



July 5, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: HHS Request for Comment on Chronic Disease of Addiction

Dear Secretary Kennedy:

For the past 55 years, the National Association of Community Health Centers (NACHC) has been the leading national, nonpartisan organization dedicated to supporting Community Health Centers (CHCs) (also known as Federally Qualified Health Centers) as the Employer, Provider, and Partner of choice in all communities. CHCs are the foundation of the primary health care system in the United States, with a primary care workforce of 326,000 serving 52 million patients. For 60 years, CHCs have provided high-quality, affordable, comprehensive care – including primary, preventive, dental, behavioral health, pharmacy, vision, and other essential health services at over 17,000 locations across rural and nonrural communities. This includes 1 in 3 rural residents and 1 in 2 in poverty.

As our nation’s largest primary care system, there is strong evidence, including from the Congressional Budget Office, that our work saves lives and also saves Medicaid and Medicare billions annually by reducing costly emergency, inpatient, and specialty care.¹ Research shows that every dollar invested in primary care yields a 13-to-1 return in overall health system savings.²

NACHC appreciates the opportunity to inform HHS policy and programming by highlighting how CHCs can support addressing the chronic disease of addiction with a focus on effective prevention, treatment, and recovery practices in communities across the nation.

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

CHCs have long been at the forefront of addressing mental and behavioral health needs in America, as they are accessible, community-based, and comprehensive. In 2024, CHCs provided care to over 3 million patients with behavioral health needs, including depression, anxiety, Post-Traumatic Stress Disorder (PTSD), Attention-Deficit / Hyperactivity Disorder (ADHD), and substance use disorders (SUD).³ As providers on the front lines of the addiction crisis, CHCs play a critical role in engaging with SUD through integrated, community-based models of care.

¹ <https://pubmed.ncbi.nlm.nih.gov/38331758/>

² <https://data.hrsa.gov/tools/data-reporting/program-data/national>

³ 2024 UDS Data

The integration of whole-person services, such as behavioral health and primary care, is at the core of the CHC program. Embedding behavioral health within primary care allows integrated behavioral health (IBH) teams to identify concerns early, intervene more quickly, expand access to treatment, improve adherence to care plans, and address the interconnected physical, behavioral, and upstream drivers that shape health outcomes. CHCs rely on interdisciplinary teams to coordinate care and provide case management for individuals experiencing trauma, sleep disorders, intimate partner violence, depression, anxiety, or alcohol or drug use, among other behavioral health conditions. CHCs offer a broad range of integrated behavioral health services for children and adults to address mental illness, substance use, and co-occurring chronic diseases. Evidence-based interventions often include:

- **Substance Use:** Certified Opioid Treatment Program (OTP), Medications for Opioid Use Disorder (MOUD), Screening, Brief Intervention, and Referral to Treatment (SBIRT), recovery services including peer support specialists, family-based prevention programs, Cognitive Behavioral Therapy (CBT), and Motivational Interviewing (MI), evidence-based psychotropic medication via shared clinical decision-making.
- **Mental Illness:** Cognitive Behavioral Therapy (CBT), Collaborative Care Model (CoCM), Acceptance and Commitment Therapy (ACT), Coordinated Specialty Care, Dialectical Behavior Therapy (DBT), supported employment, school-based psychotherapy and counseling services, and crisis services, evidence-based psychotropic medication via shared clinical decision-making.
- **Co-Occurring Disorders:** Intensive Outpatient Programs (IOPs), Integrated Dual Disorder Treatment (IDDT), integrated primary care-behavioral health, Trauma-Informed Care (TIC), CoCM for depression and SUD.

Studies have shown reductions in anxiety and depressive symptoms, decreased tobacco use, and meaningful weight loss among patients receiving integrated care.⁴ Evidence supporting CoCM, a specific form of IBH, shows improved depression remission and better management of co-occurring chronic conditions, including improved blood pressure, glucose, and cholesterol control.⁵ Large clinical trials further demonstrate that combining behavioral interventions with medical management promotes sustained lifestyle changes, strengthens treatment adherence, improves population health, and reduces long-term healthcare costs.⁶ For example, a Texas CHC implementing IBH services saw meaningful improvements in patient outcomes. Among Medicare patients, those receiving IBH support experienced a 13% greater reduction in poorly controlled hemoglobin A1c compared to those without integrated care. The CHC also achieved strong results in other areas: over 75% of patients reached blood pressure control, and depression remission improved by more than 15%, with 85% of patients ultimately free of depressive symptoms.

