Albuquerque Area Indian Health Board Inc.

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

July 18, 2025

Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
c/o Darcie L. Johnston, Principal Deputy Director
Office of the Secretary, IEA
200 Independence Ave. SW
Mail Stop: 620E.11
Washington, DC 20201

RE: Tribal Listening Session on the HHS Reorganization

Dear Secretary Kennedy,

On behalf of the Albuquerque Area Indian Health Board ("AAIHB"), I am writing to request that you reconsider and adjust the current approach to restructuring the U.S. Department of Health and Human Services ("HHS"), given the high potential for devastating effects on crucial healthcare programs relied on by Tribes across the country.

AAIHB was established in 1980 and is a consortium of several federally recognized Tribes in New Mexico and Southern Colorado.[1] AAIHB provides direct health care services to not only citizens of member Tribes, but to citizens of other Tribes throughout New Mexico, Southern Colorado, and West Texas. AAIHB's purpose is to assess and advocate for the well-being of 27 Tribal communities through the improved development of public health services and health education. AAIHB is almost entirely federally funded through HHS programs, including from the Indian Health Service ("IHS"), Centers for Disease Control ("CDC"), the Substance Abuse and Mental Health Services Administration ("SAMHSA"), and National Institutes of Health ("NIH").

Congress unequivocally expressed in the Indian Health Care Improvement Act that, "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure the highest possible health status for Indians and urban Indians and to provide all the resources necessary to effect that policy." *See* 25

[1][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.

U.S.C. § 1602(1). AAIHB is deeply concerned that the HHS restructuring will not meet that mandate.

As you know, the federal government plays a multi-faceted role in Tribal healthcare and the IHS is not the only part of HHS crucial to serving the healthcare needs on Indian Tribes and their members. Rather, Tribes have—in part—made up for deficiencies in IHS funding by securing funds from other HHS divisions and programs. The proposed restructuring to HHS that eliminates programs upon which Tribes and Tribal organizations like AAIHB rely will disrupt and negatively impact essential Tribally run programs that provide healthcare to Tribal communities, and risks running afoul the trust responsibility. Many Tribes echoed this concern during the listening sessions.

In particular, AAIHB relies on the following HHS programs outside of IHS that have already been or may be impacted by the proposed restructuring:

- CDC *Healthy Tribes Program*:
    - $1.3 million for Good Health and Wellness in Indian Country and for Tribal Epidemiology Center Public Health Infrastructure, which together support a significant proportion of the budget of the Albuquerque Area Southwest Tribal Epidemiology Center ("AASTEC"), one of just twelve regional Tribal Epidemiology Centers in the country. AASTEC is a designated public health authority and provides leadership, technical assistance, training, and resources to 27 Tribes to **strengthen tribal public health infrastructure, support emergency preparedness and outbreak response, lead surveillance and data infrastructure projects, and implement activities and interventions to manage and prevent chronic illness, including cancer, diabetes, heart disease, and stroke**.

- CDC *Division of Injury Prevention*:
    - $200,000 for alcohol impaired driving prevention to support Tribal partners in their efforts to **increase public education around the dangers of impaired driving caused by the alcohol epidemic, especially for Tribal youth, as well as to improve screenings, treatments, and interventions for alcohol use disorder** to prevent impaired driving.
    - $670,000 in Tribal opioid prevention grants to provide surveillance, data collection and monitoring, and public health support **to address the ongoing opioid epidemic** in Tribal communities.

- CDC *Division on HIV Prevention*:
    - $1.3 million to support 27 Tribal communities in **preventing and controlling HIV infections**, including by increasing access to testing,

prophylactic treatments, long-term care, and culturally appropriate disease prevention and management strategies.

- SAMHSA *Tribal Opioid Response*:
    - $1.5 million to strengthen the capacity of Tribal behavioral health treatment centers **to prevent, manage, and treat opioid use disorders created by the opioid epidemic**.

- SAMHSA *Native Connections:*
    - $250,000, which, combined with CDC funding, supports AAIHB's Community Health Education and Resiliency Program ("CHERP") to provide trauma-informed and strengths-based capacity building on **STI/HIV prevention, substance abuse prevention, positive youth development and mental health treatment**.

