Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board | 50 F Street NW | Washington, DC 20001 | (202) 507-4070 | (202) 507-4071 fax

May 7, 2026

The Honorable Terrance Cole
Administrator
US Drug Enforcement Administration
700 Army Navy Drive
Arlington, VA 22202

Re: Tribal Consultation Comments on Prescribing Controlled Substances via DEA Statutory Telemedicine and the Impact on Tribal Communities

Administrator Cole:

On behalf of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), we write to provide comments to the Drug Enforcement Administration (DEA) regarding the Tribal Consultation on Prescribing Controlled Substances via DEA Statutory Telemedicine and the Impact on Tribal Communities. The CMS-TTAG is established in statute to advise the CMS on Indian health policy issues involving Medicare, Medicaid, and the Children's Health Insurance Programs.[1] In particular, the CMS TTAG focuses on providing policy advice to improve the availability of health care services to American Indian and Alaska Native (AI/AN) beneficiaries in CMS health and other federal programs.

Diversion of Controlled Substances

1. The United States has a unique legal and political relationship with Tribal governments, established through and confirmed by the Constitution, treaties, federal statutes, executive orders, and judicial decisions. Central to this relationship is the federal government's trust and treaty responsibilities: a legal obligation to protect the interests of Indian Tribes and communities, including the provision of health care to American Indians and Alaska Natives (AI/ANs). Adequate health care includes the provision of needed prescription drugs and pharmacist care to all AI/AN peoples in the United States, including those living in the most remote and inaccessible areas of the country. To fulfill the federal government's trust and treaty responsibilities to Tribal Nations, DEA must ensure any new rules regarding prescribing controlled

[1] 42 U.S.C. § 1320b–24

substances via telemedicine will support and enhance the provision of health care to AI/AN people, whether in remote villages or urban centers.

As TTAG has previously commented, much of Indian Country is rural, with an estimated 40% of AI/AN people living in rural America.[2] Indian Country includes some of the most remote and inaccessible communities in the country. As previously noted, most villages served by the Alaska Tribal Health system have no road access, meaning the nearest community with a pharmacist, physician, or psychiatrist is, on average, an hour or more away by plane. Because of the rural nature of our communities, the Indian health system has long utilized telehealth since the mid-1970s to provide care to AI/AN patients.[3] At the height of the COVID-19 public health emergency, telehealth usage across the Indian health system increased to nearly 42,000 services per month.[4]

Additionally, both the Indian Health Service (IHS) and Tribally operated health facilities face chronic, systemic workforce shortages, challenges that are intensified by the highly rural and geographically isolated nature of many Tribal communities. As such, the DEA should consider how workforce scarcity affects the day-to-day operations, including mandatory regulatory reporting, and the ability of our facilities to provide care. In most Tribal facilities, the same staff who provide care are also responsible for compliance and reporting tasks. When reporting requirements are extensive, duplicative, or highly technical, they consume hours that would otherwise be spent delivering care, coordinating referrals, or managing chronic conditions. Unlike large health systems, most Tribal facilities lack dedicated compliance departments to absorb this workload.

2. TTAG does not have substantive comments on this question.

3. The Alaska Tribal Health System is widely recognized as one of the most effective rural health care delivery systems in the United States. Its success is rooted in a

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[2] Kozhimannil, K., Interrante, J., Story Tuttle, M., & Jacobson, I. (2025, December). Measuring rural-urban differences in Indigenous American Indian and Alaska Native health. University of Minnesota Rural Health Research Center. Rural Health Research Gateway. https://www.ruralhealthresearch.org/projects/1076

[3] IHS Telehealth Programs. Indian Health Service (n.d.). Available at: https://www.ihs.gov/telehealth/telehealthprograms/.

[4] Indian Health Service Press Release: Indian Health Service Further Expands Telehealth Services to Meet Patient Needs (October 31, 2022). Available at: https://www.ihs.gov/newsroom/pressreleases/2022-press-releases/indian-health-service-further-expands-telehealth-services-to-meet-patient-needs/

hub-and-spoke model that integrates community-based providers, regional hospitals, telehealth, and centralized specialty care to serve one of the most geographically remote populations in the world. Under the model, care is organized through a hub and spoke structure that connects community-based services with regional and statewide resources. The spokes consist of village-level clinics staffed by Community Health Aides and Practitioners (CHAPs), Behavioral Health Aides, and Dental Health Aides who live in and are deeply connected to the communities they serve. These village clinics are supported by regional Tribal hospitals and medical centers, such as those in Nome, Kotzebue, Bethel, Dillingham, and Sitka, which function as hubs for more advanced evaluation and treatment. At the top of the system is a tertiary anchor, the Alaska Native Medical Center in Anchorage, which provides specialized and advanced care for patients across the state.

