National Rural Health Association

July 2, 2026

Secretary Robert F. Kennedy Jr.
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: HHS Request for Information on Chronic Disease of Addiction and Mental Illness – Great American Recovery Initiative

Submitted electronically to REPORTSCLEARANCEOFFICER@ahrq.hhs.gov.

Dear Secretary Kennedy,

The National Rural Health Association (NRHA) is pleased to provide comments in response to the U.S. Department of Health and Human Services' Request for Information on chronic disease of addiction, mental illness, and strategies to improve prevention, treatment, and recovery efforts through the Great American Recovery Initiative. NRHA appreciates the Department's focus on identifying evidence-based programs, policies, and innovations that improve behavioral health outcomes and expand access to care.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Rural America suffers from long-standing shortages of behavioral health services, the challenges of long travel distances to obtain treatment, and the impact of stigma and cultural attitudes on efforts to ensure access to the full range of behavioral health services. The prevalence of mental illness is similar between rural and urban populations, but the availability, accessibility, and affordability of behavioral health services differ greatly. Nearly a quarter of nonmetropolitan, or rural, adults reported having a mental illness in 2023. Rural areas have just 15.8 psychologists per 100,000 people,[1] and 62% of the U.S. counties with the highest rates of opioid use disorder are located in rural areas.[2] We support HHS's commitment to strengthening prevention, treatment, recovery services and look forward to continued collaboration to ensure that rural communities are included in efforts to address substance use disorders, mental illness, and co-occurring behavioral health conditions.

[1] Mack, B., Whetsell, H., & Graves, J. M. (2022, February). Mental health in rural areas. National Rural Health Association. https://www.ruralhealth.us/getmedia/cf3c3922-25cb-49a0-bb04-0bad81d634f9/NRHA-Mental-health-in-rural-areas-policy-brief-2022.pdf

[2] Grimm CA. Geographic disparities affect access to buprenorphine services for opioid use disorder. U.S. Department of Health and Human Services Office of the Inspector General. January 2020. Accessed April 16, 2021. https://oig.hhs.gov/oei/reports/oei-12-17-00240.asp

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1. Evidence-Based Programs and Interventions

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?**
- **Care for co-occurring mental and chronic disease of addiction?**

Program #1
Title: **Rural Communities Opioid Response Program (RCORP)**
Type of activity: Federal Grant Program
Date: 2018-Present
Link: https://www.hrsa.gov/rural-health/opioid-response
Description: The Rural Communities Opioid Response Program (RCORP), housed in the Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration, supports evidence-based prevention, treatment, and recovery services for substance use disorders in rural communities.[3] RCORP is the nation's only federal grant program dedicated exclusively to addressing opioid and substance use challenges in rural communities, providing targeted resources that reflect the unique needs, gaps, and capacities of rural systems. Through community-based networks, RCORP has expanded access to medications for opioid use disorder (MOUD), workforce development initiatives, recovery support services, and care coordination.[4] Federal evaluations have found that RCORP-funded award recipients successfully implemented core activities designed to improve treatment access and strengthen local capacity to address substance use disorders.[5] In FY 2024, approximately 1.3 million individuals received prevention, treatment, and recovery services through RCORP-funded programs, including more than 57,000 rural individuals who received medication-assisted treatment (MAT) services. Additionally, 42 percent of award recipients established or expanded treatment services, and 70 percent expanded recovery services as a direct result of RCORP funding. By supporting locally driven solutions, RCORP has become a key federal strategy for addressing opioid use disorders and related behavioral health challenges in rural America.[6]
Statutory Authority: Public Health Service Act, Section 330A under rural community-based initiatives.

