American Academy of Addiction Psychiatry
Translating Science. Transforming Lives.

400 Massasoit Ave., Suite 307
East Providence, RI 02914
401 524-3076

July 2, 2026

Robert F. Kennedy, Jr
Secretary
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Dear Secretary Kennedy:

On behalf of the *American Academy of Addiction Psychiatry (AAAP)*, thank you for the opportunity to provide comments on the Request for Information (RFI) regarding substance use disorder research, policy, and strategies to improve the prevention, treatment, and recovery of the chronic disease of addiction and mental illness and how to promote the Great American Recovery Initiative.

AAAP is the preeminent professional Addiction Psychiatry organization representing Addiction Psychiatrists in the prevention, treatment, and recovery of patients at risk or with addiction, substance use disorders (SUDs), and co-occurring psychiatric disorders. AAAP's primary mission is to provide evidence-based practices, educate healthcare professionals and advocate for the prevention, treatment, and recovery of addictions, SUDs and co-occurring psychiatric disorders.

AAAP is committed to working collaboratively with the Administration, Congress, states, communities, healthcare providers, and individuals in recovery to expand access to a continuum of care that includes prevention, treatment, and recovery services. Continued progress in addressing the nation's addiction crisis depends on maintaining strong investments in evidence-based research, workforce development, and the public health infrastructure that meets the needs of people with substance use disorders, psychiatric disorders and addiction, including those with housing stability challenges. We also need flexibility to meet new and emerging drugs such as nitazenes, kratom, and nitrous oxide, as well as the harms caused by unhealthy technology use from gaming, gambling, social media, and generative AI.

While we are encouraged by recent declines in overdose deaths across much of the country, the overdose crisis remains a significant public health challenge. Nearly 80,000 Americans died from a drug overdose in

2024, and an estimated 48.4 million individuals are living with a substance use disorder. In addition, almost 49,000 people died by suicide in 2024 according to CDC data. Despite the availability of effective, evidence-based treatments, only about one in five people who needed treatment received it. These statistics underscore the need to sustain and strengthen federal investments in prevention, treatment, and recovery support services that are grounded in evidence and proven to save lives. Our members want to ensure access to cost-efficient, clinically effective models of care treatment. Especially for populations requiring long-term integrated care who benefit from biological, psychological, and social supports for medication and psychopharmacology, psychoeducation, motivational facilitation, relapse prevention, recovery support, housing, and vocational assistance.

Our recommendations below reflect the clinical experience and expertise of clinicians working every day to improve outcomes for individuals, families, and communities affected by addiction and mental illness.

Question 1: Programs and Interventions with Evidence of Effectiveness

Title: Providers Clinical Support System (PCSS-MOUD) to be changed to Provider Clinical Support System-Substance Use Disorders

Type of Activity: Clinician education, mentorship, and workforce development

Description:
The Providers Clinical Support System-Medications for Opioid use Disorder (PCSS-MOUD) is a national training, implementation, and mentorship program that provides evidence-based education on the prevention and treatment of opioid use disorder (OUD) and other substance use disorders. The grant is being changed to PCSS-SUDs, which we support.

We urge PCSS-SUD to build on lessons learned from PCSS-MOUD. This includes providing no-cost training, continuing education, clinical consultation, and mentoring physicians, nurse practitioners, physician assistants, pharmacists, social workers, counselors, dentists, and other healthcare professionals across the country. Beyond traditional educational activities, the program offers ongoing mentorship, clinical roundtables, implementation support for healthcare organizations seeking to establish medications for opioid use disorder (MOUD) services, and multidisciplinary learning opportunities designed to build clinician confidence and competency.

The program has demonstrated remarkable reach and impact. In 2025 alone, PCSS-MOUD trained more than 500,000 healthcare professionals, and between September 2023 and September 2025 nearly one million participants received training through more than 500 educational activities. The program currently houses hundreds of educational resources and training opportunities, including foundational substance use disorder curricula, webinars, clinical roundtables, implementation collaboratives, and specialized training programs for healthcare teams. PCSS-MOUD also maintains a robust mentoring network connecting experienced addiction specialists with clinicians seeking guidance on integrating evidence-based addiction treatment into practice.

