ALBUQUERQUE AREA INDIAN HEALTH BOARD, INC.

Jicarilla Apache Nation • Mescalero Apache Tribe • Ramah Band of Navajos
Southern Ute Indian Tribe • Tóhajiilee Band of Navajo • Ute Mountain Ute Tribe

August 28, 2025

Via E-Mail

Benjamin Smith, Acting Director
Indian Health Service, Headquarters
Sent via email to: consultation@ihs.gov

Re: IHS Strategic Realignment

Dear Acting Director Smith:

On behalf of the Albuquerque Area Indian Health Board ("AAIHB"), this letter provides comments on the Indian Health Service's ("IHS") strategic realignment initiative.

AAIHB was established in 1980 and is a consortium of federally recognized Indian Tribes in New Mexico and Southern Colorado.[1] AAIHB provides direct health care and public health services to citizens of Tribes throughout New Mexico, Southern Colorado, and West Texas. AAIHB's purpose is to research and implement evidence-based and culturally relevant healthcare programs within 27 Tribal communities that collectively serve more than 80,000 Tribal members.[2] AAIHB is almost entirely federally funded through U.S. Health and Human Services' ("HHS") programs, including IHS.

We appreciate IHS's commitment to Tribal consultation as the agency develops its realignment strategy. Realignment provides a critical opportunity to improve efficiencies, streamline agency operations, and ensure greater accountability and responsiveness to Tribes, all of which will strengthen health care across Indian country. These comments address each of the feedback areas requested by IHS: 1) delivery of direct patient care; 2) enterprise and operational

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[1] Member Tribes include the To'Hajiilee Band of Navajos, the Ramah Band of Navajos, the Jicarilla Apache Nation, the Mescalero Apache Tribe, the Ute Mountain Ute Tribe and the Southern Ute Indian Tribe. For financial purposes the AAIHB is considered a Tribal government entity because the AAIHB board of directors is appointed by members of Tribal governments.

[2] AAIHB serves all 27 American Indian communities in the IHS Albuquerque Area, which, in addition to its member Tribes, includes: the Alamo Band of Navajos and the Pueblos of Taos, Picuris, Santa Clara, Pojoaque, Nambe, Tesuque, Ohkay Owingeh, San Ildefonso, Cochiti, Jemez, Zia, Santa Ana, Sandia, San Felipe, Santo Domingo, Laguna, Isleta, Zuni, Acoma, and Ysleta del Sur.

management; 3) support for Tribal self-determination; and 4) Tribal Advisory Committees.

I. Delivery of Direct Patient Care

AAIHB supports strategic realignment efforts geared to improve patient care through both IHS direct-care facilities and Tribally operated facilities. Specifically, we would request that IHS do so by creating and enforcing internal systems of agency accountability, improving partnerships with Tribes, recruiting and retaining high-quality healthcare providers, expanding programming to offset HHS cuts, and prioritizing the specific, specialized healthcare needs of Native Americans.

A. Internal Accountability

IHS has announced that it intends to change how it manages its direct-care hospitals and satellite clinics by splitting oversight of IHS facilities between two Deputy Directors of Field Operations ("DDFO") rather than among Area Directors. AAIHB supports this proposal to streamline management of IHS direct-care facilities, as we believe that doing so will promote both accountability and uniformity in IHS facility operations. More than half of the Tribes served by AAIHB rely on IHS direct-care facilities, so standardized operational practices across these facilities is a key priority for AAIHB and our Tribal partners.

However, AAIHB would caution against simply adding another layer of management between Area Directors and IHS Headquarters, as doing so may slow down IHS direct-care operations. Instead, if IHS shifts to a new, consolidated accountability system for its direct-care facilities, that system should replace the local area office chain-of-command that is presently in place. In general, AAIHB would urge that through realignment, IHS identify ways to create more direct links between IHS direct-care facilities and IHS Headquarters, as doing so would streamline communications within the agency and avoid the delays and inconsistencies that seem to stem from the current regional approach to management.

