BEHAVIORAL HEALTH EXECUTIVE COMMITTEE · WRITTEN SUBMISSION

The Tribal Allocation Under the Behavior Health Reform and Investment Act (BHRIA) Regional Funding Formula

Findings and a proposed correction to the funding formula methodology

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Summary

The funding formula approved by this committee on January 20, 2026 derives each region's Native American allocation by subtracting an Indian Health Services (IHS)-based population proportion from regional shares that have already been calculated by a four-factor formula. This produces allocations in regions with no tribal government, no allocation in a region that has one, a statewide tribal share (9.50%) with no by-tribe dividing mechanism provided, and a reliance on a federal dataset that, according to the IHS Principal Statistician, should not be used to measure population or need. Additionally, the data used in the current funding formula was incomplete: Eddy County's service population was dropped from the calculation because of a text format issue.

The new funding proposal sets aside 10% of the $110M appropriation ($11,000,000) before the regional four-factor formula is applied. Dividing that 10% (tribal hold) equally among New Mexico's 23 Pueblos, Tribes, and Nations (PTNs) results in **$478,261 per government**. The IHS dataset is removed entirely from funding calculations. Following this initial calculation the committee approved four-factor formula can be applied to the remaining $99,000,000 at unchanged weights (20% equal base; 30% population; 35% service gaps; 15% disproportionate impact). Under BHRIA Section 3(B)(3) authority to establish funding strategies and structure, the committee may adopt this revision without statutory change. However, two protections should be adopted with it: tribal shares may not be repurposed under Section 6(B) without the written consent of and/or sufficient notice to the affected government, and unclaimed shares revert to the behavioral health trust fund on a date certain rather than to the region.

The current funding formula and proposed revision are presented as Figures 1 and 2, respectively.

Figure 1. Current Funding Formula

	A	B	C	D	E	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	Y
1																						
2						$ 110,000,000.0																
3								*20%*			*30%*			*35%*			*15%*		Total			
4								$ 22,000,000.0			$ 33,000,000.0			$ 38,500,000.0			$ 16,500,000.0		$ 110,000,000.0			
5																						
6		Region	NM'sTotal Population		Native American Service Population	% of Regions Native American Service Population		Equal Base (20%)		%	Population (30%)		%	Service Gaps (35%)		%	Disproportionate Impact (15%)		Sum	Native American Allocation	TOTAL Region Allocation (Minus Native American Allocation)	
7		1	218,942		16,191	7.4%		$ 1,692,307.7		10.2%	$ 3,375,659.5		6.6%	$ 2,555,144.6		6.6%	$ 1,095,062.0		$ 8,718,173.8	$ 644,718.5	$ 8,073,455.3	
8		2	670,922		48,947	7.3%		$ 1,692,307.7		31.3%	$ 10,344,311.3		3.2%	$ 1,231,944.7		3.2%	$ 527,976.3		$ 13,796,540.0	$ 1,006,524.2	$ 12,790,015.8	
9		3	232,198			0.0%		$ 1,692,307.7		10.8%	$ 3,580,041.2		3.6%	$ 1,391,413.1		8.6%	$ 1,421,319.9		$ 8,085,081.9	$ -	$ 8,085,081.9	
10		4	34,726			0.0%		$ 1,692,307.7		1.6%	$ 535,407.3		8.6%	$ 3,319,406.6		7.1%	$ 1,175,102.8		$ 6,722,224.5	$ -	$ 6,722,224.5	
11		5	202,743		1,941	1.0%		$ 1,692,307.7		9.5%	$ 3,125,902.4		8.6%	$ 3,302,296.3		8.6%	$ 1,415,269.8		$ 9,535,776.2	$ 91,292.6	$ 9,444,483.6	
12		6	57,706			0.0%		$ 1,692,307.7		2.7%	$ 889,714.2		10.1%	$ 3,901,158.3		8.6%	$ 1,424,425.0		$ 7,907,605.2	$ -	$ 7,907,605.2	
13		7	35,966		2,715	7.5%		$ 1,692,307.7		1.7%	$ 554,525.7		13.0%	$ 4,996,220.3		6.5%	$ 1,068,737.3		$ 8,311,790.9	$ 708,401.0	$ 7,603,389.9	
14		8	50,662		3,491	6.9%		$ 1,692,307.7		2.4%	$ 781,109.4		7.5%	$ 2,874,537.7		8.5%	$ 1,396,944.7		$ 6,744,899.5	$ 453,405.5	$ 6,291,494.0	
15		9	67,180			0.0%		$ 1,692,307.7		3.1%	$ 1,035,784.8		7.1%	$ 2,714,841.2		7.1%	$ 1,163,503.4		$ 6,606,437.0	$ -	$ 6,606,437.0	
16		10	9,880			0.0%		$ 1,692,307.7		0.5%	$ 152,330.4		8.4%	$ 3,216,744.6		5.4%	$ 883,604.8		$ 5,944,987.4	$ -	$ 5,944,987.4	
17		11	189,544		116,129	61.3%		$ 1,692,307.7		8.9%	$ 2,922,399.5		7.4%	$ 2,847,161.1		8.9%	$ 1,467,711.9		$ 8,929,580.3	$ 5,319,299.5	$ 3,610,280.8	
18		12	101,314		7,217	7.1%		$ 1,692,307.7		4.7%	$ 1,562,064.7		5.7%	$ 2,190,124.0		10.7%	$ 1,763,624.6		$ 7,208,120.9	$ 454,695.1	$ 6,753,425.8	
19		13	268,565		41,315	15.4%		$ 1,692,307.7		12.5%	$ 4,140,749.5		10.3%	$ 3,959,007.6		10.3%	$ 1,696,717.5		$ 11,488,782.3	$ 1,767,389.8	$ 9,721,392.5	
20			**2,140,348**		**237,946**			**$ 22,000,000.0**		**100%**	**$ 33,000,000.0**		**100%**	**$ 38,500,000.0**		**100%**	**$ 16,500,000.0**		**$ 110,000,000.00**	**$ 10,445,726.23**	**$ 99,554,273.8**	
21																						
22																						
23																			**Native American Allocation**	$ 10,445,726.23		
24																			**Total Allocation** (Minus Native American Allocation)	$ 99,554,273.77		
25																			**SUBTOTAL**	**$ 110,000,000.00**		
26																						
27																						
28																						
29																						
30																						

Figure 2. Proposed Funding Formula

		$ 99,000,000.0									
		20%		*30%*		*35%*		*15%*	Total		
		$ 19,800,000.0		$ 29,700,000.0		$ 34,650,000.0		$ 14,850,000.0	$ 99,000,000.0		
Region	NM's Total Population	Equal Base (20%)	%	Population (30%)	%	Service Gaps (35%)	%	Disproportionate Impact (15%)	New Region Sum	NEW Native American Allocation	TOTAL Regional Allocation w Native Allocation Included
1	218,942	$ 1,523,076.9	10.2%	$ 3,038,093.5	6.6%	$ 2,299,630.2	6.6%	$ 985,555.8	$ 7,846,356.4	$ 3,347,826.1	$ 11,194,182.5
2	670,922	$ 1,523,076.9	31.3%	$ 9,309,880.2	3.2%	$ 1,108,750.3	3.2%	$ 475,178.7	$ 12,416,886.0	$ 956,521.7	$ 13,373,407.8
3	232,198	$ 1,523,076.9	10.8%	$ 3,222,037.1	3.6%	$ 1,252,271.8	8.6%	$ 1,279,187.9	$ 7,276,573.7		$ 7,276,573.7
4	34,726	$ 1,523,076.9	1.6%	$ 481,866.6	8.6%	$ 2,987,466.0	7.1%	$ 1,057,592.6	$ 6,050,002.0		$ 6,050,002.0
5	202,743	$ 1,523,076.9	9.5%	$ 2,813,312.2	8.6%	$ 2,972,066.7	8.6%	$ 1,273,742.9	$ 8,582,198.6		$ 8,582,198.6
6	57,706	$ 1,523,076.9	2.7%	$ 800,742.8	10.1%	$ 3,511,042.5	8.6%	$ 1,281,982.5	$ 7,116,844.7	$ 478,260.9	$ 7,595,105.5
7	35,966	$ 1,523,076.9	1.7%	$ 499,073.1	13.0%	$ 4,496,598.2	6.5%	$ 961,863.5	$ 7,480,611.8		$ 7,480,611.8
8	50,662	$ 1,523,076.9	2.4%	$ 702,998.5	7.5%	$ 2,587,083.9	8.5%	$ 1,257,250.3	$ 6,070,409.6	$ 956,521.7	$ 7,026,931.3
9	67,180	$ 1,523,076.9	3.1%	$ 932,206.4	7.1%	$ 2,443,357.0	7.1%	$ 1,047,153.0	$ 5,945,793.3		$ 5,945,793.3
10	9,880	$ 1,523,076.9	0.5%	$ 137,097.3	8.4%	$ 2,895,070.1	5.4%	$ 795,244.3	$ 5,350,488.7		$ 5,350,488.7
11	189,544	$ 1,523,076.9	8.9%	$ 2,630,159.6	7.4%	$ 2,562,445.0	8.9%	$ 1,320,940.7	$ 8,036,622.3	$ 956,521.7	$ 8,993,144.0
12	101,314	$ 1,523,076.9	4.7%	$ 1,405,858.2	5.7%	$ 1,971,111.6	10.7%	$ 1,587,262.1	$ 6,487,308.8	$ 478,260.9	$ 6,965,569.7
13	268,565	$ 1,523,076.9	12.5%	$ 3,726,674.6	10.3%	$ 3,563,106.8	10.3%	$ 1,527,045.8	$ 10,339,904.1	$ 3,826,087.0	$ 14,165,991.0
	2,140,348	$ 19,800,000.0	100%	$ 29,700,000.0	100%	$ 34,650,000.0	100%	$ 14,850,000.0	$ 99,000,000.0	$ 11,000,000.0	$ 110,000,000.0

