241, § 242k, § 290aa–4); Title XIX, Part B (42 U.S.C. § 300x–21 et seq.); PHS Act § 311 (42 U.S.C. § 243)

Policy/Operational Idea #3: Establish foundational guardrails for Artificial Intelligence (AI) tools used in mental health and substance use care

i. *Title:* HHS should establish baseline requirements mandating that AI tools used in mental health and SUD care protect patient privacy, confidentiality and trust, specifically with Health Insurance Portability and Accountability Act (HIPAA) and, where applicable, 42 CFR Part 2.
ii. *Type of activity:* Regulatory
iii. *Description:* AI has the potential to improve mental health and SUD care.[49] As AI adoption accelerates, however, HHS should establish clear baseline expectations that AI tools used in these settings comply with HIPAA and, where applicable, the heightened confidentiality protections in 42 CFR Part 2.[50,51] This approach aligns with President Trump's June 2, 2026, Executive Order, *Promoting Advanced Artificial Intelligence Innovation and Security*, which recognizes the need for federal oversight of AI while promoting innovation.[52] Establishing privacy and data security guardrails now would protect patient trust, safeguard sensitive treatment information and support the responsible use of AI in behavioral health care.
iv. *Statutory authority:* HIPAA (42 U.S.C. §§ 1320d through 1320d-9), 42 U.S.C. § 290dd-2

Conclusion

Overdose deaths are declining, but the crisis is not over. CDC estimates show drug overdose deaths fell by 14.7 percent in 2025, demonstrating that sustained investments in prevention, treatment, recovery and overdose response can save lives.[53]

At the same time, more than 40 million adults experienced a SUD in 2024 and most people who needed treatment did not receive it.[54] The central challenge is ensuring that the systems responsible for prevention, treatment, recovery and overdose response are equipped to deliver evidence-based care consistently, quickly and in the communities facing the greatest risk. HHS has the authority and the opportunity to build on proven programs, remove administrative barriers to treatment, strengthen continuity of care, protect parity, support the workforce and sustain the data systems needed to measure progress.

EO 14379 calls for a coordinated, data-driven federal response to addiction. The Great American Recovery Initiative should strengthen the treatment recovery infrastructure that helps people survive and rebuild their lives. New priorities should not come at the expense of programs and systems that are already saving lives. As new priorities emerge, Congress

should provide the resources necessary to expand federal efforts without diminishing capacity of existing programs. We appreciate the opportunity to provide these recommendations and welcome continued engagement with HHS as the Great American Recovery Initiative moves forward.

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