March 12, 2025

Derek S. Maltz
Acting Administrator
Drug Enforcement Administration
8701 Morrissette Drive
Springfield, Virginia 22152

Re: Special Registrations for Telemedicine and Limited State Telemedicine Registrations (DEA-407)

Dear Acting Administrator Maltz:

On behalf of the American College of Physicians (ACP), we are pleased to share our comments on the Drug Enforcement Administration (DEA) notice of proposed rulemaking on special registrations for telemedicine prescribing of controlled substances. ACP is the largest medical specialty organization and the second-largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness.

In this proposed rule, the DEA proposes to establish a *Special Registration for Telemedicine* ("Special Registration") scheme to create a closed system of control for prescribing and dispensing controlled substances to ensure patient access to care while maintaining safeguards to protect against the diversion of controlled substances. The College is concerned that the DEA's proposals may have the opposite effect: limiting access to care for those who need it the most by constraining the licenses of qualified internal medicine physicians in prescribing controlled substances without a prior in-person evaluation.

Proposed Registration System for *Clinician Practitioner* Prescribers Excludes Internal Medicine Physicians to the Detriment of Patients and Access to Care

The DEA proposes that only qualified DEA-registered clinician practitioners[1] would be authorized to prescribe certain controlled substances via telemedicine without a prior in-person evaluation through either a *Telemedicine Prescribing Registration* authorizing prescription of Schedules III through V (III–V) controlled substances or an *Advanced Telemedicine Prescribing Registration* authorizing prescription of Schedules II through V (II–V) controlled substances.

Advanced Telemedicine Prescribing Registration eligibility would require physicians to demonstrate a "legitimate need" to prescribe Schedule II controlled substances in addition to Schedules III–V controlled

[1] Defined by DEA as properly registered physicians and *mid-level practitioners*. DEA defines the latter as individual practitioners (other than physicians, dentists, veterinarians, or podiatrists) who are licensed, registered, or otherwise permitted to dispense controlled substance in the course of professional practice (e.g., health care providers such as nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists and physician assistants who are authorized to dispense controlled substances by the State in which they practice.

substances. According to DEA, however, only certain specialized physicians and board-certified mid-level practitioners—excluding internal medicine physicians—have a legitimate need to prescribe Schedule II controlled substances via telemedicine in certain specified, limited circumstances or practice specialties.[2] The specified specialized practitioners have a legitimate need to prescribe Schedule II controlled substances, according to the DEA, because they "typically treat patients [who] face significant healthcare accessibility challenges, and, in some cases, who suffer from particularly debilitating or terminal illnesses" and might, for example, treat palliative and hospice patients who have accessibility challenges, are often homebound, or may need urgent pain treatment and symptom management.

Internal medicine physicians regularly treat patients facing the same kinds of accessibility challenges and debilitating illnesses, managing a broad spectrum of conditions, including some that require treatment with Schedule II controlled substances. These challenges are heightened in rural areas where physician shortages are felt even more acutely. Additionally, internal medicine physicians, like other primary care specialist physicians included on the DEA's list, are often the first point of care for patients with conditions that controlled substances, including Schedule II controlled substances, can treat. Internal medicine physicians play a critical role in fostering and maintaining longitudinal relationships that include medication adherence and management of complex conditions, often exacerbated by mental or behavioral conditions. For these reasons, ACP's *Policy Recommendations to Guide the Use of Telemedicine in Primary Care Settings* advocates for "the expanded role of telemedicine as a method of health care delivery that may enhance patient-physician collaborations, improve health outcomes, increase access to care and members of a patient's health care team, and reduce medical costs when used as a component of a patient's longitudinal care."

Moreover, recent efforts to integrate behavioral health with primary care represents a paradigm shift in caring for patients with behavioral or mental health conditions. A growing body of research shows that integrated behavioral health improves overall health and the patient experience while reducing unnecessary barriers from time, money, and delays. The DEA's proposals would drastically negate these benefits by hindering the progression of behavioral health integration, negatively impacting the health and health care access of thousands of patients across the U.S. The College firmly believes that internal medicine physicians are "uniquely positioned to provide expert care for specific, vulnerable patient populations" and "have specialized training and in-depth knowledge to equip them to make informed decisions regarding the use of Schedule II controlled substances when prescribed remotely to particularly vulnerable patient groups." If finalized, we worry that these proposals will detrimentally affect patients who depend on their primary care physician to access care and meet their comprehensive health care needs.

