National Indian Health Board

WRITTEN TESTIMONY OF THE HONORABLE JANET ALKIRE

TRIBAL COUNCIL CHAIRWOMAN OF STANDING ROCK SIOUX TRIBE AND

GREAT PLAINS AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD

BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS

"DELIVERING ESSENTIAL PUBLIC HEALTH AND SOCIAL SERVICES TO NATIVE AMERICANS – EXAMINING FEDERAL PROGRAMS SERVING NATIVE AMERICANS ACROSS THE OPERATING DIVISIONS AT THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES"

May 14, 2025

Chairwoman Murkowski, Ranking Member Schatz, and distinguished members of the Committee, on behalf of the National Indian Health Board (NIHB) and the 574+ sovereign federally recognized American Indian and Alaska Native (AI/AN) Tribal Nations we serve, thank you for this opportunity to provide testimony on Delivering Essential Public Health and Social Services to Native Americans. My name is Janet Alkire, and I serve as the Chairwoman of the Standing Rock Sioux Tribe. I also serve as the Great Plains Representative to the NIHB. I am Hunkpapa Lakota—a descendant of the Lakota leaders who signed the 1868 Fort Laramie Treaty. I am a beneficiary of the Treaty and Trust obligations enshrined in that agreement, which continue to shape the rights of our people and Indian Country as a whole. I am also a proud veteran of the United States Air Force.

The NIHB is concerned about the implementation of reorganization of the Department of Health and Human Services (HHS) and its significant implications for Tribal Nations and Tribal-serving programs. HHS programs, including those agencies and operational divisions outside the Indian Health Service (IHS), are a critical support to Tribal Nations, their citizens, and their communities, and HHS programs are an integral part of the federal trust responsibility to Tribes. For example, in FY 24, HHS provided Great Plains Area Tribes and Tribal organizations approximately $124 million in funding, less than 0.002% of the HHS budget, which supports life-saving programs that address some of the most extreme health disparities in the nation. Although Tribes support efforts to improve efficiency within HHS, any reorganization, reduction in force, and changes to this funding must be conducted in a manner that upholds the federal trust and treaty obligations to Tribal Nations. An obligation for which Tribes have pre-paid for centuries through land and resources. We have urged HHS to promptly schedule a series of Tribal Consultations to discuss the implications for Tribal Nations and ensure that Tribal-serving programs, set-asides, and staff are preserved.

The United States maintains a unique political, legal, and historical relationship with Tribal Nations, established and affirmed by the Constitution, federal law, Supreme Court rulings, and executive orders. Born out of this relationship is the federal government's trust responsibility – including the duty to provide the necessary resources to deliver high-quality healthcare to AI/AN people.

The reorganization of HHS is part of the implementation of Executive Order 14210, "Implementing the President's 'Department of Government Efficiency' Workforce Optimization Initiative", signed on February 11, 2025. The implementation of this Executive Order through the reorganization of HHS has resulted in the immediate reduction of full-time employees at the Department by no less than 24 percent. The reduction in staff has impacted grant funding access and distribution to Tribes, the operation of Tribal Technical Advisory Committees, and is causing remaining Tribal program staff to seek opportunities outside federal employment. Without Tribal Consultation, Tribal Nations have already incurred significant harm, including the abrupt cancellation of no less than $6 million in grants from various HHS agencies – jeopardizing the sustainability of health and public health systems in Indian Country.

One pattern NIHB has noted is the preservation of divisions of Tribal affairs (DTA) within HHS' agencies and operational divisions. This is a positive recognition of the importance of these offices and their staff. These DTAs, however, are frequently only engagement-level offices, and do not host critical programs and funds supporting services in Indian Country. It is the programmatic offices, discussed in this testimony, which work to meet the trust and treaty obligations for healthcare. All of this impacts the ability of HHS programs to deliver on the trust and treaty obligations to Tribal Nations.

Centers for Disease Control and Prevention

Under this reorganization, several key public health programs have been impacted, including the National Center for Injury Prevention and Control (NCIPC) in AI/AN Communities, Healthy Tribes, the Reproduction Health Division (RHD), and Pregnancy Risk Assessment Monitoring System (PRAMS). Further, the Center for Chronic Disease Prevention and Health Promotion would face elimination, including the elimination of its Maternal and Infant Health branch, Division of Oral Health, Division of Diabetes Translation, the Division of Cancer Prevention and Control, and the Office of Smoking and Health. These programs provide critical support to Tribal providers nationwide on healthcare disparities impacting our communities.