Through this integrated structure, more than 170 remote villages, many of which have no road access, are linked to hub clinicians using telemedicine, standardized clinical protocols, and medical evacuation systems when higher levels of care are required. This design allows health services to be delivered at the lowest safe and most appropriate level of intensity, ensuring timely access to care close to home while enabling rapid escalation to regional or tertiary facilities only when it is clinically necessary. The hub-and-spoke model has demonstrably improved access to care in rural Alaska. Most villages have no resident physicians, yet residents receive rapid access to primary care through their village clinics. Telemedicine consultations allow regional physicians to support CHA/Ps in real time, reducing unnecessary travel and delayed treatment. Peer-reviewed research has shown that telemedicine-enabled referral systems in rural Alaska significantly reduce time to specialty follow-up, especially for pediatric and preventive services.[5]

4. TTAG does not have substantive comments on this question.

5. Access challenges in urban settings are often cumulative rather than singular, including transportation barriers, long travel distances to Urban Indian Organizations (UIOs), and the absence of nearby Indian Health Service (IHS) or Tribal facilities. In some states, UIOs are the only culturally competent providers available, requiring patients to travel over 100 miles to receive care.

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[5] Emmett, S. D., Platt, A., Turner, E. L., Gallo, J. J., Labrique, A. B., Inglis, S. M., Jenson, C. D., Parnell, H. E., Wang, N. Y., Hicks, K. L., Egger, J. R., Halpin, P. F., Yong, M., Ballreich, J., & Robler, S. K. (2022). Mobile health school screening and telemedicine referral to improve access to specialty care in rural Alaska: a cluster- randomised controlled trial. *The Lancet. Global health*, *10*(7), e1023–e1033. https://doi.org/10.1016/S2214-109X(22)00184-X

These barriers are compounded by fragmented urban service delivery, where access depends on both availability and geographic reach across dispersed systems. In addition to logistical barriers, access is shaped by trust and prior experiences. Care must not simply be available, but culturally safe and usable within the patient's lived context.

Telemedicine has played a critical role in improving access and continuity of care in urban AI/AN communities, particularly for behavioral health and substance use services. Audio-only telemedicine has been especially important given variability in limited broadband access, housing instability, and digital access barriers. Maintaining flexibility in telehealth prescribing is essential for continuity of care during disruptions. Loss of prescribing flexibility would not shift patients to in-person care but would increase treatment disengagement, particularly where no IHS or Tribal facilities exist as fallback options.

6. As TTAG previously commented, the Internet Eligible Controlled Substance Providers designated under 21 U.S.C. § 831(g)(2) is extremely limited in scope and has not been widely usable across the Indian Health System.[6] The designation is available only on a practitioner-by-practitioner basis, requiring individual IHS or Tribal practitioners to apply for approval as an Internet Eligible Controlled Substances Provider, rather than applying at the facility or system level. This individualized process creates administrative burden and limits scalability.

   The designation is restricted to practitioners serving "sufficiently remote" locations where access to medical services is limited, which does not fully account for the broader access barriers that make telemedicine essential in both rural and urban Indian Country, including workforce shortages and lack of specialty care. UIOs are excluded because they do not meet this threshold.

   It is limited to practitioners employed by IHS or Tribes operating programs under the Indian Self-Determination and Education Assistance Act, excluding Urban Indian Organizations and the patients they serve. IHS has further limited its use to Medication for Opioid Use Disorder/Medication Assisted Treatment for substance use disorders rather than broader clinical application.

[6] See: https://www.nihb.org/wp-content/uploads/2025/04/2023-03-31_DEA_TTAG-Letter-on-DEA-407.pdf

These constraints, narrow eligibility, individualized application, limited clinical and limited clinical scope, prevent the designation from functioning as a meaningful telemedicine solution. These structural limitations are compounded by the exclusion of UIO practitioners, further constraining the designation's applicability across the full I/T/U system. The NPRM does not remedy this exclusion. As a result, when these flexibilities expire, UIO practitioners may lack any pathway to initiate controlled substances via telemedicine. DEA should ensure that any framework explicitly includes UIO practitioners and avoids administrative requirements that effectively preclude participation.

7. Yes. In-person and technology-dependent requirements may reduce telemedicine access to controlled substances, particularly for rural and behavioral health patients. The NPRM would likely drive shorter telemedicine prescribing with increased scrutiny, especially for Schedule II medications. More broadly, Tribal health systems anticipate that the proposed rule will result in a meaningful reduction in telemedicine access for controlled substances, particularly affecting psychiatrists and Medication for Opioid Use Disorder (MOUD), also known as Medication Assisted Treatment (MAT) clinics that rely heavily on telehealth modalities to maintain continuity of care. These impacts will be most acute for rural patients and those receiving behavioral health services.