Moreover, as discussed in greater detail in Section II.B of these comments, AAIHB would also support efforts by IHS to centralize the agency's coordination with Tribally operated programs from the local area office model to a system that provides a direct line of communication between Tribes and IHS Headquarters.

B. Improved Parternships with Tribes

While AAIHB supports the agency's realignment efforts to exercise more centralized oversight over IHS direct-care facilities, we would also encourage IHS to work toward developing more direct relationships with Tribes.

One way to do so is to incorporate local Tribal leadership in the governance structure over IHS direct-care facilities. Tribal leadership within several IHS service unit areas in our region have repeatedly requested the restoration of local advisory health boards made up of Tribal officials to provide local insight on ways to improve direct-care operations, but these requests have been ignored by the facilities, the area office, and Headquarters. Through its realignment, IHS has the opportunity to accommodate the long-standing requests of Tribal leadership to create and sustain these local boards, which in turn would support Tribal self-governance and improve Tribal communities' trust in, and relationship with, their IHS direct-care providers.

Another way to do so is through engaging Tribes in formal consultation prior to considering permanently closing or scaling-back any IHS facility. Tribes often learn of closure plans only upon the agency's notice of intent to Congress. AAIHB urges IHS to instead formally consult with Tribes early in the agency's deliberative process to close or substantially downsize a facility. Specifically, we would recommend that IHS engage in Tribal consultation at least one-year prior to providing notice to Congress, which would give Tribes a two-year lead time to plan and strategize before their local IHS facility is closed. This would allow the agency and Tribes the opportunity to work together to tackle facility-level challenges before resorting to closures that deprive a community of local care that they have come to rely on. It would also provide impacted Tribes with sufficient time to consider transitioning to a self-determination model ahead of a facility's closure.

C. Recruitment and Retention of Healthcare Providers

Clinical positions within both IHS direct-care and Tribally operated facilities have been understaffed for far too long. Open positions sit vacant for years on end, leading facilities to resort to reducing service delivery or bringing on costly contract, consultant, and locum tenens providers to temporarily fill gaps in care. Temporary staffing contracts not only drain facilities' overburdened budgets, but they leave patients without the opportunity to develop relationships and build trust with long-term providers. Through realignment, AAIHB urges IHS to prioritize creative

recruitment and retention initiatives to reverse this trend. For example, IHS may consider expanding its student loan repayment program, covering moving costs, offering sign-on bonuses, expanding educational pipeline programs such as the Indians into Medicine Program, and allowing employees to work under flexible scheduling policies. These strategies have been successfully implemented by Tribal programs to recruit healthcare providers, even in remote areas.

It is also critical to recruitment and retention efforts that IHS speed up its background check and credentialing systems. The lengthy and cumbersome credentialing process presently used by IHS curtails clinical hiring for both IHS direct-care facilities and for Tribally operated programs that rely on IHS facilities for clinical space. For example, IHS took more than a year to verify the credentials of one of AAIHB's newly hired audiology providers, ultimately leading the provider to resign before he was even granted clinical privileges within the IHS facility to which he was assigned. Slow credentialing wastes time and money, frustrates existing healthcare staff, and lowers the quality of patient care. Realignment presents an opportunity for IHS to expedite credentialing so that all healthcare programs serving Indian country — whether operated by IHS or a Tribe — can quickly and competitively meet their medical staffing needs.

To build efficiencies into the credentialing process, IHS may consider emulating models within the private industry. Private hospitals tend to take between 60 and 180 days to complete credentialing for new healthcare providers. In the meantime, temporary privileges are often granted while a physician's full credentialing is pending. We would urge IHS to hold itself accountable to shorter credentialing timeframes and to consider offering temporary privileges to providers who are awaiting a credentialing determination from IHS. These changes should be applied to both direct-hires of IHS and to providers of Tribally operated programs who will be working within IHS-operated facilities.