Program #2
Title: **Certified Community Behavioral Health Clinics (CCBHCs)**
Type of activity: Federal Integrated Behavioral Health Care Model
Date: 2014-Present
Link: https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics

[3] Health Resources and Services Administration. (n.d.). *Rural Communities Opioid Response Program (RCORP).* U.S. Department of Health and Human Services. https://www.hrsa.gov/rural-health/opioid-response
[4] Health Resources and Services Administration. (n.d.). *Rural Communities Opioid Response Program (RCORP).* U.S. Department of Health and Human Services. https://www.hrsa.gov/rural-health/opioid-response
[5] Office of Inspector General. (2025). *HRSA Rural Communities Opioid Response Program Award Recipients generally met all core activities and benchmarks.* U.S. Department of Health and Human Services. https://oig.hhs.gov/reports/all/2025/hrsa-rural-communities-opioid-response-program-award-recipients-generally-met-all-core-activities-and-benchmarks/
[6] Health Resources and Services Administration. (n.d.). *Rural Communities Opioid Response Program (RCORP).* U.S. Department of Health and Human Services. https://www.hrsa.gov/rural-health/opioid-response

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Description: Certified Community Behavioral Health Clinics (CCBHCs) provide comprehensive mental health and substance use disorder services regardless of a patient's ability to pay operate through two federal mechanisms: competitive CCBHS Expansion Grants from the Substance Abuse and Mental Health Services Administration (SAMSHA) to help clinics adopt the model and the CCBHC Demonstration Program alternative Medicaid payment model through SAMSHA and the Centers for Medicare and Medicaid Services (CMS). Research has found that CCBHCs improve access to behavioral healthcare, increase the availability of crisis services, and support integrated treatment for individuals with co-occurring mental health and substance use disorders.[7] Rural access to CCBHCs has expanded significantly, increasing by nearly 58 percent between 2022 and 2023, demonstrating the model's growing role in addressing behavioral health needs in underserved communities.[8] The integrated nature of CCBHCs makes them well-suited for individuals with co-occurring conditions who require coordinated treatment and recovery services.[9]
Statutory Authority: Protecting Access to Medicare Act of 2014 (PAMA) (Pubic Law 113-91), Section 223.

Program #3
Title: **Tele-behavioral Health Services**
Type of Activity: Behavioral Health Service Delivery Model
Date: Ongoing
Link: https://telehealth.hhs.gov/
Description: Tele-behavioral health services have emerged as an effective strategy for expanding access to mental health and substance use disorder treatment, particularly in areas experiencing provider shortages.[10] Research has demonstrated that individuals receiving substance use treatment through telehealth were approximately 38 times more likely to receive medications for opioid use disorder (MOUD) than those not receiving virtual treatment services.[11] Tele-behavioral health has also been associated with improved continuity of care, reduced transportation barriers, and increased access to behavioral health specialists.[12] These benefits make tele-behavioral health an important intervention for improving prevention, treatment, and recovery outcomes, particularly in rural and underserved communities.[13]

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[7] Substance Abuse and Mental Health Services Administration. (n.d.). *Certified Community Behavioral Health Clinics (CCBHCs).* U.S. Department of Health and Human Services. https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics
[8] Smith, A. P. (2025). *Rural access to Community Behavioral Health Clinics (CCBHCs).* University of Kentucky Rural Health Research Center. https://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1024&context=ruhrc_reports
[9] Substance Abuse and Mental Health Services Administration. (n.d.). *Certified Community Behavioral Health Clinics (CCBHCs).* U.S. Department of Health and Human Services. https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics
[10] Jones, C. M., Han, B., Baldwin, G. T., Einstein, E. B., & Compton, W. M. (2023). Use of Medication for Opioid Use Disorder Among Adults With Past-Year Opioid Use Disorder in the US, 2021. JAMA network open, 6(8), e2327488. https://doi.org/10.1001/jamanetworkopen.2023.27488
[11] Jones, C. M., Han, B., Baldwin, G. T., Einstein, E. B., & Compton, W. M. (2023). Use of Medication for Opioid Use Disorder Among Adults With Past-Year Opioid Use Disorder in the US, 2021. JAMA network open, 6(8), e2327488. https://doi.org/10.1001/jamanetworkopen.2023.27488
[12] Jones, C. M., Han, B., Baldwin, G. T., Einstein, E. B., & Compton, W. M. (2023). Use of Medication for Opioid Use Disorder Among Adults With Past-Year Opioid Use Disorder in the US, 2021. JAMA network open, 6(8), e2327488. https://doi.org/10.1001/jamanetworkopen.2023.27488
[13] Jones, C. M., Han, B., Baldwin, G. T., Einstein, E. B., & Compton, W. M. (2023). Use of Medication for Opioid Use Disorder Among Adults With Past-Year Opioid Use Disorder in the US, 2021. JAMA network open, 6(8), e2327488. https://doi.org/10.1001/jamanetworkopen.2023.27488