Regional Allocation (Minus Native American Allocation)	$ 99,000,000.0
Native American Allocation	$ 11,000,000.0
SUBTOTAL	$ 110,000,000.0

1. Basis for Formula Funding Revision

Three questions prompted my review of the funding formula. (1) Why does a behavioral health region containing no PTNs receive a Native American allocation? (2) Why does a region containing one receive nothing? And (3) What is an IHS service area and what are its use implications for state behavioral health (BH) regional infrastructure planning? When the data narrative provided by Health Care Authority (HCA) stated it used IHS service area data to determine the Native American funding proportion.

On April 13, 2026, I attended the Tribal Health Councils Statewide Convening, hosted by the New Mexico Alliance of Health Councils (106 participants, including tribal health councils, tribal programs, tribal providers, community health representatives, 638 clinics, tribal members, and state agency staff). (See Appendix A). Three concerns recurred:

1. First, confusion about regions showing a Native American allocation with no Tribe located within them, and no guidance on who would receive or administer those funds.
2. Second, indirect costs being taken first by the Accountable Entity and again at the tribal level, reducing what reaches services.
3. Third, non-contiguous Navajo chapters excluded from the region their geography and service relationships would suggest and directed instead to Region 11.

To improve my understanding and work towards a solution I followed the Tribal Health Councils Statewide Convening by setting up consultations and 1-on-1 meetings with Accountable Entities, tribal providers, agency tribal liaisons, and tribal government & staff. Concerns about the adequacy of tribal consultation in BHRIA's rollout were widespread. But the most pressing requests were narrower and shared across every group, including the Accountable Entities: how much, when, and through what process. Those questions cannot currently be answered. No guidance exists on how a Native American allocation is divided among multiple Tribes within a region, what a region with an allocation and no Tribe should do, or when funds become available.

On May 26, 2026, I emailed the IHS Public Health Support Acting Director, who I was referred to by HCA as the source of the initial IHS dataset. The Acting Director cc'd the IHS Principal Statistician who quickly responded. (See Appendix B). My takeaways:

- The IHS dataset measures federal service responsibility, not population
- Zero cells do not mean absence of people: Counties are missing because no IHS service obligation covers them, not because no Native people live there. (i.e., Low counts must not be read as low need.)
- The original file was wrong: Eddy County belongs to the Mescalero Service Unit (a corrected file was provided)
- IHS data is a compilation of datasets and estimates, resulting in narrower American Indian/Alaska Native counting than the U.S. Census.
- Explicit warning to **not** use the data as a stand-alone measure of AI/AN population, behavioral health burden, or service need.

2. Findings

Finding 1. The current Native American allocation does not match where Tribal Governments are regionally located.

In the current funding formula Region 7 contains no standalone government but does contain a satellite chapter of Navajo Nation and receives $708,401. Region 5 contains no identified PTN and receives $91,293, likely due to the IHS service area boundary for the Mescalero Service Unit extending into Eddy County. Region 6 contains the Fort Sill Apache Tribe and receives no allocation. Region 1, home to seven Pueblos and the Jicarilla Apache Nation, receives $644,718 (less than Region 7). Region 7's allocation illustrates a concern raised directly at the Tribal Health Councils convening: it traces principally to Socorro County, home of the Alamo Navajo community (a non-contiguous chapter of the Navajo Nation). The formula generates a tribal allocation from the chapter's member presence, in a region with no tribal government to receive it, because the Navajo Nation is assigned to Region 11.

See Figure 1 and the regional crosswalk shown in Figure 3.

Figure 3. Regional Crosswalk

Region	Counties	Nations, Tribes, and Pueblos	Tribal governments	Native American allocation (current formula)
1	Santa Fe, Rio Arriba, Los Alamos	Nambé, Pojoaque, San Ildefonso, Tesuque, Santa Clara, Ohkay Owingeh, Jicarilla Apache	7	$644,718
2	Bernalillo	Isleta, Sandia	2	$1,006,524
3	Doña Ana	None	0	-
4	San Miguel, Guadalupe, Mora	None	0	-
5	Chaves, Eddy, Lea	None	0	$91,293
6	Grant, Luna, Hidalgo	Fort Sill Apache	1	-
7	Catron, Sierra, Socorro, Torrance	None	0	$708,401
8	Colfax, Taos, Union	Taos, Picuris	2	$453,406
9	Curry, Roosevelt	None	0	-
10	De Baca, Harding, Quay	None	0	-
11	McKinley, San Juan	Navajo Nation, Zuni	2	$5,319,300
12	Lincoln, Otero	Mescalero Apache	1	$454,695
13	Sandoval, Cibola, Valencia	Cochiti, Jemez, San Felipe, Santa Ana, Santo Domingo, Zia, Acoma, Laguna	8	$1,767,390
Total	**33 counties**	**4 regions contain more than one tribal government**	**23**	**$10,445,726**
Share of $110,000,000 appropriation				**9.50%**

Finding 2. The dataset measures federal service responsibility, not population and not need.

The formula derives each region's Tribal allocation from the IHS Service Population file. In response to methodology questions submitted in May 2026, the IHS Principal Statistician stated in writing that inclusion in that dataset "is determined by organizational service responsibility, not census-identified AI/AN presence alone," that non-appearance "reflects that IHS has no defined service delivery obligation to that county," and that the dataset "should not be used as a stand-alone measure of AI/AN population size, behavioral health burden, or total service need." He further advised that low or absent counts "should not be interpreted as low behavioral health

need," because urban and non-service-area residents face compounded access barriers while being underrepresented in the data.

Anchoring the allocation to this dataset directs money toward areas with established federal health infrastructure and away from areas without it.

Finding 3. The data used was incomplete, and due to the order of operations in the current formula (regional share calculated via the four-factor formula followed by the tribal proportion subtraction) the current method results vary broadly depending on which dataset is selected.

Eddy County's service population of 1,776 does not appear in the current formula. The statewide figure used is 237,946; the source file totals 239,722. Eddy is the only county in the file recorded under a non-standard name, and the only one classified under two Service Units (the misclassification IHS corrected in May 2026).

Separately, the allocation is highly sensitive to the chosen dataset. Running the same four-factor formula and Native American (NA) proportion subtraction method with three data sources (the IHS Service Population file as used in the current formula, the corrected file IHS transmitted in May 2026, and US Census 2025) produces statewide tribal allocations of $10,445,726, $11,319,879, and $11,694,318 respectively, (range= $1,248,592).

Because nothing in the method or current funding theory supports one over the other, the BHEC choosing to rely on one over the other would be an arbitrary decision. Even correcting the Eddy error, the statewide NA Allocation figure range is $374,440, (Region 11's alone swings $385,791). A funding method, this sensitive to an unforced choice of data source (this is an entirely optional BHEC decision) sets subsequent allocation decisions on unsure grounds. Furthermore, use of any of these datasets fails to resolve the multi-tribe region, no-tribe region anomalies. Under the corrected IHS file, Regions 3 and 4 would receive $219,190 and $273,334 despite containing no tribal government.

See Figure 4 showing unstable tribal share depending on data source.