To expand access to effective behavioral health programs and interventions, NACHC urges HHS to broaden Medicare and Medicaid reimbursement for integrated care, including the CoCM, peer support, and SBIRT. NACHC’s recent report on CHC implementation strategies shows that current payment structures still treat behavioral health and primary care as separate

⁴ https://www.pbgh.org/wp-content/uploads/2023/11/Reiter2018_Article_ThePrimaryCareBehavioralHealth.pdf

⁵ <https://aims.uw.edu/resource/evidence-base-for-collaborative-care/>

⁶ <https://aims.uw.edu/resource/evidence-base-for-collaborative-care/>

services.⁷ This fragmentation creates significant barriers for CHCs working to deliver fully integrated care. While CHCs may participate in Medicare’s monthly care management programs—such as IBH and CoCM—reimbursement remains below Medicare Part B rates, under which CHC services are typically covered.

To strengthen access to behavioral health services, HHS should encourage CMS to amend the Medicare Physician Fee Schedule to fully include CHCs and support the long-term sustainability of behavioral health integration in community-based primary care. Updating reimbursement policy would also help center primary care in substance use disorder treatment. Practical steps include allowing CHCs to bill key codes such as depression screening (G0444) and substance use disorder screening and brief intervention (G0369, G0397). Additionally, there may be opportunities within CMS’ authority to expand and simplify billing for CoCM, PCBH, and other models to support CHCs. Updating the Medicare Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) to include the full range of comprehensive behavioral health services being offered by CHCs and ensuring appropriate reimbursement for these services by enhancing the PPS rate would also encourage more CHCs to offer expanded behavioral health services for their patients.

To further expand access to effective, evidence-based treatment, **NACHC recommends that HHS invest in innovative addiction treatment models, such as the hub-and-spoke model, to increase access to MOUD.** In this model, each hub is staffed by an addiction specialist who provides expert consultation to primary care clinicians, delivers direct patient care including MOUD, and coordinates connections to additional services. Each spoke consists of primary care providers who also deliver MOUD and link patients to needed support. By offering treatment through spokes located closer to where patients live, the model reduces barriers to care and improves access to timely, community-based treatment.

States have adopted hub-and-spoke models to address gaps in access to MOUD, particularly in areas with high overdose rates and too few MAT-prescribing clinicians. In Pennsylvania, for example, one CHC participated in the state’s hub-and-spoke initiative, serving as a hub alongside local health systems to expand the number of MAT providers in the community. Since 2018, PacMAT has created 115 spokes across Pennsylvania, serving 26 counties and providing coordinated care services to over 8,000 patients.⁸

Evidence from other states demonstrates the model’s effectiveness. Vermont’s Hub and Spoke Pilot significantly improved access to opioid use disorder (OUD) treatment by enabling “unstable” patients to begin care in hubs and transition to spokes once stabilized.⁹ California’s Hub and Spoke Model also showed strong results: 3,480 new patients initiated buprenorphine across 118 spokes, representing a 94.7% increase in treatment starts.¹⁰ Continued investment and technical assistance from the Substance Abuse and Mental Health Services Administration (SAMHSA) such as through the Providers Clinical Support System (PCSS) and updating resources to include

⁷ <https://www.nachc.org/resource/advancing-behavioral-health-integration-in-community-health-centers-policy-pathways-to-whole-person-care/>

⁸ https://nasadad.org/wp-content/uploads/2024/09/Pennsylvania-SOR-Brief-Draft-2024_Final.pdf

⁹ <https://pmc.ncbi.nlm.nih.gov/articles/PMC5537005/pdf/nihms873070.pdf>

¹⁰ <https://www.sciencedirect.com/science/article/pii/S0740547219301230>

innovative addiction treatment models like hub-and-spoke will help ensure that more patients can access timely, evidence-based care.

In 2024, over 247,000 CHC patients received MOUD treatment with medications specifically approved by the Food and Drug Administration (FDA), including buprenorphine, methadone, and naltrexone, from the over 14,900 on-site health center providers.¹¹ A 2020 study of over 40,000 patients with opioid use disorder found that buprenorphine and methadone treatment were both associated with overdose and serious opioid-related acute care use reductions compared to the other treatments of inpatient detoxification and intensive behavioral health care.¹² MOUD is a safe and effective form of treatment that CHCs and other providers can use for treatment and recovery. However, obstacles exist that limit patients' access to this crucial form of treatment.

