



**United States Department of Health and Human Services
Request for Comment on Chronic Disease of Addiction (Document Number 2026-11602)
July 5, 2026**

The Rehabilitation and Community Providers Association (RCPA) is a statewide association representing the gamut of human services providers, including those who provide substance use disorder (SUD) and mental health treatment services, in Pennsylvania. With more than 400 member organizations, the majority of whom are provider organizations, RCPA is one of the country's largest state associations. Nearly half of Pennsylvania's approximately 800 licensed SUD facilities are counted among the RCPA membership.

It is predominantly through the lens of supporting SUD provider members that RCPA is responding to the [U.S. Department of Health and Human Services Request for Comment on the Chronic Disease of Addiction](#).

RCPA is grateful to the United States Department of Health and Human Services for this opportunity to share its experience and perspective.

Question No. 1

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

There is a substantial body of research on substance use treatment and recovery, but the strength of evidence varies considerably. The following approaches offer the most rigorous empirical support, especially from randomized controlled trials, systematic reviews, and long-term outcome studies.

Medications for Opioid Use Disorder (MOUD)

Among all interventions in addiction treatment, [MOUD has the strongest evidence](#) for effectiveness and outcomes. Research consistently demonstrates that methadone and buprenorphine, including long-acting injectables, reduce overdose deaths and improve treatment retention; reduce illicit opioid use;

reduce criminal justice involvement; and improve social functioning and other quality-of-life measures ([Laroche, M., et al., 2018](#); [Mattick, R., et al., 2014](#); [Sordo, L., et al., 2017](#)) .

Further, when making these treatments more accessible through telemedicine, the findings are even more compelling. As an example, [in Pennsylvania, utilization of a telemedicine bridge clinic](#) resulted in higher medication engagement, linkage to ongoing care with retention including medication treatment, reduced unplanned care cost, and overall savings.

RCPA's treatment provider members are strong advocates for the use of medication and behavioral therapies as the most effective pathway for patients to stop their use of illicit opioids and begin to make the many difficult changes that will enable them to sustain their recovery and achieve their goals.

Although RCPA acknowledges that medication is most effective when paired with counseling (e.g., cognitive-behavioral therapy, trauma-informed care), we also support several other positions, including:

- Medication alone is treatment and prevents overdose deaths, more so than behavioral therapies alone.
- Medication must be accessible regardless of whether an individual agrees to counseling or other recovery supports.
- We must not place artificial limits on the amount of time someone uses a medication to treat their addiction.
- Individuals must have the freedom to choose the treatment path that works best for them to find the recovery that they seek.

Contingency Management

SAMHSA defines contingency management (CM) as a healthcare intervention in which tangible reinforcers, or motivational incentives, are given to participants contingent on objective evidence of change in a specific, incentivized behavior. CM is widely studied and has been successful in treating a variety of SUDs in diverse populations with demonstrated long-term benefit (a median of 24 weeks after reinforcement ended) beyond other active, evidence-based treatments such as cognitive behavioral therapy, 12-Step facilitation, and community-based intensive outpatient treatment ([Ginley et al., 2021](#)). Other meta-analyses demonstrate the effectiveness of CM ([Benishek et al., 2024](#); [Bolivar et al., 2021](#); [Prendergast, et al., 2006](#)).

CM continues to demonstrate outcomes that support broadening its use as an effective treatment for SUD. In fact, Pennsylvania has begun to develop the policy and funding infrastructure to support it.

[The Pennsylvania Department of Drug and Alcohol Programs \(DDAP\) includes CM in its guidance to Single County Authorities \(SCAs\)](#). DDAP permits SCAs and contracted treatment providers to implement CM. In addition, counties such as Allegheny and Susquehanna are [using opioid settlement funds to pilot](#)

[CM programs with evaluation components](#). Lastly, the Pennsylvania General Assembly has [introduced legislation to create a Contingency Management Support Grant Program](#).

Funding Recovery Housing as a Core Component of the Treatment Continuum

Recovery housing provides alcohol- and drug-free living environments that combine stable housing with varying levels of peer support, accountability, and recovery-oriented services.

Evidence indicates that housing is one of the strongest non-clinical predictors of sustained recovery from SUD. [One of the largest national studies analyzed over 1.2 million treatment discharges from the federal Treatment Episode Data Set \(TEDS-D\)](#) found that most people who enter SUD treatment while homeless leave treatment without stable housing. Those who remained homeless at discharge were more likely to leave treatment early; have shorter treatment episodes; be unemployed, and have entered primarily for detoxification rather than longer-term treatment. Conversely, [studies of supportive housing have found that people who obtain housing after treatment](#) are more likely to initiate outpatient SUD treatment; more likely to remain engaged; less likely to require substance-related hospitalization; and less likely to visit emergency departments for substance-related crises.

Recovery housing is not treatment in itself, but for many people it is the foundation that enables evidence-based treatment to be effective. As the recovery field has evolved, housing has shifted from being viewed as an ancillary social service to being recognized as a core component of a comprehensive recovery-oriented system of care. For individuals with significant housing instability or homelessness, expanding access to stable, recovery-supportive housing is likely to improve both individual outcomes and the return on investment in publicly funded treatment services.

