AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

September 12, 2023

DEA Representatives, Leaders, and Guests:

My name is Dr. Sterling Ransone, and I am a practicing family physician in a small practice in rural Deltaville, Virginia. I am the immediate past-president and am currently serving as the Board Chair of the American Academy of Family Physicians (AAFP). I am honored to be here today representing the 129,600 physicians and student members of the AAFP.

Family physicians provide comprehensive, person-centered primary care to patients across the lifespan, forming long-standing relationships with our patients. We are often our patients' first call for chronic care management, acute illness, and increasingly, mental health concerns. Our training and uniquely broad scope of practice enable us to be responsive to the needs of our communities, including offering telehealth visits and providing treatment for opioid use disorder (or OUD).

During the COVID-19 pandemic, family physicians like me found that telehealth helped improve access to care for our patients by removing transportation and other barriers that prevented them from getting in to see us. The long-standing relationships I have with my patients enabled me to determine whether a telehealth or in-person visit was most appropriate, such as when a patient needed a new or renewed prescription for a controlled medication. But we also observed how appointments conducted by telehealth companies without these relationships led to care fragmentation and, at times, low-quality care.

That's why the AAFP recommends permanent telehealth prescribing regulations that prioritize established patient-physician relationships while also facilitating equitable access to care for our patients – millions of whom live in health shortage areas and are facing months-long waitlists for an in-person appointment. To achieve this, we strongly recommend that DEA not impose additional telehealth prescribing restrictions for controlled substances on physicians who have already established a patient relationship through an in-person visit. As family physicians, we want to support our patients by providing them time and flexibility to overcome issues caused by transportation, cost, child-care, stigma, and other barriers to treatment. It's vital for DEA to partner with us in supporting our patients' access to care, and telehealth prescribing is key to maintaining that access.

Second, **DEA should allow prescribers to manage a patient's condition via telehealth for six months before requiring an in-person exam.** Family physicians believe six months of telehealth-only prescribing of schedule III-V medications achieves the appropriate balance of facilitating access to care and protecting patient safety. With long appointment wait times in communities like mine, a shorter time limit will create operational challenges for physician practices and patients alike – and ultimately exacerbate health disparities.

Third, **we recommend DEA permanently allow telehealth-only prescribing of buprenorphine for the treatment of opioid use disorder.** Studies conducted during the public health emergency found that telehealth prescribing of buprenorphine improved treatment access and retention, as well as patient satisfaction, while reducing illicit opioid use. Given the robust evidence in support of telehealth

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OUD treatment, limited access to OUD treatment providers, and low rates of buprenorphine diversion, we strongly encourage DEA not to finalize any proposal that would require an in-person exam for prescribers of buprenorphine for OUD treatment. As family physicians, we stand with the Biden Administration in strongly supporting expanded access to OUD treatment through telehealth.

Finally, **we urge DEA to focus on addressing diversion and improving oversight of telehealth companies instead of imposing complex, burdensome regulations on physicians.** While we have advocated to permanently expand coverage and payment for telehealth services and strongly support our patients' ability to access telehealth services from their usual source of care, the AAFP has also repeatedly shared concerns that services provided by direct-to-consumer telehealth companies may drive care fragmentation and pose significant patient safety risks. Most helpful for family physicians would be increased Agency oversight on telehealth provided by companies that are not part of a patient's usual source of care. Better, more targeted oversight will be more effective than burdensome reporting mandates and duplicative licensing requirements for telehealth prescribing of controlled medications within established patient-physician relationships. Physicians are already overburdened, particularly in small and rural practices like mine, and we encourage DEA to work with other agencies to harmonize licensing requirements for prescribers. We urge DEA to focus its efforts on addressing diversion and stopping bad actors through law enforcement activities – not healthcare regulations.

In closing, family physicians are uniquely positioned to safely offer comprehensive care that integrates telehealth without additional burdensome requirements that prevent us from caring for our patients or risk negatively impacting patient outcomes. We look forward to partnering with DEA to uphold safe prescribing practices and to ensure patients' continuous, equitable access to care after PHE-era flexibilities end.

Thank you for the opportunity to provide this testimony. I look forward to answering your questions.

Sterling Ransone, Jr., MD, FAAFP
American Academy of Family Physicians, Board Chair