Finally, we ask IHS to build more robust accountability systems into the agency's decision to transfer healthcare providers from one facility to another. Although IHS imposes lengthy credentialing verification systems on new providers, the agency seems to seamlessly transfer existing healthcare employees with records of serious misconduct or poor performance between IHS facilities. Doing so provides relief to one IHS facility at the expense of another, wasting scarce management resources on healthcare practitioners who are not fit to provide quality care. Worse, retaining substandard practitioners within the IHS system risks Centers for

Medicare and Medicaid Services ("CMS") certification and accreditation for IHS facilities. We ask that, through realignment, IHS consider imposing corrective action plans on employees with adverse quality-of-care or compliance records before allowing such employees to apply for internal transfers. IHS may also consider routinely auditing its healthcare personnel across all facilities to identify and correct poor performers. Doing so would help to improve patient trust in IHS providers, alleviate direct-care facilities' CMS accreditation concerns, and improve morale among the many IHS physicians who work hard to provide quality care.

D. Impacts of HHS Restructure on IHS

For realignment to have positive impacts, IHS must be cognizant of, and take steps to remedy, the healthcare gaps created throughout Indian country by HHS's program eliminations and reductions. IHS is primarily equipped to deliver acute and primary care services. To meet the needs of their communities, Tribally operated health programs have supplemented IHS's basic services by participating in HHS programs to research the unique health needs of, and deliver specialized and preventive care to, their patients. But many of those HHS programs have now been proposed for elimination, including those supporting maternal and infant health, chronic disease prevention, and injury prevention. IHS must be prepared to fill these gaps by expanding traditional IHS services to re-establish the public health and specialty programs cut from HHS. Doing so will support overall cost savings efforts of HHS while also allowing IHS to directly respond to the specific healthcare needs of Tribes.

For example, IHS must be prepared to support the Tribal Epidemiology Centers that rely on HHS programs presently slated for cuts. AAIHB operates the Albuquerque Area Southwest Tribal Epidemiology Center ("AASTEC"), one of just twelve regional Tribal Epidemiology Centers in the country. AASTEC is the designated public health authority for all Tribal communities within the IHS Albuquerque Area, fulfilling a critical regional need. While AASTEC receives IHS funding, it also relies on funding from programs within the Centers for Disease Control ("CDC") and the Substance Abuse and Mental Health Services Administration ("SAMHSA") that may be terminated by HHS. Even with the recently announced $10 million increase in IHS epidemiology funding adopted by the House Appropriations Committee for FY26, AASTEC and other Tribal Epidemiology Centers would suffer a substantial loss — and may even risk closure — if the CDC's epidemiology funding to Tribes were cut without full replacement

under IHS. We urge IHS to take steps through realignment to avoid such negative consequences as it plans its realignment.

E. Responsiveness to Specific Needs

Finally, agency realignment must prioritize healthcare services that respond to the most pressing needs of Tribal communities, including psychiatric care, immunization access, and community health liaisons.

i. Need for Improved Mental Health, Behavioral Health, and Substance Abuse Treatment Programs

One such need is inpatient and outpatient care for behavioral health, mental health, and substance abuse disorders. None of the 27 Tribes served by AAIHB have a residential substance abuse or psychiatric treatment facility within their communities. Neither IHS-operated nor Tribally operated outpatient facilities are sufficiently equipped to fill this gap in care, as low staffing rates within these clinics result in months-long delays for intake, counseling, and medication management appointments, even for patients in crisis.

As a result, behavioral and mental health patients are left to rely on far away facilities, which may or may not have availability and which offer neither the support network nor culturally competent care that would otherwise be available if located within the patients' home communities. Worse, the vast majority of these off-site treatment facilities do not accept IHS/Tribal/Urban ("ITU") funds as a payment option. Given this, it is not surprising that Native Americans represent the demographic with the highest suicide rates in the country.[3] To address this, psychiatric inpatient care must be incorporated within IHS direct-care facilities and IHS must support —and adequately fund — the same for Tribally-operated facilities. As part of its realignment, we urge IHS to undergo initiatives to fund, construct, adequately staff, and otherwise sustain and support inpatient and outpatient behavioral health, psychiatric, and substance abuse treatment facilities within Indian country.

ii. Need for Improved Vaccination Programming

[3] U.S. Department of Health and Human Services, Office of Minority Health, *Mental and Behavioral Health – American Indians/Alaska Natives*, available at: https://minorityhealth.hhs.gov/mental-and-behavioral-health-american-indiansalaska-natives.

