American Nurses Association

8403 Colesville Road, Suite 500
Silver Spring, MD 20910
+1 (301) 628.5000
ana.org

March 11, 2025

The Honorable Derek Maltz
Acting Administrator
Drug Enforcement Administration
8701 Morrissette Dr.
Springfield, VA 22152

Submitted electronically to www.regulations.gov

RE: Special Registration for Telemedicine and Limited State Telemedicine Registrations [Docket No. DEA-407]

Dear Acting Administrator Maltz,

The Drug Enforcement Administration (DEA) is proposing a special registration for telemedicine. The American Nurses Association (ANA) strongly opposes the proposed rule and believes DEA should work with all stakeholders, including nurses, to rewrite and improve a new, proposed rule. The DEA is currently operating under a waiver that lasts through the end of 2025, and ANA encourages the DEA to use this time to review and edit the current proposal and to propose a new rule later this year. ANA looks forward to working with the Administration during the current regulatory freeze on a new rule that addresses the concerns of both registered nurses (RNs) and advanced practice registered nurses (APRNs).

While we appreciate that the DEA fulfilled Congressional requirements with the proposed rule, ANA urges the DEA to incorporate the following changes into a new proposed rule:

- Whether In-person Visits are Necessary;
- ANA Opposes Use of Inappropriate Terms;
- ANA Opposes Board Certifications;
- ANA Opposes the Requirements for Audio/Video Capability;
- ANA Opposes the Location of Prescribers Requirement; and
- ANA Opposes the 50% Requirement.

ANA is the premier organization representing the interests of the nation's over 5 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. ANA members also include the four APRN roles: nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs). RNs serve in multiple direct care, care coordination, and administration leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions

including essential self-care, and provide advice and emotional support to patients and their family members.

Nurses are critical to a robust health care system. Nurses meet the needs of patients and provide quality care that leads to better health outcomes for all patients. Moreover, nurses are critical to coordinated care approaches for Medicare beneficiaries in all settings, including hospital outpatient settings. Patient-centered care coordination is a core professional standard for all RNs and is central to nurses' longtime practice of providing holistic care to patients.

We appreciate the agency's thoughtful consideration of our comments.

1. **This Proposal Only Applies where the Patient Has Never Had an In-person Visit**

The DEA proposes that this rule would only apply where there has never been an in-person visit. **ANA thanks the DEA for clarifying the limitation in this rule**. This limitation will help practitioners practice medicine in ways that are most beneficial to their patients and will not require new, overly burdensome, in-person visits where there have been in-person visits in the past.

2. **DEA Must Refrain from Categorizing APRNs as Mid-level Practitioners**

The DEA refers to APRNs throughout the proposed rule as mid-level practitioners. While ANA supports the inclusion of these practitioners in the proposed rule, we remain concerned about categorizing these clinicians as mid-level practitioners. This outdated terminology does not fully capture these clinicians' authority to practice to the full extent of their education and expertise. APRNs are licensed, independent practitioners that are integral parts of the health care delivery system—providing needed, quality services to patients. Further, the term *mid-level practitioner* denotes an inaccurate hierarchy within clinical practice and only serves to confuse patients about the role of APRNs.

Starting with the calendar year 2024 Physician Fee Schedule, CMS removed the distinction between physician and non-physician providers and instead uses the term *practitioner* to denote all medical professionals. **ANA encourages the DEA to follow CMS' lead and to use the term *practitioner* to cover all medical providers who prescribe medication under the proposed rule**. ANA understands that this change will require time to amend the code of federal regulations. Until this change can be completed, ANA urges the agency to either use the practitioner's professional titles or refer to them as *advanced practice providers* in this and other regulations, guidance, and other agency documents.

3. **DEA Must Change the Board Certification Requirements**

The DEA proposes that a practitioner have board certification as one of the requirements for special registration. ANA does not offer comments on the board certification requirements but does oppose the list of proposed certifications. APRNs, usually NPs, prescribe controlled substances, but they are not eligible to receive some of the listed certifications. **ANA urges the DEA to either widen the list of allowed board certifications to include certifications that APRNs receive or eliminate the list of allowed board certifications and only require that the practitioner have a certification showing that they have expertise in the field.**

The board certifications that physicians receive have different requirements from the certifications that NPs, and other APRNs, receive. These requirements have no bearing on the ability of the practitioner to practice medicine and therefore have no bearing on the ability of the practitioner to prescribe medicine. The result of the different requirements is that the board certifications are not equivalent, and it could

exclude all APRNs from being eligible for this registration, which would force many patients to either switch providers or not receive their required medications, resulting in poorer health care outcomes.