NACHC recommends that HHS work closely with the Drug Enforcement Administration (DEA) for solutions to the addiction epidemic. Methadone treatment for OUD, a gold-standard treatment, is heavily regulated in the U.S. and can only be provided by licensed opioid treatment programs (OTPs). This represents a substantial barrier for access, especially among rural, historically underserved populations, as about 80% of counties in the U.S. lack an OTP.¹³ To increase access, the federal government could allow pharmacies, with specialized training, to dispense methadone like they would other controlled substances. This practice is already allowed in Australia, Canada, and the United Kingdom.

As medication experts, more than 3,000 CHC pharmacists¹⁴ are uniquely positioned to expand access to MOUD and help address the ongoing overdose crisis, which continues to disproportionately affect rural and underserved communities. In many areas, pharmacists have stepped in to fill gaps created by a shortage of OUD treatment providers. The Mainstreaming Addiction Treatment (MAT) Act was a major step toward reducing overdose deaths, but additional action is needed to fully leverage pharmacists' expertise. Several states now authorize pharmacists to prescribe MOUD; however, these pharmacists face operational barriers because the DEA's registration system does not allow them to register as MOUD prescribers—even when state law explicitly permits it.

To resolve this misalignment, the DEA must update its “[Mid-Level Practitioners Authorization by State](#)” table and its online registration application to reflect states that allow pharmacists to prescribe MOUD. Aligning federal registration processes with state scope-of-practice laws would immediately expand access to evidence-based treatment and strengthen the nation's response to the opioid crisis. We urge HHS to work with the DEA to ensure these updates are made without delay.

Utilizing the geographic accessibility of pharmacies across the U.S., as 90% of Americans are within five miles of a community pharmacy¹⁵, would substantially increase access to MOUD. This strategy would also align with E.O. 14379 to reduce SUD stigma by limiting the stigma associated

¹¹ 2024 UDS

¹² [Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder - PMC](#)

¹³ https://www.congress.gov/crs_external_products/R/PDF/R45782/R45782.2.pdf

¹⁴ 2024 UDS Data

¹⁵ [https://www.japha.org/article/S1544-3191\(22\)00233-3/fulltext](https://www.japha.org/article/S1544-3191(22)00233-3/fulltext)

with having to seek daily care at an OTP. In line with this proposal, NACHC also supports the recently introduced bipartisan Modernizing Opioid Treatment Access Act 2.0, which would strengthen America’s response to the overdose crisis by, at states’ discretion, allowing qualified clinicians to expand access to methadone for the treatment of OUD when clinically appropriate. To ensure these actions are successful, NACHC encourages HHS to ensure reimbursement policies¹⁶ support the proposed expanded delivery model for MOUD.

In addition to expanding provider ability to prescribe evidence-based medications, NACHC recommends that HHS require all Medicaid Managed Care Organizations (MCOs) to eliminate prior authorization requirements for all three FDA-approved MOUD formulations. This builds on the SUPPORT Act’s coverage mandate by removing bureaucratic barriers that continue to delay or deny treatment to patients who seek it. Despite the SUPPORT Act requiring coverage, almost 40% of Medicaid MCOs bypass the mandate as they are not fee-for-service plans, and a 2018 SAMHSA analysis confirmed these requirements directly prevent timely access to treatment.¹⁷ A controlled study found¹⁸ that complete prior authorization removal in Illinois Medicaid produced an immediate, statistically significant increase in buprenorphine dispensing relative to control states, providing direct evidence that utilization management reform translates into measurable treatment access gains.

While we appreciate the DEA’s continued flexibility on telemedicine prescribing of controlled substances, NACHC urges the adoption of permanent policies that allow eligible clinicians to prescribe MOUD via telemedicine when clinically appropriate. Without a long-term solution, already strained primary care and behavioral health systems will face additional pressure, and CHC patients—who encounter significant barriers to care—will be disproportionately affected. Additional administrative hurdles will further limit access and worsen clinician burden. CHC providers have safely and effectively used telehealth to manage a wide range of conditions for years. We encourage HHS and DEA to ensure a clear, nationwide pathway for clinicians to use telehealth without unreasonable restrictions, while maintaining necessary protections.