Indian country should have the same opportunity as the rest of the country to determine whether or not to vaccinate based on individual risk factors and health conditions. Native Americans experience significantly worse health outcomes from contagious diseases than other populations, but vaccination rates among patients of the IHS Albuquerque Area District are waning. IHS must ensure that this downward trend is not the result of reduced access to immunization programs within patients' home clinics — whether IHS-operated or Tribally operated — especially as many Tribal communities are isolated from and may not be able to afford alternative vaccination providers.

We recognize that the CDC has recently recommended that eligibility for some vaccines should hinge on patient comorbidities, reducing the nationwide pool of persons eligible for certain vaccinations. However, relative to other demographics, American Indians have the highest rates of comorbidities relevant to adverse communicable disease outcomes, including hypertension, obesity, diabetes, lung disease, and heart disease.[4] In light of this, we urge IHS to take steps to increase, or at least maintain, the supply of vaccines to both direct-care and Tribally operated facilities as the pool of vaccine-eligible patients within IHS is not likely to have been reduced by the revised CDC guidance. We further urge IHS to seek other ways to improve the engagement of Tribal communities in immunization programs. These steps would protect the fundamental rights of Native Americans to make informed decisions to manage their own healthcare risks.

iii. Need for Community Health Representatives

Through realignment, IHS should prioritize securing Community Health Representative ("CHR") programs as a long-term means to address the specific healthcare needs of Tribal communities. CHRs are frontline public health workers in Tribal communities, conducting home visits to provide health education, outreach, and navigational services to patients of IHS facilities. Importantly, CHRs are also trusted community members. As such, CHRs provide services that other healthcare providers cannot, including language translation and culturally relevant patient education. CHRs are a critical piece of the IHS direct-care system, even though they are generally employed through Tribally operated programs.

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[4] U.S. National Center for Health Statistics, Centers for Disease Control, Interactive Summary Health Statistics for Adults, 2019-2024, available at: https://wwwn.cdc.gov/NHISDataQueryTool/SHS_adult/index.html.

Despite broad Tribal support for the CHR program, IHS has historically attempted to eliminate CHRs or replace them with Community Health Aide Programs ("CHAP"), which would be staffed by healthcare workers with higher licensing than CHRs but without the same connections to Tribal communities. While CHAPs may also benefit Tribal communities, the interpersonal and cultural links between CHRs and patients are irreplaceable. Realignment presents an opportunity for IHS to protect CHR programs as an effective model of patient care in Indian country. Doing so would show Tribes that IHS will support the healthcare programs that actually work for Tribal communities rather than simply imposing healthcare models from other communities on Tribes.

II. Enterprise and Operational Management

IHS has acknowledged that current inefficiencies within the agency's internal operations slow down Tribes' administration of healthcare programs. AAIHB supports the agency's realignment efforts to streamline funding, records management, and IT systems, as administrative improvements within these sectors will have positive downstream effects on Tribes' delivery of patient care. For IHS to do so, the agency must prioritize administrative staffing, prompt and uniform program management across all local area office districts, expanded access to patients' electronic records among Tribally hired healthcare providers, and protection against cybersecurity threats.

A. Adequate Administrative Staffing

For improvements through realignment to be successful, the agency must adequately staff its administrative divisions. Administrative personnel and ancillary staff are just as critical to both IHS and Tribal operations as healthcare providers. The agency's administrative employees are relied upon by Tribally operated healthcare programs to timely communicate agency decisions, secure revenue to sustain and expand clinical care services, process and navigate referral systems for specialty care, and administer funds.