   At the same time, additional PDMP checks, documentation, and compliance tracking would increase administrative burden and force shifts toward hybrid care models. From a pharmacy operations perspective, multiple required identifiers (DEA, federal telemedicine, and state telemedicine numbers), new monthly reporting, and state-location requirements for Schedule II prescriptions would significantly increase verification workload, require system changes, and shift more legal responsibility onto pharmacists, including the need to implement processes to track and verify submission of required electronic reports. These requirements will also necessitate system and process updates across pharmacy operations, compliance, and technology infrastructure. Requirements that prescribers be located in the same state as the patient for Schedule II medications (e.g., 21 CFR 1306.45(b)) may create operational challenges for Tribal health systems that routinely serve patients across state lines or rely on regional provider networks. The NPRM also does not clearly address how patient identity would be matched across systems or how patient expectations around mailed controlled substances would be managed, including how systems will prevent or detect instances where the same patient may receive prescriptions under different names or identifiers.

8. TTAG does not have substantive comments on this question.

9. By necessity, health care delivery must operate differently in these locations than it may in more populated and accessible regions of the United States. Most health care and pharmacy care in these remote regions depends on village clinics' lower- or mid-level providers, connected through technology to supervising providers in other locations. These unique health care systems successfully provide essential care for hundreds of Tribes.

10. Telemedicine models reduce costs by delivering care at the lowest appropriate level while reserving higher-cost resources for cases that truly require them. Within the hub-and-spoke model, routine and preventive care provided at sites keeps patients close to home, which significantly reduces spending on patient travel, medical evacuations, and lodging. Early assessment and triage at the community level also prevent avoidable emergency department visits and hospital admissions, lowering inpatient costs. By allowing community-based clinicians to manage common conditions, the model uses specialists and advanced hospital services at hub facilities more efficiently, reducing duplication and maximizing the value of scarce, high-cost personnel. In addition, in the spoke clinics operate with smaller footprints and lower overhead than full hospitals, and telemedicine connections to hubs minimize unnecessary in-person visits. Together, these features create a system that improves access while controlling costs through smarter use of staff, facilities, and travel resources.

11. Reductions in telemedicine prescribing flexibility are unlikely to increase in-person utilization and are more likely to result in treatment disengagement. Current telemedicine models support continuity of care; removing them risks disruption. Urban AI/AN patients often lack fallback access to IHS or Tribal facilities, meaning loss of telemedicine removes care rather than redirecting it.

12. Across Indian Country, telehealth visits conducted in patients' homes have become an important way to expand access to care, particularly in rural, remote, and workforce-constrained communities. Home-based telehealth allows patients to receive primary care, behavioral health services, chronic disease management, and follow-up visits without traveling long distances to clinics that may be hours away or accessible only by air. This model is especially valuable for elders, individuals with disabilities, and patients managing behavioral health or substance use conditions, where continuity and privacy are critical.

Telehealth visits from home help mitigate longstanding barriers such as limited transportation, severe weather, and provider shortages, while reducing missed appointments and care delays. For Tribal health systems, home-based telehealth also supports hub-and-spoke care delivery by allowing community-based providers and specialists to stay connected to patients between in-person visits. As previously discussed, CHAPs, Behavioral Health Aides, and Dental Health Aides often accompany patients during telehealth visits with doctors or other mid-level providers.

Diversion of Controlled Substances

13. As we have previously discussed, diversion prevention can unintentionally complicate access to care.[7] Geographic isolation and fragmented care also create diversion risk. AI/AN patients may receive care from Tribal, IHS, and non-Tribal providers, sometimes across state lines, where PDMP data may not be fully interoperable or timely. This fragmentation can delay detection of duplicative prescribing or multiple-provider episodes. Additionally, the rurality of our patient population means that follow-up and on-going treatment are complicated by the distances many of our patients must travel and the lack of reliable transportation. Both factors contribute to patients' nonadherence to treatment plans. As we have previously noted, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), "patients who discontinue OUD medication generally return to illicit opioid use" and "arbitrary time limits on the duration of treatment with OUD medication are inadvisable."[8] Potential consequences of discontinued use include relapse, overdose, and death, all of which are far too common in Indian Country.

14. DEA should ensure that telemedicine regulations respect the federal government's trust and treaty responsibility to provide access to health care for AI/AN communities. Oversight mechanisms should support continuity of care and health equity while preventing diversion, recognizing that in many remote communities, telemedicine is not a convenience, but the only practical means of accessing timely and medically necessary treatment. In designing oversight and recordkeeping requirements, DEA should rely on safeguards already embedded within Tribal health systems, including mandatory PDMP use, integrated electronic health records, closed or coordinated pharmacy systems, and team-based care models. Regulatory

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[7] See: https://www.nihb.org/wp-content/uploads/2025/04/2023-03-31_DEA_TTAG-Letter-on-DEA-407.pdf
[8] Treatment Improvement Protocol 63 for guidance on medication for OUD. Medications for Opioid Use Disorder, Treatment Improvement Protocol 63, SAMHSA (2021). Available at: https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf.

approaches should allow flexibility in how compliance is demonstrated, including system- or facility-level oversight, rather than duplicative encounter-level requirements.