Additionally, as state and local governments continue to receive more than \$50 billion in opioid settlement funds, **NACHC recommends HHS invest in federal technical assistance programs to support states on how to best leverage their settlement dollars to implement and expand access to evidence-based interventions for OUD and co-occurring mental health and SUD.**¹⁹

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

¹⁶ <https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00344>

¹⁷ <https://www.milbank.org/publications/increasing-access-to-medications-for-opioid-use-disorder-policy-strategies-during-and-after-covid-19-pandemic/#footnote-46>

¹⁸ <https://pmc.ncbi.nlm.nih.gov/articles/PMC9233239/>

¹⁹ <https://bipartisanpolicy.org/wp-content/uploads/2022/04/FINAL-Combating-the-Opioid-Crisis-Smarter-Spending-to-Enhance-the-Federal-Response.pdf>

As community-based providers of whole-person care, CHCs improve outcomes for patients with substance use disorders, mental illness, and co-occurring conditions. Policies that would strengthen CHCs' ability to deliver this care include:

Recovery-Focused Funding: Improving outcomes in mental health and substance use prevention, treatment, and recovery requires intentional investment across the entire continuum of care. Relapses are a common feature of SUD, with studies estimating that 40-60% of individuals experience recurrence following treatment.²⁰ When funding is not strategically allocated across each stage, states are often compelled to prioritize immediate and acute needs, such as crisis response systems and inpatient treatment, while upstream interventions and long-term recovery supports receive less attention. Current federal law requires that at least 20% of SUD Block Grant funding be dedicated to prevention activities, with the remaining funds supporting early intervention, treatment, and recovery.²¹ Additionally, the focus of current SAMHSA addiction grants needs to be nimbler to address all types of substance addictions. Encouraging funding specifically for recovery services would ensure that states build a more comprehensive recovery-oriented system and improve individuals' ability to sustain long-term recovery.

Same-Day Billing: We appreciate that CHCs can now bill Medicare for multiple visits on the same day. In 2023, CMS enhanced flexibilities, strengthening the integration of behavioral health within primary care.²² Before this change, a patient could receive a medical visit and be referred to the same day to a clinical psychologist for medication management. However, CHCs could not bill for that mental health service because it did not qualify as a standalone visit. The Medicaid program, however, has not aligned its visit policies with Medicare. NACHC's interviews with national policy experts and CHC leaders consistently identified Medicaid same-day billing restrictions as a major obstacle for providing integrated care.

Unfortunately, six states have enacted policies that limit CHCs to either one encounter per patient per day (e.g., Indiana, Kentucky, New York, Utah) or up to two encounters per patient per day (e.g., California, Minnesota). This policy makes it harder for CHCs to provide coordinated care, conduct warm handoffs, or address multiple needs in a single visit. Providers in these situations must choose which services to lose reimbursement for or navigate complex administrative workarounds, which may discourage streamlined, whole-person care.

CHCs in states without same-day billing restrictions conducted approximately 45.3 behavioral health visits per 1,000 patients, compared with 38.0 visits in states that restrict same-day billing. This represents roughly a 20% higher volume of behavioral health visits in states where health centers can bill for behavioral health and medical services delivered during the same encounter.²³

²⁰ <https://www.addictiongroup.org/resources/relapse-rates-statistics/>

²¹ <https://www.samhsa.gov/grants/block-grants/subg>

²² [Federal Register: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program](#)

²³ <https://www.nachc.org/resource/advancing-behavioral-health-integration-in-community-health-centers-policy-pathways-to-whole-person-care/>

Reimbursement for Social Workers: In 2024, more than 6,000 licensed clinical social workers (LCSWs) were part of the care team at CHCs in 2024, helping diagnose and treat patients.²⁴ CHCs often employ LCSWs to deliver care coordination rather than an outside psychiatric consultant. However, the operational and care team structures within CHCs differ from those of other Medicare providers, and Medicare payment policies do not fully reflect these structures. Under the Medicare Physician Fee Schedule, LCSWs are reimbursed at only 75% of the rate paid to clinical psychologists, despite the years of training, supervision, and licensure requirements needed to become an LCSW.²⁵ While recent improvements in reimbursement have helped expand access, gaps remain.