Figure 4. Three datasets under current funding arithmetic

Region	IHS Service Population, as used	IHS Service Population, corrected	US Census 2025	Range across the three
Region 1	$644,718	$628,353	$632,932	$16,366
Region 2	$1,006,524	$1,016,868	$1,006,771	$10,343
Region 3	-	$219,190	$281,901	$281,901
Region 4	-	$273,334	$261,912	$273,334
Region 5	$91,293	$251,443	$282,532	$191,239
Region 6	-	$220,897	$234,189	$234,189
Region 7	$708,401	$950,520	$868,710	$242,119
Region 8	$453,406	$456,654	$473,962	$20,556
Region 9	-	$182,813	$200,612	$200,612
Region 10	-	$208,195	$179,312	$208,195

Region 11	$5,319,300	$4,668,874	$5,054,665	$650,425
Region 12	$454,695	$512,609	$476,894	$57,914
Region 13	$1,767,390	$1,730,130	$1,739,926	$37,260
Statewide	**$10,445,726**	**$11,319,879**	**$11,694,318**	**$2,424,454**

Finding 4. No guidance exists on how these funds would be divided or administered.

Four regions contain more than one tribal government; Region 13 contains eight plus the non-contiguous Navajo Chapter. No metric has been established for dividing a regional allocation among them, and no entity has been assigned to make that determination. Four regions with no tribal government hold an allocation with no designated recipient. Accountable Entities, Tribal Governments, and tribal providers interviewed for this review raised the same three questions: "how much, when, and through what process?"

The concern is not confined to tribal stakeholders: in their April 22, 2026, consensus letter to this committee, all thirteen regional Accountable Entities requested the region-specific calculation detail, underlying inputs, weighting assumptions, and supporting documentation behind their allocations, and noted the absence of guidance on how tribal partners participate in the regional plan format.

Finding 5. The current tribal allocation is a mathematical byproduct of the formula's order of operations, not a deliberate policy decision.

The 9.50% tribal share in the current funding formula is an arithmetic consequence of subtracting IHS population proportion from already-calculated regional shares. Because this subtraction occurs after the regional formula runs, the tribal figure inherits the assumptions within the regional weights and fluctuates depending on which dataset is utilized. This instability demonstrates that the current 9.50% figure was never an intentional policy outcome but rather a byproduct of a formula that lacked a front-facing tribal set-aside strategy.

While the BHEC acted quickly to establish a funding baseline to advance BHRIA work, this mathematical byproduct has caused substantial confusion, strained government-to-government relationships, and created potential competitive tensions between tribes within regions.

See Figure 1.

3. Proposal

Set the tribal allocation before the regional formula runs and set it per government rather than per capita.

Ten percent of the $110 million (=$11,000,000) is set aside from the start. It is divided equally among New Mexico's 23 Nations, Tribes, and Pueblos, producing a share of **$478,261 per government**. The remaining $99,000,000 runs through the existing four-factor formula at unchanged weights: 20% equal base, 30% population, 35% service gaps, 15% disproportionate

impact. Each region's formula result is therefore exactly 10% lower than under the current calculation. Tribal shares are then reflected in the region where each government is located, so that regional plans account for the full amount of funding flowing into the region.

I chose 10% because it was a clean number, not because of any special logic. Similarly, the four-factor formula of 20/30/35/15 was chosen with little reference points and voted on by the committee.

See Figure 1.

The IHS dataset is not used to calculate funding.

The proposal removes it from the allocation entirely. It remains available to regions and tribal governments as one input to planning, which is the use IHS describes as appropriate.

Majority of the funding formula is unchanged.

The four factors, their weights and the regional planning process, stay the same. The requirement that funds tie to an approved regional plan and the Accountable Entity structure as prescribed by BHRIA are observed.

Why per government?

Pueblos, Tribes, and Nations are sovereign governments, they are the entities that will hold contracts, employ staff, and file reports. Those fixed costs do not scale down for a smaller government. A share that recognizes each government's standing, rather than its enumerated population, is also the only measure available that does not depend on a federal dataset that was not selected or ratified through tribal consultation.

Approving this motion is a deliberate equal treatment of Tribal Governments. The change will reduce the allocation of the largest PTN, it will increase for the smallest, and it reduces most individual regional shares, although this is minimal and allows for clear guidance on each government's share.

While we know the current appropriation is below what the behavioral health system requires, this proposal provides necessary stability in three ways. First, it addresses the administrative uncertainty communicated by Accountable Entities and tribal partners by establishing clear, per-government allocations. Second, it intentionally sets a tribal share for each sovereign government, resolving open questions regarding how funds are divided and administered. Third, it aligns the funding model with BHRIA's mandate to prioritize disproportionately impacted communities, ensuring resources are not directed solely to areas where federal health infrastructure already exists.

A funding structure that encourages, but does not mandate, tribal-regional BH coordination.

Nothing here limits tribal governments or tribal providers from participating in regional BH planning or accessing the full regional share. BHRIA Section 4(D)(8) permits different entities to be accountable for different regional funding priorities, which means a tribal government may serve as the Accountable Entity for its own share and may also contract for regional services.

This supports more local coordination, PTNs share borders, people and services with tribal and non-tribal neighbor governments. To be effective, the funding structure adopted should not impose a specific collaborative model any more than it should create barriers to it.

Additional advisements to the committee

First, BHRIA Section 6(B) requires the Health Care Authority to approve a region's request to repurpose an unexpended grant balance when the recipient has not reported, has not met performance measures, or has been found to have implemented ineffectively. To avoid misunderstandings or the application of this rule to the tribal set aside. The committee should establish that a tribal share is not subject to repurposing without the written consent of and/or sufficient notice to the affected tribal government.

Second, unclaimed tribal shares should be held through a date certain and then revert to the behavioral health trust fund under the 2025 budget bill (SB 2) reversion provisions, rather than to the region. This gives governments time to organize, encourages regions to engage with tribes to keep money 'in-region' and it removes the incentive for a region to wait out a tribal government's planning process.

Authority

BHRIA Section 3(B)(3) directs the behavioral health executive committee to establish funding strategies and structure based on approved regional plans. Section 3(B)(4) directs the committee to monitor and track deliverables and expenditures and to address deficiencies and implementation issues of regional plans. Section 6(A)(2) requires that appropriated money be equitably distributed for all eligible priorities identified in each regional plan and prioritize funding behavioral health services for disproportionately impacted communities, as that term is defined at Section 2(E). These are continuing duties, and nothing in BHRIA limits the committee to a single exercise of its Section 3(B)(3) authority.

On January 20, 2026, the committee approved the funding formula as presented by BHSD Deputy Director of Finance Rick Martinez, by a vote of five to two, on a motion I made and Secretary Armijo seconded. The committee acted before any regional plan had been approved; members acknowledged the difficulty of finalizing a formula ahead of the plans and proceeded because regions needed guidance to complete them. In the same discussion, Mr. Martinez stated that the formula remains open to refinement; the committee acknowledged that adjustments may be needed over time; members recommended that the formula rationale be documented for future reference; and the chair invited members to consider alternative approaches to refining the formula. (See Appendix C for the January 20, 2026 Meeting Minutes)

Revising the formula requires no new grant of authority and no statutory amendment. The committee would be exercising the same Section 3(B)(3) power it exercised in January, on a record that expressly contemplated refinement and that predates the approved regional plans on which Section 3(B)(3) conditions the exercise.

4. Effects

Every region's formula-derived regional allocation is exactly 10% lower. Tribal shares are then added where the governments are located. The net effects by region shown in Figure 5.

Figure 5. Net Effects on Region and PTN Share of Proposed Formula Revision

Region	PTNs	Current total *(PTN Share)*	Proposed total *(PTN Share)*	Total Change *(PTN Change)*
1	7	**$8,718,174** *($644,719)*	**$11,194,182** *($3,347,826)*	**+$2,476,009** *(+2,703,208)*
2	2	**$13,796,540** *($1,006,524)*	**$13,373,408** *($956,522)*	**−$423,132** *(-$50,003)*
3	0	**$8,085,082** *($0)*	**$7,276,574** *($0)*	**−$808,508** *($0)*
4	0	**$6,722,224** ***($0)***	**$6,050,002** *($0)*	**−$672,222** *($0)*
5	0	**$9,535,776** *($91,293)*	**$8,582,199** *($0)*	**−$953,578** *(-$91,293)*
6	1	**$7,907,605** *($0)*	**$7,595,106** *($478,261)*	**−$312,500** *(+$478,261)*
7	0	**$8,311,791** *($708,401)*	**$7,480,612** *($0)*	**−$831,179** *(-708,401)*
8	2	**$6,744,900** *($453,406)*	**$7,026,931** *($956,522)*	**+$282,032** *(+$503,116)*
9	0	**$6,606,437** *($0)*	**$5,945,793** *($0)*	**−$660,644** *($0)*
10	0	**$5,944,987** *($0)*	**$5,350,489** *($0)*	**−$594,499** *($0)*
11	2	**$8,929,580** *($5,391,300)*	**$8,993,144** *($956,522)*	**+$63,564** *(-$4,362,778)*
12	1	**$7,208,121** *($454,695)*	**$6,965,570** *($478,261)*	**−$242,551** *(+23,566)*
13	8	**$11,488,782** *($1,767,390)*	**$14,165,991** *($3,826,087)*	**+$2,677,209** *(+$2,058,697)*
Sum	**23**	**$110,000,000** (10,445,726)	**$110,000,000** *($11,000,000)*	—

Numbers rounded to the nearest dollar and totals include both the regional-plan allocation and tribal government shares located in the region.

