CHILDREN'S HOSPITAL ASSOCIATION

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Scott A. Brinks
Regulatory Drafting and Policy Support Section
Diversion Control Division
Drug Enforcement Administration
8701 Morrissette Drive
Springfield, Virginia 22152

Dear Mr. Brinks:

The Children's Hospital Association (CHA) appreciates the opportunity to comment on the Drug Enforcement Administration's (DEA) proposed special registration process that allows telemedicine prescribing for controlled substances without an in-person medical evaluation. Thank you for proposing this policy that will maintain access to care for patients. We support a special DEA registration that alleviates administrative burdens for providers and leads to continued access to needed care for children.

The more than 200 children's hospitals across the country are dedicated to the health and well-being of our nation's children and advance child health through innovations in the quality, cost and delivery of pediatric care. We serve as a vital safety net for uninsured, underinsured and publicly insured children and are regional centers for children's health, providing highly specialized pediatric care across large geographic areas. Although they account for less than 5% of hospitals in the United States, children's hospitals care for almost one-half of children admitted to hospitals and serve the majority of children with serious illnesses and complex chronic conditions.

Pediatric Telehealth Needs

The regionalization of pediatric specialty care means that it's not uncommon for children to live long distances from a children's hospital. As a result, telehealth is a vital tool to maintain access to quality care in a timely manner. Telehealth plays a critical role in addressing the constraints that children and their families face accessing care due to geography—particularly in rural and underserved areas. Telehealth flexibilities provided during the federal public health emergency facilitated continuity of care across state lines, especially for patients with complex health conditions and those in families with transportation challenges. Without the special registration, providers have to maintain a physical address in a state in order to prescribe controlled substances. With the long distances noted above, this would greatly impact access as providers would not be able to maintain physical addresses in every state where we see some of our most vulnerable patients.

In addition, telemedicine allows children's hospitals to address the persistent mental health workforce shortages which are projected to increase over time. One of our member hospitals reports that the time-to-next-appointment for kids to see an in-person psychiatrist is 6-12 months, while the wait for tele-psychiatry services is 4 months.

Furthermore, tele-prescribing of controlled substances is beneficial for pediatric behavioral health services, treating medically complex children and as part of substance use disorder programs (SUD) for adolescents.

- **Schedule IIN**
  A sub-set of the Schedule IIN stimulants, such as Ritalin and Adderall, are often prescribed for children with attention-deficit/hyperactivity disorder. One of our hospitals reports that over the last six months, over 1,100 patients have received telepsychiatry services and nearly 50 percent are on Schedule IIN stimulant.

- **Schedule III-V**
  Children diagnosed with epilepsy must have seizure rescue medications readily available, including Schedule IV controlled substances, with some of the most prominent drugs being diazepam and midazolam, both Schedule IV controlled substances. The requirement to be seen in-person to be prescribed this medication could delay potentially life-saving care and place undue burden on families.

- **Buprenorphine**
  Children's hospitals manage buprenorphine prescriptions for youth with SUD through a combination of telehealth and in-person visits. We strongly support Boston Children's Hospital's comments that highlight how telehealth is critical for substance abuse engagement services for adolescents.

To ensure the safety of pediatric patients when prescribing these medications, we recommend that the DEA continue utilizing the Prescription Drug Monitoring Program (PDMP). The PDMP currently collects data on patients, prescribers, prescriptions and pharmacy information to identify and prevent diversion. If additional data is required beyond the PDMP framework, we recommend that it be standardized and electronic.

In conclusion, telehealth has been a crucial tool to connect children to specialty care and behavioral health care, especially for those living in rural or underserved areas. It is vital that the DEA work with children's hospitals, pediatric health care professionals and patient families to ensure vulnerable populations have continued access to these services in a timely manner. We thank you for the opportunity to provide comments and look forward to continuing to work with you to ensure this policy works for children. Please contact Natalie Torentinos at natalie.torentinos@childrenshospitals.org or (202) 753-5372 should you need more information.

Sincerely,

Aimee C. Ossman
Vice President, Policy
Children's Hospital Association