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Statutory Authority: Public Health Service Act; Medicare and Medicaid telehealth authorities under the Social Security Act as outlined at https://telehealth.hhs.gov/providers/telehealth-policy

2. Federal Policy Improvements Using Existing Funding

Using existing funding, what policies or changes to federal programs might improve outcomes in:

- **Substance use prevention, treatment, and recovery?**
- **Mental illness, prevention, treatment, and recovery?**
- **Care for co-occurring mental and chronic disease of addiction?**

Policy #1
Title: **Modernize the Rural Health Clinic Program**
Type of policy: Medicare Condition of Participation
Description: NRHA strongly recommends HHS revise the definition of "*a facility which is primarily for the care and treatment of mental diseases*" as it pertains to how much behavioral health care Rural Health Clinics (RHCs) can furnish under the Medicare program. In the CY 2025 PFS final rule, CMS declined to define the term "mental disease", which is found in the RHC statute. NRHA believes a "*facility which is primarily for the care and treatment of mental diseases*" should be defined as clinic types that provide behavioral health care only, including certified community behavioral health centers, community mental health centers, and standalone opioid treatment programs. Doing so would allow RHCs that predominantly provide primary care to increase the provision of much-needed behavioral health services in rural communities across the country.
Statutory Authority: 42 U.S.C. 1395x(aa)(2)(ii) ("The term "rural health clinic" means a facility which […] is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases").

Policy #2
Title: **Ryan Haight Act Permenant Telehealth Fix**
Type of activity: Drug Enforcement Administration Regulation
Description: Drug Enforcement Agency (DEA) and HHS should establish a clear, permanent regulatory mechanism that allows clinicians to prescribe buprenorphine via telemedicine without a prior in-person visit, ensuring continuity of care and reducing preventable overdose deaths in rural America. The Ryan Haight Act of 2008 restricts virtual prescribing of controlled substances. The Act includes a provision directing the DEA to create a "special telemedicine registration" that would allow clinicians to prescribe controlled substances via telemedicine without an in-person exam. The DEA has not yet implemented this authority, making regulatory action necessary to establish a permanent telemedicine pathway. HHS and DEA issued a fourth temporary rule extending the full set of COVID-19 telemedicine flexibilities, including Ryan Haight Act considerations, for prescribing controlled substances through December 31, 2026. The rule stated *"…the extension will provide time for DEA to promulgate a final set of regulations, to ensure a smooth transition for patients and providers that have come to rely on the availability of telemedicine to prescribe controlled substances to patients for whom they have never had an in-person medical evaluation, and allow sufficient time for providers to come into compliance with any new DEA registration, recordkeeping, or security requirements*

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eventually adopted in a final set of regulations." Without long-term action, rural patients will lose a critical lifeline to evidence-based care.
Statutory Authority: Relevant statutory: Ryan Haight Act of 2008 (21 U.S.C. § 829(e)); Regulatory authorities: Fourth Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications, 90 Fed. Reg. 61301 (Dec. 31, 2025).

Policy #3
Title: **Expanding Co-Location Flexibilities to Strengthen Rural Health System Integration**
Type of activity: Medicare Condition of Participation and Payment policy
Description: Rural communities face persistent volume, workforce, and financial constraints that make it difficult for standalone providers to sustain critical services such as behavioral health and substance use treatment. Allowing co-location of these services within rural hospitals and clinics would enable integrated care models that reflect the realities of rural delivery systems, where aggregation under a single organization is often necessary for viability. CMS should explore regulatory and payment flexibilities that permit rural Critical Access Hospitals (CAHs) and PPS hospitals to offer multiple service lines and receive an add-on to PPS or fee-schedule rates to support this co-location. This approach mirrors the precedent established through Method II billing in CAHs, which recognizes the unique operational needs of rural facilities. Enabling co-location would strengthen access, stabilize rural infrastructure, and improve care coordination across the continuum.
Statutory Authority: Conditions of participation, payment methodologies, and billing structures for rural hospitals, CAHs, and outpatient services: Section 1861 and Section 1833 of the Social Security Act; CAH regulatory flexibility under Section 1820 of the Social Security Act.