- NIH *Native Collective Research Effort to Enhance Wellness ("N Crew")*:
    - $497,000 to research **overdose, substance use, mental health, suicide, and pain management** issues in Tribal communities, with a specific focus on prevention strategies. These are critical services to address mental health issues related to drug and alcohol epidemics that have a disproportional impact on Tribal communities.

- NIH *Community Partnerships to Advance Science for Society ("ComPASS"):*
    - $990,000 to research effective strategies to address **fall risk injury, daily stressors, and respiratory health (specifically, asthma) within Tribal communities**.

Elimination of these and related programs would greatly impact AAIHB, the 27 Tribal communities we serve, and the health of the southwest's Tribal populations. For example, AAIHB is concerned that the President's FY 2026 Budget eliminates the CDC's Good Health and Wellness in Indian Country program altogether, which as stated above, presently supports an epidemiology center that is uniquely tailored to preventing, managing, and treating chronic illnesses within the region's Tribal communities. The President's FY 26 Budget also proposes more than $128 million in cuts to mental and behavioral health funding to Tribes, which is highly concerning to AAIHB given that our member Tribes rely on HHS funding to research, monitor, and treat substance abuse disorders, mental health issues, suicidal ideation, and opioid use. AAIHB appreciates that you have recognized as a top priority for American healthcare: "reducing the initiation of drug use, particularly among young people, and increasing the number of individuals receiving evidence-based treatment, leading to long-term recovery from substance abuse

disorders."[2] However, eliminating programs targeted to address these issues and reducing the funding on which Tribes rely to achieve this exact health outcome is counterproductive. We urge HHS to uphold its trust responsibility to Tribes by, at a minimum, retaining FY25 funding levels to HHS programs on which Tribes rely as a baseline in FY26 and beyond. We understand that restructuring could consolidate or move programs, but it is essential to ensure funding for Indian country is retained.

Even if current funding levels are preserved, reductions of HHS staff would also adversely affect our healthcare delivery programs. Federal employees within these programs are key to the efficient delivery of direct healthcare services within our partner Tribes' communities. We are concerned that staff reductions, office closures, and programmatic consolidations will delay the administration of funding streams that have been granted to AAIHB, which in turn will delay AAIHB's healthcare service delivery. This will mean reduced and delayed services for patient populations that cannot wait for care.

In fact, AAIHB has already experienced delays and inefficiencies due to staff reductions within NIH. For instance, draw-down requests from NIH grants now take multiple weeks to process, whereas they used to take days. The processing delays appear to be caused, at least in part, by the Department's implementation of its new Defend the Spend initiative, which requires grants management staff to engage in a heightened review process for expenditure requests, paired with the Department's reductions in force, which have eliminated the workforce necessary to timely complete that review. As a result, AAIHB has had to resort to using its administrative funds, which are limited, to reimburse Tribal healthcare partners while awaiting draw-down approvals from NIH. This causes significant stress to AAIHB's budget, as AAIHB is primarily funded by use-specific grants which cannot be diverted to make up for NIH's temporary shortfalls. When attempting to expedite draw-down requests through NIH's Grants Management Officers, AAIHB has been routed to federal contractors who lack programmatic knowledge and decision-making authority.

Similarly, AAIHB's programs have been adversely impacted by the elimination of staff positions within the CDC's Healthy Tribes Program. The CDC Division of Population and Health, which oversees the Healthy Tribes Program, is also proposed for elimination as part of the HHS reorganization. The CDC's Healthy Tribes Program provides a significant portion of AAIHB's budget for the Albuquerque Area Southwest Tribal Epidemiology Center, which serves as a designated public health authority to 27 Tribes,

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[2] Statement of Robert F. Kennedy, Jr. Secretary, U.S. Department of Health and Human Services on the President's Fiscal Year 2026 Budget, Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, at 4 (May 14, 2025). *See* https://docs.house.gov/meetings/AP/AP07/20250514/118230/HHRG-119-AP07-Wstate-KennedyR-20250514.pdf.

supporting their management of chronic illness, including through direct sub-awards to Tribal communities. The loss of staffing, expertise, and institutional knowledge within the CDC's Healthy Tribes Program has created delays and administrative burdens for our Epidemiology Center, ultimately risking slower and potentially lower quality care for the patients who rely on the program.

