NPAC
NATIONAL PAIN ADVOCACY CENTER

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March 31, 2023

Honorable Anne Milgram
Administrator
Drug Enforcement Administration
8701 Morrissette Drive
Springfield, VA 22152

Dear Administrator Milgram:

**Re: DEA proposed rule, Expansion of Induction of Buprenorphine via Telemedicine, RIN: 1117-AB78; DEA-948 (DEA-2023-0028, 2023-04217).**

On behalf of the National Pain Advocacy Center (NPAC), we write in response to the DEA's Proposed Rule, *Expansion of Induction of Buprenorphine via Telemedicine*, to express grave concern that its roll-back of telemedicine prescribing will impose dangerous impediments to life-saving care.

This comment supplements our more extensive comment on the DEA's concurrent proposal, *Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation*, RIN 1117-AB40 DEA -2023-04248, DEA-2023-0029-0001, DEA-407.

NPAC is a 501(c)(3) nonprofit alliance of clinicians, scientists, public health experts, and people with lived experience, working to advance the health and human rights of people living with pain. We envision a world in which pain is treated equitably and effectively. NPAC includes experts in pain and addiction and people with lived experience of pain as well as those in recovery from addiction.

NPAC was also one of 70 organizations, including the American Medical Association, the American Psychiatric Association, the American Association of Nurse Practitioners, and the American Mental Health Counselors Association, that urged the DEA to extend telemedicine prescribing of controlled medication after the COVID-19 public health emergency ends to the extent permitted by the Ryan Haight Act.

We urge the DEA to withdraw its rule and extend the telehealth flexibilities for prescribing buprenorphine under the Public Health Emergency related to illicitly-manufactured opioids and drug overdose mortality or to substantially revise the rule to allow for telemedicine prescribing of buprenorphine with safeguards that do not impede access to essential medication and care.

Amid a drug overdose crisis driven by illicitly-manufactured fentanyl and its analogs that continues to take an unconscionable toll on human life—with drug-related mortality surpassing 107,000 persons in 2021—medication for opioid use disorder is a life-saving treatment that cuts the risk of overdose in

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half. The DEA should expand, not curtail, access to interventions that curb preventable mortality.

It is already a reality that too few people with use disorders have access to medication. Data from the Substance Abuse and Mental Health Services Administration (SAMHSA) surveys show that fewer than 22% of those who may benefit from the medication actually receive it. Access in rural areas is especially burdened. People who are most multiply marginalized disproportionately suffer overdose and barriers to treatment: Black, American Indian, and Alaska Native people have experienced the highest rates of overdose and the most limited access to lifesaving medications for opioid use disorder.

Studies on primary care programs that provided buprenorphine treatment via telehealth during the COVID-19 public health emergency found that the removal of the requirement for an in-person visit significantly increased access to care and mitigated health inequities. Others suggested that induction of buprenorphine via telehealth encounters in Medicare beneficiaries reduced the odds of medically-treated overdose and the use of emergency health services and improved retention in care. A study published just two days before the DEA's comment deadline confirmed that increased use of telehealth services and prescribing for opioid use disorder during the COVID-19 pandemic reduced the risks of overdose mortality.

Given that a key administration priority has been to expand access to medication for opioid use disorder, which was advanced by the recent removal of the X-waiver, the DEA should not now undermine those efforts by cutting proven and necessary access to care.

Nor are there observable downsides to expanding telemedicine prescribing. A key study endorsed by the National Institutes of Health confirmed that there was no increase in overdose deaths involving buprenorphine during the public health emergency when prescribing via telehealth began. The authors of that study represent members of our major public health agencies – the Centers for Disease Control and Prevention, the National Institute on Drug Abuse, and the Center for Medicare and Medicaid Services.

Conversely, there are significant dangers to interruptions of care once a medication for opioid use disorder is initiated. Most patients who go off buprenorphine or those who complete only a four-week course of the medication (the rough equivalent of the DEA's proposed 30-day supply) return to active opioid use.

The DEA's requirement to arrange in-person care within 30 days will be unworkable for many people. In 2022, the average wait time for an appointment with a new primary care provider in U.S. cities was 26 days; in some areas, the wait was 45.6 days. Given the limited supply of buprenorphine prescribers, the wait time is likely to be often significantly longer. People living in rural areas who initiate buprenorphine with a geographically-distant

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practitioner will confront especially significant barriers to finding in-person care within 30 days.

Likewise, the DEA's proposed retention of location requirements mandating that a telemedicine prescriber be licensed in their location as well as where the patient lives will burden care for those in greatest need. The requirement that remote evaluations be conducted in the physical presence of a DEA-registered practitioner may also limit the use of low-barrier and mobile buprenorphine prescribing efforts used in harm-reduction programs.

We recognize that there remains a digital divide in America, with persistent disparities in broadband access and infrastructure, and we will continue to advocate for the mitigation of those disparities. Nevertheless, the induction of buprenorphine through telemedicine encounters saves lives.

For the foregoing reasons, the DEA should withdraw this rule and extend the telehealth flexibilities for buprenorphine under the Public Health Emergency related to illicitly-manufactured opioids and drug overdose mortality or substantially revise the rule to allow for telemedicine prescribing of buprenorphine with safeguards that do not impede access to lifesaving care.

Sincerely,

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