Proposed Requirements and Conditions of Special Registration Are Too Onerous and Limit the Value of Telemedicine

The requirements and conditions proposed by the DEA for this regulatory framework are overly prescriptive and burdensome on clinician practitioners. Requirements include, for example, maintaining an ancillary State Telemedicine Registration for every state in which a patient is treated by the

[2] The specified limited circumstances and practice specialties include: (1) psychiatrists; (2) hospice care physicians; (3) palliative care physicians; (4) physicians rendering treatment at long term care facilities; (5) pediatricians; (6) neurologists; and (7) mid-level practitioners and physicians from other specialties who are board certified in the treatment of psychiatric or psychological disorders, hospice care, palliative care, pediatric care, or neurological disorders unrelated to the treatment and management of pain.

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practitioner unless otherwise exempted. The implementation burden of the proposed Prescription Drug Monitoring Program (PDMP) check requirements must be balanced with the need to monitor for fraud, waste, and diversion. Given that a nationwide PDMP database does not exist, the College appreciates the delay and urges the DEA not to impose the nationwide PDMP check requirement until a nationwide database is available.

In addition to a seemingly arbitrary requirement that practitioner prescriptions for Schedule II controlled substances average less than 50% of the practitioner's total prescriptions per month, the practitioner must also be physically located in the same state as the patient when issuing a special registration prescription for a Schedule II controlled substance. This condition is likely to exacerbate clinician shortages, especially in rural areas. Additionally, there are many geographic areas where it is extremely common to cross state borders to access care (e.g., the DC-Maryland-Virginia, Kansas City, St. Louis, New York City, and Philadelphia metro areas) and these conditions would impede care access in those areas, among others.

Proposed Multi-State Licensure Requirements Negatively Impact Access to Care with Little Benefit

In addition to being physically present in the U.S. when conducting telemedicine and issuing special registration prescriptions, the DEA proposes that practitioners be licensed and authorized within the state or territory where they are located when the telemedicine encounter takes place. To issue special registration prescriptions, practitioners would also have to comply with the laws and regulations of the state in which they are located during a telemedicine encounter, the state in which the patient is located during the telemedicine encounter, and any state or states in which they maintain a DEA registration to dispense controlled substances or a medical license if the law or regulation applies to telemedicine visits between practitioners and patients located in the states in which the prescriber and the patient are each located during the telemedicine encounter.

These proposed multi-state licensure requirements are too rigid and burdensome and are not likely to decrease fraud, abuse, and diversion at the expense of patients' access to care. ACP recognizes that licensure flexibilities are essential to ensuring access to telehealth services and urges policymakers to establish nationally appropriate exceptions to physician licensure requirements for interstate medical care. Licensure requirements can disrupt long-term patient care, causing many to seek new physicians and leading to changes and delays in their care. Studies have shown that this is more prominent in rural areas where the distance between the patient and physician is two to three times greater than in urban areas, and accessing care may require crossing state lines.

Given the ongoing national concerns about health care workforce shortages and limited access to care in rural areas, the evolving nature of telehealth-based care delivery can support a physician's ability to care for their patients, regardless of where the patient or physician is located. ACP supports a streamlined process to obtaining several medical licenses that would facilitate the ability of physicians and other clinicians to provide telemedicine services across state lines while allowing states to retain individual licensing and regulatory authority. Policymakers must develop a modernized, national approach to licensure that allows licensed physicians to provide telehealth care to their patients in a state other than their primary licensed state. ACP believes DEA's multi-state licensure proposals should be withdrawn or postponed, at least until such a process or national approach exists.

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Conclusion

ACP thanks the DEA for the opportunity to provide comments on this proposed rule. We welcome working with you on our shared interests of expanding access to care while avoiding fraud, abuse, and diversion. If you have any questions about the content of this letter, please contact Dejaih Johnson, JD, MPA, at djohnson@acponline.org, or (202) 261-4506.

Sincerely,

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