We have received troubling reports that the seven-member Tribal Support Team within the NCIPC in AI/AN communities has been reduced to just one remaining staff member. This small team but essential team, was responsible for managing $18 million in funding that directly supports 15-

Tribes and Tribal organizations, ten Tribal epidemiology centers, and seven urban Indian organizations. The NCIPC was one of few HHS divisions deeply committed to developing tribally centered injury prevention initiatives, particularly those focused on healing from the devastating impacts of the overdose crisis in Indian Country. Grantees under this program have implemented culturally responsive overdose-prevention strategies including sweat lodges, smudging, talking circles, engaging in ceremony, and other culturally centered practices. In many rural and remote areas, these programs represent the only available treatment services for hundreds of miles. The Tribal Support Team served as a lifeline for individuals and families and their dismissal will undoubtedly harm access to treatment for AI/AN populations.

The proposed cancellation of Healthy Tribes funding agreements and termination of staff as part of the agency's reduction in force has already impacted the delivery of three critical projects, including Good Health and Wellness in Indian Country (GHWIC), Tribal Practices for Wellness in Indian Country, and Tribal Epidemiology Centers Public Health Infrastructure. These programs, while representing a minimal fraction of federal spending, are lifelines in Indian Country. In at least one instance, a grantee has already received notice of the termination of the Good Health and Wellness in Indian Country funding. Some Tribal programs have already received termination notices for their GHWIC grants.

The dismantling of RHD and the suspension of PRAMS would decimate the limited maternal and child health surveillance tools available to AI/AN communities. PRAMS is already not being updated and data not being tracked due to staff layoffs. PRAMS is one of the few national data sources that tracks maternal and infant health disparities in AI/AN populations. Without it, federal and Tribal health agencies will lose a vital tool for identifying risks, informing interventions, and saving lives. The provisional data released last month by the National Center for Health Statistics shows that maternal mortality has started to rise again after two years of declining mortality rates.[1] We need these data sets now more than ever. Likewise, the reduction of RHD staff has stripped Tribal communities of critical technical assistance. We are already aware of Hear Her campaign staff being let go interrupting resources available to pregnant women, families, and healthcare professionals. It remains unclear whether funding will continue for Maternal Mortality Review Committees (MMRCs) which are vital to preventing maternal deaths in local communities.

In reviewing the publicly available information, the new proposed reorganization of CDC centers would focus funding and efforts into the National Center for State, Tribal, Local, and Territorial Public Health Infrastructure and Workforce. We commend the need to provide more direct funding to Tribes and Tribal organizations for this work, but to date we have not seen this. In fact, in 2022, the CDC denied Tribes access to public health infrastructure funding, claiming that

[1] CDC National Center for Health Statistics, April 9, 2025. Maternal Mortality Surveillance, *Provisional Maternal Death Rate*. Accessed 5/11/2025: https://www.cdc.gov/nchs/nvss/vsrr/provisional-maternal-deaths-rates.htm.

funding had been sent to IHS which was then rescinded from IHS by Congress in 2024. Any refocusing of the agency to send more funding to States and local governments directly must include direct funding sources to Tribal programs.

CDC has also seen a nearly 20% reduction in staffing which has had an impact on public health response in Indian Country. CDC, particularly Commissioned Corps staff, frequently do temporary duty stations or tours in areas with extreme public health need. Because of the extreme disparities in Indian Country, there are frequent tours to address public health needs in our communities. One individual working with the Great Plains Tribal Epidemiology Center (TEC) raised concern about several staff from CDC who have been terminated who did several tours with their TEC to address a public health crisis in their region. Following the termination of these staff, the individual shared that the response efforts would not be possible now because those individuals' positions do not exist anymore. This also includes the technical assistance their CDC division provides on capacity to test samples and other clinical/lab approaches to the crisis. Those types of positions are vital to the work that they have done related to syphilis and other STIs that may come around again. It is quite concerning; these positions just do not exist anymore.