Although Secretary Kennedy has repeatedly voiced the importance of maintaining current staffing levels within IHS, the agency has lost employees through its voluntary buyout and early retirement programs and has implemented a hiring freeze for administrative personnel. Moreover, the President's proposed

FY26 budget represents a loss of 7% of IHS staff since the President took office.[5] AAIHB is concerned that these policies will lead to stalled funding and operations for Tribal programs.

Administrative staff are not only essential within IHS Headquarters, but also within IHS direct-care facilities, where significant backlogs for Purchased/Referred Care, billing, and collections are common. Administrative billing and collections staff are crucial to supporting facility's budgets. Similarly, staff vacancies within direct-care facilities' human resources, patient registration and scheduling, and records management departments result in poor management outcomes that impact staff and patient retention alike. Without adequate administrative support, IHS direct-care facilities are unable to operate smoothly or deliver quality care.

Thus, AAIHB urges IHS to implement policies to fill administrative vacancies and increase administrative positions within both the agency's Headquarters and in IHS direct-care facilities. Doing so will be key to the agency's realignment efforts to improve both accuracy and speed in distributing funds and issuing program determinations to Tribal programs, as well as in providing well-managed patient care within IHS-operated clinical programs.

B. Prompt and Uniform Program Administration

We also request that through realignment, IHS prioritize prompt and uniform program administration across all local area service units. AAIHB encourages IHS to do so by providing its administrative and local area office staff with sufficient training, support, and oversight to ensure that their duties are accomplished efficiently and uniformly across all local area service units.

AAIHB would also encourage IHS to consider linking Tribally operated healthcare programs directly to Headquarters for program administration, decisions, and communications, rather than routing Tribes through local area offices. Presently, local area offices direct nearly all Tribal programs' questions — even those that are simple and straightforward — up to IHS Headquarters or the agency's Office of General Counsel. When this happens, Tribes are left with no response at all, even when an immediate decision is warranted. Realignment

[5] When the President took Office, IHS was operating under the FY 2024 Budget, which funded 8,923 FTEs. However, the proposed FY 2026 Budget funds only 8,293 FTEs, which is consistent with the FY 2025 Budget but lower than the FY 2024 Budget. We urge IHS to implement staff levels that are at least as high as FY 2024.

efforts should seek to improve how IHS makes and communicates decisions to Tribes. If Tribal programs remain relegated to area offices for purposes of program administration, area offices should not be permitted to simply defer decisions to Headquarters with no accountability for a timely response. AAIHB recognizes and appreciates that IHS's proposed shift to a DDFO model of management and accountability for IHS facilities may address this specific concern for direct-service Tribes, but AAIHB urges that standardized and centralized accountability should be applied to the agency's coordination with all Tribes, including those that operate their own healthcare programs.

Building direct links between Tribes and IHS Headquarters would also standardize agency decision-making for Tribally operated healthcare programs across the country rather than allowing for contradictory practices between different area offices. Historically, AAIHB has had program requests denied by its local area office, even when the same requests by other Tribal health programs were approved in other IHS regions. For example, AAIHB requested permission from the local area office to implement a research program to study new strategies to increase uptake of colorectal cancer screening among American Indians. After three years of delays, AAIHB's request was denied even though a related request from another Tribal program in a different region had been approved. Similarly, it took nearly four years for the local area office to approve AAIHB's request to conduct data linkages to improve the accuracy of tribal public health surveillance in our service area, despite far more expedited approvals by other Area Directors for the Tribal program led data linkages within their regions. These inconsistencies across IHS regions make it difficult for Tribes to effectively manage and strategically plan their healthcare programs. IHS's realignment efforts should focus on holding regional decision makers accountable to both agency management and Tribes, including by providing direct connections between Tribal programs and Headquarters staff.