Effect on Region 11

The largest single change falls on Region 11, where the Native American allocation moves from $5,319,300 to $956,522, a reduction of $4,362,778. This warrants an explanation. Region 11 contains 116,129 of the 237,946 people in the IHS Service Population file as used (61% of the statewide total), because it encompasses the IHS service delivery area(s) with the most established federal health infrastructure.

The IHS Principal Statistician has confirmed in writing that this dataset measures where IHS holds service responsibility, and that it should **not** be used as a measure of population or of behavioral health need. Applying it as a population proportion concentrated tribal dollars where federal infrastructure already exists and reduced them where it does not, which is not in alignment with BHRIA intentions of serving disproportionately affected areas.

Region 11's total allocation is not reduced. It moves from $8,929,580 to $8,993,144, an increase of $63,564.

The regional plan is the mechanism SB3 establishes for building behavioral health infrastructure, and Region 11 is where the state's largest tribal government and the state's most

significant tribal service footprint coincide. Navajo Nation's scale, administrative capacity, and existing health system position it to shape that plan and to apply for priority-service contracts within it. The per-government share is a floor rather than a ceiling; this proposal encourages tribal governments or tribal providers to contract for additional regional funds.

The non-contiguous Navajo chapters

Convening participants raised the position of the non-contiguous Navajo chapters (Alamo, Ramah, and To'Hajiilee). The convening report documents that the three chapters were omitted from the initial regional maps, and that regional assignment can diverge from actual service patterns. For example, To'Hajiilee receives services from the Albuquerque area.

My consultation with the Indian Affairs Department firmly established that the State's government-to-government relationship runs to the Navajo Nation. How the Nation allocates its share among its chapters, contiguous or not, is a matter of Navajo law and internal governance.

However, nothing in BHRIA prevents chapters from coordinating within the regions where they are located and applying for regional priority funding within, beyond the Navajo Nation tribal set aside.

Effect on Region 6 and the Fort Sill Apache Tribe

The Fort Sill Apache Tribe receives a share of $478,261 where the current formula provides none. The Tribe's trust lands at Akela Flats fall outside any IHS service delivery area, which is why the dataset renders the Tribe invisible. The reason its land base and resident population in New Mexico are small is the federal removal of the Chiricahua and Warm Springs Apache from this state and their imprisonment for twenty-seven years. The current allocation method based on population estimates and IHS catchment areas results in a state level funding decision to disregard the existence of that tribal entity and its established sovereignty. The proposed per-government funding model acknowledges what the initial formula does not. Here it is important to note that as with all funding activities under BHRIA use of the Fort Sill Apache tribal shares remains subject to an approved plan aligned with Region 6's regional plan, and an unclaimed share reverts to the behavioral health trust fund.

5. Motion Language

1. Adopt the revised funding structure: 10% of the appropriation set aside and divided equally among the 23 Pueblos, Tribes, and Nations; the remaining 90% distributed through the existing four-factor formula at unchanged weights.
2. If the 10%/23 motion fails, then direct the Health Care Authority to correct the Eddy County omission and to document the population source used in any figure presented to the committee. AND specify guidance to tribes and AEs the method, amounts, and timeline for funding.
3. If the 10%/23 motion succeeds, then adopt a policy that tribal government shares are not subject to BHRIA Section 6(B) repurposing absent the written consent of the affected

government, and that unclaimed shares revert to the behavioral health trust fund on a date certain. (Identify the authority necessary for setting that date)

4. Regardless of pass/fail, direct the Health Care Authority to amend BHRIA Section 5(A) behavioral health service standards to require documented government-to-government consultation as mandated under the State-Tribal Collaboration Act for any regional plan element affecting tribal lands or tribal citizens.
5. Regardless of pass fail, establish explicit transparency on availability of government-to-government funding, and indirect costs (admin) taken from tribal amounts if AE pass through.
6. Regardless of pass/fail, confirm that a tribal government may serve as the Accountable Entity for its own share.

Appendices

Appendix A: NM Alliance of Health Councils, Report on the Tribal Health Councils Statewide Convening, April 13, 2026; and Regional Accountable Entities Consensus Document, April 22, 2026.

Appendix B: Methodology correspondence with the IHS Office of Public Health Support and Principal Statistician, May 2026, reproduced in full.

Appendix C: January 20, 2026, Meeting Minutes

Appendix A

new mexico ALLIANCE of Health Councils

MOBILIZING COMMUNITIES FOR HEALTH

Report on the Tribal Health Councils Statewide Convening: SB3/BHRIA Implementation and Tribal Priorities - April 13th, 2026

This report synthesizes feedback from the Tribal Health Councils Statewide Convening, focusing on the critical behavioral health needs of tribal communities and significant systemic concerns regarding the rollout of the **Behavioral Health Reform and Investment Act (SB3/BHRIA)**.

Key Behavioral Health Priorities for Tribal Communities

Tribal participants identified **several urgent priorities that require culturally grounded and community-specific interventions:**

- **Crisis Intervention and Suicide Prevention:** Strengthening the **988 Crisis Line**, improving real-time support during active emergencies, and implementing comprehensive suicide prevention programs are top priorities.
- **Substance Misuse and Harm Reduction:** There is a critical need for **overdose prevention**, expanded **naloxone distribution**, and culturally tailored harm reduction strategies to combat stigma and prevent fatalities. Ongoing technical assistance, ongoing support and funding for Traditional Healing Services was identified as a need.
- **Youth and Maternal Wellness:** Participants emphasized **youth mental wellness**, prevention programs for students, and addressing gaps in **tribal maternal mental health** for mothers and infants.
- **Trauma and Grief Support:** Access to **trauma-informed care** and ongoing grief support services was frequently cited as a foundational community need.
- **Social Determinants of Health:** Priorities extend beyond clinical care to include **stable housing** (particularly for parents and those in recovery), justice/diversion services, and addressing the impacts of alcohol on community health.
- **Localized Innovation:** Include the "Cones of Silence" as a case study of community-driven solutions within Santa Clara Pueblo. These soundproof units address the need for private access to the 988 crisis line and therapy in public spaces like recreation centers.

- **Youth-to-Senior Connection:** Highlight programs that bridge generational gaps, such as youth spending days with seniors to address stress and isolation.

Concerns and Issues with SB3/BHRIA Rollout

The convening highlighted **deep-seated frustrations regarding the handling and implementation of SB3, particularly concerning tribal sovereignty and inclusion.**

1. Lack of Pre-Legislative Inclusion and Consideration

A primary criticism was that the **State did not adequately consider tribes before passing the legislation**. Participants noted that while New Mexico has a **State-Tribal Collaboration Act, it is often not followed,** leading to a process where tribes feel "woven into" a state-designed system rather than being partners from the outset. The mapping of tribes into **13 judicial districts** was described as an "injustice" because it **fails to respect the status of each tribe as a sovereign nation.**

2. Geographical and Regional Misalignment

The regional structure of SB3/BHRIA created several logistical and jurisdictional barriers:

- **Exclusion from Initial Planning: Alamo Navajo, Ramah Navajo, and To'Hajiilee**, were not initially listed on the official regional maps as they do not fall under the larger "Big Navajo Nation".
- **Service vs. Geography: Regional assignments often ignore existing service delivery patterns.** For example, the community of To'Hajiilee receives services from the Albuquerque area, but was assigned to a different geographic region, raising questions about the logic of the rollout.
- **Unclear Leadership:** A recurring barrier was the **inability to identify regional leads** or determine which region a community officially belonged to due to an **unclear framework in the NM AOC website.**

3. Ineffective Communication and Awareness

Many tribal representatives reported they were **unaware of ongoing SB3 discussions** or felt they were **not invited or included in engagement opportunities.** Even when feedback was provided, participants expressed skepticism about whether their comments would lead to action, noting a **history of**

"engagement" without transparent follow-up or implementation of tribal recommendations.