HHS also cut funding for the Strengthening Public Health System and Services in Indian Country that was a data modernization initiative project. We understand it was due to funding being attached to COVID supplements, but for Indian Country this funding is vital to modernize our healthcare infrastructure in the face of chronic underfunding. Other COVID-linked funding has also been terminated for things including support of Community Health Representative programs, supplies including personal protective equipment, and funding for Tribal vaccination programs. Many of our facilities are outdated and need new equipment and modern electronic health record systems. Without this funding Indian Country continues to be left out of modern advancements.

Health Resources and Services Administration

The Health Resources and Services Administration (HRSA) is proposed to be rolled up into a new Administration for a Healthy America (AHA). This concerns Tribes as there are a number of programs that Tribes rely on programs delivered across HRSA's offices and bureaus. HRSA serves as a grant-making agency but also provides technical support across workforce, maternal and child health, rural healthcare, and supporting access to underserved communities, including Tribes.

One of HRSA's primary functions is to develop and support the healthcare workforce, and as part of that, HRSA administers the National Health Service Corps and its loan and scholarship programs. This is one critical source of funding to support providers who work in Indian Country. The NHSC includes a 15% set aside for Tribes to support recruitment and retention in our underserved communities. In the middle of April, NIHB held a Tribal Townhall to get a better understanding of the impacts of the HHS Reorganization on Tribal health programs. The NHSC

Loan Repayment program was raised as an example where participating Tribal providers has received stop notices on their repayments. Without the additional resources of the NHSC programs, our communities will struggle to find providers. The Funding for Indian Health Professions within the IHS budget is insufficient, and its loan repayment and scholarship programs are not tax exempt like HRSA's programs are.

HRSA's Maternal and Child Health programs are another important source of funding to Indian Country. The President's FY 2026 Proposed Budget, which begins to spell out what HHS Reorganization will look like in detail, includes a recommended $274 million reduction to maternal and child health programs. It explains these funds as "duplicative" and that they should be addressed through State block grants. Most of this funding already goes to the States with no set asides for Tribes, and consolidating the remaining funds will only worsen this situation. AI/AN women are three times more likely to die from pregnancy-related causes than non-Hispanic White (NHW) women[2] and the AI/AN mortality rate is two times the rate of NHW population.[3] HRSA administers the Healthy Start program, which aims to improve maternal and infant health outcomes, reduce infant mortality, and address adverse perinatal conditions through Tribally tailored programming. Several Tribal health programs receive this funding enabling screenings, nurse visits, and the Tribal Home Visiting program. Tribes and Tribal health programs only receive small portions of funding for maternal and child health through programs, so some Tribes also access funding through State allocations of HRSA funding. Instead of pushing more funding to the State, we should be creating Tribal set asides withing the Maternal and Child Health Block Grant. The proposal to reduce funding and centralize these services at a critical time for maternal health in Indian Country and the United States could cause harm to Tribal programs.

HRSA is also responsible for programs providing healthcare in underserved communities. They do this through a series of programs including the Health Professions Shortage Area designation process, the section 340B program for reduce-cost pharmaceuticals, and the section 330 program which funds and provides technical assistance to Community Health Centers (CHC) and Federally Qualified Health Centers. HHS's proposal to dissolve HRSA into the new AHA without Tribal consultation is concerning for the future of these programs. Specifically, 37 Tribal and Urban Indian organizations participate in the section 330 grant program, to ensure that their patients receive quality health services. The proposed reorganization raises concerns about whether HRSA programmatic support will be maintained or diminished in the transition, which would affect continuity of care for Tribal citizens. Some grantees have already reported delays in receiving payments or only getting short-term grant renewals.

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[2] Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765. DOI: http://dx.doi.org/10.15585/mmwr.mm6835a3

[3] CDC, 2024. Infant Mortality in the United States, 2022: Data from the Period Linked Birth/Infant Death File. National Vital Statistics Reports, vol. 73, no. 5. Table 2.