Realignment should also prioritize efficient decision-making within IHS Headquarters itself, where internal delays can have catastrophic consequences for Tribal healthcare programs. For instance, last year, IHS delayed its administration of the Community Opioid Intervention Prevention Program for a period of nine months, leading to AAIHB's forced suspension of the program. IHS did not advise Tribes as to why the program was stalled, how long the suspension period would last, or whether funding would continue at all. The suspension period risked

permanent losses to Tribal programs' clinical and administrative staff as limited Tribal budgets were left to absorb the costs of slow-downs and uncertainty within IHS. Worse, the suspension period postponed care for patients in need of emergency substance abuse interventions. AAIHB urges IHS to use its realignment process to prioritize internal accountability within the agency so that Tribes and patients can confidently rely on the programs administered by IHS rather than worrying that such programs may be suddenly halted without notice.

C. Electronic Record System Access and Data Sharing

In its realignment efforts, IHS should prioritize streamlining and standardizing security procedures for Tribal healthcare providers to be cleared to access IHS patients' electronic health records. Often, healthcare providers hired or contracted by AAIHB and other Tribally operated healthcare programs practice in coordination with IHS direct-care facilities. Many work on-site at IHS facilities. Others, such as CHRs and Special Diabetes Program for Indians ("SPDI") staff, coordinate care between IHS direct-care facilities and their patients. In these situations, patient care would improve if Tribal medical personnel could access their patients' records within the IHS system and log relevant notes for IHS direct-care providers. Patients expect as much and are frustrated when their healthcare providers from Tribally operated programs cannot see their medical histories or interact with their IHS charts. Even when patients have expressly authorized records-sharing, AAIHB's healthcare providers are routinely blocked from accessing their patients' records through the agency's electronic system. Instead, Tribal healthcare providers are routed through a maze of security clearance protocols that vary from facility-to-facility and that never appear to result in any determination at all, let alone a determination of clearance. Realignment presents a prime opportunity for IHS to institute uniform electronic records policies that clearly state what is required for healthcare providers from Tribally operated programs to obtain clearance to access their patients' electronic records through IHS. These policies should impose deadlines on IHS-operated facilities to approve a Tribal provider's access request as long as the provider has fulfilled all requisite criteria.

Additionally, AAIHB urges IHS to address Tribes' need for aggregate, anonymous public health data from IHS direct-care facilities. Tribal leaders need up-to-date data on their communities' healthcare needs and on the efficacy of specific healthcare interventions. IHS direct-care facilities have that data. Tribal

leadership recognizes that IHS is prohibited from sharing its patients' Protected Healthcare Information. However, IHS should not use legal protections applicable to individual patient records as an excuse to withhold summary statistics or other forms of deidentified, aggregate public health data from Tribes. Doing so frustrates the ability of Tribes to understand and manage the specific healthcare needs of their Tribal Members. AAIHB and our partner Tribes have repeatedly requested this type of data from both IHS Service Units and the Albuquerque Area Office, but our requests have either gone unanswered or have been denied without explanation. For IHS to meet its federal trust responsibility to Tribes, the agency must ensure that Tribes have sufficient information to drive public healthcare policies for their communities. We urge IHS to direct or even automate such data-sharing between IHS-facilities and Tribes as part of its realignment process.

D. Cybersecurity Vulnerabilities

We also urge IHS to ensure that its sensitive patient data is adequately protected from cybercrime. As recently as this summer, users of on-premises SharePoint servers within IHS direct-care facilities were notified of a critical vulnerability exposing the server's data to cyber theft. Our Tribal partners who rely on IHS facilities must have assurance that their Tribal Members' sensitive healthcare and financial information is protected from unauthorized disclosures and malicious actors. Realignment presents an opportunity for IHS to assess the cyber protections its facilities presently have in place and to reinforce or supplement those protections wherever necessary.

III. Supporting Tribal Self-Determination

Realignment efforts should be tailored to support the inherent rights of self-determination and self-governance of every Tribe, regardless of how health care is administered within that Tribe. To do so, IHS must secure adequate funding for IHS direct-care and Tribally operated facilities alike. IHS must also improve its process for Tribes to transition their communities' IHS direct-care programs and facilities into Tribal ownership and operation.

