AAIHB
Albuquerque Area Indian Health Board Inc.

Board Represented Tribes

Jicarilla Apache Nation
Mescalero Apache Tribe
Ramah Band of Navajo
Southern Ute Indian Tribe
To'Hajiilee Band of Navajo
Ute Mountain Ute Tribe

February 26, 2026

The Honorable Robert F. Kennedy Jr.
Secretary of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201
consultation@hhs.gov

Clayton Fulton, Acting Director
Indian Health Service, Headquarters
consultation@ihs.gov

RE: IHS Proposed Realignment

Dear Secretary Kennedy and Acting Director Fulton:

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 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 which 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.

[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 government 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.

We appreciate IHS's stated commitment to Tribal consultation as the agency develops its realignment strategy. Realignment presents a significant opportunity to improve operational efficiency, strengthen accountability, and enhance responsiveness to Tribes - outcomes that are essential to improving health care delivery across Indian Country. That said, any major restructuring of the primary federal agency responsible for providing health care to American Indian and Alaska Native people must be carefully considered, in full alignment with tribal priorities, and not rushed. We strongly urge IHS leadership to delay implementation of any realignment for a minimum of 6 months following the conclusion of the tribal consultation process. This delay is necessary to ensure that Tribal feedback is meaningfully incorporated into the final realignment plan, rather than treated as an afterthought. Tribes must have a substantive role in shaping these decisions - not merely the opportunity to respond after implementation has already begun. Although IHS considers its consultation with Tribal leaders to have begun in June 2025, no specific details about realignment plans were provided until December 2025. Therefore, the process feels unnecessarily rushed and devoid of meaningful tribal input.

We also strongly urge the IHS to maintain the current tribal composition within each IHS Administrative Area. Any changes to this composition should be subject to a separate tribal consultation, and not be implemented until this consultation has been completed and documented approval is obtained from leadership within the affected Tribe(s). At the same time, AAIHB wants to emphasize the critical importance of having a Senate-confirmed, permanently appointed IHS Director in place during implementation. Major structural decisions such as agency realignment require stable, accountable leadership with the authority and continuity to engage in meaningful consultation, respond to Tribal concerns, and oversee implementation in a manner consistent with the federal trust responsibility. Proceeding with a significant realignment absent an appointed Director risks undermining transparency, accountability, and Tribal confidence in the process. We therefore urge the Administration to prioritize the appointment and confirmation of an IHS Director and to refrain from advancing major realignment actions until permanent leadership is in place.

1. Indian Health Service Programs

Although not included in the predecisional realignment documents, we strongly urge the agency to retain each of the following Indian Health Service programs, and to ensure that they are fully funded and fully operational: Division of Epidemiology and Disease Prevention, Tribal Epidemiology Centers (TEC), Special Diabetes Program for Indians (SDPI), Community Health Representatives (CHR), Division of Behavioral Health, Injury Prevention, and HIV/HCV/STI Program. These programs provide critical, life-saving services and deliver substantial value to Tribes and Tribal organizations nationwide. The majority focus upon public health initiatives that support health promotion and disease prevention which are highly cost-effective, reduce the burden of illness and disease, and avoid long-term, expensive chronic disease management. Any proposed changes to the structure, placement, or funding of these

programs must be subject to a separate and specific Tribal consultation, as they have not been included in the current realignment proposals or consultation sessions. In addition, these programs should be explicitly identified on the agency's organizational chart to ensure transparency, accountability, and continued Tribal confidence in their stability and support.

a. Tribal Epidemiology Centers

With regard to the Tribal Epidemiology Center (TEC) Program, we strongly urge IHS to continue to sustain 12 Tribal Epidemiology Centers (TECs), one in each IHS Area as well as an Urban Indian serving TEC. TECs are public health authorities that significantly enhance epidemiology and public health support and capacity among all 575 federally recognized tribes and urban AI/AN populations. The TECs have successfully worked with IHS, Indian Tribes, Tribal organizations, and Urban Indian organizations for more than 30 years to collect data; monitor health status objectives; evaluate systems that impact the improvement of Indian health; assist in identifying highest-priority health status objectives and the services needed to achieve those objectives; make recommendations for improving health care delivery systems and services needed; provide technical assistance in the development of tribal health service priorities and incidence and prevalence rates of health conditions in tribal communities; and provide disease surveillance and outbreak response to assist Tribes, Tribal organizations, and Urban Indian communities to prevent disease and promote public health. Through the years, TECs have established and sustained highly effective and trusting partnerships with Tribes in their respective service areas – an essential ingredient to advance critical public health initiatives that are aligned with tribe-specific priorities and honor important cultural considerations.