Office of the Assistant Secretary for Health (OASH)

The Office of the Assistant Secretary for Health (OASH) is a critical operating division for many public health related activities and programs. In the initial days following the mass termination of employees within OASH, NIHB tracked staff departures that disrupted the Office of Minority Health (OMH) and the Office of Infectious Disease and HIV/AIDS Policy (OIDP). NIHB has heard from numerous Tribal leaders that their OASH funding has been paused, withheld or terminated without clear communication or consultation. Combined with the significant reduction in force, Tribes are concerned about their current access to resources and technical assistance from OASH. OASH has historically provided support that is critical for addressing region-specific health challenges such as chronic disease prevention, maternal health, youth wellness, and behavioral health services. OASH is also one of the few HHS divisions with a focus on community-level engagement and cross-agency coordination.

For example, the OMH provided outreach and support to Tribal communities and was working to implement a new Center for Indigenous Innovation and Health Equity (CIIHE) to support the elimination of health disparities in Tribal communities. This new center, created in 2021, was to help identify and disseminate evidence- and practice-based interventions for AI/AN populations to improve public and healthcare delivery in our communities. The CIIHE also include the Tribal advisory committee (TAC) responsible for advising the Assistant Secretary of Health. Without any details for what is happening to these programs, Tribes and TAC members do not know how this program is moving forward. Until the release of the FY 2026 President's Proposed Budget, it was believed that OMH was eliminated in its entirety.

The OIDP develops, coordinates, and supports a range of infectious disease initiatives including *Ending the HIV Epidemic in the U.S.*, the Minority HIV/AIDS Fund (MHAF), and actions to prevent healthcare-associated infections. In 2022, AI/AN males were 1.8 times more likely to have a diagnosis of HIV infection than NHW males and AI/AN females were 1.6 times more likely to have AIDS.[4] Many staff who oversaw HIV/AIDS programming have already been eliminated impacting local efforts. The Reorganization has terminated staff working on MHAF and *Ending the HIV Epidemic* which is undermining lifesaving care and prevention efforts for AI/AN individuals living with or at risk of HIV/AIDs. Since 2012, HIV screening among adults/adolescents increased from 31%to 57%. In 2024, The Phoenix Indian Medical Center achieved viral suppression of over 90% for people living with HIV, leading Arizona's viral suppression rate. IHS was also able to develop the national HIV/HCV/STI dashboard to monitor trends and support outbreak response. Despite these advances, AI/AN communities remain

[4] Centers for Disease Control and Prevention (CDC), 2024. HIV Surveillance Report: Diagnoses, Deaths, and Prevalence of HIV in the United States and 6 Territories and Freely Associated States, 2022, v.35. Tables 3a and 1a.https://stacks.cdc.gov/view/cdc/156509 (Back to top)

disproportionately impacted. HCV-related mortality is highest among Native people. Congenital syphilis has increased by over 5,000% in the past decade, leading to preventable infant deaths. Further, when we look at just the Great Plains Area, from 2020 to 2022, syphilis rates among AI/AN people surged by 1,865% — that is ten times the national rate. It will now be harder to track these types of rate changes as well. Further, the staff responsible for tracking HIV, HCV, and Syphilis data at CDC have been let go, and these data sets are no longer being maintained. This data has been crucial to understanding the spread of these diseases, particularly the syphilis epidemic in the Great Plains. Without MHAF, OIDP, and the CDC's data tracking, IHS and Tribes are losing their only dedicated federal funding source and support for HIV, HCV, and STI response.

In FY25 alone, MHAF awarded $16 million to 17 Tribal health organizations, with funding intended through FY29. The loss of this support would dismantle programs and destabilize essential services, particularly because these Tribal programs largely treat all STIs concurrently and often support screenings in clinical environments during regular check-ups, like for expecting mothers. This is also coupled with uncertainty for HRSA's Ryan White program to treat HIV/AIDS, which is often part of the larger strategy on HIV/AIDS/STIs and is slatted for "consolidation".[5] These programs provide treatment, testing, and wraparound services that help reduce the spread of HIV and other STIs and increase access to healthcare services and screenings.

Administration for Community Living

The Administration for Community Living (ACL) plays a critical role in delivering essential services under the Older Americans Act (OAA) and is a lifeline for AI/AN Elders, people with disabilities, and other vulnerable populations. ACL's funding structure ensures that resources reach communities through state, Tribal, and local programs, supporting wraparound services that are vital for maintaining independence, dignity and quality of life. The proposal to eliminating the ACL division would create gaps in care, destabilizing systems on which communities have come to rely.