Importantly, PCSS-MOUD addresses many of the barriers that prevent clinicians from treating patients with substance use disorders, including lack of training, limited access to mentorship, stigma surrounding addiction treatment, and insufficient support for managing co-occurring psychiatric disorders. The program promotes screening, diagnosis, and treatment of both substance use disorders and co-occurring mental health conditions, helping clinicians deliver comprehensive, patient-centered care. Surveys consistently demonstrate that participants report greater confidence and willingness to provide MOUD, with 75 percent of surveyed clinicians indicating they would not feel comfortable treating patients with OUD and prescribing medications without PCSS-MOUD training and support.

Statutory Authority: Public Health Service Act §§ 501, 509, and 547 (42 U.S.C. §§ 290aa, 290bb-2, and related SAMHSA authorities), authorizing activities related to substance use disorder prevention, treatment, recovery support services, workforce development, technical assistance, and professional training. PCSS-MOUD and the new PCSS-SUD is funded through SAMHSA's Substance Abuse Treatment, Programs of Regional and National Significance (PRNS) account under the Opioid Treatment Programs/Regulatory Activities line.

Title: State Opioid Response and Tribal Opioid Response Technical Assistance

Type of Activity: Technical assistance and community capacity building

Description:
The SORTOR-TA grant was awarded to AAAP from inception with a large coalition of national organizations across prevention, treatment, recovery, public health and public safety to form the Opioid Response Network (ORN). ORN provides no-cost, locally tailored training, education, consultation, and technical assistance to states, territories, Tribal communities, healthcare organizations, community-based organizations, and other stakeholders working to address substance use disorders. Established to support State Opioid Response (SOR) and Tribal Opioid Response (TOR) efforts, ORN brings together a multidisciplinary coalition of national organizations representing prevention, treatment, recovery, public health, and public safety professionals, with a collective reach of more than two million constituents.

Since 2018, ORN has delivered technical assistance in every state and eight U.S. territories, facilitating training and consultation that has impacted at least one million individuals nationwide. Unlike traditional training programs that focus solely on education, ORN works directly alongside communities to assess local needs, identify strengths and barriers, and to expand capacity locally and foster and support building sustainability that support evidence-based prevention, treatment, harm reduction, and recovery services. Through a network of expert and experienced local ORN consultants located in every state and territory throughout the US, ORN provides tailored assistance designed to meet the unique needs of each community rather than relying on one-size-fits-all approaches.

A key strength of ORN is its focus on building long-term community capacity. The program helps organizations and communities develop the infrastructure, workforce competencies, partnerships, and implementation strategies needed to sustain evidence-based practices long after federal technical assistance concludes. By combining local engagement with national expertise, ORN has strengthened community responses to opioid, stimulant, and other substance use disorders, increased adoption of evidence-based practices, and expanded access to prevention, treatment, and recovery support services across diverse settings. AAAP believes ORN represents one of the federal government's most effective models for translating evidence-based addiction practices into sustainable community action. A major unique strength of ORN has been to convene representatives across all sectors to work collaboratively, optimize use of resources not to duplicate or compete with others but to focus on filling gaps ensuring we are effective and efficient.

Statutory authority: SOR/TOR TA grant is authorized under the Further Consolidated Appropriations Act, 2024, Division D, Title II, [Public Law 118-47] and section 1003 of the 21st Century Cures Act [Public Law 114-255] (42 USC 290ee–3 note), as amended.

Question 2: Policy Changes Using Existing Funding

Title: Expanding the Addiction Treatment Workforce

Type of Activity: Workforce development

Description:
The addiction treatment workforce remains insufficient to meet national demand. HHS should work with the Health Resources and Services Administration (HRSA) and other federal partners to improve access to loan repayment programs, increase participation by physicians and addiction specialists, and modernize eligibility requirements.

The Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR-LRP) is a critical workforce development initiative that helps recruit and retain clinicians in high-need communities by reducing the financial burden associated with professional education. Established through the SUPPORT for Patients and Communities Act, STAR-LRP provides loan repayment assistance to clinicians who commit to serving in substance use disorder treatment settings, helping expand access to care in areas experiencing significant workforce shortages. Demand for the program has consistently exceeded available funding, demonstrating both the need for loan repayment assistance and the strong interest among clinicians in serving individuals with substance use disorders. For example, in Fiscal Year 2021, HRSA received 3,184 applications but was only able to make 255 awards, including just 12 awards to physicians.