b. SDPI

The Special Diabetes Program for Indians (SDPI) provides critical resources for diabetes treatment and prevention, and has demonstrated significantly improved health outcomes for American Indian and Alaska Native (AI/AN) communities, where Type 2 Diabetes continues to be disproportionately elevated. For example, since 1997, SDPI has led to a 37% reduction in diabetes-related mortality, a 54% reduction in end-stage renal disease, and sustained decreases in diabetes prevalence. As a result of this program, AI/AN communities now have much needed diabetes resources and increased access to quality diabetes care. There is also strong evidence that the SDPI program has significantly reduced Medicare spending by preventing diabetes-related complications, saving an estimated $436 to $520 million over a ten-year period. Consequently, there is an urgent need to protect the SDPI program to sustain these community-directed programs that bring high value and impact by tailoring diabetes prevention and treatment to local needs.

c. CHR

Through realignment, IHS has an important opportunity to affirm and strengthen the Community Health Representative (CHR) program as a cornerstone of effective, community-

driven health care in Tribal communities. CHRs are frontline public health workers who conduct home visits and provide health education, outreach, care coordination, and navigation services for patients served by IHS facilities. Just as importantly, CHRs are trusted members of the communities they serve, uniquely positioned to bridge health systems and community needs.

Because of these trusted relationships and cultural connections, CHRs provide forms of care that cannot be replicated elsewhere, including language interpretation, culturally grounded patient education, and sustained engagement with patients and families. Although CHR programs are generally operated by Tribes, they are an indispensable part of the IHS direct care system and contribute directly to improved access, continuity and coordination of care, and better health outcomes.

Realignment presents a positive opportunity for IHS to invest in and protect CHR programs as a proven model of patient-centered care in Indian Country. Doing so would send a clear and affirming message that IHS is committed to supporting community-driven solutions and strengthening health care models that Tribes know work best for their people.

d. Division of Behavioral Health

Indian Country continues to experience pervasive and chronic behavioral health needs. Tribes throughout our area have long recognized how deeply substance use disorders impact their communities and the healing that can occur when our relatives receive effective treatment and support on their recovery journeys. In our Area and nationwide, there are also high rates of depression and suicide. Our tribes need a substantial investment of resources to address mental health provider shortages and expand services. We are particularly concerned about our AI/AN youth. Suicide is the second leading cause of death for AI/AN adolescents and young adults. At the same time, however, many barriers impact access, quality, and availability of health, behavioral health, and related services for AI/AN people. These issues include provider and personnel shortages, limited resources, and obtaining services without traveling great distances. There is a need for increased and sustained funding to support behavioral health initiatives and interventions in Indian Country. This should include initiatives to strengthen the tribal behavioral workforce. At a minimum, we urge the agency to fully support the continuation of its current behavioral health programming including the Community Opioid Intervention Pilot Project, Domestic Violence Prevention, Substance Abuse and Suicide Prevention, Treatment and Aftercare, Youth Regional Treatment Center Aftercare Program, and the Zero Suicide Initiative.

e. Injury Prevention

The Indian Health Service (IHS) Injury Prevention Program (IPP) provides essential funding and other resources to support Tribes to build capacity, reduce high injury rates (leading cause of

death for Native Americans age 1-44), and implement evidence-based strategies to lower the burden of unintentional injury. Injury prevention strategies—such as seat belt usage, helmet laws, and improved environmental safety—are crucial in reducing years of potential life lost (YPLL) from unintentional injuries, particularly among American Indian/Alaska Native children and young adults. By targeting leading causes like motor vehicle accidents, falls, and suffocation, these interventions decrease premature mortality and associated economic burdens. The IHS IPP must therefore be sustained in realignment. Additionally, the Tribal Injury Prevention Cooperative Agreement Program (TIPCAP) should be expanded to support more than the few dozen tribes and tribal organizations that currently receive this vital funding. For example, no tribes or tribal organizations within the IHS Albuquerque Area were funded for the 2026-2030 TIPCAP cycle despite tremendously high need to develop infrastructure that supports targeted strategies to reduce motor vehicle fatalities, falls, and injuries, such as car seat clinics, home assessments, and evidence-based fall prevention programs.

f. HIV/HCV/STI Program

The Indian Health Service (IHS) STI Initiative combats rising STI rates in AI/AN communities through a comprehensive approach, focusing on education, prevention, and increased access to testing and care. Cost analyses have demonstrated that preventing sexually transmitted infections (STIs) significantly reduces U.S. health care expenditures, with every $1 spent on prevention saving an estimated $7.09 in direct medical cost. IHS's current syndemic approach further maximizes resources by recognizing the connection between HIV, Hepatitis C, and other STIs and coordinating care to address all these infections simultaneously. It is also important to note that Hepatitis C, HIV, and syphilis can be transmitted from mother to infant (vertical transmission) during pregnancy or childbirth, leading to serious, rising health issues in children. Early testing, preventive intervention, and treatment are critical. As a priority of realignment, IHS must continue to fund tribes and tribal organizations to adopt a four-pillared approach to STI control throughout Indian Country – diagnosing STIs early, treating rapidly and effectively, preventing new infections, and responding quickly to potential outbreaks. Any realignment of Indian Health Service programs must recognize that HIV, Hepatitis C, and sexually transmitted infection prevention efforts are not ancillary services, but essential components of comprehensive, culturally responsive healthcare for Tribal communities. Tribal Nations continue to experience disproportionate impacts from HIV, HCV, and STIs due to historic underfunding, geographic barriers, and limited access to specialty and preventive care. Community-based and Tribal-serving prevention programs are effective because they are rooted in trust, cultural knowledge, and long-standing relationships, often serving as the first—and sometimes only—point of access for education, screening, linkage to care, and harm reduction services.