ACL's Office of Older Indians (OOI) oversees the OAA Title VI which provides support for home and community-based care wrap around services and nutritional support for Native Elders. These services are the only direct Tribal programs to offer these important services enabling our Elders to stay in community. Even though the Indian Health Care Improvement Act (IHCIA) authorizes funds to support long-term services for our Elders, Congress has never funded those provisions and no Administration has ever requested such funding. This means that our Elders' Programs are severely underfunded in Indian Country. Tribes frequently turn to the State's Title III and other OAA funding to support other wraparound services to our Elders. NIHB has heard that the OOI staff have been preserved, but OOI staff are not responsible for grant payment processing. As we

[5] Office of Management and Budget, 2025. President's Proposed FY 2026 Budget. Accessed 5/9/25: (https://www.whitehouse.gov/wp-content/uploads/2025/05/Fiscal-Year-2026-Discretionary-Budget-Request.pdf).

understand it currently, ACL staff responsible for the payment of grant awards have been let go without notice to grantees. This has meant huge disruption to Tribes awaiting funds.

This means that changes to all of ACL impact Tribal programs. The proposed HHS reorganization states intent to dissolve ACL and move programs to the Administration for Children and Families and the Centers for Medicare and Medicaid Services. This would dismantle core ACL programs, eliminate the Chronic Disease Self-Management Education (CDSME) which empowers older adults to manage chronic conditions and avoid costly medical services, and would transfer the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR), weakening evidence-based approaches to care. It is also unclear what will happen to funding for the Native American Caregivers Support, a program that provides critical assistance to families caring for Elders.

ACL is the only agency that has programs working to keep Elders and those with disabilities in their homes and communities. With the loss of these programs, more and more preventable injuries and advanced chronic conditions will fall to the Medicare and Medicaid programs—frequently at higher costs than the preventive care being cut/reduced. Keeping our Elders in community is also important for the preservation of our cultures. Our Elders are the keepers of our knowledge, stories, and culture; when they remain in community, they have stronger relationships particularly with our youth who learn from them and carry on our traditions. Without these programs, more of our Elders would need to leave community—breaking these important cultural bonds. ACL's ability to reach our vulnerable communities cannot be replicated by transferring programs to the ACF and CMS. ACL programs are a critical lifeline for older adults, AI/AN Elders, and individuals with disabilities, and the transition of such programs could break the process and institutions that currently deliver this lifeline of funding.

National Institutes of Health

HHS Reorganization proposes to retain a much reduced National Institutes of Health (NIH). The detail for a reorganized NIH can be found in the President's FY 26 Proposed Budget which proposes a 42 percent decrease from FY 2025 and would eliminates several key programs. The preservation of the Tribal Health Research Office and staff has been essential to providing technical assistance to Tribes and understand the cancelations or pauses of no less than 18 grants, including one Native American Research Center for Health (NARCH) award. NARCH is the premier health science grant recognizing excellence in AI/AN health science research. Of the many Institutes proposed to be closed in the NIH reorganization, we are concerned that it includes the National Institute of Nursing Research, National Center for Complementary and Integrative Health, and National Institute on Minority Health and Health Disparities, which reports out data on AI/AN populations. The proposal would also consolidate the remaining 23 institutes into a total of eight.

Tribal and Tribal research programs have already been impacted by funding cuts, recissions, and direct funding cancelation. Tribes, Tribal public health agencies, and Tribal research programs must be exempted from any further disruptions to uphold the federal trust and treaty obligation.

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA programs save lives in Indian Country. In the Great Plains Area, the Great Plains Tribal Leaders Health Board's (GPTLHB) Connecting With Our Youth (CWOY) program, funded by SAMHSA. Based in Pennington County, South Dakota, CWOY applies traditional Lakota values — compassion, wisdom, generosity, and respect — to reduce youth suicide through mentorship, advocacy, and culturally grounded interventions. Partnering with the Rapid City Police Department, the program offers early intervention and long-term support. From 2019 to 2024, CWOY achieved a 78 percent reduction in suicide deaths among Native youth (ages 10–24), from 9 deaths to just 2. This has resulted in a consistent year-over-year decline in suicide mortality and an 11 percent drop in suicide-related police calls in 2024. These outcomes illustrate what is possible when federal investments are tailored to community needs and delivered in partnership with tribal leadership.