While STAR-LRP has been successful, modifications are needed to maximize its impact on the addiction treatment workforce. Current program requirements mandate that participants spend at least 90 percent of their time providing direct treatment or recovery support services, which can unintentionally exclude Addiction Psychiatrists and other specialists whose responsibilities often include teaching, supervision, consultation, research, and program leadership. With the increasing complexities and expansion of need, having experts in handling mental health disorders coupled with substance use disorders is imperative as most people have a mental health disorder. These activities are essential to expanding treatment capacity because they support frontline clinicians, strengthen systems of care, and extend the reach of limited addiction expertise. AAAP recommends that HRSA expand its definition of direct service to include these patient-care-supporting activities so that more physicians and addiction specialists can qualify for loan repayment assistance.

Addiction Psychiatrists complete extensive training and often accumulate substantial educational debt, frequently exceeding hundreds of thousands of dollars. At the same time, reimbursement and workforce shortages make recruitment and retention increasingly difficult. Federal policymakers should recognize that workforce development requires both accessible educational financing and robust loan repayment opportunities. The Proposed Rules that would eliminate Graduate PLUS loans or impose new limits on federal student borrowing could create significant barriers for students pursuing medical, psychiatric, counseling, social work, and other behavioral health professions, particularly those from middle- and lower-income backgrounds. Such policies risk shrinking the pipeline of future addiction and mental health professionals at a time when demand for services far exceeds capacity.

Statutory authority: 42 U.S.C.§295h (Section 781 of the Public Health Service Act)

Title: Expanding Research and Infrastructure for Behavioral Addictions

Type of Activity: Research and policy development

Description:
Behavioral addictions remain a significantly underfunded and understudied area of addiction science

despite growing prevalence and mounting public health concerns. Gambling disorder—whether associated with online sports betting, mobile gambling applications, or digital gaming—is estimated to affect approximately 3 percent of Americans, with prevalence reaching nearly 10 percent among men ages 18 to 30. Yet gambling disorder receives only a fraction of the federal research investment devoted to substance use disorders, despite strong evidence that behavioral addictions share many of the same neurobiological mechanisms, including reward processing, impulsivity, and dopamine-mediated reinforcement pathways.

Currently, gambling disorder is the only behavioral addiction formally recognized in the DSM-5, creating a diagnostic and reimbursement gap for other emerging behavioral addictions. As concerns continue to grow regarding problematic social media use, online gaming, generative AI, and other compulsive digital behaviors, federal research investments should support the development of diagnostic criteria, prevention strategies, treatment interventions, and reimbursement pathways for a broader range of behavioral addictions. Greater scientific understanding is needed to distinguish normative behaviors from clinically significant addiction and to establish evidence-based approaches to prevention and treatment.

Expanding research on behavioral addictions also offers an important opportunity to advance our understanding of addiction more broadly. Nearly all individuals with gambling disorder experience at least one co-occurring mental health or substance use condition, and behavioral and substance addictions frequently overlap in both clinical presentation and underlying neurobiology. Research on gambling and other behavioral addictions allows investigators to study core addiction processes without the confounding effects of psychoactive substances, potentially yielding important insights into relapse, recovery, and the mechanisms that drive addictive behaviors. Increased federal investment can help establish the scientific foundation necessary to ensure that individuals affected by behavioral addictions receive the same evidence-based, effective care available for other addictive disorders.

Statutory authority: Public Health Service Act §§ 301 and 405 (42 U.S.C. §§ 241 and 284), which authorize NIH to conduct and support research on the causes, diagnosis, prevention, and treatment of physical and mental diseases and impairments, including behavioral and neuropsychiatric disorders. These authorities provide NIH, NIDA, and NIMH with broad authority to support research on behavioral addictions, gambling disorder, compulsive behaviors, co-occurring psychiatric conditions, and their relationship to substance use disorders.

Title: Minimizing Coverage Disruptions Resulting from Medicaid Community Engagement Requirements

Type of Activity: Program Administration and Coverage Continuity

Description:
As states implement new Medicaid community engagement requirements, we urge HHS to prioritize strategies that minimize unnecessary loss of coverage among individuals with SUDs and co-occurring mental health conditions. Individuals with SUDs and/or serious mental illness often experience unstable housing, periods of crisis, cognitive impairment, and justice-system involvement that can make compliance with reporting and documentation requirements particularly difficult. While many individuals may qualify for exemptions based on medical frailty or participation in substance use disorder treatment, the process of demonstrating eligibility for these exemptions may itself create substantial barriers to maintaining coverage. Under the proposed rules, individuals with SUDs seeking a medical frailty exemption may be required to demonstrate not only the existence of their condition but also that it significantly impairs their ability to comply with community engagement requirements; we are concerned

that such a requirement may create an additional administrative hurdle for a population already facing significant challenges.

