AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

AAHPM Public Statement
Practice of Telemedicine Listening Sessions
September 12, 2023

Good morning/afternoon.

My name is Joe Rotella, and I am the Chief Medical Officer of the American Academy of Hospice and Palliative Medicine. AAHPM is the national professional organization for physicians who specialize in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, researchers, and other health professionals deeply committed to improving quality of life for the expanding and diverse population of patients of all ages living with serious illness as well as their families and caregivers. Together, we strive to ensure that patients across all communities and geographies have access to high-quality, safe, and equitable palliative care, at any stage of a serious illness, and hospice care for those nearing the end of life.

The timely and effective management of pain and other distressing symptoms is central to providing high-quality palliative care to patients with serious illness, and opioid analgesics and other controlled substances are critical tools in alleviating their suffering. AAHPM appreciates the intention of the proposed rules to advance public safety and urges taking a balanced approach that also prioritizes access to care and relief of suffering. Therefore, we believe it is imperative for DEA and the Department of Health and Human Services to account for the unique needs of seriously ill patients – including those near the end of life – when finalizing policies related to the prescribing of controlled substances via telemedicine.

In particular, my comments today focus on three main areas:

- The need to clarify that in-person requirements for prescribing of schedule II – V controlled substances do not apply to patients enrolled in hospice.
- The need to establish a special telemedicine registration, such that qualifying practitioners may prescribe schedule II – V controlled substances without conducting an in-person medical evaluation, to enable ready access to controlled medications for patients with serious illness; and
- The need to extend telemedicine prescribing flexibilities for controlled substances that have been in place in response to the public health emergency (PHE) for COVID-19, through at least calendar year 2024, to provide for a reasonable transition period while a special telemedicine registration process is implemented.

DEA asks if there are any circumstances in which telemedicine prescribing of schedule II medications should be permitted, and if so, what safeguards stakeholders would recommend. AAHPM asserts that telemedicine prescribing of schedule II medications should be permitted in cases where patients have elected to enroll in hospice. Likewise, telemedicine prescribing should be permitted in cases where patients outside of hospice are clearly identified as having a serious illness and uncontrolled symptoms, with the added safeguard that the prescriber has demonstrated training and expertise in pain management or palliative care and met any qualifications for a special registration.

We understand that in-person evaluation requirements are intended to ensure that an established patient-physician relationship is in place prior to the prescribing of controlled substances via the Internet. The Academy takes the position that a proper physician-patient relationship can be created – and that sufficient safeguards are in place to support telemedicine prescribing without an in-person evaluation – when a patient is certified as having a terminal illness and enrolled in a hospice program. Under the Medicare hospice benefit, hospice patients must be certified to be "terminally ill" by two physicians who each attest the patient has an estimated life expectancy of 6 months or less. Once enrolled, the hospice model of care creates the equivalent of a physician-patient relationship, in the form of care provided by interdisciplinary hospice team members under the supervision of a hospice physician. These hospice team members – including advanced practice registered nurses, physician assistants, nurses, social workers, chaplains, and others based on need – conduct comprehensive skilled admission evaluations and are in regular face-to-face contact with patients, including through frequent home visits, extensive education and supervision, and 24/7 availability, making them better equipped to detect and address drug diversion and safety concerns than a physician in a typical outpatient medical clinic.

In addition to these guardrails inherent to the structures and processes of hospice care that protect against diversion or misuse, we note that hospice patients have a particularly urgent need for ready access to opioids and other pain medications. As they contend with their terminal illnesses, they often develop pain or symptom crises, which represent a true medical emergency. Hospice programs must be able to prescribe and administer medications for pain and other severe symptoms quickly, including Schedule II controlled substances when indicated. Requiring hospice patients to obtain in-person evaluations with a prescriber could delay treatment by hours or days, prolong suffering, and drive many to go to the emergency department or hospital even when their primary goal for their care is to remain comfortable at home.

Given the wraparound hospice care management structure as defined by the Medicare Hospice Benefit Conditions of Participation, as well as the high clinical need for urgent management of pain and symptoms in a home setting, it is clear that the benefits of telemedicine prescribing of controlled substances outweigh the risks for patients enrolled in hospice. We therefore respectfully request that DEA provide clarification that specifies that in-person evaluation requirements for telemedicine prescribing do not apply to hospice patients.

AAHPM also believes that other, non-hospice patients with serious illness should likewise not have to face unnecessary barriers in accessing medications to address their pain, including Schedule II controlled substances. Patients with serious illness often experience significant challenges in accessing in-person care, including mobility and/or cognitive limitations; pain, frailty, and medical instability; and disproportionate reliance on caregivers to assist with transportation. These challenges and burdens underscore the need to allow telemedicine prescribing of controlled substances without in-person evaluation for this high-need population. For example, imagine an 86-year-old homebound woman with moderate dementia and a flareup of bone pain due to metastatic breast cancer who receives oral chemotherapy and accesses all her oncology and palliative care from her home via telehealth. It is highly unlikely that a physician home visit would be available on an emergency basis. Transporting her to an emergency department or outpatient clinic for in-person evaluation just to prescribe pain medication would be extremely challenging for her and her caregivers and only add to her distress.

Timely access to a palliative care specialist to manage distressing symptoms is an even bigger challenge for pediatric patients with serious illness. It is not unusual for a child suffering from a life-limiting rare childhood disease to receive their specialty care from a tertiary care hospital many hours away by car.

Local medical resources are often unavailable, unwilling, or incapable of prescribing controlled substances for such complex patients. It would be inhumane to subject the child and family to a long car or ambulance transport to the specialized medical center simply to access a prescription for a controlled substance that could otherwise be managed safely and effectively at home.

To provide safeguards while supporting access to urgent symptom management for people with serious illness, AAHPM recommends that DEA implement a telemedicine special registration process enabling qualified practitioners to prescribe schedule II-V controlled substances via telemedicine without a prior, in-person medical evaluation . We support robust requirements for special registration, for example, demonstration of specialized training in palliative care or pain management, and would be happy to work with DEA on identifying appropriate qualifications.

Finally, we appreciate that Congress extended Medicare telehealth flexibilities through calendar year 2024. AAHPM urges DEA to likewise extend the telemedicine prescribing flexibilities for controlled substances through at least the end of 2024 while it implements a telemedicine special registration process. While we appreciate that DEA extended flexibilities for 6 months after the PHE for COVID-19, and for an additional year thereafter for relationships established between the start of the PHE and November 11, 2024, we believe that the flexibilities should be extended more broadly, including for all telemedicine encounters for new and established patients – including for hospice patients if they are not clarified to be exempt – through the end of 2024.

Thank you for considering our comments in support of patients with serious illness and their families and caregivers.