SAMHSA programs also combat the substance use disorder crisis we are facing. In 2022, 1,543 non-Hispanic AI/AN individuals died from overdose, which was the highest overdose rate of any racial or ethnic group.[6] While we have successes, this data underscores the urgency of expanding, not reducing, behavioral health resources in Indian Country.

SAMHSA's Center for Mental Health Services was one of the divisions within the Agency that saw a massive staffing reduction. CMHS was responsible for several Tribal behavioral health grant programs, including the Circles of Care program and part of the Native Connections grant program. Circles of Care was a program to strengthen the mental health care infrastructure for Tribal communities. Native Connections was a youth-focused behavioral health grant to Tribes. While staff are no longer available, it is not clear what will happen to these life-line programs; some Tribes have even heard from SAMHSA staff that their Native Connections grants will be non-renewed in the 2026 grant year.

The elimination of CMHS is not the only concern we have tracked at NIHB. Tribal Behavioral Health Grants for Substance Use Disorder for a particular Tribe were also terminated as reflected on a March 31, 2025 HHS Grants Termination List. Later iterations of the HHS Grants Termination List[7] have removed the line-items, which does not clarify whether these grants have

[6] Centers for Disease Control. (2024). Opioid Overdose Prevention in Tribal Communities. Retrieved from: https://www.cdc.gov/injury/budget-funding/opioid-overdose-prevention-in-tribal-communities.html

[7] HHS Grants Termination List can be found at https://taggs.hhs.gov/Content/Data/HHS_Grants_Terminated.pdf (Last Accessed 5/9/2025).

been restored. However, even if such grants were restored—the act of terminating funding and restoring it in the middle of a grant year severely impacts the work of the grantee and can damage the programs reliant on these funds.

Other critical funding streams for Tribes, such as the Tribal Opioid Response Grants, have not yet been cut. However, without further details of the proposal to relocate SAMHSA programs in the new AHA, it is hard to understand exactly how much further Tribes will be impacted by the HHS Reorganization to behavioral health programs. Eliminating these programs will result in irreversible harm during a declared Public Health Emergency on Opioids.[8] Tribal behavioral health systems are already chronically underfunded, and we cannot allow prevention and treatment programs to disappear when AI/AN populations need them most.

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) is a critical agency in supporting the delivery of the trust and treaty obligations for healthcare to Tribal Nations. The agency does this through the administration and regulation of the Medicare, Medicaid, Children's Health Insurance Program, and the federal and state Marketplaces. Although the primary mission of the agency is to delivery these healthcare coverage programs which have up to now been unaffected by HHS reorganization, other administrative work and activities have been impacted.

The CMS Office of Minority Health (OMH) had its entire staff terminated in the days following the announcement of reorganization. CMS OMH, like all offices of Minority Health throughout HHS, are statutorily created by the Patient Protection and Affordable Care Act (ACA). CMS OMH not only had programs supporting rural health and widely used data, it also housed CMS' work on Health Equity. The CMS Framework for Health Equity involved significant input by Tribes, particularly through the CMS Tribal Technical Advisory Group (TTAG). The Framework is now missing from the CMS OMH webpage, and there are no staff left to support this work which included Tribal Nations.

CMS Administrative funding also supports critical programs for outreach and education to support Americans access their healthcare coverage programs. This includes funding to Tribes to support outreach and enrollment focused on supporting Tribal citizens accessing Medicaid and other healthcare coverage. Tribal Nations are concerned that this funding may be in jeopardy because in the President's Proposed FY 26 Budget proposes doing away with such funding. It reads, "[The Budget] eliminates health equity-focused activities and Inflation Reduction Act-related outreach and education activities." Outreach and enrollment are critical activities and resources for Tribes.

[8] RENEWAL OF DETERMINATION THAT A PUBLIC HEALTH EMERGENCY EXISTS, March 18, 2025. Accessed 5/9/2025: https://aspr.hhs.gov/legal/PHE/Pages/Opioid-Renewal-18Mar2025.aspx.

Without additional information or context, it is hard to understand how this will impact Tribal Nations.