3. Reducing Stigma Against Addiction Treatment and Recovery:

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

Program #1
Title: **Integrate Substance Use Disorder Treatment into Routine Healthcare Settings**
Type of Activity: Program Enhancement
Description: Federal agencies should continue supporting the integration of substance use disorder treatment into primary care practices, RHCs, Federally Qualified Health Centers (FQHCs), and other community-based healthcare settings. Research has shown that integrated behavioral health models improve access to treatment, increase screening and identification of behavioral health conditions, and improve patient engagement in care.[14] Integrating behavioral health services into routine healthcare environments can reduce stigma by normalizing treatment and making behavioral healthcare a standard part of overall healthcare delivery rather than a separate service.[15] When mental health services are provided in the same healthcare setting as primary care, people are more

[14] Balasubramanian, B. A., Cohen, D. J., Jetelina, K. K., Dickinson, L. M., Davis, M., Gunn, R., Gowen, K., deGruy, F. V., 3rd, Miller, B. F., & Green, L. A. (2017). Outcomes of Integrated Behavioral Health with Primary Care. Journal of the American Board of Family Medicine : JABFM, 30(2), 130–139. https://doi.org/10.3122/jabfm.2017.02.160234
[15] Balasubramanian, B. A., Cohen, D. J., Jetelina, K. K., Dickinson, L. M., Davis, M., Gunn, R., Gowen, K., deGruy, F. V., 3rd, Miller, B. F., & Green, L. A. (2017). Outcomes of Integrated Behavioral Health with Primary Care. Journal of the American Board of Family Medicine : JABFM, 30(2), 130–139. https://doi.org/10.3122/jabfm.2017.02.160234

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likely to utilize those services, and stigma is substantially reduced, making co-location of services a particularly high-impact stigma-reduction strategy for rural communities.
Statutory Authority: Public Health Service Act; Social Security Act, Medicare and Medicaid authorities

Program #2
Title: **Strengthen Recovery Awareness and Community Engagement Initiatives**
Type of Activity: Public Awareness and Community Engagement
Description: HHS should leverage existing prevention and public health programs to increase awareness of addiction as a chronic but treatable health condition. Research has found that stigma is associated with lower treatment-seeking behavior, poorer treatment engagement, and worse recovery outcomes among individuals with substance use disorders.[16] Public education campaigns that highlight recovery success stories, increase awareness of available treatment options, and promote recovery-oriented messaging can help normalize treatment seeking and foster a culture that celebrates recovery.[17] These initiatives can be particularly impactful in rural communities where concerns about privacy and stigma often serve as barriers to care.[18] More than 80% of rural adults report they are most likely to trust their primary care doctor for information on mental health, and that lack of privacy in rural communities, where individuals often fear that seeking treatment will become known in their interconnected social networks, is a frequently cited barrier to treatment seeking in rural areas.[19] People are less likely to access mental health care when stigma and health literacy issues are present.[20] Higher rates of mental health stigma in rural areas inhibit help-seeking behavior.[21] Limited health literacy, also a challenge in rural communities, impacts individuals' awareness of mental health conditions and treatment options.[22]
Statutory Authority: Public Health Service Act, Title V, Sections 510-520

4. Expanding the Behavioral Health Practitioner Supply:

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?