For those seeking recovery or being discharged from SUD treatment, there simply are not enough affordable safe housing options. Discharging patients into whom we invest significant resources from an ever-tightening pool of Medicaid funds to unsafe housing situations or no housing at all is a major factor in any return to use. Where housing options do exist, lack of funding for patients in early recovery is a problem. In Pennsylvania, where there are various yet relatively small, restricted grants to fund recovery housing, we often see this happen. Only licensed recovery houses are able to receive state and federal funds. The relatively small number of licensed recovery houses and limited funds available for those homes juxtaposed against the tremendous need has created a major imbalance.

Peer Recovery Programs

[A growing body of evidence](#) demonstrates that peer recovery support services significantly improve [treatment linkage](#), initiation, engagement and retention. Peer recovery specialists are a strong complement to evidence-based treatment. They are particularly effective at helping individuals navigate the transition from crisis to treatment and sustaining engagement during the vulnerable early stages of recovery.

In Pennsylvania, for example, the [Opioid Use Disorder Centers of Excellence \(COE\)](#) are built largely on peer supports. Specifically, certified recovery specialists (CRS) – individuals who have received specialized training and certification to provide support and assistance to clients in recovery from substance use disorder – are charged with fostering connection and understanding, which are powerful factors in achieving successful, sustained recovery. These professionals play a vital role in helping clients achieve and maintain their recovery goals. Each COE is expected to employ a CRS.

In addition, in Pennsylvania, DDAP has provided [grant funding to nine regional recovery hubs](#), which are designed to embed, expand, and promote a coordinated network of community-based services and supports that are person-centered, with the ultimate goal of improving the health, wellness, and quality of life for individuals in recovery from substance use disorder. [Recovery hub initiatives](#), for example, address licensed recovery housing, transportation, recovery support service workforce development, recovery friendly employment, and recovery community organizations.

Question No. 2

Using existing funding, what policies or changes to federal programs might improve outcomes in substance use prevention, treatment, and recovery?

Improving integration of mental health and substance use disorder (SUD) services is widely recognized as one of the most important pathways to improving outcomes. Nearly half of individuals with an SUD have a co-occurring mental illness, yet the U.S. behavioral health system remains fragmented across financing, regulation, licensing, and service delivery. The evidence suggests that integration improves engagement, retention, clinical outcomes, and patient experience, while reducing unnecessary emergency department visits and hospitalizations.

Better Integrate SUD and Mental Health Services

Streamlining regulations, licensing requirements and payment models, and removing regulatory and administrative burdens that today result in disparate facility and service types, including but not limited to mental health walk-in centers, crisis centers and SUD facilities, have the potential to produce better outcomes than treating either SUD or mental health alone in a silo ([Chetty, A., et al., 2023](#); [Eddie, D., et al., 2025](#); [Hesse, M., 2009](#)).

[Certified Community Behavioral Health Clinics are one of the strongest examples of integrated SUD and mental health services](#). CCBHCs are a successful, integrated, and modern way of delivering 21st century mental health and substance use care to individuals and families in our country. CCBHCs have shown to be instrumental in reducing the use of more costly settings for care. Data have shown clinics help decrease costly emergency department and hospitalization usage and reduce patient wait time to get care. Additionally, clinics have reported per-member-per-month cost-savings. CCBHCs have proven

effective at working to reduce homelessness and addressing its root causes. [Findings](#) have shown that people who receive care at CCBHCs experience a 40.7 percent reduction in homelessness.

Although Pennsylvania has undertaken several initiatives to better integrate SUD and mental health treatment, including its [COE program](#); transition to ASAM Criteria and co-occurring capable levels of SUD treatment; and its own version of the CCBHC model (i.e., [Integrated Community Wellness Centers](#)), the regulatory, licensing and administrative burdens and requirements previously mentioned have hampered these efforts.

Treat SUD as a Chronic Health Condition

This RFI acknowledges addiction as a chronic disease. Although the system has made strides toward ensuring access to the appropriate intensity and duration of care based on clinical need, chronic disease management, and a full continuum of care, more work is necessary to move away from an acute, episodic approach. Recovery is rarely achieved through a single episode of care. Large cohort studies have shown that multiple treatment episodes are common, sustained remission often develops over years, and continuing recovery support improves long-term outcomes. To achieve a system that truly treats SUD as a chronic condition, federal and state policy must support:

- Expanding insurance coverage from short treatment episodes to long-term disease management, including [funding greater lengths of stay at higher levels of care for those experiencing the most severe effects of the disease](#).
- [Supporting long-term access to evidence-based medications](#) for opioid and alcohol use disorders without arbitrary duration limits.
- [Funding ongoing recovery supports](#) such as peer recovery services, recovery housing and recovery check-ups.
- Integrating addiction treatment into primary care and chronic disease management models.
- Measuring outcomes over years (e.g., sustained recovery, employment, housing stability, reduced mortality) rather than only at treatment discharge.