CHCs also continue to face persistent workforce shortages. Licensed Social Workers (LSWs), who typically hold a master's degree and complete substantial training, play a critical role in behavioral health care delivery, particularly in care coordination, patient support, and addressing social drivers of health. Yet LSWs are not eligible for Medicare reimbursement, limiting CHCs' ability to fully leverage this essential segment of the workforce.

Allowing Medicare reimbursement for LSWs, alongside LCSWs, would expand the behavioral health workforce, support earlier recruitment into the field, and strengthen CHCs' capacity to meet growing patient needs. This policy change would better align Medicare payment with the realities of CHC care teams and help ensure timely, comprehensive behavioral health services for underserved communities.

Establishing Clinical Care Pathways: Across many areas of medicine, clinical care pathways have been instrumental in translating evidence into standardized care processes, reducing unwarranted variation, strengthening care coordination, and improving both outcomes and efficiency. By operationalizing best practices, they support more reliable and consistent care delivery.

In behavioral health and substance use care, while substantial progress has been made in developing clinical guidelines and identifying best practices, these fields have not yet achieved the same level of consistent pathway implementation across care settings and delivery systems. Variability in training requirements, continuing education, implementation support, and quality measurement continues to contribute to uneven care delivery. Addressing these gaps will require stronger alignment around evidence-based practices, enhanced workforce support, and more clearly defined, shared expectations for quality.

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

Primary care remains the principal avenue of care for patients with OUD and presents a prime opportunity for intervention at the point of care. However, primary care providers have been found to face their own stigma regarding OUD patients that affects their willingness to facilitate MOUD.

²⁴ 2024 UDS

²⁵ <https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/marriage-family-therapists-mental-health-counselors>

A 2017 HRSA study²⁶ that funded MOUD care curricula integration in primary care academic programs found that providers held pervasive stigmatizing beliefs across multiple levels of clinical training, which directly impeded training uptake and MOUD delivery.

Achieving stigma-free OUD care requires a culture shift in clinical and educational settings that can be supported by sustained funding for targeted OUD trainings. A curriculum that addresses the classification of addiction as a treatable disease, dispels misperceptions about who experiences OUD, and incorporates trauma-informed care approaches alongside the chronic care framework into a clinician's understanding of OUD treatment would mitigate against the stigma of addiction. **NACHC advises HHS could build upon existing programs such as SAMHSA's PCSS and HRSA's Primary Care Training and Enhancement (PCTE) and Pediatric Mental Health Care Access Program (PMHCA) by increasing funding for sustained, stigma-focused MOUD curricula for primary care providers** that go beyond pharmacology to produce the lasting clinical culture shift that one-time compliance training alone cannot achieve.

Additionally, one of the most persistent drivers of stigma in addiction services is rooted in confusion among healthcare providers on what information can and cannot be shared when a patient discloses a substance use disorder²⁷. This confusion and misinterpretation of shareability perpetuates stigma in that it indicates SUD treatment as being specifically burdensome and complicated. The 2024 final rule updating 42 CFR Part 2²⁸ brought SUD treatment records into alignment with HIPAA by allowing a single patient consent to cover all future uses and disclosures for treatment, payment, and healthcare operations. This was a significant simplification of the previous system that required separate consent for each disclosure. While the rule went into effect in April of 2024, with enforcement starting in February 2026, many providers remain unaware of this key update. **NACHC recommends that HHS issue a training module on the alignment between 42 CFR Part 2 and HIPAA for all providers participating in Medicaid, Medicare, and SAMHSA-funded programs.**

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?

NACHC agrees that workforce shortages remain one of the most significant barriers to ensuring Americans can access timely addiction and mental health treatment. More than 137 million Americans currently live in Mental Health Professional Shortage Areas,²⁹ and HRSA projects shortages of nearly 88,000 mental health counselors and 114,000 addiction counselors by 2037.³⁰ Federal policy levers to address the workforce shortage include:

NACHC supports expanding and increasing funding for the THCGME program, which supports residency training in community-based settings, including those focused on

²⁶ <https://pmc.ncbi.nlm.nih.gov/articles/PMC9970664/>

²⁷ <https://www.ches.org/resource/changes-to-substance-use-disorder-confidentiality-regulations/>

