ADVOCATES FOR COMMUNITY HEALTH

March 31, 2023

Scott A. Brinks
Section Chief, Regulatory Drafting and Policy Support
Diversion Control Division
Drug Enforcement Administration
Attention: DEA-407 and DEA-948
8701 Morrissette Drive
Springfield, VA 22152

RE: Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation (DEA-407) and Expansion of Induction of Buprenorphine via Telemedicine Encounter (DEA-948)
Sent via electronic transmission at regulations.gov

Dear Section Chief Brinks:

Advocates for Community Health (ACH) is comprised of leading federally qualified health centers (FQHCs) focused on health equity and innovation to drive health care systems, policies, and health programs. Our members serve over two million people and provide high-quality, comprehensive primary health care, mental health services, preventive care, and social services to patients most in need. By mission and definition, all community health centers (CHCs) provide high-quality care regardless of a patient's ability to pay.

ACH appreciates the opportunity to comment on Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation (DEA-407) and Expansion of Induction of Buprenorphine via Telemedicine Encounter (DEA-948). The proposed rule addresses prescribing controlled substances via telemedicine after the COVID-19 Public Health Emergency (PHE) expires.

We appreciate the DEA's guidance and narrative clarification[1] of where the proposed rule does not affect patient care. The proposed rules maintain current telehealth flexibilities in place during the PHE for prescribing controlled substances and as applicable by state and federal law in certain scenarios listed below, and we provide an overview of our comments:

- Telehealth flexibilities would remain in place if a provider has evaluated a patient in person at least once; the provider may prescribe that patient any scheduled controlled medication via telemedicine. **ACH agrees.**
- Providers serving as consults can prescribe any scheduled controlled medication via telemedicine if the patient was evaluated by a provider who previously conducted an in-person

[1] https://www.dea.gov/sites/default/files/2023-03/Telehealth_Practitioner_Narrative_312023.pdf

evaluation, but referrals would require additional record keeping. **ACH provides additional comments.**

- First-time telemedicine consultations that result in a prescription for a Schedule III-V non-narcotic controlled medication would require an in-person medical evaluation of the patient to issue more than a 30-day supply. **ACH provides additional comments.**
- First-time telemedicine consultations that result in a prescription for buprenorphine as medication for opioid use disorder would require an in-person medical evaluation of the patient to issue more than a 30-day supply. **ACH strongly recommends buprenorphine be exempt from in-person visit requirements.**
- Medical practitioner-patient relationships formed over telemedicine during the COVID-19 PHE are extended for 180 days after the end of the PHE. During those 180 days, additional record keeping is required. Beyond the 180 days, an in-person medical evaluation of the patient is required. **ACH provides additional comments.**

For our specific comments, please see our recommendations below:

Audio-Only for Practice of Telemedicine Definition

ACH supports DEA's revised definition of "practice of telemedicine" to use interactive telecommunications under 42 CFR 410.78(a)(3), or, "services furnished for purposes of diagnosis, evaluation, or treatment of a mental health disorder to a patient in their home, interactive telecommunications may include two-way, real-time audio-only communication technology if the distant site physician or practitioner is technically capable to use an interactive telecommunications system as defined in the previous sentence, but the patient is not capable of, or does not consent to, the use of video technology." We support audio only telemedicine for patients that use FQHCs for care, especially in rural areas where broadband is scarce. We also recommend DEA work with CMS on further telehealth flexibilities, such as flexibilities related to locations, provider types, and for all medical and behavioral visits, to best meet the need of patients.

Reinstating In-Person Medical Evaluation Requirements in Order to Continue Prescription Past 30 Days for a Schedule III-V Non-Narcotic Controlled Medication

ACH recommends DEA <u>not require</u> patients, especially those at FQHCs, to be seen in person after the first 30 days of treatment for Schedule III-V non-narcotic controlled medication, especially for behavioral health. We are concerned with the potential delay in care if FQHC patients cannot comply with the in-person requirement. The harm of delay outweighs the benefit of an in-person appointment, as it is more detrimental to patients if a medication cannot be filled due to the delay and is stopped abruptly. As UDS data shows, between 2020 and 2021, health centers experienced an increase of 138,000 patients, or +6% of patients, seeking behavioral health services (as in mental health and substance use disorder services). 54% and 31% of virtual visits were mental health and substance use disorder related, respectively. We also recommend that providers serving as consults can prescribe any scheduled controlled medication via telemedicine if the patient was evaluated by a provider who previously conducted an evaluation either in person or via telehealth. We understand and appreciate that referrals would require additional record keeping in order to best manage the patient's care. We ask DEA

consider a provider's clinical judgement for an in-person evaluation, especially since FQHCs may not be able to keep up with the demand for reinstating so many in-person visits.