Better Integrate Behavioral Health Into Physical Health Services

Because behavioral health conditions are closely intertwined with physical health, [integrating behavioral health with primary care can improve outcomes](#), reduce costs, improve access, and streamline the patient experience. Unfortunately, separate payment systems for behavioral and physical health hamper meaningful integration efforts. Shifting Medicare and Medicaid away from paying for behavioral and physical health separately and creating payment models specifically designed for integrated behavioral health-primary care practices is among the most effective policy changes the federal government could make.

Federal policy could direct payment and regulatory reforms that not only encourage integration broadly but also facilitate adoption of evidence-based models, [such as the Collaborative Care Model](#).

Question No. 3

[E.O. 14379](#) calls for Federal efforts to, “increase awareness of the disease of addiction” and to “foster a culture that celebrates recovery.” How can Federal policies and programs be improved to mitigate the stigma against Americans seeking addiction treatment and recovery?

Over the past 10 years, much progress has been made in destigmatizing the disease of addiction. Through a combination of person-first language and general public and targeted awareness campaigns featuring people in recovery telling their stories, knowledge, attitudes, and intended behaviors among people who have been exposed to this messaging have changed. In Pennsylvania, the [Life Unites Us campaign](#) reports improved attitudes toward evidence-based treatment, reduced employment-related stigma, and increased recognition of the opioid crisis from a multiyear anti-stigma effort. Unfortunately, even with this progress, significant stigma still exists.

Require Training for Federally Funded Healthcare Providers

In particular, [stigma remains especially prevalent among healthcare professionals](#). As such, patients report delaying or avoiding healthcare because they expect discrimination. Evidence exists that demonstrates [improvements in provider attitudes toward patients with opioid use disorder](#) and greater acceptance of evidence-based treatment following healthcare provider training.

U.S. HHS could establish policies requiring stigma-reduction and recovery-oriented communication training for federally funded healthcare providers, including, where possible, professional peers (e.g., doctor to doctor, nurse to nurse) and always including people with lived experience in the trainings.

Change Federal Policy That Enables Structural Stigma

[Research also suggests structural stigma – policies and institutional practices – negatively affect people with SUD](#). Examples include insurance policies that make MOUD harder to access, restrictive employment practices, punitive licensing questions, exclusionary housing policies, and criminal justice practices that discourage treatment. Changes in federal policy may reduce structural stigma.

Question No. 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 insufficient supply of addiction and

mental health counselors (a shortfall estimated by HHS-HRSA at about 77,050 and 99,780 respectively).^[16] 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?

A major challenge in addiction treatment is not only funding services, but ensuring there are enough qualified professionals to provide them. Many counties in the United States have shortages of addiction counselors, psychiatrists, psychologists, social workers, and clinicians who can treat SUD. Federal policies could influence both workforce supply and access barriers.

Improve Reimbursement Rates

Increasing reimbursement rates is one of the most significant policy levers for improving clinician recruitment and retention.

Behavioral health treatment providers consistently report that [reimbursement affects their ability to offer competitive salaries](#), reduce turnover, and recruit psychiatrists, addiction medicine physicians and clinicians. Specifically in rural Pennsylvania, the Center for Rural Pennsylvania found that [low salary is among the top three issues in recruiting quality SUD clinicians](#).

With fewer physicians and clinicians, fewer patients are seen. When fewer patients are seen, the sustainability of the provider organization is at risk, eventually affecting patient access. Conversely, states increasing Medicaid payment rates for SUD treatment experience measurable increases in providers and treatment capacity.

[Medicaid reimbursement rates often fail to cover the full costs of delivering behavioral health care](#), including documentation, care coordination, and administrative requirements. This same research also notes that behavioral health providers often earn substantially more through commercial insurance or private-pay practice, creating a financial incentive to avoid working with Medicaid recipients.

Reduce Administrative Burden

There is evidence that excessive administrative burden contributes to burnout, lower job satisfaction, and reduced participation in insurance networks (e.g., Medicaid managed care networks) ([Hallett, M., et al, 2023](#); [National Academies of Sciences, Engineering, and Medicine, 2024](#)), all of which have the potential to affect the quality of patient care, including outcomes, as well as system sustainability. There is also evidence that policies that reduce these burdens make behavioral health more attractive and sustainable.

The Centers for Medicare and Medicaid Services (CMS) regulations and billing rules that cascade to the state level and ultimately front-line providers are two areas for immediate consideration in reducing administrative burden, particularly for duplicative and low-value documentation requirements. In

Pennsylvania, these federal regulations are often implemented inconsistently among the state's five behavioral health managed care organizations, essentially forcing treatment providers to operate in various subsystems.

CMS's [Interoperability and Prior Authorization Final Rule](#) offers some hope to SUD treatment providers in Pennsylvania relative to prior authorization processes, but the likelihood that it will result in fewer documentation requirements is low.

Question No. 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?

As more treatment system overseers, including Medicaid managed care organizations, continue to implement artificial intelligence (AI) into their processes, ensuring that providers are able to leverage the same technology is important. While MCOs have significant resources to access this technology, [cost to many providers, especially smaller ones, puts AI and other critical technology out of reach](#). Making federal grants and matching dollars available to behavioral health providers for AI and other critical technologies would help them implement these solutions.