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Addiction Medicine

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July 2, 2026

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

Re: HHS Request for Comment on Chronic Disease of Addiction

Dear Secretary Kennedy,

On behalf of the American Society of Addiction Medicine (ASAM), a national medical specialty society representing more than 8,000 physicians, clinicians, and associated professionals dedicated to increasing access to and improving the quality of addiction services, we appreciate the opportunity to provide comments on the Request for Information (RFI) on the Chronic Disease of Addiction. **ASAM strongly recommends continued categorization of addiction as a chronic, treatable medical condition and alignment of federal programs around evidence-based prevention, risk reduction, treatment engagement and retention, recovery support, and continuous quality improvement. We encourage a focus on federal policies that prioritize interventions supported by rigorous evidence; reduce administrative barriers that disrupt patient care; expand access through telehealth and team-based models; and modernize data systems to support continued learning.**

Of particular importance, ASAM is concerned that the RFI appears to characterize overdose and infectious disease prevention services as counterproductive or damaging to health, inconsistent with empirical evidence. Syringe services programs are supported by decades of evidence demonstrating that they reduce HIV and hepatitis C transmission, improve safety, and create pathways to care without increasing drug use or crime.¹⁻⁵ ASAM encourages federal policy to avoid deprioritizing services that reduce transmission of viruses like HIV and HCV. Instead, we encourage enhancements in federal policy that reward treatment engagement, treatment continuity, and improved

health outcomes. Recurrence can happen in someone's recovery journey and if it does, it should trigger reengagement, rather than exclusion from care.

ASAM hopes the information offered below is helpful in making the progress necessary to continue expanding the capacity to treat addiction and save more lives. If you have any questions or need further clarification, please do not hesitate to contact Corey Barton, Director, Practice Management and Regulatory Affairs at ASAM at cbarton@asam.org.

Sincerely,

Stephen M. Taylor

Stephen Taylor, MD
President, American Society of Addiction Medicine

Question 1: What are programs or interventions that have rigorous, empirical evidence of effectiveness in improving outcomes for: a) substance use prevention, treatment, and recovery, b) mental illness prevention, treatment, and recovery, c) care for co-occurring mental and chronic disease of addiction?

1A. Developmental, family, school, community, and healthcare-based prevention programs

Type of activity: Program implementation and technical assistance

Links: [NIDA prevention evidence-based strategies](#)

Description: Evidence-based prevention should be implemented across the life course and matched to developmental stage, risk level, setting, and population. This strategy would strengthen prevention and improve early identification of youth and families who need additional behavioral health or substance use supports.

- HHS can use existing prevention, block-grant, and technical-assistance infrastructure to support implementation of family-based models such as Nurse-Family Partnership, school-based approaches such as the Good Behavior Game, community coalitions such as Communities That Care, and primary-care screening approaches for adolescents. ^{6, 7, 33, 34}

1B. Evidence-based treatments for substance use disorders

Type of activity: Treatment access, payment alignment, and clinical implementation

Links: [NIDA medications for opioid use disorder](#); [SAMSHA's Advisory: Low Barrier Models of Care for Substance Use Disorders](#)

Description: Addiction treatment should be matched to patient need using a multidimensional assessment and delivered across a continuum of levels of care consistent with *The ASAM Criteria* ([here](#)). HHS should prioritize evidence-based treatment approaches for substance use disorders (SUD) including medications for opioid use disorder (MOUD), alcohol use disorder (MAUD), and tobacco cessation, as well as evidence-based behavioral treatments such as contingency management, cognitive behavioral therapies, and motivational interviewing. Methadone, buprenorphine, and naltrexone are FDA-approved MOUDs that represent the standard of care due to their effectiveness in reducing cravings, risk of relapse, and infection transmission-related mortality among people with opioid use disorder (OUD). Methadone and buprenorphine are also associated with reduced risk of overdose and mortality, ^{8, 9} and have demonstrated safety/efficacy during pregnancy and breastfeeding. ^{10, 11} Evidence-based behavioral interventions, including contingency management, cognitive behavioral therapies, and motivational interviewing, are essential components of addiction care and support medication adherence and recovery goals. ^{16-19, 35-39} In particular, contingency management is currently the most effective treatment for stimulant use disorders, including addiction

involving methamphetamine and/or cocaine.^{12, 13} Additional actions that HHS should take include:

- Modernizing outdated regulatory frameworks that limit access to methadone for OUD treatment, consistent with regulatory proposals advanced by ASAM ([here](#)) or an emerging bipartisan legislative proposal that builds on the [Modernizing Opioid Treatment Access Act](#). These efforts would expand access to methadone through appropriately trained and registered clinicians and additional medical settings leveraging pharmacy-involved models, while maintaining appropriate clinical oversight and patient safety.
- Continuing to prioritize and expand low-threshold access to MOUD through opioid treatment programs (OTPs), office-based care, emergency departments, correctional and reentry settings, telehealth, mobile units, and integrated primary care.^{14, 15}
- Recommending against payer policies that include arbitrary dosage restrictions inconsistent with the FDA label, as well as limits on treatment duration, given that longer retention in MOUD treatment is associated with better health outcomes and lower overdose risk.¹⁶
- Expanding use of MAUD, including naltrexone, acamprosate, disulfiram, and FDA-approved tobacco cessation treatments,¹⁷ including nicotine replacement therapy, varenicline, and bupropion.
- Reducing morbidity and mortality from stimulant use disorder by incentivizing implementation of SAMHSA's recent [advisory](#) improving provision of contingency management in federally-funded addiction programs.
- Supporting retention-oriented recovery services rather than policies that condition medication access on abstinence or strict attendance thresholds, because recurrence and fluctuating engagement are expected features of a chronic condition.¹⁸ Moreover, HHS should foster cross-agency collaboration to ensure that all individuals have access to the full spectrum of evidence-based addiction care, from medications to psychosocial treatments, to empower people to build a life that is meaningful to them.
- HHS should prioritize and expand large-scale clinical research evaluating glucagon-like peptide-1 (GLP-1) receptor agonists as potential treatments for substance use disorders. Early evidence suggests these medications reduce craving and substance use behaviors across multiple substances; however, rigorous, large-scale randomized trials are needed to establish efficacy, safety, and appropriate clinical use.

1C. Recovery supports

Type of activity: Treatment access, payment alignment, and clinical implementation

Links: [SAMSHA Recovery and Recovery Support](#); [NIDA Recovery](#)

Description: HHS should support recovery services that improve health and wellness while supporting individuals' ability to live self-directed lives. Importantly, HHS should maintain a

clear distinction between recovery supports and evidence-based clinical treatments. Recovery is highly personal and may occur through many different paths including (but not limited to) clinical treatment, medications, peer-support, employment and education support, faith-based or spiritual supports, and culturally responsive community-based services. Faith-based and spiritual programs may be meaningful sources of connection and support for some individuals; however, evidence supporting these programs as a first-line treatment for addiction is limited.¹⁹⁻²¹ Thus, such programs should not be presented as substitutes for evidence-based treatments for addiction such as MOUD, MAUD and evidence-based behavioral treatments. Accordingly, HHS should consider supporting research to clarify the roles and efficacy of spiritual, religious, or other recovery support pathways within the continuum of addiction care, while ensuring that federal policy protects patient choice and prioritizes access to evidence-based care.