A. Funding

The primary way for IHS to support Tribal self-determination is to ensure that healthcare programs across Indian country, whether operated by IHS or by Tribes, are adequately funded. Current funding levels do not meet the healthcare needs of

Tribes. Although an estimated $73 billion is needed for health care in Indian country,[6] the President's proposed budget for FY26 provides only 11% of that to IHS. The poor health outcomes of Native Americans as compared to other demographics reflect the dismal reality that healthcare funding in Indian country falls far short of the need.

AAIHB and our Tribal Epidemiology Center operate through self-determination funding agreements and competitive grants to manage our healthcare programs. AAIHB presently relies upon the following IHS funding streams:

- Self-Governance Contracts
  - $1.5 million to provide audiology services.
  - $100,000 to administer HIV prevention programs.

- Office of Environmental Health & Engineering, Injury Prevention Program – *Tribal Injury Prevention Cooperative Agreement Program*
  - $125,000 annually over a 5-year period to address the high-rate of injury-related deaths among American Indians.

- Division of Behavioral Health - *Community Opioid Intervention Prevention Program*
  - $500,000 annually for a 5-year period to research, prevent, and treat opioid addiction and related substance abuse disorders.

- Office of Clinical and Preventive Services, Division of Clinical and Community Services - *Ending the HIV/HCV/Syphilis Epidemics in Indian Country ("ETHIC")*
  - $200,000 annually over a 3-year period to address communicable diseases like HIV, hepatitis C, and syphilis.

- Division of Epidemiology and Disease Prevention – *Epidemiology Program Cooperative Agreements*
  - $3.6 million over a 5-year period to support the Albuquerque Area Southwest Tribal Epidemiology Center ("AASTEC"), one of just

[6] IHS National Tribal Budget Formulation Workgroup, *The Federal Trust Responsibility to Tribal Nations: A Strategy to Advance Indian Health Care,* (April 2025), available at: https://www.nihb.org/wp-content/uploads/2025/04/fy-2027-ntbfwg-budget-book.pdf.

twelve regional Tribal Epidemiology Centers in the country and the designated public health authority for the region's Tribes.

Elimination or reduction of any of these funding sources would greatly impact the healthcare capacity of AAIHB and our 27 partner Tribes. Even flat funding would hurt our ability to continue to manage our own healthcare programs, given the cuts proposed for HHS. We would strongly urge against IHS using its realignment approach as a means to reduce programmatic funding. To the contrary, to support Tribal self-determination in health care, IHS must seek to increase the total funding available to Tribally operated programs.

AAIHB recognizes that IHS's proposed realignment may present an opportunity for the agency to save on administrative costs, an initiative which we support. We would encourage IHS to consider awarding the administrative dollars saved by the agency directly to Tribally operated healthcare programs to support public health services and direct patient care. We would also encourage IHS to address barriers for Tribally operated programs to efficiently access funds, such as burdensome drawdown procedures and reporting requirements. Doing so would reduce administrative costs for IHS and Tribes alike and would allow us to maximize resources for patient care.

We also urge IHS to support advanced appropriations for all healthcare programs in Indian country. IHS-operated healthcare facilities are at risk of shutting down entirely each time Congress fails to timely adopt a budget. Temporary closures of federal healthcare facilities impede Tribal self-governance, as Tribes end up diverting their non healthcare resources, like law enforcement and social services personnel, to respond to crises that ultimately require healthcare intervention. Even for those Tribes with multi-year self-determination agreements, the long-term strategic planning necessary to operate an effective healthcare system and to build community-wide patient trust is hampered when federal funding is constantly in the news as under threat. Thus, supporting advanced appropriations is a means for IHS to support Tribal self-determination.

Additionally, we urge IHS to prioritize the timely administration of the contract support costs to which Tribes are now entitled pursuant to the U.S. Supreme Court's decision in *Becerra v. San Carlos Apache Tribe / Northern Arapaho Tribe*. IHS must efficiently process and approve post-award and ongoing

contract support cost claims so that Tribal programs can finally operate under the budgets that they should have had in place decades ago.