²⁸ <https://www.govinfo.gov/content/pkg/FR-2024-02-16/pdf/2024-02544.pdf>

²⁹ <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf>

³⁰ <https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand>

addiction medicine and behavioral health. The 90 Teaching Health Centers (THCs), serving over 1,200 resident physicians (including 100 psychiatrists) and dentists in 30 states and Washington, D.C.³¹ are critically important for addressing the supply issue to ensure that every American seeking treatment for addiction has access to qualified practitioners. Since its creation in 2010, the Teaching Health Center Graduate Medical Education (THCGME) program has shifted the primary care physician, psychiatrist and dentist training paradigm away from a focus on large academic hospitals toward ambulatory settings, such as CHCs, where primary care and integrated behavioral health services are best delivered. THCGME residency programs collaborate with 635 training sites to provide clinical training experiences for residents in medically underserved communities, primary care settings, and rural areas.³² These residency programs developed or enhanced 2,189 courses and training activities, effectively impacting over 20,000 health care trainees.³³

Expanding THCGME would strengthen the pipeline of clinicians trained in addiction medicine, psychiatry, and integrated primary care, specifically in the rural and underserved communities where workforce gaps are most severe. HRSA has found that community-based training models increase the likelihood that graduates will practice in underserved settings after completing their training,³⁴ making THCGME a high-impact investment for closing geographic gaps in addiction and mental health care access. THCGME program is also estimated to have saved Medicare and Medicaid about \$1.8 billion over five years, a significant return on investment for taxpayers.³⁵

Furthermore, the Advanced Nursing Education (ANE) - Nurse Practitioner Residency and Nurse Practitioner Optional Fellowship Programs (NPRF), which support enhanced training for licensed primary care and behavioral health NPs working in CHCs and other community-based organizations located in Health Professional Shortage Areas (HPSA), are also an avenue for expanding access to integrated behavioral health services in more rural, remote and underserved communities, with nearly 80% continuing to serve in these settings after program completion.³⁶

Additionally, NACHC recommends leveraging the Behavioral Health Workforce Education and Training (BHWET) Program for Professionals³⁷ to increase the supply of behavioral health professionals, which also aims to improve distribution and expand access to behavioral health services. This program has a special focus on children, adolescents, and youth at risk for behavioral health disorders. Expanding BHWET funding would increase the number of addiction counselors, psychiatric nurses, social workers, and licensed counselors trained to serve in community health settings. NACHC appreciates that HHS has previously supported behavioral health service expansion through allowing Integrated SUD Treatment Program (ISTP) grantees to cover costs for behavioral health professions trainees completing clinical hours required for licensure. NACHC encourages HHS to allow grantees similar flexibilities in their use of other behavioral health-related grant funds, including BHWET.

³¹ <http://www.bhw.hrsa.gov/>

³² Ibid

³³ Ibid

³⁴ <https://bhw.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education>

³⁵ https://geigergibson.publichealth.gwu.edu/sites/g/files/zaxdzs4421/files/2022-01/GG-IB-58-THC_3.18_Final.pdf

³⁶ <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2025.pdf>

³⁷ <https://www.hrsa.gov/grants/find-funding/HRSA-21-089>

NACHC also encourages HHS to expand the National Health Service Corps (NHSC), Nurse Corps, SUD Treatment and Recovery (STAR) and Pediatric Subspecialty scholarship and loan repayment programs,³⁸ which support recruitment and retention of health professionals in rural and underserved areas to expand access to primary care and behavioral health services through a multi-year service commitment. Over 84% of NHSC and Nurse Corps clinicians continue to practice in HPSAs after completing the required term of service. There is data suggesting these clinicians save \$3.55 per behavioral health visit compared to those not supported by NHSC and up to \$7.95 per visit in rural areas.³⁹ Thus investing in NHSC could save taxpayer dollars in addition to improving access to affordable behavioral health services in more rural and underserved communities.

NACHC appreciates the opportunity to respond to this Request for Information on the Chronic Disease of Addiction, and we look forward to continuing to engage with HHS on this prominent issue. If you have any questions, please contact Erin Prendergast, Director of Federal Policy, eprendergast@nachc.org.

Sincerely,

A handwritten signature in cursive script that reads "Joe Dunn".

Joe Dunn
Chief Policy Officer

³⁸ <https://nhsc.hrsa.gov/loan-repayment/nhsc-sud-workforce-loan-repayment-program>

³⁹ <https://pubmed.ncbi.nlm.nih.gov/34524239/>