HHS should encourage states to maximize the use of automated eligibility determinations, claims and encounter data, self-attestation where permitted, and data matching to identify eligible individuals and minimize documentation burdens. States should be encouraged to adopt broad definitions of qualifying substance use disorders, utilize a wide range of qualified practitioners to verify medical frailty, develop simple and standardized documentation processes, and ensure that individuals receiving substance use disorder treatment can access available exemptions without unnecessary administrative complexity. Particular attention should be paid to individuals transitioning from incarceration, those experiencing homelessness, and those with co-occurring mental illnesses who may be especially vulnerable to coverage loss.

Loss of Medicaid coverage can interrupt access to medications for opioid use disorder (MOUD), behavioral health services, recovery supports, and other essential healthcare services, increasing the risk of relapse, overdose, hospitalization, and adverse health outcomes. Because substance use disorder is a chronic, relapsing medical condition, continuity of coverage is critical to maintaining treatment engagement, supporting recovery, and preventing avoidable harm. Federal implementation efforts should prioritize keeping eligible individuals connected to care and reducing administrative barriers that may inadvertently undermine access to evidence-based treatment.

Statutory Authority: Section 71119 of P.L. 119-21

Question 3: Reducing Stigma and Promoting Recovery

Title: Normalizing Integration of Addiction Treatment into Mainstream Healthcare

Type of Activity: Healthcare system reform

Description:
Integrating addiction, substance use, and mental health disorders screening, diagnosis, treatment, and care management into primary care, emergency departments, and other healthcare settings helps reduce stigma and improve access by treating these conditions like other chronic relapsing mental disorders. However, integration is most effective when it functions as part of a broader continuum of care that includes timely access to specialty mental health and substance use disorder services when patients require a higher level of care. HHS should continue promoting integrated behavioral health models, interoperability of health records, and coordination across physical and behavioral health systems while also ensuring adequate community-based specialty treatment capacity and reimbursement. In addition, federal policies should support bidirectional integration by bringing primary care and other physical health services into mental health and substance use disorder treatment settings, allowing providers to meet patients where they are and address the full range of their healthcare needs. Strengthening care coordination across settings can improve outcomes, reduce stigma, facilitate earlier intervention, and ensure that individuals with co-occurring mental health and substance use disorders receive comprehensive, patient-centered care throughout their recovery journey.

Statutory authority: Public Health Service Act §§ 501 and 509 (42 U.S.C. §§ 290aa and 290bb-2) and Titles XVIII and XIX of the Social Security Act. These authorities permit HHS, SAMHSA, and CMS to support integrated behavioral health care, collaborative care models, substance use disorder treatment, mental health services, care coordination, interoperability initiatives, and payment policies that promote

comprehensive, patient-centered care across primary care, emergency department, specialty behavioral health, and community-based treatment settings.

Question 4: How can Federal policies and programs be improved to address the addiction and mental health practitioner shortage and better ensure that every American seeking addiction treatment can find affordable help covered by their insurance in their area?

Title: Strengthening Mental Health and Substance Use Disorder Parity Enforcement to Expand Provider Networks

Type of Activity: Regulatory and Programmatic Action

Description:
Although the Mental Health Parity and Addiction Equity Act (MHPAEA) requires mental health and substance use disorder (MH/SUD) benefits to be provided on par with medical and surgical benefits, patients continue to face significant barriers accessing in-network addiction treatment providers. Inadequate provider networks, low reimbursement rates, inaccurate provider directories, and restrictive utilization management practices discourage clinician participation in insurance networks and contribute to workforce shortages. HHS should strengthen enforcement of MHPAEA network adequacy and reimbursement requirements, require regular audits of provider directories, and ensure plans maintain sufficient addiction treatment capacity. Improved parity enforcement would increase provider participation, expand patient access to affordable care, and reduce treatment delays.

Statutory Authority: Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. §1185a); Public Health Service Act §2726; Employee Retirement Income Security Act (ERISA); Internal Revenue Code §9812.