Funding and Administrative Challenges

- **Competition for Limited Resources:** There is significant concern that the **funding structure will force tribal communities to compete against one another** for the same small pool of Native American set-aside funds. One participant described the process as a "race" between neighboring tribes to secure money.
- **Indirect Cost (IDC) Rates:** Tensions exist regarding **high administrative cost rates**. Participants argued that for relatively small grants (e.g., $100,000), state and regional entities claiming high IDC rates (25–45%) leave **insufficient funds for direct services and programming.**
- **Bureaucratic Burden:** Participants criticized the **redundant and inadequate reporting systems**, noting that the **requirement to write extensive "books" to justify community needs is a major hurdle for smaller tribes.**

Data Sovereignty and Framework Issues

- **Cultural Incompatibility of Models:** The **E-SIM** (Enhanced Sequential Intercept Model) used for the rollout was criticized as an **evidence-based practice that is not based on tribal communities.**
- **Data Privacy:** There is ongoing confusion and concern regarding the **type of data the state is requesting** (e.g., encounter vs. diagnostic data) and how this information will be used without compromising **tribal data sovereignty**.
- **Workforce Barriers:** Rural areas face severe challenges with **licensing and practicum availability**, making it difficult for tribal members to enter the behavioral health workforce to sustain these new initiatives.

Recommendations for Meaningful Engagement

Based on the discussions from the Tribal Health Councils Statewide Convening, there are several specific and systemic recommendations for **achieving meaningful engagement with tribal communities.** These suggestions go **beyond basic participation** and focus on **co-leadership, cultural literacy, and transparent accountability.**

1. Structural Co-Leadership Models

A recurring recommendation is to move away from state-centric leadership toward a shared model.

- Regional Co-Leadership: Every behavioral health region containing tribal communities should have both a **state/regional co-leader and a tribal co-leader sharing leadership responsibilities.**
- Engaging the "Right" People: Meaningful engagement requires having **timely and appropriate individuals at the table** and **understanding tribal governance structures from a state agency and legislative perspective.**
- This includes **listening to multiple constituents:** tribal leadership, health providers/administrators, and the community members themselves.
- Direct Advocacy: Regional leads should **work directly with established tribal organizations**, such as the Albuquerque Area Indian Health Board (AAIHB), to obtain technical assistance for developing MOUs and MOAs.

2. Deep Community and Chapter-Level Outreach

Participants emphasized that engagement must happen where the people are, rather than at centralized state or regional hubs.

- In-Person Interaction: There is a **strong preference for in-person, community-based outreach** over virtual meetings to gather localized input
- The Chapter Level: Engagement **should start at the chapter, pueblo, or village level (e.g., 638 IHS programs) to ensure communities are aware** of funding and resource processes before they reach higher administrative levels.
- Inclusion in Invitation Lists: Tribal members expressed **frustration at being left off invitation lists;** meaningful engagement requires ensuring all interested parties are proactively invited to the table **from the beginning and not an after thought.**

3. Cultural Responsiveness and Education

Meaningful engagement is hindered when state and regional partners do not understand tribal contexts.

- **Educating Non-Tribal Partners and Regional Leads:** Tribal leaders suggested they could **provide training to regional leads and state partners** to help them understand tribal governance structures, processes and nuances.
- **Respecting Sovereignty in Legislation:** The state must consult with tribes before passing legislation.
- **Participants noted that the State-Tribal Collaboration Act is often not followed,** leading to "injustices" like weaving sovereign nations into judicial districts without prior consent.
- Localized Knowledge: **Leaders must be culturally responsive enough to understand specific structures,** such as Navajo Chapter Houses, rather than deferring all tribal matters to a **single state tribal liaison.** Although state tribal liaisons offer great expertise in coordination and education, they do not represent Tribes, Pueblos, and Nations.

4. Transparency and Accountable Follow-Up

Participants noted that "engagement" feels hollow when there is no feedback loop.

- **Documented Action:** Recommendations and comments must be **broadly shared and followed up on with clear evidence** of what actions were taken to implement them from the state agencies, executive committee, and regional leads.
- **Consistent Communication:** Meaningful tribal engagement requires quarterly regional meetings and **frequent, consistent updates to keep communities prepared and empowered.**
- **Clear State Direction:** The state needs to provide **clearer timelines, deliverables and direction** so that tribal representatives can effectively convey information back to their tribal leaderships and councils.

5. Collaborative Funding Approaches

To prevent tribes, nations, and pueblos from feeling they must "race" or compete for limited funds, participants suggested:

- **Joint Applications:** Smaller communities or neighboring tribes should be encouraged to apply for funding together, writing collaborative programs that serve both populations.

- **Simplified Processes:** The state should move toward **short and simple grant applications rather than requiring tribes to "write a book"** to justify needs that are already well-documented.

Attendance Summary: 106

The count for "Unique Attendees" reflects every individual that logged into the virtual session. In-Person attendees at 35, totalling: 106

Participation by Behavioral Health Region

This table compares the number of approved registrants against the total number of unique participants observed online during the convening.

Behavioral Health Region	Pre–Registrants	Unique Attendees Online
Region 1	7	6
Region 2	11	11
Region 6	2	2
Region 8	5	4
Region 11	23	23
Region 12	1	1
Region 13	22	22
Unmapped / Staff / Phone	0	2
TOTAL	**71**	**71**

Counts by Region

This table breaks down the reported tribal and county affiliations for all approved registrants within each region.

Behavioral Health Region	Count of Affiliations Represented
Region 1	Tesuque Pueblo (2), Acoma Pueblo (1), Nambé Pueblo (1), Navajo Nation (1), Rio Arriba County (1), Santa Fe County (1)
Region 2	Navajo Nation (6), Bernalillo County (4), Santo Domingo Pueblo (1)
Region 6	Hidalgo County (1), Luna County (1)
Region 8	Taos Pueblo (3), Picuris Pueblo (2)
Region 11	Navajo Nation (22), Zuni Pueblo (1)
Region 12	Mescalero Apache Tribe (1)
Region 13	Santo Domingo Pueblo (6), Acoma Pueblo (3), Laguna Pueblo (3), San Felipe Pueblo (3), Santa Ana Pueblo (2), Cochiti Pueblo (2), Mescalero Apache Tribe (1), Sandoval County (1), Santa Fe County (1)

Based on the registration data, the following tables categorize participants according to the roles and specific details they provided. There were **71 approved registrants** in total.

Participant Numbers by Role

Primary Role	Number of Participants
Other *(See Breakdown of "Other" Affiliations Table)*	31
Tribal Health Council	13
Tribal Program	11
Tribal Member	7

Community Health Representative	4
Tribal Service Provider	3
IHS/638 Clinic	2
TOTAL	**71**

Breakdown of "Other" Affiliations

For the **31 participants who selected "Other,"** the following categories were identified from the "If 'other' please share more details here" column.

Affiliation Category (from "Other" details)	Number of Participants
Social Services & Case Management (Social Workers, Case Managers, Housing, Advocates)	7
State/Public Health Agencies (DOH, IAD, Suicide Prevention, Health Educators)	7
New Mexico Alliance of Health Councils (NMAHC) Staff	3
Tribal Health Board Members (Kewa / KPHC)	3
University & Health Extension (UNM, UNM HERO)	3
Judiciary & Legal (USDOJ, AOC, LOPD)	3
Community Programs & Philanthropy (NM Foundation, SJC Partnership, Search & Rescue)	3
Other / No additional details provided	2
TOTAL	**31**

"Other" Role Highlights

Examples of unique affiliations provided in the detailed descriptions include:

- **Justice & Advocacy:** Missing and Murdered Indigenous Persons (MMIP) Coordinators, and Victim Service Providers.
- **Administrators**
- **Public Health:** Tribal Public Health Consultants and Behavioral Health Reform Program Managers.
- **Specialized Services:** Rapid Re-Housing coordinators and TEWA Roots

Appendix B

Methodology question — IHS Service Population data for New Mexico (2025)

6 messages

Violette Cloud <violettecloud@gmail.com> Tue, May 26, 2026 at 8:32 PM
To: "robert.pittman@ihs.gov" <robert.pittman@ihs.gov>
Cc: "Martinez, Ricky, HCA" <ricky.martinez@hca.nm.gov>

Dear Mr. Pittman,

Ricky Martinez from the New Mexico Health Care Authority shared your contact information with me in reference to the 2025 IHS Service Population dataset for New Mexico (attached). I hope you are appropriate person for methodology questions. I'm working on documentation that will accompany the use of this dataset for state behavioral health planning, and I want to make sure I describe the data accurately and represent its limitations honestly.

A few specific questions:

1. County inclusion criteria. The New Mexico extract contains 16 counties. Several counties with self-identified AI/AN residents (per Census data) do not appear — for example, Catron, Grant, San Miguel, Mora, and Torrance. Could you help me understand the criteria that determine whether a county appears in the Service Population dataset at all? Specifically, is non-appearance an indication of an IHS-determined Service Population of zero, or does it reflect a methodological boundary that excludes counties from enumeration regardless of underlying AI/AN presence?