B. Improved Transitions to Tribal Self-Governance

Tribal self-determination not only requires stable and predictable funding for existing Tribally operated healthcare programs, but it also demands an accessible and efficient process to transition IHS facilities and programs into Tribal ownership. It presently takes months, or even years, for Tribes to negotiate agreements with IHS. Even after negotiations are complete, Tribes must wait substantial amounts of time to be reimbursed for the up-front costs they incurred in assuming new programs. The prolonged nature of this process punishes Tribes for simply seeking control over their own healthcare systems. Worse, it discourages lower-resourced Tribes from even attempting to transition into self-determination.

To remedy these delays and the cost-burdens they create for Tribes, IHS should streamline the entire transition process, including by changing the culture and operations within the agency's self-determination negotiations teams. For instance, IHS should emphasize to its negotiations staff the importance of teamwork between the agency and Tribes rather than promoting adversarial negotiations tactics. IHS should also ensure that negotiations teams are adequately staffed to provide Tribes with constant access. Further, IHS negotiations staff must be held accountable to meet internal benchmarks and deadlines to ensure that self-determination transitions move forward at an acceptable pace. Finally, IHS should work to shift the culture within its negotiations teams to establish that, when desired by Tribes, Tribal control over healthcare operations is an agency goal to be efficiently pursued not just a Tribal request to be considered.

AAIHB also urges IHS to consider through realignment how to support seamless transitions from federal to Tribal operations once self-determination agreements are executed. Presently, upon a funding agreement's execution, IHS abruptly hands off all administrative, record keeping, IT, and facilities maintenance functions to Tribes without any opportunity to maintain existing practices for a temporary transition period. Moreover, when Tribes assume operations of healthcare programs housed within IHS-operated facilities, IHS isolates the Tribal programs from the rest of the facility's healthcare teams, cutting Tribal programs off from the facility's referral processes, records systems, and other facility-based supports. These poor transition procedures frustrate patients and providers alike.

AAIHB urges IHS to use its realignment process to implement policies to support the smooth transfer of facility and program operations from the agency to Tribes so that even after a funding agreement's execution, the agency may temporarily continue to provide operational support for a transition period, if requested by the Tribe. Such policies should emphasize the importance of Tribal control in determining how facility transitions should be timed and executed.

IV. Tribal Advisory Committees

Finally, AAIHB recommends that IHS maintain each of its Tribal Advisory Committees ("TAC") as a critical part of the government-to-government relationship between AAIHB, its partner Tribes, and IHS. AAIHB understands that IHS is considering consolidating all nine of its TACs into one. AAIHB strongly recommends against doing so. The TACs cover such a breadth of subject matter — from funding to facilities to diabetes care to behavioral health — that the members of one consolidated TAC could never be subject matter experts in all relevant areas.

We would also urge IHS to provide all TAC members with advanced stipend funding to support their travel and participation in meetings. Presently, some TACs provide stipends on a reimbursement basis, with reimbursements directed to individual TAC members rather than to the Tribal programs that employ or fund those members. This leaves TAC members responsible for their own travel costs upfront, thus shrinking the pool of eligible candidates willing to serve.

Finally, AAIHB encourages IHS to implement policies requiring TACs to meet consistently, even among transition periods in agency leadership. Many of the TACs have not yet met this year, leaving Tribes out of important policy discussions during a critical period of transition for IHS. Changes in agency leadership should not reduce Tribes' opportunities to participate in IHS's policy making.

V. Conclusion

We thank IHS for engaging in this Tribal consultation and for the opportunity to offer these written comments. Even so, to uphold IHS's federal trust responsibility to Tribes, IHS should reinitiate this formal consultation process once the agency has more concrete plans relating to its realignment. Until the agency communicates how specifically it intends to restructure its operations and programs, Tribes are unable to meaningfully comment on how those changes may impact Tribal healthcare operations. We appreciate IHS's early engagement and

hope that this Tribal consultation period represents the beginning of the realignment conversation between the agency and Tribes.

Sincerely,

Ayn Whyte
Executive Director
Albuquerque Area Indian Health Board