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[16] Crapanzano, K., Vath, R. J., & Fisher, D. (2014). Reducing stigma towards substance users through an educational intervention: harder than it looks. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 38(4), 420–425. https://doi.org/10.1007/s40596-014-0067-1
[17] Crapanzano, K., Vath, R. J., & Fisher, D. (2014). Reducing stigma towards substance users through an educational intervention: harder than it looks. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 38(4), 420–425. https://doi.org/10.1007/s40596-014-0067-1
[18] Crapanzano, K., Vath, R. J., & Fisher, D. (2014). Reducing stigma towards substance users through an educational intervention: harder than it looks. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 38(4), 420–425. https://doi.org/10.1007/s40596-014-0067-1
[19] Townsend T. "Patient Privacy and Mental Health Care in the Rural Setting". AMA J Ethics. May 2011; https://journalofethics.amaassn.org/article/patient-privacy-and-mental-health-care-rural-setting/2011-05. Accessed Sept 3, 2021.
[20] Clement S, Schauman O, Graham T, et al. What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychol Med. 2015;45(1):11-27.
[21] Rost K, Smith GR, Taylor JL. Rural-Urban Differences in Stigma and the Use of Care for Depressive Disorders. J Rural Health. 1993;9(1):57-62.
[22] Zahnd WE, Scaife SL, Francis ML. Health literacy skills in rural and urban populations. Am J Health Behav. 2009;33(5):550-557.

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Policy #1
Title: **Expand Behavioral Health Workforce Pipeline and Loan Repayment Programs**
Type of activity: Behavioral Health Workforce Distribution
Description: To strengthen the rural behavioral health workforce, HRSA could expand eligibility, and/or give priority, within the National Health Service Corps (NHSC) for bachelor's-level addiction counselors, psychiatric nurse practitioners, specialized physician assistants, and school-based mental health providers—roles that are essential in rural communities but currently may be excluded from, or could be further elevated in, NHSC programs. Workforce incentive programs, including loan repayment and scholarship programs, have been shown to improve provider recruitment in Health Professional Shortage Areas and increase the likelihood that clinicians practice in underserved communities.[23] An further increased emphasis on behavioral health placements in rural Mental Health Professional Shortage Areas would help address the estimated shortfall of over 77,000 addiction counselors and 99,000 mental health professionals identified in the RFI.
Statutory Authority: Public Health Service Act, Title III, Section 331–338

Policy #2
Title: **Assisted Outpatient Treatment (AOT) Technical Assistance for Rural Providers**
Type of activity: Program Technical Assistance
Description: As HHS expands SAMSHA Assisted Outpatient Treatment (AOT) opportunities for individuals with serious mental illness, the Department should ensure rural providers receive targeted technical assistance and implementation support, recognizing that many rural communities lack the psychiatric infrastructure and civil-commitment capacity necessary to fully utilize these programs. AOT's programming could be enhanced by explicitly recognizing the unique barriers rural communities face in delivering court-linked outpatient treatment. Rural providers often lack psychiatrists, mobile crisis teams, transportation infrastructure, and care coordination capacity—making it difficult to meet AOT's intensive engagement requirements. Strengthening AOT for rural areas could include allowing funds to support telehealth-based psychiatric care, mobile outreach, transportation assistance, and cross-county collaboration.
Statutory Authority: Public Health Service Act, Title V, Section 520 (Protecting Access to Medicare Act of 2014 (PAMA), Section 224)

Policy #3
Title: **Expand Peer Support Specialists and Recovery Workforce Capacity in Rural Areas**
Type of activity: Workforce development, training, and reimbursement reform
Description: Rural communities continue to face severe shortages of behavioral health and addiction treatment providers, making peer recovery specialists and community health workers (CHWs) essential components of a sustainable workforce. Peer recovery specialists improve engagement, retention, and navigation of treatment and recovery services,[24] while CHWs serve as trusted

[23] Health Resources and Services Administration. (n.d.). National Health Service Corps Rural Community Loan Repayment Program. U.S. Department of Health and Human Services. https://nhsc.hrsa.gov/loan-repayment/nhsc-rural-community-loan-repayment-program
[24] Reif, S., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Salim, O., & Delphin-Rittmon, M. E. (2014). Peer recovery support for individuals with substance use disorders: assessing the evidence. Psychiatric services (Washington, D.C.), 65(7), 853–861. https://doi.org/10.1176/appi.ps.201400047

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connectors who reduce stigma and strengthen care coordination.[25] HHS should expand training, certification, and reimbursement pathways for these roles through existing SAMHSA grant programs, HRSA rural workforce initiatives, and CMS Medicaid reimbursement authorities. Supporting nontraditional behavioral health workforce models will increase capacity, reduce pressure on licensed clinicians, and improve access to recovery-oriented services in rural areas. Integrating CHWs and peer specialists into rural behavioral health teams will create a more robust, community-anchored infrastructure capable of meeting rising mental health and substance use needs.