2. "Non Service Unit" designation. Three counties in the New Mexico extract — Chaves (1,941), Colfax (422), and Eddy (1,776) — appear under a "NON SERVICE UNIT" classification within the Albuquerque Area. Could you clarify what this designation represents? My current working understanding is that these are AI/AN populations IHS enumerates for planning purposes but does not assign to a specific Service Unit catchment. I'd like to confirm or correct this understanding.

3. Relationship to PRCDA eligibility. Are all counties appearing in the dataset (including Non Service Unit counties) within Purchased/Referred Care Delivery Areas as defined at 42 CFR §136.22, or does the Service Population dataset have inclusion criteria that operate independently of PRCDA boundaries?

4. Known limitations for non-IHS applications. The Service Population dataset is built for IHS resource planning. When the data is used outside that context — for example, as one input to state behavioral health planning — are there limitations or considerations you'd recommend documenting? I'm particularly interested in any guidance on how the dataset compares to Census-based AI/AN counts, and on appropriate framing of what the dataset does and does not capture.

I'd be happy to discuss by phone or video call if that's easier than a written response. My goal is methodological accuracy in how the data is described and applied, and I appreciate any time you can offer.

Thank you for your work in maintaining this dataset and for any clarification you can provide.

Respectfully,

Violette Cloud, JD, PhD
Behavioral Health Expert
NM SB 3 Behavioral Health Executive Committee

505.328.9762
violettecloud@gmail.com

Service Population - New Mexico - 2025 - 11-12-2025 (002)-.xlsx
12K

Pittman, Robert (IHS/HQ) <Robert.Pittman@ihs.gov> Wed, May 27, 2026 at 7:03 AM
To: Violette Cloud <violettecloud@gmail.com>
Cc: "Martinez, Ricky, HCA" <ricky.martinez@hca.nm.gov>, "Greenway, Kirk (IHS/HQ)" <Kirk.Greenway@ihs.gov>

Thank you for your questions. I have included Kirk Greenway, IHS Principal Statistician, to respond.

Robert E. Pittman, BPharm, MPH

Acting Director

Office of Public Health Support

Indian Health Service

5600 Fishers Lane, Rm 6N25, MS 06NWH04

Rockville, MD 20857

Phone: 301-443-0977

E-mail: Robert.pittman@ihs.gov

From: Violette Cloud <violettecloud@gmail.com>
Sent: Tuesday, May 26, 2026 10:33 PM
To: Pittman, Robert (IHS/HQ) <Robert.Pittman@ihs.gov>
Cc: Martinez, Ricky, HCA <ricky.martinez@hca.nm.gov>
Subject: Methodology question — IHS Service Population data for New Mexico (2025)

This Message Is From an Untrusted Sender

You have not previously corresponded with this sender.

[Quoted text hidden]

Service Population - New Mexico - 2025 - 11-12-2025 (002)-.xlsx
12K

Greenway, Kirk (IHS/HQ) <Kirk.Greenway@ihs.gov> Wed, May 27, 2026 at 7:56 AM
To: "Pittman, Robert (IHS/HQ)" <Robert.Pittman@ihs.gov>, Violette Cloud <violettecloud@gmail.com>
Cc: "Martinez, Ricky, HCA" <ricky.martinez@hca.nm.gov>

We are working on a response for you. It would really help us to know how you obtained these files As they are not publicly available yet. Kirk Greenway

Get Outlook for iOS

From: Pittman, Robert (IHS/HQ) <Robert.Pittman@ihs.gov>
Sent: Wednesday, May 27, 2026 9:03:31 AM
To: Violette Cloud <violettecloud@gmail.com>
Cc: Martinez, Ricky, HCA <ricky.martinez@hca.nm.gov>; Greenway, Kirk (IHS/HQ) <Kirk.Greenway@ihs.gov>
Subject: RE: Methodology question — IHS Service Population data for New Mexico (2025)

[Quoted text hidden]

Violette Cloud <violettecloud@gmail.com> Wed, May 27, 2026 at 9:29 AM
To: "Greenway, Kirk (IHS/HQ)" <Kirk.Greenway@ihs.gov>
Cc: "Pittman, Robert (IHS/HQ)" <Robert.Pittman@ihs.gov>, "Martinez, Ricky, HCA" <ricky.martinez@hca.nm.gov>

Hello and thank you for your time and assistance!

I sit on the Behavioral Health Executive Committee for New Mexico for the Behavioral Health Reform and Investment Act. The Health Care Authority hired Kristie Brooks to assist with initial planning and she had prior experience and connections with the SAMHSA, BJA and IHS. I believe out of her professional connections she was able to source this IHS data to inform the funding formula calculations for this New Mexico initiative.

Ricky Martinez of the HCA worked with Kristie and Mr. Pittman to identify the NM specific IHS Service Area data.

Please let me know if there are additional questions.

Respectfully,
Violette Cloud
[Quoted text hidden]

Greenway, Kirk (IHS/HQ) <Kirk.Greenway@ihs.gov> Wed, May 27, 2026 at 12:21 PM
To: "Pittman, Robert (IHS/HQ)" <Robert.Pittman@ihs.gov>, Violette Cloud <violettecloud@gmail.com>
Cc: "Martinez, Ricky, HCA" <ricky.martinez@hca.nm.gov>

Dear Dr. Cloud,

See attached file. It contains non service population as well as service population.

When IHS includes a county in its Service Population dataset, the reason for doing so is determined by organizational service responsibility, not Census-identified AI/AN presence alone. Non-appearance reflects that IHS has no defined service delivery obligation to that county. We are a health provider, not a statistical agency.

Question 1: Why Non-Service Counties Don't Appear

Catron, Grant, San Miguel, Mora, Torrance are absent because they fall outside any Tribe's service delivery area or PRCDA. IHS doesn't enumerate them in its Service Population because IHS isn't organizationally responsible for the population there, regardless of Census-documented AI/AN residents.

Question 2: The "Non Service Unit" Counties

Chaves, Colfax, and Eddy occupy an intermediate category. They appear in the dataset (unlike fully non-service counties) but aren't assigned to a specific Service Unit catchment. Your working understanding is correct: these are AI/AN populations IHS does enumerate for planning purposes but hasn't integrated into a formal Service Unit. One important exception is Eddy County. Eddy's assignment to Mescalero SU wasn't reflected in the dataset you had previously received. See attached file.

Question 3: PRCDA Relationship

Service delivery area and PRCDA boundaries are operationally distinct:

Service delivery areas may be subset, superset, or exact match to PRCDA

Non-Service Unit counties fall outside service delivery areas entirely

This means PRCDA eligibility does not necessarily guarantee Service Population enumeration

Question 4: Source and Limitations related, applicability to the organization requesting the data points

The IHS Service Population dataset reflects administrative service responsibility, not total AI/AN demographic presence. Those are conceptually different measures. The IHS Service Population is not equivalent to the total number of AI/AN people living in a state, county, or behavioral health planning region.

The dataset is designed for IHS resource planning. It estimates the AI/AN population for whom IHS has service responsibility within defined service delivery areas. It should not be interpreted as a complete count of all AI/AN residents.

Several limitations are especially important for non-IHS applications.

First, **the dataset's coverage scope is narrower than the demographic universe captured by Census-based AI/AN counts**. The IHS Service Population generally reflects individuals connected to IHS through tribal affiliation, eligibility, and residence within defined service delivery areas. It does not fully capture AI/AN individuals living outside those service delivery areas, including residents of counties designated as "NONSERVICE." In New Mexico, for example, the 17 NONSERVICE counties still have AI/AN residents according to Census data, but those residents are not part of the IHS Service Population because IHS does not have service responsibility for those areas. See attached for the counts of service and non service populations. The dataset could potentially underrepresent these groups: urban AI/AN populations who are not tied to a specific Tribe's IHS service catchment, individuals who self-identify as AI/AN in Census data but do not have tribal enrollment or IHS service eligibility, and some multi-race AI/AN individuals depending on how they are represented in administrative and population estimation processes.

Second, there is a **definitional divergence** between Census-based AI/AN counts and the IHS Service Population. Census and ACS data are based on self-identification. They can be reported as "AI/AN alone" or "AI/AN alone or in combination," and they include people who identify as AI/AN regardless of whether they are enrolled in a Federally recognized Tribe or eligible for IHS services.

By contrast, the IHS Service Population is an administrative planning measure tied to Tribal eligibility and geographic service responsibility. It is based on NCHS Bridged Race population data, extrapolated using cohort-component projection methods, with race misclassification adjustment factors applied. Because of these definitional and methodological differences, Census-based AI/AN counts for New Mexico should be expected to be substantially larger than the IHS Service Population total. The difference will likely be most pronounced in urban areas and in counties outside IHS service delivery areas.