15. The best way to establish reporting mechanisms for suspicious activities related to telemedicine and controlled substances is to recommend that the DEA meaningfully consult with Tribal officials early in the development of these mechanisms. Federally recognized Tribes are sovereign governments, not stakeholders or interest groups. When the DEA regulates telemedicine, prescribing, or registration in ways that affect Indian Country, it implicates federal trust and treaty responsibilities to provide health care to AI/AN people and the government-to-government relationship recognized in federal law and policy.

DEA Registration

16. The DEA can ensure registration requirements do not impede access to care for AI/AN communities by adopting flexible, system-aware approaches that reflect how care is delivered in Indian Country. This includes allowing system-level or facility-based registration options for Indian Health Service (IHS) and Tribally operated health systems, rather than requiring individual providers to obtain duplicative or specialty telemedicine registrations. DEA should also recognize existing federal and Tribal safeguards, such as closed or integrated pharmacy systems and mandatory PDMP use, as satisfying oversight requirements.

    Additionally, registration requirements should account for workforce shortages, hub-and-spoke care models, and cross-jurisdictional practice common in Tribal health systems and avoid requirements that assume large commercial telemedicine platforms or urban provider density. Ongoing Tribal consultation during implementation would further ensure that registration processes protect against diversion without unintentionally restricting access to medically necessary care in AI/AN communities.

17. TTAG does not have substantive comments on this question.

Buprenorphine for Treatment of OUD

18. The opioid epidemic has disproportionately affected Indian Country, with American Indians and Alaska Natives (AI/ANs) experiencing the highest adjusted drug overdose rates and the highest rates of increase in opioid overdose deaths over the past ten years of any group. Geographic isolation and limited provider availability

further constrain access to treatment. For patients who must then travel hundreds of miles from their community to reach the nearest prescribing practitioner, a 30-day initial prescription is insufficient. Expanding supply allowances or removing in-person requirements where appropriate would improve continuity. According to Tribal MOUD prescribers in California, a minimum 90-day allowance has been shown to improve continuity.

Audio-only telemedicine must be permitted for OUD treatment, not limited to mental health services. Prior to the PHE, IHS patients used audio-only telehealth in ~60% of encounters. Urban AI/AN patients, particularly those experiencing housing instability, face major barriers to video-based care. DEA has already permitted audio-only buprenorphine prescribing (DEA-948, Jan 2025); this should extend to the broader OUD framework.

While buprenorphine has a six-month allowance, similar flexibility is not clearly extended to other controlled substances. Supply limits should support continuity for patients facing mobility, housing instability, and follow-up barriers.

19. Most villages served by the Alaska Tribal Health system have no road access, meaning the nearest community with a pharmacist, physician, or psychiatrist is, on average, an hour or more away by plane. This is assuming adequate weather and available flights, which is not a guarantee. Further, access to alternative methods of transportation, including snowmachines, rail, and air is often prohibitive.

20. Many communities across Indian Country have limited access to reliable broadband internet, with many communities lacking access to broadband completely. Audio-only modalities allow patients in communities with limited or no broadband infrastructure to access real-time medical care.

21. The DEA should leverage existing safeguards and be cautious of implementing over burdensome requirements for practitioners working within the Indian Health Service and Tribal health system. Both IHS and Tribally-operated health facilities face chronic, systemic workforce shortages that are compounded by both the highly rural and geographically isolated areas of our communities. The GAO has consistently identified isolation, travel barriers, and insufficient housing as major deterrents to recruitment and retention of various provider types within the Indian health system.[9]

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[9] US Government Accountability Office, *Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies,* GAO-18-580 (Aug. 2018). See https://www.gao.gov/assets/gao-18-580.pdf

As such, any additional safeguards must balance the need for continued access to OUD treatment, diversion prevention, and the limited staffing capacity of our facilities.

Conclusion

We appreciate the seriousness of the work entrusted to the DEA. Preventing diversion of controlled substances is important to Tribal Nations. We appreciate your consideration of the above comments and recommendations and look forward to engaging further with the agency.

Sincerely,

W. Ron Allen

W. Ron Allen, CMS/TTAG Chair
Jamestown S'Klallam Tribe, Chairman/CEO

Cc: Rachel Ryan Pederson, Acting Director, CMS Division of Tribal Affairs
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