National Indian Health Board

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BEFORE THE U.S. SENATE COMMITTEE ON INDIAN AFFAIRS
"HEARING ON IMPACTS OF GOVERNMENT SHUTDOWNS AND AGENCY REDUCTIONS IN FORCE ON NATIVE COMMUNITIES"
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Chairwoman Murkowski, Vice Chairman 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 Tribal Nations we serve, thank you for this opportunity to provide testimony on the Impacts of Government Shutdowns and Agency Reductions in Force on Native Communities. This partial government shutdown is not an administrative inconvenience for Native communities and the health-related services on which they rely. It is a direct test of the United States' ability to uphold its trust and treaty responsibilities to Tribal Nations. Every shutdown, every delay, and every reduction in the federal workforce has real and lasting consequences for Native communities. Consequences that are even more dire for our communities and Tribes because of the historical underfunding faced by Indian Tribes and the Indian health system, and are compounded by the unique and varying needs of Indian Tribes. My name is A.C. Locklear. I am a member of the Lumbee Tribe of North Carolina and serve as the Chief Executive Officer for the National Indian Health Board (NIHB).

Founded in 1972, the National Indian Health Board (NIHB) is the only national Tribal organization solely dedicated to advocating for the health and public health of all 574 federally recognized American Indian and Alaska Native Tribal Nations. Governed by a Board of Directors representing each of the twelve Indian Health Service Areas, NIHB serves as the unified voice of Tribal governments to reinforce Tribal sovereignty, strengthen Tribal health systems, secure resources, and build capacity to achieve the highest level of health and well-being for our People.

TRUST AND TREATY OBLIGATION

Tribal Nations have a unique legal and political relationship with the United States. Over the course of a century, sovereign Tribal Nations and the United States entered more than 300 Treaties that required the federal government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. Through its acquisition of land and resources, the United States formed a fiduciary relationship with Tribal Nations, recognizing a trust relationship to safeguard Tribal rights, lands, and resources.[1] In fulfillment of this Tribal trust relationship, the United States "charged itself with moral obligations of the highest responsibility and trust" toward Tribal nations.[2] Congress affirmed this duty through the Indian Health Care Improvement

[1] *Worcester v. Georgia*, 31 U.S. 515 (1832).
[2] *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942).

Act (IHCIA)[3], declaring it the policy of the United States "to ensure the highest possible health status for Indians and to provide all resources necessary to effect that policy."

In 1955, in partial fulfillment of its constitutional obligations, Congress established the Indian Health Service (IHS), one of three entities that comprise the Indian health system. The Indian health system is a three-part network that includes federally operated, Tribally operated, and urban Indian health programs, often referred to collectively as the "I/T/U system." Today, the Indian health system includes 43 Indian hospitals (51 percent of which are Tribally operated) and 650 Indian health centers, clinics, and health stations (86 percent of which are Tribally operated).[4] Federally operated IHS hospitals range in size from six to 133 beds and are open 24 hours a day for emergency care. IHS-operated facilities offer a range of care, including primary care, pharmacy, laboratory, and x-ray services. However, when specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded purchased/referred care (PRC) program. Additionally, 41 urban Indian programs offer services ranging from community health to comprehensive primary care.

Tribally operated facilities are managed by sovereign Tribal Nations through self-determination contracts and self-governance compacts authorized under the Indian Self-Determination and Education Assistance Act (ISDEAA). These Tribal health systems now deliver most care across Indian Country, managing hospitals, clinics, behavioral health centers, and public health departments. These entities are indistinguishable from their federal counterparts in scope and professionalism despite being funded primarily through IHS appropriations and third-party reimbursements. Urban Indian organizations (UIOs), authorized under Title V of the IHCIA, extend culturally grounded care to the American Indian and Alaska Native people who live in urban areas. Together, the I/T/U system forms the backbone of health care delivery for Native people. Each of the three components is essential, and each is dependent on predictable, equitable federal funding.

The federal obligation to provide health care to American Indians and Alaska Natives extends beyond the IHS. Congress and the courts have consistently affirmed that the federal trust responsibility encompasses all programs that affect the health and welfare of Tribal Nations, not only those that carry the word "Indian" in their title. Accordingly, the U.S. Department of Health and Human Services (HHS), through its various agencies and offices, shares in this duty. Each HHS division that funds, regulates, or delivers health, and public health, services to Tribal communities is acting in furtherance of that same trust and treaty responsibility.