Third, there is a geographic boundary mismatch. IHS service delivery areas do not align cleanly with Census geographies, county boundaries, state behavioral health regions, Medicaid managed care regions, or other planning zones commonly used by state agencies. The "NONSERVICE" designation should be explained carefully: it means IHS does not have service responsibility for that county or area; it does not mean AI/AN residents are absent.

For behavioral health planning, I would recommend framing the dataset as follows:

“The IHS Service Population dataset represents the IHS-enumerated AI/AN service population within defined service delivery areas. It is appropriate for understanding IHS service responsibility and resource planning populations, but it should not be interpreted as a complete demographic count of all AI/AN residents. The nonservice population is also produced by IHS, and it should be used with caution since it does not represent IHS catchment areas of its serviced patients.”

For a 2026 planning document, the description could be made more specific:

“These figures represent the IHS-enumerated service population within defined service delivery areas as of 2026, with estimates for years prior to 2020 and projections for later years.”

This is particularly important in behavioral health because service-population counts may understate need in exactly the places where access barriers are greatest. Urban AI/AN populations may be underrepresented in IHS service population data but still experience significant behavioral health disparities. AI/AN residents in non-service areas may face compounded barriers related to distance, eligibility, provider availability, cultural responsiveness, or lack of connection to IHS-funded services. As a result, low or absent IHS Service Population counts should not be interpreted as low behavioral health need.

In summary, the dataset is useful for understanding IHS administrative service responsibility, but it should not be used as a stand-alone measure of AI/AN population size, behavioral health burden, or total service need. For non-IHS applications, especially state behavioral health planning, the key documentation point is that the dataset captures a service-responsibility population, not the full AI/AN population residing in the state.

Thank you,

Kirk

KIRK GREENWAY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

INDIAN HEALTH SERVICE

DIRECTOR, OPHS DIVISION OF PROGRAM STATISTICS

PRINCIPAL STATISTICIAN, INDIAN HEALTH SERVICE

301/443-6704 (work line, forwards to work cell)

From: Pittman, Robert (IHS/HQ) <Robert.Pittman@ihs.gov>
Sent: Wednesday, May 27, 2026 9:04 AM
To: Violette Cloud <violettecloud@gmail.com>
Cc: Martinez, Ricky, HCA <ricky.martinez@hca.nm.gov>; Greenway, Kirk (IHS/HQ) <Kirk.Greenway@ihs.gov>

[Quoted text hidden]

[Quoted text hidden]

NewMexico_ServicePopulation.zip
51K

Violette Cloud <violettecloud@gmail.com> Fri, Jun 5, 2026 at 12:38 PM
Cc: "Martinez, Ricky, HCA" <ricky.martinez@hca.nm.gov>

Hello Ricky,
The full dataset is here.

Could you update the funding chart with these numbers?

Also, could you run some alternatives? Rather than having a by region NA carve out, take a proportion from the full 110M. How would that affect the regional numbers? Remove the NA column entirely.

A main sticking point for me is switching from IHS eligible pop data to TNP specific funding.

Sorry writing this on the move. Let me know if you cant open the datafile.

VC

[Quoted text hidden]

Appendix C

Administrative Office of the Courts
Karl W. Reifsteck, Director
Sarah Jacobs, Deputy Director

Michelle Lujan Grisham, Governor
Kari Armijo, Cabinet Secretary
Alex Castillo Smith, Deputy Secretary
Kathy Slater-Huff, Deputy Secretary
Niki Kozlowski, Acting Deputy Secretary
Alanna Dancis, Acting Medicaid Director

Behavioral Health Reform and Investment Act Executive Committee
Meeting Minutes
Date: January 20, 2026 | Time: 8:00 a.m. – 10:00 a.m.
37 Plaza la Prensa, Santa Fe, NM 87507

- **Welcome and Roll Call**
  - Committee Present:
    - Nick Boukas, *Executive Committee Chair, Behavioral Health Services Division Director at the New Mexico Health Care Authority*
    - Kari Armijo, *New Mexico Health Care Authority Cabinet Secretary*
    - Alanna Dancis, *Acting Medicaid Director*
    - Karl W. Reifsteck, *Administrative Office of the Courts Director*
    - Dr. Violette Cloud, *Behavioral Health Expert (Attended Via Zoom)*
    - Dr. Stacey Cox, *Behavioral Health Expert*
    - Senator Gerald P. "Jerry" Ortiz y Pino, *Behavioral Health Expert*
  - Behavioral Health Reform and Investment Act Leads:
    - Kristie Brooks, *New Mexico Health Care Authority Director of Behavioral Health Transformation & Innovation*
    - Esperanza Lucero, *Administrative Office of the Courts Behavioral Health Reform & Investment Administrator*
- **Quorum Confirmation**
  - A quorum was established.
- **Meeting Called to Order**
  - The meeting was convened at 8:00 a.m.
  - Chairman Boukas welcomed attendees
- **Approval of Minutes and Agenda**
  - Agenda for January 20, 2026 BHEC Meeting
    - Senator Gerry Ortiz y Pino requested that the agenda include a brief discussion of the current legislative session, specifically the Executive and Legislative budget items. Chairman Boukas stated that this item can be addressed later in the agenda.
    - Dr. Cox moved to approve the minutes, seconded by Director Reifsteck.
    - The motion passed unanimously.
  - Minutes from November 12, 2025 BHEC Meeting
    - Director Boukas requested additions, edits, or deletions to the minutes.

- Sen. Ortiz y Pino asked whether CYFD had participated in the NOFO application reviews. Chairman Boukas informed him that this information would be addressed later in the agenda.
- With no further questions, Director Reifsteck motioned to approve the minutes, and Secretary Armijo seconded the motion.
- All members present voted in favor, and the minutes were approved.

- **Old Business** | New Mexico Health Care Authority
  Presented by Kristie Brooks, Director of Behavioral Health Transformation and Innovation with the New Mexico Health Care Authority
  - Tribal Consultation
    - The Tribal Consultation was held on December 2, 2025, and included participation from approximately 12–14 Nations, Pueblos, and Tribes, both in person and online.
    - The discussion focused on Senate Bill 3 and tribal involvement. Representatives from the Nations, Pueblos, and Tribes offered extensive feedback on how the regions were identified, funding distribution, ensuring equitable allocation, and approaches for ongoing engagement.
    - Director Brooks reiterated the state's commitment to continued engagement, noting her offer to meet individually with the Nations, Pueblos, and Tribes. Members expressed interest in more frequent consultations. HCA and IAD will continue working together to support that request.

- **Old Business | Administrative Office of the Courts Updates**
  Presented by Esperanza Lucero, Administrative Office of the Courts Behavioral Health Integration and Reform Administrator
  - Enhanced Sequential Intercept Mapping (E-SIM) Workshops
    - Ms. Lucero reported that there will be multiple sessions in the 13 regions.
    - Successful workshops took place last week in Lincoln and Otero Counties, as well as Mescalero Apache—with an average of 90+ attendees.
    - There has been strong partnership and engagement, in all workshops that have occurred up to this point, organized by UNM Health Science Center.
    - AOC has developed five priorities from these workshops, which are still being compiled.
    - Secretary Armijo inquired when the first regional plans might start to roll in.
    - Ms. Lucero shared that once the regional plan template and the funding formula are received, that will start the clock for Bernalillo County and all regions that attended workshops in 2025. Draft of those plans should start appearing within 60 to 90 days.
  - Operations Subcommittee Updates

- Director Brooks presented the procedural document reviewed by the subcommittee. The document outlines how Behavioral Health Executive Committee meetings will be conducted moving forward.
- The document includes guidance on meeting cadence, member responsibilities, handling vacancies and proxies, and the process for calling ad hoc meetings. It also outlines expectations for confidentiality, posting agendas and minutes for public access, and ensuring compliance with the Open Meetings Act.
- Director Brooks noted the document formalizes practices discussed over recent months.
- **Member Recommendations**
  - **Terms of Office:** Clear and accurate; however, vacancy language was inconsistent and recommended for removal.
  - **Chair's Voting Role:** Clarification requested; draft appeared to allow two interpretations. Members recommended selecting one clear approach.
  - **Remote Attendance:** Support expressed due to geographic diversity.
  - **Proxy Language:** Recommended specifying that proxies must be other Committee members.
  - **Voting Procedures:** Committee discussed procedures when fewer than seven members are present. Under Section 7, actions require more than 50% of votes cast; therefore, a 3–3 tie would result in failure.
- **Amendments Agreed Upon**
  - Vacancy language to be removed.
  - Language limiting the Chair's vote to tie-breaking situations to be struck.
- Senator Ortiz y Pino moved to adopt the meeting procedures document as amended.
- Dr. Cox seconded the motion.
- The motion passed unanimously.