1D. Evidence-based overdose, infectious disease prevention, and treatment engagement interventions

Type of activity: Program implementation, prevention, treatment engagement, and public health

Links: [CDC fentanyl and overdose-prevention resources](#); [NIH RTC Overdose Prevention Centers](#)

Description: HHS should recognize overdose prevention and infectious disease prevention services as evidence-based components of the addiction care continuum. ASAM is concerned that the characterization of services such as syringe service programs and provision of drug checking services as counterproductive or damaging to health is inconsistent with the empirical evidence and risks undermining programs that save lives, prevent infectious disease, and create pathways to treatment and recovery. There are decades of research demonstrating that syringe services programs reduce HIV and hepatitis C transmission and other infectious disease related complications, support safer syringe disposal, and can facilitate linkage to treatment and healthcare services, without increasing drug use or crime.¹⁻⁵ There is also evidence supporting newer approaches, including naloxone and overdose education, and drug checking. These interventions reduce overdose risk, unsafe-use behaviors, and disconnection from care, without evidence of increasing drug use or surrounding crime.^{1, 22-26}

- Because addiction is a chronic condition and engagement often fluctuates, syringe services programs, naloxone provision, and drug checking services should continue to be treated as part of the necessary continuum of care along with prevention, treatment engagement, and recovery support rather than as separate from recovery.
- Federal decisions that characterize provision of sterile supplies and drug-checking tools as harmful and deprioritize support for study and implementation of such services risk increasing preventable overdose, infectious disease, and loss of trust among communities least connected to traditional treatment.²³

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

2A. Align federal guidance around retention, continuity, and transitions rather than administrative discharge

Type of activity: Federal guidance, technical assistance

Description: Recurrence is a common and expected element of the addiction disease course and should be reflected in health policy decisions to improve patient outcomes. This framing is consistent with *The ASAM Criteria*, which emphasizes reassessment, individualized treatment, and transitions across levels of care.

- HHS should issue cross-agency guidance encouraging states and grantees to review policies that unintentionally remove people from care, such as mandatory discharge after positive drug tests, forced transfers after a fixed number of recurrences, or program rules that deny care when patients are not abstinent.¹⁸
- Licensing and level-of-care requirements should support step-up and step-down transitions within the same organization whenever clinically appropriate, rather than requiring patients to leave one program and enroll elsewhere.
- Federal technical assistance could help states align licensing, payer, and quality standards with chronic disease management principles, where recurrence triggers reassessment, outreach, and treatment adjustment versus termination of care.
- HHS should address barriers related to 42 CFR Part 2 that can impede appropriate information sharing among treating providers. Limitations on data exchanges between primary care, behavioral health, and SUD treatment programs can disrupt care transitions and fragment treatment. Federal guidance and technical assistance should clarify permissible disclosures for treatment, and support state and provider adoption of compliant data-sharing frameworks that enable coordinated, whole-person care.

2B. Permit reimbursement and reporting for outreach, re-engagement, and care-continuity work

Type of activity: Payment policy, performance measurement

Description: Current payment and performance systems do not consistently recognize the full scope of activities required to deliver effective addiction treatment, including outreach, care coordination, medication management, and re-engagement activities across all care settings. These gaps persist across both inpatient and outpatient settings. Experience from hospital-based addiction consult models shows that the primary issue may be inconsistent capture of existing billable services in the absence of official guidance and technical assistance. At the same time, Medicare outpatient payment policies also remain misaligned with clinical practice,

as Medicare reimbursement varies by site of service despite comparable services, creating financial disincentives for certain non-OTP providers and limiting access to care. Paying for re-engagement would align financing with the clinical reality of addiction as a chronic condition and would reduce incentives for administrative discharge. To those ends:

- HHS should pursue a coordinated payment strategy that strengthens DRG-based accuracy and consistency for SUD in hospital settings to promote adoption of addiction consult models ([here](#)) and modernizes Medicare’s outpatient SUD payment and coding policies by developing a more clinically appropriate bundled payment in non-OTP settings that align with ASAM Level 1.7, as described in a recent ASAM letter addressing Medicare’s outpatient SUD disparities ([here](#)).
- HHS should encourage CMS, SAMHSA, and HRSA programs to recognize outreach, care coordination, and re-engagement as billable or reportable services when patients miss visits, leave treatment, experience incarceration, or transition across care settings.¹⁸
- HHS should also encourage continuous coverage and simplified re-enrollment processes around incarceration, release, housing loss, and other destabilizing life events.
- Federal performance measures should reward continuity of care and successful re-engagement, rather than focusing on strict abstinence.
- HHS should clarify 42 CFR Part 2’s application to hospital-based addiction consult services (ACS) to support integrated care. In some hospitals, ACS are treated as “Part 2 programs,” leading to siloed documentation and patient consent requirements that can impede care and patient safety. This interpretation does not accurately reflect ACS teams’ role as providers of acute care medical services that diagnose and treat SUD alongside other co-occurring conditions and rely on integration in hospital medical records to ensure patient safety and effective care transitions. HHS should consider issuing guidance or establishing a clear regulatory safe harbor confirming that hospital-based ACS are not Part 2 programs.

2C. Preserve evidence-based overdose and infection-prevention services as engagement points for treatment and recovery

Type of activity: Program alignment and public health implementation

Description: Naloxone, syringe services, drug checking (including test strips), HCV/HIV testing and treatment, wound care, and overdose prevention education are evidence-informed tools that can engage people who are not yet ready or able to enter abstinence-based care.^{1, 22, 23}

The evidence does not demonstrate that these services increase drug use; instead, they should be positioned as core components of a strong continuum of care that reduce harms and connect people to health care and social services.^{24, 25}

- HHS should reconsider policy and funding restrictions that deprioritize these tools, because limiting access to evidence-supported syringe services and drug checking programs is likely to increase preventable overdose, infectious disease transmission, and distrust of health systems.²³
- HHS should align existing overdose, HIV, HCV, and SUD programs around interventions that reduce immediate mortality and infection risk (including provision of naloxone, sterile supplies, and drug checking services) while creating trusted pathways to treatment and recovery.

Question 3: How can Federal policies and programs be improved to mitigate the stigma against Americans seeking addiction treatment and recovery?

3A. Adopt HHS-wide non-stigmatizing language standards for addiction, treatment, and recovery

Type of activity: Federal communications policy and grant guidance

Description: One immediate and effective approach is removing stigmatizing language from official communications. It has been demonstrated that terminology choice can negatively impact the care that patients with addiction receive.²⁷

- HHS should require federally funded public-facing materials, grant notices, training products, and performance-measure definitions to use person-first, clinically accurate, non-stigmatizing language. Terms such as “addict,” “abuse,” “dirty,” and “clean” should be replaced with terms such as “person with a substance use disorder,” “substance use,” “positive toxicology result,” and “in remission” or “in recovery,” while respecting individuals’ right to self-identify.²⁷⁻²⁹
- HHS should also update templates and training materials across agencies so that stigma reduction is not treated as an optional communications preference.

3B. Implement requirements for stigma reduction as a healthcare workforce competency

Type of activity: Training, quality improvement

Description: Stigma among health professionals can reduce willingness to treat patients with SUD and can undermine the provision of evidence-based care.³⁰

- HHS should incorporate stigma reduction quality-improvement programs. These programs should apply not only to addiction specialists but also to other specialties/settings, including, but not limited to primary care, emergency medicine, obstetrics, pediatrics, behavioral health, pharmacy, corrections health, and social service settings.
- For continued evaluation, HHS can consider pairing training with performance feedback, patient-reported experience measures, and incentives for timely initiation and continuation of evidence-based addiction treatment.

3C. Counter stigma against evidence-based overdose and infection-prevention services and low-threshold care as part of recovery culture

Type of activity: Federal communications policy, grant guidance, and community partnership

Description: Stigma does not only affect how people are described, but it also affects which interventions are funded, permitted, and treated as legitimate. When federal policy frames evidence-based overdose and infection prevention services, including syringe services programs, as facilitating drug use or as a damaging practice, this stigmatization drives people away from evidenced-based services which can be lifesaving entry points to treatment and recovery.²³

- HHS should require federal communications, grant guidance, and technical assistance to describe overdose and infection-prevention services accurately as an evidence-based, person-centered approach that reduces immediate risk, protects public health, and creates pathways to treatment while still supporting prevention, treatment, and long-term recovery goals. Low-threshold care and risk-reduction services should be framed as compatible with recovery-oriented systems of care.