4. ANA Opposes the Audio/Video Requirements in the Proposed Rule

Research has shown that both phone and video encounters are effective in terms of reduced symptomology management, continuity of care, client satisfaction, therapeutic rapport, and other important clinical outcomes.[1] ANA agrees with the supposition that audio and video capabilities are superior to audio only visits for telehealth appointments, and there are times when audio/video requirements are warranted, but that is not always the case and may create unnecessary barriers to care. For example, in cases where the practitioner is concerned that a patient is abusing some medications that have a tendency to become addictive, being able to see a patient's face is very beneficial; in cases like that, a video requirement is very helpful and should possibly be required.

In some behavioral health cases, a patient's psychological conditions may pose a barrier for them to be on camera, and a video requirement could cause patients to forego necessary appointments and the possible prescriptions that arise from these appointments. Skipping these appointments is dangerous for the patient and, depending on the patient, could be dangerous for others. As a result, **ANA opposes the DEA's proposal requiring audio/video requirements in order to prescribe controlled substances via telehealth.**

5. ANA Opposes the Requirement that Prescribers and Patients be Physically Located in the Same State

The DEA proposes that patients and prescribers be physically located in the same state in order for the prescriber to prescribe controlled substances. In large, rural states this might make sense, but in smaller states, or near state borders, that requirement could be detrimental to a patient. An example of where this requirement could be detrimental is the Washington, DC area. Many practitioners practice in Washington, DC, but their patients might live and work in either Virginia or Maryland. These practitioners are also frequently licensed to practice in all three jurisdictions. ANA does not oppose requiring that a practitioner be licensed in a jurisdiction where patients and practitioners are physically located to prescribe to that patient, but **ANA strongly opposes the requirement for patients and practitioners to be physically located within the same state.** Licensure within the state where the patient is treated ensure accountability as intended by the proposed rule.

A requirement for patients and practitioners to be in the same state could lead to dangerous situations and it currently limits access to care for some patients. Furthermore, it is not always possible for patients, especially behavioral health patients, to be in the same state as their practitioner. A significant percentage of patients live in mental health professional shortage areas. In these areas, it is very possible that the few practicing mental health practitioners do not have the ability to handle more patients. This shortage could result in patients not receiving the care they need or must travel for hours to physically be in the same state as the practitioner. Lower-income patients frequently cannot afford

[1] Chen, P. V., Helm, A., Caloudas, S. G., Ecker, A., Day, G., Hogan, J., & Lindsay, J. (2022). Evidence of Phone vs Video-Conferencing for Mental Health Treatments: A Review of the Literature. *Current psychiatry reports*, *24*(10), 529–539. https://doi.org/10.1007/s11920-022-01359-8

the time it would take to travel and be in the same state as their practitioner and, as a result, may not receive the care they need.

6. ANA Opposes the 50% Requirement for Schedule II Narcotics

The DEA proposes to require that fewer than fifty percent of prescriptions for a calendar month be schedule II controlled substances. This fifty percent combines both in-person and virtual encounters. ANA understands that DEA is concerned about over prescribing these medications and that there are dangers to both the patient and general public. The DEA has not provided reasoning for either the 50 percent requirement or how they derived this percentage. Depending on the patient and the month, a practitioner might violate this requirement without realizing it. For example, a practitioner could see a number of patients at the beginning of the month that require controlled substances and then have unforeseen events that prevent them from working for the rest of the month. This can hinder a practitioner's ability to provide needed care, under prescribe, or place them in a position where they have violated the requirement even though their original schedule would not have violated the rule. As a result, **ANA opposes the requirement that fewer than fifty percent of prescriptions in a calendar month be schedule II controlled narcotics.**

ANA urges the DEA to establish a less burdensome approach to ensure practitioners do not over-prescribe such as systematic reviews of prescribing outliers instead of the fifty percent limitation.

ANA appreciates the opportunity to submit these comments and looks forward to continued engagement with the DEA. Please contact ANA's Executive Vice President, Policy & Government Affairs at (301) 628-5166 or tim.nanof@ana.org with any questions.

Sincerely,

Jennifer Mensik Kennedy PhD, MBA, RN, NEA-BC, FAAN
President

cc: Angela Beddoe, ANA Chief Executive Officer