Good Morning.

**CN:** My name is Christa Natoli. (SPELL OUT). I am the executive director of CTeL, the Center for Telehealth and eHealth Law. We are a 501 C3 non-profit telehealth research institute focused on policies and regulations that impact the delivery of virtual care. We are both politically and vendor agnostic.

I would like to express the deep gratitude of CTeL for the opportunity to provide comments today concerning the crucial role played by the Drug Enforcement Administration (DEA) in the prescribing of controlled substances via telehealth. CTeL stands alongside the DEA in their commitment to safeguarding our communities from drug abuse and diversion, supporting policies that promote quality medical care.

As a research institute, we aim to present evidence supporting the long-term viability of the DEA flexibilities implemented during the COVID-19 public health emergency (PHE) waivers. Dr. Yael Harris and her team have collaborated with CTeL as impartial third-party researchers. Most recently on CTeL’s Telehealth Cost Effectiveness and Quality Study which examines the cost and quality of telehealth both before and during the pandemic. In this discussion, we will present data that reinforces the ongoing use of telehealth for prescribing life-saving treatments.

It's my pleasure to introduce Dr. Yael Harris, the CEO of Laurel Health Advisors. Dr. Harris has been an invaluable independent researcher for CTeL, gathering and analyzing data from across the United States to evaluate the effects of telehealth.

**YH:** Good morning.  My name is Yael Harris (SPELL OUT). I am the Chief Executive Officer of Laurel Health Advisors, a health services research company focused on using data to drive health care access and equity. I am a health services researcher with over 25 years of experience- more than half as a federal employee.

Like most researchers, I love data and always start any research with a review of the existing evidence.

If we look at pre-pandemic data, research found that in most instances, diversion was associated with a real need for treatment among those unable to access a provider or obtain medication. This is an important finding- even though there was illegal diversion taking place, the root cause was access NOT misuse.

Data collected during the pandemic provides substantial evidence that the expanded use of telehealth, despite waivers and unprecedented growth, did not lead to an increase in diversion.

According to the National Forensic Laboratory Information Systems (NFLIS) data, during the pandemic there was a decrease in buprenorphine diversion. There has not been any documented evidence that the use of telehealth increased the rate of stimulant diversion.

The data shows evidence that the ability to initiate and renew prescriptions for controlled substances via telehealth increased access to critical vulnerable populations including:

a. children and young adults struggling to focus and succeed in school (esp. during a period of high anxiety and untested new methods for instruction)

b. pain management for individuals unable to leave home and seek treatment

c access to MAT for individuals living with a substance use disorder.  As this is demonstrated to be most effective treatment for substance use disorder, lack of access to MAT is associated with higher rates of relapse

d. continued access to gender affirming care

The data points to the fact that in the absence of telehealth, we would have seen lower levels of compliance for substance use disorder treatment.

This means long wait times to get into insurance-covered programs even for those living in areas where there is a psychiatrist.

According to recent data, the national average wait time for behavioral health services is 48 days- that is nearly 7 weeks.

Among those seeking treatment for substance use disorder, this wait is untenable. If you ask substance use specialists, they will tell you that when a person living with a substance use disorder is ready for treatment, even a 24-hour wait can be too much.

Data from the American Academy of Pediatrics show significant, persistent shortages. Wait times for pediatric subspecialists often exceeds 2 weeks and, according to the Children’s Hospital Assn, families wait an average of almost 15 weeks to see a developmental-behavioral pediatrician.

As the mother of children with Attention Deficit and Hyperactivity Disorder, I know first-hand the importance of timely diagnosis and treatment.  While my children were struggling in school, many pediatric psychiatrists were not taking new patients.  As any parent knows, weeks can mean the difference between academic success or failure for your child which then impacts their self-esteem, confidence, and mental health. According to the CDC, less than half of children with ADHD/ADD receive treatment.

Additionally, people needing gender affirming care benefit from accessing telehealth to receive these services. Without access, the impact on this population can be devastating.

Multiple studies have demonstrated the impact of how increased enforcement to avoid patient harm associated with controlled substances has led to fear and unintended consequences including:

o Higher rates of diversion of opioid agonists

o Greater fear of disciplinary action against opioid prescribers which resulted in forced tapering and under-prescribing.

o Providers refusing to take on patients who legitimately require opioids

The Controlled Substances Act proposed establishing a special registration process with the key objective of increasing access to needed medications.

The rationale provided for establishing this registry was to prevent illegal prescribing and potential harms associated with diversion and inappropriate use.

**CN:** CTeL is in support of any policy change that will eliminate unnecessary administrative burden on prescribers while improving access to quality healthcare interactions. This includes use of existing electronic data sources including the prescription drug monitoring programs in every state, pharmacy data, and interoperable electronic health records.

Historically, the DEA has prioritized public safety. However, several studies have shown that provider fears of being non-compliant have reduced access to treatment, leading to more harm from increased illicit substance use.

We understand DEA is seeking input on potential guardrails.  We urge DEA to partner with provider groups to identify guardrails that do not hinder access and unintentionally limit care.

Overprescribing was an issue even before the widespread use of telehealth.

Limiting access via telehealth is not going to solve the issue of diversion but may exacerbate it.

Experience shows any new burdens are likely to lead to great public health and safety concerns when patients are unable to access needed medications in a timely manner.

To recap, CTeL supports the continuation and permanency of telehealth flexibilities made available during the PHE, the creation of the special registration, and guardrails to protect against inappropriate prescribing as long as it doesn’t create barriers that may restrict providers.

On the behalf of CTeL and the telehealth community we appreciate your attention to these important matters.