Indian Health Service

Although the Indian Health Service has not been included in public facing details about the proposed HHS Reorganization and broad Reduction in Force initiatives, the Agency and its staff are impacted by the loss of contacts and partners across their sister agencies. The IHS works with agencies and offices to implement their programs, provide effective public health programming, support staffing recruitment and retention, and ensure services are available and reimbursable. IHS providers, like all physicians and extenders, rely on the guidance documents outlining standards of care, stable staffing, and federal health care coverage to deliver the best care to AI/AN people. When staff at other HHS agencies are terminated, the government-wide hiring freeze is preventing new employees to fill those roles depriving the IHS of technical assistance and support for outside programs.

Although IHS staff have not been included in RIF actions, the instability of sudden firings across the Department is creating an environment of uncertainty which is making it even more difficult to hire and retain providers and other healthcare professionals. The healthcare industry in general has experienced significant attrition as providers and healthcare professionals leave the industry, burnt out by years of difficult work during the COVID-19 pandemic. HHS and IHS must work to stabilize the workforce to ensure that we are able to attract and retain the best providers. This includes the maintenance of loan repayment programs in other federal agencies, such as the Health Resources and Services Administration's National Health Service Corps loan repayment opportunities. Further, the IHS has been given few exemptions from the federal hiring freeze making this even more difficult and threatens the ability of IHS facilities to retain sufficient staffing to keep beds operational and accreditation requirements met.

Finally, the initial proposals for the HHS Reorganization included the centralization of core functions, including "Human Resources, Information Technology, Procurement, External Affairs, and Policy."[9] The IHS is unique because it is one of only four direct healthcare providers in the federal government, and is the only one in HHS which provides healthcare nationwide. In fact, IHS is the 18th largest healthcare system in the United States.[10] For this reason, the IHS depends on a separate set of core functions which hire providers, maintain accreditation, maintain electronic health records, and ensure access to medications and supplies critical to direct healthcare services. For this reason, Tribes believe it is inappropriate to centralize IHS core functions with other HHS

[9] U.S. Department of Health and Human Services, March 27, 2025. "HHS Announces Transformation to Make America Healthy Again". Accessed 5/9/2025: https://www.hhs.gov/press-room/hhs-restructuring-doge.html.
[10] U.S. Department of Health and Human Services, March 27, 2025. "Fact Sheet: HHS' Transformation to Make America Healthy Again". Accessed 5/9/2025: https://www.ihs.gov/newsroom/ihs-updates/january-2-2025-ihs-updates-for-tribes-and-tribal-and-urban-indian-organizations/.

agencies. We urge HHS to maintain IHS' independence to ensure it can continue its work to improve their core systems and urge the Administration to request adequate resources for IHS to operate its core functions.

Restructuring of HHS Headquarters and Closure of HHS Regional Offices

HHS regional offices have been reduced from 10 to 5, a consolidation that now places over 400 Tribes under the jurisdiction of a single office in the Western United States. This restructuring now requires Tribes in remote Alaska and Southern California to work with staff in Denver. Many Tribes have already reported losing access to essential technical assistance, cross-agency coordination, and localized programmatic guidance that these regional offices once provided.

The IHS has a 12-region structure designed to facilitate operational efficiency and responsive engagement with Tribal governments. HHS' initial 10-regions also provided regionally-specific policy support, technical assistance, and trust-based relationships that support Tribal needs. The closure of numerous regional offices limit the government's ability to meet its legal obligations, and puts the health of AI/AN communities at risk. The elimination of regional offices without consultation violates the principles of Tribal sovereignty.

This consolidation will especially harm rural and remote Tribal communities, where regional offices often served as a lifeline to federal programs, helping Tribes navigate complex grant applications, interpret policies, and respond to time-sensitive funding opportunities. By eliminating these offices, HHS has created coverage gaps, increased the burden on remaining offices, and eroded local institutional knowledge built over years of partnership and trust. Tribes have already reported being redirected to regional offices in places like Atlanta for program guidance, an office with little-to-no knowledge of Tribes or their unique government-to-government status. These closures will diminish quality, timeliness, and cultural relevance of supportive assistance.