Title: Expanding and Modernizing Federal Loan Repayment Programs for Addiction Specialists

Type of Activity: Workforce Development

Description:
As discussed above, the addiction treatment workforce shortage is exacerbated by educational debt and reimbursement disparities that discourage physicians and other clinicians from pursuing addiction specialties. Federal loan repayment programs, including the Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR-LRP), are highly oversubscribed and currently reach only a small percentage of qualified applicants. HHS should increase funding for existing loan repayment programs and revise eligibility criteria so that activities such as teaching, supervision, consultation, research, and systems-level clinical support count toward service obligations. These changes would improve recruitment and retention of Addiction Psychiatrists and other behavioral health professionals, particularly in underserved communities.

Statutory Authority: Public Health Service Act §§ 776 and 781 et seq. (National Health Service Corps and Loan Repayment Programs); SUPPORT for Patients and Communities Act (P.L. 115-271).

Title: Sustaining and Expanding Federal Addiction Training and Technical Assistance Programs

Type of Activity: Workforce Training and Capacity Building

Description:
Federal investments in clinician training programs have successfully expanded the number of providers prepared to deliver evidence-based addiction treatment. Programs such as the Providers Clinical Support System (PCSS-MOUD) and the Opioid Response Network (ORN) provide free education, mentoring, and technical assistance to healthcare professionals and communities nationwide. HHS should maintain and expand support for these programs to increase clinician confidence in treating substance use disorders, strengthen local treatment capacity, and improve access to care in rural and underserved areas. Expanding these initiatives would allow the federal government to rapidly build workforce capacity using proven infrastructure already operating in every state.

Statutory Authority: Public Health Service Act §§ 501, 509, and 547; Substance Abuse and Mental Health Services Administration (SAMHSA) authorities under Title V of the Public Health Service Act; State Opioid Response and Tribal Opioid Response appropriations.

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?

Title: Modernizing National Substance Use and Mental Health Surveillance Systems

Type of Activity: Data Infrastructure and Performance Measurement

Description:
HHS should modernize and integrate existing federal surveillance systems, including the National Survey on Drug Use and Health (NSDUH), Drug Abuse Warning Network (DAWN), overdose surveillance programs, and other federal datasets to enable more timely monitoring of substance use, mental health trends, treatment utilization, and recovery outcomes. Improved interoperability and more frequent reporting would allow policymakers to identify emerging threats, evaluate program performance, and allocate resources more effectively. Near real-time surveillance would also support earlier detection of changes in overdose patterns, substance use trends, and treatment access challenges, particularly in underserved communities. Maintaining and strengthening these data systems is essential to ensure that federal policies remain responsive to evolving public health needs.

Statutory Authority: Public Health Service Act §§ 301, 501, and 505; 42 U.S.C. § 290aa et seq. (SAMHSA authorities); 21 U.S.C. § 1708 (National Drug Control Strategy data and evaluation authorities).

Title: Establishing a Federal Outcomes Dashboard for Substance Use Disorder Treatment and Recovery Programs

Type of Activity: Program Evaluation and Accountability

Description:
HHS should develop a standardized outcomes framework and public-facing performance dashboard for federally funded prevention, treatment, and recovery programs. Common measures could include treatment engagement, retention in care, medication utilization, overdose outcomes, workforce capacity, housing stability, employment, and recovery indicators. Standardized reporting across agencies and grant

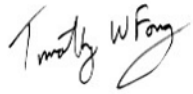
programs would improve accountability, allow comparisons across interventions, and identify successful models for replication. Such a system would provide policymakers with continuous performance monitoring rather than relying solely on periodic grant reports and retrospective evaluations.

Statutory Authority: Government Performance and Results Act (GPRA) Modernization Act of 2010; Public Health Service Act §§ 501 and 505; Foundations for Evidence-Based Policymaking Act of 2018 (P.L. 115-435).

Conclusion

AAAP appreciates the opportunity to provide input on HHS' Request for Comment on the Chronic Disease of Addiction. We support efforts to expand access to evidence-based prevention, treatment, and recovery support services, strengthen the addiction workforce, reduce stigma, and improve scientific understanding of addiction. We look forward to continued collaboration with HHS to ensure that individuals and families affected by substance use disorders, mental illness, and behavioral addictions have access to effective, evidence-based care.

Sincerely,



Tim Fong , MD
AAAP President