Question 4: 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?

4A. Make telehealth and cross-jurisdiction practice a routine part of addiction and mental health access strategy

Description: Telehealth is a critical tool to expand access to specialty addiction care, particularly in rural and underserved communities where local providers are scarce, and transportation barriers are substantial.^{14, 15}

- HHS should preserve and strengthen telehealth pathways for SUD and mental health care, while supporting states in reducing interstate and intrastate barriers to behavioral health practice, including through licensure compacts, streamlined credentialing across states, and clarification of federal requirements such as DEA registration for prescribing controlled substances via telehealth.
- HHS should additionally support teleconsultation, mobile units, community health centers, OTPs, and cooperative-extension partnerships³¹ so local sites can connect patients to remote addiction and mental health expertise.

4B. Expand and target behavioral health workforce training, loan repayment, and fellowship programs toward addiction care

Type of activity: Workforce development and targeted funding alignment

Description: America’s ongoing addiction crisis is exacerbated by a workforce shortage that often impacts communities where improved access to evidence-based treatment would have the greatest impact on health. Strengthening the addiction and mental health workforce in all communities can improve patient trust, provision of patient-centered care, language access, and treatment retention.³²

- HHS should use existing HRSA and SAMHSA workforce programs such as the [Addiction Medicine Fellowship Program](#), [STAR-LRP](#), and [Minority Fellowship Program](#) to prioritize addiction medicine, addiction psychiatry, psychology, social work, counseling, nursing, peer support, and community health worker pipelines.
- Existing programs should be targeted toward shortage areas (e.g., rural communities, Tribal communities, low socioeconomic status communities).
- HHS should preserve and expand programs that reduce financial barriers for trainees from these communities, including fellowship, mentoring, and career-development supports.

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?

5A. Expand open-science and Findable, Accessible, Interoperable, Reusable (FAIR) data principles for addiction and related (e.g., pain and mental health) programs

Type of activity: Data infrastructure and research-to-practice translation

Description: Strengthening data infrastructure is essential to informing HHS efforts to improve both forward and reverse research-to-practice translation. For example, the [NIH Helping to End Addiction Long-term® Initiative \(HEAL\) Data Ecosystem](#) was created to broaden addiction and mental health program evaluation, and aims to accelerate sharing of data from HEAL studies with researchers, clinicians, community leaders, policymakers, advocates, and other stakeholders, while the HEAL Data Platform provides a federated discovery and analysis environment for HEAL-supported studies.

- HHS should promote open-science requirements and FAIR data principles for addiction science.
- HHS can use common data elements, metadata standards, data-use agreements, privacy-preserving linkages, and public dashboards to make federal investments easier to evaluate and reuse.
- Open-science requirements should be paired with technical assistance so smaller community and Tribal organizations can participate without excessive administrative burden.

5B. Use privacy-preserving AI and advanced analytics to detect gaps, target resources, and generate testable hypotheses

Type of activity: Analytics, AI governance

Description: AI tools are poised to improve both addiction research and clinical practice. ASAM emphasizes that these tools should be used to augment, not replace, clinical and community judgment, and should include bias testing, transparency, privacy safeguards, and meaningful review by patients, providers, and community partners.

- HHS should use advanced analytics and AI to identify treatment deserts, overdose and infectious-disease risk signals, prescribing and pharmacy access barriers, care-transition gaps, and patterns of treatment discontinuation.
- HHS can also use real-world data from EHRs, claims, registries, and patient-reported outcomes to detect promising medication-repurposing signals and implementation strategies that merit formal study. A responsible analytics framework would help HHS learn faster while protecting patients from surveillance, discrimination, and inappropriate automated decision making.

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