These regional office closures also included announcements of the consolidation of HHS Office of General Counsel regional branches. This included the closure of the OGC offices in Seattle and San Francisco which were responsible for a significant portion of the Indian Self-Determination and Education Assistance Act (ISDEAA) compact and contract negotiations and review. Over 375 Tribal Nations participate in IHS self-governance utilizing over 60% of the IHS' appropriation to delivery culturally tailored and quality healthcare. The reduction of OGC staff and these offices not only removes regional knowledge and history of the self-governance negotiations process, it also places significantly more strain on OGC staff in Headquarters. This could severely delay the execution of ISDEAA contracts and compacts.

Other recommendations related to the Office of the Secretary will have impacts on Tribes. One change which stands to dramatically impact Tribal Nations and their relationship with HHS is the relocation of the Office of Intergovernmental and External Affairs (IEA). The IEA is home to HHS Tribal Affairs, the office responsible for supporting the HHS Secretary's Tribal Advisory Committee, organizing department-wide Tribal Consultations, and coordinating departmental policies related to Tribal Nations. Recent critical work from this office has included the development of the HHS Tribal Consultation Policy, coordination of new Tribal and TEC data policies, and the hosting of the Annual Tribal Budget Consultation where the IHS National Tribal Budget Formulation Workgroup's Annual Tribal Budget Recommendations are released. The current proposal for reorganization envisions removing this critical office from direct report to the Secretary to a newly created Assistant Secretary for External Affairs. The removal of this work from its current position would significantly reduce the responsiveness of its work to Tribes and a critical link directly to the HHS Secretary.

Disruptions to Tribal Advisory Councils and Tribal Serving Programs

Tribal Advisory Councils (TACs) have also largely been paused since January 2025, leaving Tribal Leaders with questions about their future amid the changes occurring at HHS. Without Tribal Consultation on the HHS Reorganization, it is not clear how TACs will be structured and which TACs will continue related to SAMHSA, HRSA, and the OASH Center for Indigenous Innovation and Health Equity Tribal Advisory Committee slatted to be reorganized into the new AHA—but without further details it is hard to know. Our TACs form a critical part of the government-to-government relationship and support a robust system of policy input and feedback as Agencies work to regulate healthcare coverage and programs.

As discussed at the Secretary's Tribal Advisory Council meeting, we reiterate our request for exemptions for employees within Tribal Affairs Offices and Tribal-serving programs. These federal staff are critical to delivering legally mandated services to AI/AN beneficiaries and are essential extensions of the government-to-government relationship. The dismissal of staff from the CDC's Healthy Tribes and SAMHSA's Circles of Care programs further erodes this relationship.

Current disruptions have left communication gaps between Tribal Nations and federal offices. Tribal Affairs Offices previously provided transparency and technical assistance, but today there is often delayed and miscommunication with federal agencies. As political entities, Tribal Nations deserve access to proper communication channels and a list of grants and programs impacted by the reorganization.

Government-to-Goverment Relations Through Tribal Consultation

These Tribal-serving programs have a minimal fiscal impact on the federal government but are foundational to improving chronic health conditions in Indian Country. Without formal Tribal

Consultation and meaningful input from Tribal leaders, the HHS Reorganization is likely to unintentionally impede the effectiveness of these programs and impinge on the government-to-government relationship between the United States and Tribal Nations.

Tribes share the vision for a Healthy America and a more efficient HHS, but Tribes must be active in these discussions as they impact our direct relationship with HHS programs and obligated funding for HHS programs. Some examples of efficiency we see that could be part of the HHS Reorganization include the reduction of onerous grant and U.S. Department of Government Efficiency Services (DOGE) reporting requirements, providing direct funding to Tribes instead of reliance on State block grant pass throughs, and the expansion of Tribal self-governance outside the IHS. Tribal Self-Governance has time and again proven one of the most successful, quality-improving, and efficient programs pursued by the United States. Tribes can be the solution, and fit well into a reorganized HHS. We welcome the opportunity to achieve these efficiencies and improve services to our communities. These programs and personnel are not only operational necessities to our public health systems, they are part of the federal government's legal and moral obligation to Tribal Nations.

I thank the Committee for this opportunity to provide testimony on this very important issue, and look forward to working with you further to ensure the federal government meets and upholds its trust and treaty obligations to Tribal Nations.