March 31, 2023

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

SUBMITTED ELECTRONICALLY VIA http://www.regulations.gov

RE: Expansion of Induction of Buprenorphine via Telemedicine Encounter (Docket No. DEA-948)

Dear Administrator Milgram:

On behalf of the Society of General Internal Medicine (SGIM), we are pleased to submit comments on the Drug Enforcement Administration (DEA) proposed rule on the Expansion of Induction of Buprenorphine via Telemedicine Encounter. SGIM is a member-based internal medical association of more than 3,000 of the world’s leading academic general internal medicine physicians, who are dedicated to improving the access to care for all populations, eliminating health care inequities, and enhancing medical education. Our members appreciate all efforts to secure access to buprenorphine, as it is a life-saving medication and critical component of the response to the Nation’s opioid overdose crisis.

We applaud the DEA for your efforts to improve access to buprenorphine for persons with opioid use disorder (OUD). However, based on our experience caring for patients with OUD, we have grave concerns regarding the proposed requirement that a patient would have to be examined, within 30 days, by the prescribing practitioner, or the prescribing practitioner would have to examine the patient remotely while the patient is in the physical presence of another DEA-registered practitioner participating in an audio-video telemedicine encounter with the prescribing practitioner. We believe the requirement of a face-to-face visit will create unnecessary barriers to care, which will worsen the opioid epidemic, and counteract the DEA’s stated goal of improving access to buprenorphine treatment for OUD.

Evidence from the pandemic shows that telehealth increased patients’ retention in care, and decreased risk of subsequent overdose.1 Further, evidence suggests that placing limits on telehealth access to opioid use disorder care will have a greater disruptive impact on the health of more marginalized groups, such as people experiencing homelessness and Black individuals.2

SGIM members are primary care physicians specializing in care for patients with complex medical, mental health and social conditions and their substantial overlap. We provide care for

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patients in rural areas where there is a lack of all health care providers, including primary and specialty care, and dedicated outpatient treatment programs. Our patients, being complex and often with few resources, are those at greatest risk of harm under the currently proposed regulations.

SGIM agrees that when a face-to-face interaction is possible, it can improve care and should be the standard. However, our members have experienced countless situations in which our patients with OUD face barriers, including transportation and geographic barriers. For those in rural areas, even if transportation is available, time and financial constraints due to family caregiving responsibilities, or participation in structured rehabilitation and job training programs, or simply the cost of gas also limit the ability to travel many hours to attend in-person visits. The induction period for buprenorphine treatment is a critical and difficult time, and we strongly believe that a 30-day window for an in-person visit will lead to worse care and lost engagement, precipitating unnecessary withdrawal and ultimately loss of life due to missed treatment, for the subset of patients with OUD who are facing the highest social and structural barriers to care. Even for those without such extreme social hardships, an in-person appointment within 30 days is not realistic for many people, given the dearth of available providers in rural areas. We believe this proposal is unnecessarily restrictive when virtual care for OUD is safe and effective.

For these reasons, we recommend that the allowed length of time for telehealth-only visits be extended to 6 months, with exemptions for infeasibility of in-person visits for circumstances, such as lack of transportation. We recognize the concern that a lack of guardrails on telehealth may lead to diversion and misuse. However, evidence does not support this; buprenorphine-associated overdoses did not increase as buprenorphine prescribing increased in the early months of the COVID-19 pandemic. In fact, studies demonstrate that people without access to buprenorphine are more likely to seek out diverted drugs, suggesting that restricting access is more of a risk factor for diversion than liberalizing restrictions.

To ensure that patients do not face additional barriers to buprenorphine treatment, SGIM respectfully requests that the DEA consider the following recommendations:

- For patients already receiving care across state lines during the COVID-19 public health emergency, there should be a 6-month grace period for the newly proposed regulations requiring the provider to have DEA registration in the state in which the patient resides.
- The DEA should extend, indefinitely, the waiver of requirement for the buprenorphine provider to have a DEA registration in the state in which the patient resides for patients who live within 20 miles of a state border, and for patients residing within Health Professional Shortage Areas (HPSA).

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Lastly, SGIM applauds the DEA for proposing to continue audio-only care for treatment of OUD. We agree that when available, synchronous audio-video and in-person care offer significant benefits, but that there are many instances when this is not feasible for the patient. Audio-only care has also been demonstrated to be safe and effective and is a critical tool which must be preserved to continue to combat the opioid epidemic.5

SGIM welcomes the opportunity to engage with you further on this topic. Should you have any questions, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,

[Signature]

LeRoi Hicks, MD, MPH
President, Society of General Internal Medicine

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