- **<u>Funding Formula</u>**
  Presented by Ricky Martinez, Deputy Director of Finance for the Behavioral Health Services Division of the New Mexico Health Care Authority
  - Director Martinez presented the Funding Formula and explained that regions requested clearer allocation estimates to support planning. BHSD developed the formula to provide consistency and collaborated with leadership from Nations, Pueblos, and Tribes to refine statewide population figures used in the population component.
  - Mr. Martinez noted that the formula reflects extensive work and remains open to refinement.
    - **Formula Components**
      - **Equal Base Allocation (20%)** – Approximately $22 million divided equally among 13 regions (~$1.7M each).
      - **Population (30%)** – Based on each region's share of New Mexico's ~2.1 million residents.

- **Service Gaps (35%)** – Uses aggregated Health Professional Shortage Area (HPSA) scores, incorporating provider shortages, poverty, travel time, and access barriers.
- **Disproportionate Impact (15%)** – Focuses on outcomes such as suicide and overdose rates, rurality, and tribal service-area factors.

▪ **Committee Questions and Clarifications**

- BHSD received 16–18 public comments and incorporated relevant feedback.
- A minor correction was made to disproportionate-impact data; members were asked to reference the printed version.
- Senator Ortiz y Pino expressed concern that some factors may be counted multiple times, resulting in large per-resident disparities (e.g., Region 2 at ~$20 per resident vs. Region 10 at ~$6,400). He recommended increasing the population weight to 50% and reducing overlapping measures.
- BHSD responded that relying heavily on population would disadvantage rural and tribal regions and conflict with statutory intent.
- Service gaps and disproportionate impact measure different types of need—access barriers vs. Outcomes.

○ **Additional Discussion**

- Members emphasized that concerns centered on the scale of disparities, not on rural investment. Very small regions may struggle to spend large allocations effectively.
- BHSD clarified that allocations span four years, not one.
- Challenges exist in attracting providers to rural areas and stressed the need to balance equity with feasibility while ensuring rural regions are not under-invested.
- Members highlighted the complexity of balancing rural and urban needs, noting that urban hubs serve residents from surrounding counties.
- BHSD explained that differences between Regions 3 and 13 are largely due to Native American population distribution and associated behavioral-health outcomes.

• **Clarifications on Native American Data**

- BHSD used Indian Health Service service-population figures to determine each region's Native American population share, applying that proportion across all formula components.

• **Broader Considerations**

- Members noted the difficulty of finalizing a formula before regional plans are complete but agreed that regions need guidance to proceed.

- It was recommended to document the formula rationale for future reference. Members emphasized the importance of supporting rural infrastructure and accounting for transportation needs in regional plans.
- The Committee acknowledged the difficulty between moving forward and refining the formula, noting that adjustments may be needed over time.

- **Funding Formula Discussion**
  - Members discussed the difficulty moving forward to support regional planning and refining the funding formula to address concerns about disparities across regions. Several members noted that regions need timely guidance to complete their plans, while also acknowledging that the formula may require adjustments as implementation progresses.
  - The importance of balancing population, service gaps, and disproportionate-impact measures was emphasized. It was noted that regions vary in size, infrastructure, and capacity. Concerns were raised about the potential for very small regions to receive allocations that exceed their ability to spend effectively, as well as the risk of over-weighting population in a way that disadvantages rural and tribal communities.
  - **Motion and Failed Vote**
    - A motion was introduced to amend the formula by increasing the population component from 30% to 50%, reducing the service-gap component from 35% to 15%, and including a list of appropriations and associated timeframes alongside the formula. Members discussed the potential impacts of these changes, including the effect on rural regions, the intent of the legislation to address service gaps, and the possibility of overlapping measures across formula components.
    - Following discussion, the motion failed, with 2 votes in favor and 4 opposed.
    - Chairman Boukas invited members to consider alternative approaches for refining the formula while maintaining momentum for regional planning.
  - **Second Motion and Passed Vote**
    - After a lengthy and difficult discussion, Dr. Cloud motioned to approve the funding formula as originally presented by Finance Director Rick Martinez.
    - Secretary Armijo seconded the motion.
    - The motion was passed with a vote of five to two.
- **Regional Plan Proposals**
  Presented by Kristie Brooks, Director of Behavioral Health Transformation and Innovation with the New Mexico Health Care Authority

- Director Brooks presented the regional plan template for Committee approval. She explained that the document outlines the requirements regions must follow when developing and submitting their implementation plans. The template includes:
    - A table of contents detailing each section of the funding opportunity
    - Award and application process information
    - Allowable and unallowable uses of funds
    - Alignment with internal standards
    - Selection criteria, compliance expectations, and accountability requirements
    - Data collection and evaluation guidelines, including use of a logic model
    - An appendix with definitions, terminology, and the scoring rubric the Committee will use
  - Director Brooks noted that the template is modeled on the Early Access Notice of Funding Opportunity but is more extensive due to the larger scope and funding amount. It is intended to ensure regions demonstrate feasibility, capacity, and readiness to implement their plans over the four-year funding period.
  - She also highlighted requirements for each region to designate an accountable entity and described expectations for reporting, auditing, and coordination with both BHSD and the Behavioral Health Executive Committee.
  - **Committee Discussion**
  - Members raised several questions regarding the regional plan template:
    - **Rural service delivery:** Members asked whether the template explicitly requires regions to describe how they will serve rural areas. Director Brooks agreed this expectation could be made more explicit.
    - **Flexibility for accountable entities:** Members emphasized the need to avoid language that could conflict with varying procurement rules across counties, councils of government, and tribal governments.
    - **Tribal engagement:** Members supported requiring letters of support but requested clearer language stating that Nations, Pueblos, and Tribes may join the process at any time. They recommended reinforcing this message during regional workshops.
    - **Technical assistance:** Staff confirmed that regions will have access to support, including legislative funding provided to AOC for planning assistance.
    - **Native American allocation:** Members requested additional language in Section 1.5 to clarify how tribal governments should access the Native

American allocation and to specify that requests must be submitted through the accountable entity.
    - **Allocation amounts:** Members recommended clarifying Section 2 to emphasize that funding requests should be based on regional mapping, identified needs, and workshop findings—not limited by preliminary allocation estimates. Regions may request more or less than the initial estimate, and unrequested funds may be reallocated.
- **Director Brooks reported that all 13 regions submitted Early Access proposals for up to $2 million each, focused on:**
    - Residential treatment
    - Crisis continuum services
    - Medication-assisted treatment for justice-involved individuals
    - Prenatal and perinatal substance use disorder treatment
- BHSD conducted an expedited review. **Eleven proposals were recommended for approval**, while **two require additional clarification** regarding spending timelines, service access, and feasibility. Two regions requested additional time to submit supplemental information, which BHSD recommended granting.
- Members discussed several proposal-specific issues:
    - **Vehicle Purchases:** Some proposals included multiple vehicle requests. BHSD requested additional information on maintenance, insurance, driver qualifications, and sustainability before final approval.
    - **Region 13:** Senator Ortiz v Pino expressed concern that the proposal did not include activities benefiting Rio Rancho. BHSD noted that the region's workshop has not yet been completed and that outreach to Sandoval County and Rio Rancho will be strengthened.
    - **CYFD Involvement:** A member asked whether CYFD reviewed proposals related to child drug-exposure concerns. BHSD clarified that CYFD did not participate in the Early Access review because the funding opportunity focused on expanding existing services, but CYFD has been present at regional workshops and will be involved in future planning.
    - BHSD emphasized that regions are at different stages of workshop completion, which may have affected proposal detail, but overall submissions were strong.
- After additional discussion, Director Reifsteck moved to approve the recommended Early Access awards. Director Dancis seconded.

  - With no further discussion, the motion passed unanimously.
- **Public Comment**
  - Comments were received from both in-person and online attendees
- **Closing Comments**
  - Conflicting dates for the next Behavioral Health Executive Committee meeting in April have been identified. The Committee will follow up to confirm a single meeting date and will provide updated information to members.
  - Chairman Boukas acknowledged the significant work occurring behind the scenes at the AOC, HCA, and with partners from the Legislative Finance Committee. He noted the shared commitment to this effort and emphasized the importance of ensuring the initiative remains rooted in and responsive to community needs so that individuals receive appropriate support and system capacity continues to grow.
- **Adjournment**
  - Dr. Reifsteck moved to adjourn the meeting, seconded by Dr. Cox.
  - The motion passed unanimously.
  - Meeting adjourned at 10:20 a.m.