Rather than creating efficiencies and streamlining the Department's functions as intended, the Department's staff reductions have increased administrative burdens and slowed down service delivery for Tribes. We appreciate that you have recognized that the Department's layoffs have created "gaps in our abilities to perform our duties," specifically within the CDC and NIH, where some layoffs were ultimately reversed because "we were not able to do our job."[3] However, AAIHB's operations continue to be impacted by staff reductions within HHS and we fear that more may be coming through any reorganization. AAIHB urges HHS to maintain key staff positions to ensure timely administration of funding by technical experts. As sovereign entities, Tribes deserve access to dedicated federal personnel who understand Indian Country and who have the institutional knowledge necessary to support the operation of local programs. This could be accomplished by embedding Tribal Affairs Offices within the leadership structures of each operating division, agency, and bureau of HHS, and ensuring that such offices are staffed with policy experts as well as liaisons tasked with driving Tribal engagement.

Additionally, AAIHB urges HHS to maintain its Tribal Advisory Committees, which are a critical part of the government-to-government relationship between AAIHB, its partner Tribes, and HHS and which support a robust system of policy input and feedback on the agency's programs. We are particularly interested in the preservation of the Tribal Advisory Committees for the CDC/Agency for Toxic Substances and Disease Registry, SAMHSA, HRSA, NIH, and Office of the Assistant Secretary for Health's Center for Indigenous Innovation and Health Equity.

Finally, we urge that savings from restructuring efforts are passed on directly to Indian Tribes, rather than further reducing federal resources to Indian country. We would encourage HHS to use restructuring as an opportunity to shift funding opportunities from competitive grants to formula-based funding for Tribes and Tribal organizations. Doing so would reduce the administrative costs of HHS, Tribes, and Tribal organizations alike and would allow funding to flow directly to the patients and research that these programs are intended to benefit. Even in moving to a formula-based or other

[3] Testimony of Robert F. Kennedy, Jr. Secretary, U.S. Department of Health and Human Services on the President's Fiscal Year 2026 Budget, House Committee on Energy and Commerce, Subcommittee on Health, beginning at 59:14 (June 24, 2025), available at: https://energycommerce.house.gov/events/health-subcommittee-hearing-the-fiscal-year-2026-department-of-health-and-human-services-budget.

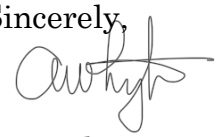
non-competitive funding model, however, HHS should retain a staff of technical experts with institutional knowledge in order to provide ongoing support to Tribes.

We thank HHS for the opportunity to participate in the July 16th and 17th listening sessions and to offer these written comments. However, to ensure that HHS's federal trust responsibility is not impeded by the agency's reorganization efforts, HHS should immediately initiate formal Tribal consultation on the proposed reorganization. Although we appreciate that leaders from each HHS agency attended the listening sessions to hear feedback from Tribes, most of the agencies did not engage in any discussion with or answer any questions from the Tribal participants. This has severely limited the ability of Tribes to meaningfully comment on the Department's restructuring plans, demonstrating why substantive government-to-government consultation must be offered. While the listening sessions were appreciated, they did not fulfill the HHS's consultation obligations to Tribes. Federal statute, HHS's Tribal Consultation Policy, and Executive Order 13175 all detail federal requirements for Tribal consultation and should guide the Department's Tribal consultations on its restructuring plans.

We also urge the HHS to extend the written comment period for the listening sessions beyond July 18, 2025 to allow Tribal leaders sufficient time to assess and communicate the potential impacts of the proposed changes to their Tribal citizens, especially given that the final listening session was held the day before the comment deadline.

We look forward to future engagements on the HHS' reorganization.

Sincerely,



Ayn Whyte
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Albuquerque Area Indian Health Board