Statutory Authorities:

- Public Health Service Act Title V (42 U.S.C. §§ 290aa–290bb) — SAMHSA's authority to fund behavioral health workforce, recovery support services, and community-based programs.
- Public Health Service Act Title III (PHSA §§ 330, 330A, 331–338) — HRSA's authorities for community health centers, rural health programs, and workforce initiatives.
- Social Security Act § 1905(a) — CMS's Medicaid authority to reimburse peer support specialists and CHWs when defined in state plans or waivers, supported by CMS's 2007 State Medicaid Director guidance recognizing peer support as a Medicaid-covered service.

5. Strengthening Program Evaluation, Data Modernization, and AI

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?

Operational Change #1

Title: **Standardize Rural Behavioral Health Data Collection and Reporting**

Type of activity: Data Modernization and Program Evaluation

Description: HHS should establish standardized reporting requirements across behavioral health programs within the Department agencies (SAMSHA, HRSA, CMS, etc.) to improve outcome measurement and program evaluation. Behavioral health providers continue to face challenges related to electronic health record adoption and data exchange, limiting the ability of providers and federal agencies to evaluate outcomes across prevention, treatment, and recovery settings.[26] Standardized behavioral health measures would allow HHS to better evaluate treatment access, workforce shortages, service utilization, and recovery outcomes across rural and underserved

[25] National Rural Health Association. (2022, October 18). Letter to Senate Finance Committee on behavioral health [Letter to Chairman Ron Wyden and Ranking Member Mike Crapo]. National Rural Health Association. https://www.ruralhealth.us/getmedia/ad5e8cc2-5e27-4434-a605-51fdb2682261/Updated-Mental-Health-Letter.pdf

[26] Office of the Assistant Secretary for Technology Policy. (2024). *Electronic health record adoption and exchange capabilities among substance use and mental health treatment facilities.* U.S. Department of Health and Human Services. https://healthit.gov/data/data-briefs/electronic-health-record-adoption-and-exchange-capabilities-among-substance-use-and-mental-health-treatment-facilities-2024/

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communities.[27] Improved data quality would also support more informed funding decisions, program improvement efforts, and resource allocation.[28]

Statutory Authorities:

- Public Health Service Act, Title V, Sections 501–520 (SAMSHA data and programs)
- Public Health Service Act, Title III, Sections 330-338 (HRSA programs)
- Social Security Act, Sections 1875 (Medicare data collection and reporting),1902(a)(6) (Medicaid reporting requirements), 1903(m) (Managed care data reporting)

Policy #2

Title: **Strengthen Behavioral Health Data Interoperability and Information Sharing**

Type of activity: HHS Regulation

Description: HHS should support interoperability efforts that allow behavioral health providers, primary care providers, hospitals, and public health agencies to securely exchange information. Studies have found that improved interoperability is associated with better care coordination, reduced duplication of services, and improved patient outcomes, particularly for individuals with complex behavioral health needs.[29] Enhanced information sharing would provide HHS with more comprehensive data to evaluate prevention, treatment, and recovery programs while supporting real-time monitoring of service utilization and patient outcomes.[30] As HHS advances the Behavioral Health Information Technology (BHIT) initiative through the Assistant Secretary for Technology Policy (ASTP/ONC) and SAMHSA, rural providers and Critical Access Hospitals should be prioritized in pilot implementation and technical assistance efforts to ensure that interoperability improvements reach communities with the greatest behavioral health challenges. Improved interoperability is particularly important for individuals receiving care across multiple providers and treatment settings.[31]

Additional Statutory Authorities:

- Public Health Services Act, Sections 3001–3009 (HITECH Act)
- Social Security Act, Sections 1848 & 1903 (HITECH Act amendments)

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[27] Office of the Assistant Secretary for Technology Policy. (2024). *Electronic health record adoption and exchange capabilities among substance use and mental health treatment facilities.* U.S. Department of Health and Human Services. https://healthit.gov/data/data-briefs/electronic-health-record-adoption-and-exchange-capabilities-among-substance-use-and-mental-health-treatment-facilities-2024/

[28] Office of the Assistant Secretary for Technology Policy. (2024). *Electronic health record adoption and exchange capabilities among substance use and mental health treatment facilities.* U.S. Department of Health and Human Services. https://healthit.gov/data/data-briefs/electronic-health-record-adoption-and-exchange-capabilities-among-substance-use-and-mental-health-treatment-facilities-2024/

[29] Office of the Assistant Secretary for Technology Policy. (2024). *Electronic health record adoption and exchange capabilities among substance use and mental health treatment facilities.* U.S. Department of Health and Human Services. https://healthit.gov/data/data-briefs/electronic-health-record-adoption-and-exchange-capabilities-among-substance-use-and-mental-health-treatment-facilities-2024/

[30] Office of the Assistant Secretary for Technology Policy. (2024). *Electronic health record adoption and exchange capabilities among substance use and mental health treatment facilities.* U.S. Department of Health and Human Services. https://healthit.gov/data/data-briefs/electronic-health-record-adoption-and-exchange-capabilities-among-substance-use-and-mental-health-treatment-facilities-2024/

[31] Office of the Assistant Secretary for Technology Policy. (2024). *Electronic health record adoption and exchange capabilities among substance use and mental health treatment facilities.* U.S. Department of Health and Human Services. https://healthit.gov/data/data-briefs/electronic-health-record-adoption-and-exchange-capabilities-among-substance-use-and-mental-health-treatment-facilities-2024/

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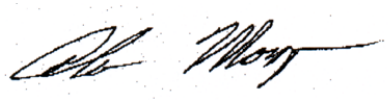
Operational Change #3
Title: **Leverage Advanced Analytics and Artificial Intelligence to Identify Service Gaps and Emerging Trends**
Type of activity: Advanced Analytics
Description: HHS should utilize advanced analytics and artificial intelligence tools to identify behavioral health service gaps, workforce shortages, overdose trends, and emerging community needs in real time. Recent research has demonstrated that machine learning and predictive analytics can identify individuals at increased risk for overdose and other behavioral health crises, highlighting their potential to support earlier intervention and more targeted resource allocation.[32] Advanced analytics could also help HHS monitor program performance, identify emerging trends, and evaluate outcomes across prevention, treatment, and recovery programs on a more continuous basis.[33] As HHS expands the use of these technologies, appropriate privacy protections, transparency standards, and safeguards should be implemented to ensure equitable use across rural and underserved communities.[34]
Statutory Authorities: Aforementioned

Thank you for the opportunity to submit information on this important topic. We look forward to continuing to work with HHS leadership to improve behavioral health access and outcomes for rural communities. For more information, please contact NRHA's Chief Policy Officer, Carrie Cochran-McClain, at ccochran@ruralhealth.us

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

[32] Ramírez Medina, C. R., Benitez-Aurioles, J., Jenkins, D. A., & Jani, M. (2025). A systematic review of machine learning applications in predicting opioid associated adverse events. NPJ digital medicine, 8(1), 30. https://doi.org/10.1038/s41746-024-01312-4
[33] Ramírez Medina, C. R., Benitez-Aurioles, J., Jenkins, D. A., & Jani, M. (2025). A systematic review of machine learning applications in predicting opioid associated adverse events. NPJ digital medicine, 8(1), 30. https://doi.org/10.1038/s41746-024-01312-4
[34] Ramírez Medina, C. R., Benitez-Aurioles, J., Jenkins, D. A., & Jani, M. (2025). A systematic review of machine learning applications in predicting opioid associated adverse events. NPJ digital medicine, 8(1), 30. https://doi.org/10.1038/s41746-024-01312-4

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