Buprenorphine (Docket No. DEA-948; RIN 1117–AB78)

ACH strongly recommends that buprenorphine to treat Opioid Use Disorder be exempt from an in-person medical evaluation following the initial 30-day prescription and that patients are allowed audio-only evaluations. A recent study from JAMA[2] demonstrated that between September 2019 and February 2021, Medicare beneficiaries emergency authorized telehealth expansion and MOUD provision during the COVID-19 pandemic were associated with significantly lower odds of fatal drug overdose, demonstrating the potential benefits of continuing these services. Additionally, another study looking at Veterans Health Administration patients receiving buprenorphine in the year following COVID-19 telehealth flexibilities, telehealth was positively associated with retention. As the study points out, these findings that discontinuing or reducing audio=only access may disrupt treatment for patients with health care access issues, and telehealth buprenorphine may support continued treatment for these patients.[3]

Telemedicine allows patients who may be medically, socially, or logistically unable to see their provider in-person to receive care from appropriate healthcare providers. Patients may be immunocompromised, be located far from providers (especially for those in rural or medically underserved areas), lack transportation, lack time off to travel to appointments, or require childcare. One ACH FQHC member in California has 2 providers that serve the most rural and severely medically underserved areas in the state. The FQHC serves 4,500 patients through telehealth, many of which have opioid use disorder.

Beyond removing barriers to access to care, we wish to reduce stigma towards Opioid Use Disorders. According to HHS, tele-treatment for substance use disorders does this and more, shortening wait times, increasing patient privacy, reducing stigma, allowing for continuity of care, allowing providers to see and understand the home environment, and digital tools provide immediate support where applicable.[4]

Medical Practitioner-Patient Relationships Formed over Telemedicine during PHE

ACH urges the DEA continue to work with CMS, SAMHSA, and HHS on the development of PHE telemedicine requirements, for behavioral health and medical visits. The Consolidated Appropriations Act, 2023, extended many telehealth flexibilities through December 31, 2024 for Medicare beneficiaries, and those beneficiaries may not understand DEA flexibilities do not extend through the same timeframe. While we appreciate the additional 180 days of telemedicine flexibilities, we urge DEA to consider permanent telemedicine flexibilities, especially for FQHC patients in rural and medically underserved areas. Many of the 30 million Americans who use FQHCs are children and adolescents,

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[2] Jones CM, Shoff C, Blanco C, Losby JL, Ling SM, Compton WM. Association of Receipt of Opioid Use Disorder–Related Telehealth Services and Medications for Opioid Use Disorder With Fatal Drug Overdoses Among Medicare Beneficiaries Before and During the COVID-19 Pandemic. *JAMA Psychiatry.* Published online March 29, 2023. doi:10.1001/jamapsychiatry.2023.0310

[3] Frost MC, Zhang L, Kim HM, Lin L. Use of and Retention on Video, Telephone, and In-Person Buprenorphine Treatment for Opioid Use Disorder During the COVID-19 Pandemic. *JAMA Netw Open.* 2022;5(10):e2236298. doi:10.1001/jamanetworkopen.2022.36298

[4] https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-for-behavioral-health/tele-treatment-for-substance-use-disorders

people in rural communities, persons identifying as racial and/or ethnic minorities, veterans, and/or those living in poverty, all of whom benefit from the expanded access to care afforded by telemedicine. We see this synergy as DEA proposes the "practice of telemedicine" definition to allow certain telehealth visits be delivered via audio-only. We urge DEA, CMS, SAMHSA, and HHS to consider the needs of these populations when making important healthcare policies related to telemedicine.

Conclusion

ACH thanks the DEA for the opportunity to provide comments on these proposed rules and stand ready to discuss these issues further if helpful. For more information, please contact me at apearskelly@advocatesforcommunityhealth.org or Stephanie Krenrich, our Senior Vice President of Policy and Government Affairs, at skrenrich@advocatesforcommunityhealth.org .

Sincerely,

Amanda Pears Kelly
Chief Executive Officer