2. Tribal Advisory Committees

AAIHB recommends that IHS retain its Tribal Advisory Committees (TACs) as a core component of its government-to-government relationships with Tribes, and that **Tribal representation continue to be maintained at the Area—not regional—level**. These TACs include the Contract Support Costs Advisory Group (CSCAG); Direct Service Tribes Advisory Committee (DSTAC); Director's Workgroup on Improving Purchased/Referred Care (PRC Workgroup); Facilities Appropriations Advisory Board (FAAB); Information Systems Advisory Committee (ISAC); National Tribal Advisory Committee on Behavioral Health (NTAC); National Tribal Budget Formulation Workgroup (NTBFWG); Tribal Leaders Diabetes Committee (TLDC); and the Tribal Self-Governance Advisory Committee (TSGAC).

Each of these TACs serves a distinct purpose and must remain separate, with Area-level representation preserved. While we recognize that IHS may determine that consolidation of certain Tribal Advisory Committees is necessary, any such consideration must be preceded by meaningful Tribal consultation and accompanied by full transparency regarding the rationale, scope, and potential impacts of consolidation. Maintaining this structure, and engaging Tribes early and consistently, is critical to ensuring that the diverse perspectives of Tribes across all IHS Areas are meaningfully represented and that Tribes continue to have consistent, direct communication with agency leadership. It is also important to consider that any changes to representation across IHS TACs may also have unintended consequences for representation on TACs operated by other HHS agencies, i.e., CDC, NIH, etc. Currently, membership on these TACs follows the IHS Service Area model for representation, which again must be preserved to maintain diverse perspectives of Tribes across all IHS Areas.

3. Service Unit Health Boards and Workforce Initiatives

While AAIHB supports the agency's realignment efforts to exercise more regional oversight over IHS direct-care facilities, IHS must incorporate local Tribal leadership within the governance structure over these facilities. Tribal leadership within several IHS service unit catchment areas in our region have repeatedly requested the restoration of local advisory/governance health boards made up of Tribal officials to oversee IHS direct-care facilities, but these requests have been ignored by IHS 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.

At the same time, both IHS direct-care and Tribally operated facilities have been understaffed for far too long. Open clinical positions sit vacant for years on end, leaving 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 – a demonstrated pathway to improved

health outcomes. Through realignment, AAIHB urges IHS to prioritize creative recruitment and retention initiatives to reverse this trend.

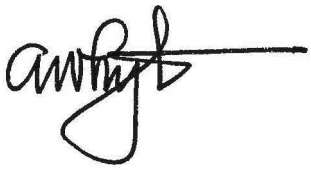
One way to accomplish this is by significantly improving the agency's background check and credentialing systems. The lengthy and cumbersome credentialing process presently used by IHS curtails clinical hiring for both IHS direct-care facilities and for Tribally operated programs that rely on IHS facilities 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. Other recruiting and retention initiatives by IHS may include providing student loan repayment, covering moving costs, offering sign-on bonuses, expanding pipeline programs such as the Indians into Medicine Program, and allowing flexible scheduling. These strategies have been successfully implemented by Tribal programs to recruit healthcare providers, even in remote areas.

4. Public Law 93-638 Contracting

Finally, AAIHB currently has a 638 contract with IHS to provide clinical audiology services to the majority of Tribes who have left their shares with the IHS ABQ Area Office. It is not clear in the current realignment plan if this contract will be negotiated and administered at the area, regional, or headquarter level? If this contract is moved for management at the regional or headquarter level, those residuals were negotiated based on a certain number of positions tied to specific functions within the Area Office. If these positions will no longer be performing those functions full-time for Area Tribes, then we recommend that the portion of those positions' salaries that will be spent performing duties for other Areas or Headquarters (the "savings") should be distributed to Area Tribes. This would ensure no tribal shares are actually impacted by IHS's realignment efforts. It is also critical that any consolidation of 638 contract management to the regional or headquarters level does not impact the timeliness of fully executing these contracts, which is essential to ensure an interrupted flow of service delivery to patients throughout our service area.

We thank IHS for the opportunity to offer these written comments. As realignment planning and implementation continues, we urge IHS to uphold tribal sovereignty and the agency's Tribal Consultation Policy and work in partnership with Tribes to ensure they have unfettered access to the critical resources and services needed to address current and future public health challenges, and support, strengthen, and sustain the health and wellness of American Indian and Alaska Native people.

Sincerely,



Ayn Whyte, M.S.
Executive Director
Albuquerque Area Indian Health Board