While IHS serves as the primary federal agency charged with delivering direct health services to Tribes, the broader HHS plays an equally vital role in upholding the federal trust and treaty responsibility for Indian health. Programs housed across HHS agencies, such as the Health Resources and Services Administration's (HRSA) maternal and child health grants, the Substance

[3] 25 U.S.C. § 1602
[4] Indian Health Service. (2024). The Indian Health Care System – Fact Sheet. Retrieved from: https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/IHSProfile.pdf

Abuse and Mental Health Services Administration's (SAMSHA) behavioral health and substance-use prevention initiatives, the Centers for Disease Control and Prevention's (CDC) Tribal public health infrastructure and disease prevention programs, the Centers for Medicare and Medicaid Services' (CMS) administration of Medicaid and Medicare, as well as the Administration for Children and Families' (ACF) long term supports and service programs, and the Administration for Community Living's (ACL) Native American Caregivers Support program, all provide essential support to Tribal governments and health systems as part of the federal government's trust responsibility. These investments strengthen the economies and health of Native communities by funding providers, expanding behavioral health capacity, supporting workforce development, and ensuring public health preparedness.

When coordinated effectively, these HHS programs act in concert with IHS to fulfill the United States' fiduciary responsibility to provide for the health and well-being of Tribal Nations. Ensuring their stability through consistent appropriations and dedicated Tribal engagement is therefore not only good public health policy, but also a continuation of the federal government's enduring legal and moral commitments to the first peoples of this nation. Although we know that Tribal health funding streams reach far beyond the Indian health system, it is often difficult to properly document and track the totality of Tribal health funding and the shortfalls without a proper Office of Management and Budget annual funding report, commonly referred to as a "crosscut." When funding streams are not clearly identified, it becomes difficult to link financial resources to health-data infrastructure, staffing, or surveillance capacity in Tribal communities. Without a clear funding map, Tribal public health systems are under-resourced in staffing, data systems, or IT infrastructure because the link between funding and capability isn't visible. Without a clear funding map, Tribal public health systems may be under-resourced in staffing, data systems, or IT infrastructure because the link between funding and capability isn't visible.

THE INDIAN HEALTH SERVICE FUNDING

This year, IHS will celebrate its 70th anniversary. However, at no point in the 70 years has Congress fully funded the agency at the level of need. Although NIHB is glad Congress has provided nominal increases to the IHS each year, these increases are insufficient to keep up with rising medical and non-medical inflation, population growth, and often geographically isolated communities that increase facility maintenance costs and other expenses. The result is that, year after year, the Indian health system is unable to make meaningful improvements in reducing the significant health disparities experienced by American Indian/Alaska Native (AI/AN) Peoples.

Year after year, the federal government has failed Native communities by drastically underfunding the IHS far below the demonstrated need. According to the IHS National Tribal Budget Formulation Workgroup, IHS appropriations must reach $73 billion in FY 2027 to fully meet the current health needs. This amount includes full estimates for all services, facilities, and improvements needed to bring the Indian health system up to the same standards as the general U.S. population. In contrast, the FY 2024 enacted amount for IHS was $7.22 billion. Similarly, in 2023, IHS spending on medical care per user was only $4,078, while the national average was $13,493. However, some IHS areas and Tribes are not even funded at the IHS national average of $4,078 per user. This is despite years of statements to this effect from NIHB and Tribes across the

country. In 2018, the U.S. Commission on Civil Rights found that, "Federal funding for Native American programs across the government remains grossly inadequate to meet the most basic needs the federal government is obligated to provide. Native American program budgets generally remain a barely perceptible and decreasing percentage of agency budgets."[5]

Meanwhile, in FY 2024, IHS accounts were reduced to make room for growing Contract Support Costs (CSC) and Section 105(*l*) Lease Payments. With an already dramatically underfunded health system and the rising costs of providing health care nationwide, there is little room to crimp to accommodate these costs. The accounts that bore the brunt were the facilities and the electronic health record line item. This, of course, is compounded by years of sub-inflationary budget increases the agency has weathered, further diminishing IHS' purchasing power.

According to the IHS and Tribal Health Care Facilities' Needs Assessment Report to Congress, the need for facilities funding remains enormous. In 1992, the IHS established its current new construction priority list. Over 30 years later, of the original 27 facilities on the list, seven remain to be fully funded. IHS hospitals now average 39 years of age, more than three times the average age of U.S. not-for-profit hospitals (11.5 years). Aging facilities risk code non-compliance, lower productivity, and compromises for healthcare services. At the existing replacement rate, a new 2026 facility would not be replaced ***for 290 years.***

IHS exists to serve the health care needs of AI/ANs. However, as a direct result of the continued underfunding of IHS, quality and comprehensive health services remain inaccessible across many Tribal communities. In 2023, the CDC reported that the life expectancy for AI/ANs declined by nearly seven years, to 65.2 years, the same as the total U.S. population in 1944. This difference is 11.2 years fewer than the life expectancy of 76.4 years for the non-Hispanic white population.

AI/ANs experience some of the worst health outcomes in the United States and are dramatically poorer compared with the rest of the U.S. population. Additionally, AI/ANs continue to experience historical trauma from damaging federal policies, including those from the boarding school era and the forced removal from Tribal lands, as well as continuing threats to culture, language, and access to traditional foods. These compounding events along with chronic underfunding and access in Native communities have resulted in AI/AN populations experiencing high rates of poverty, high unemployment rates, barriers to accessing higher education, poor housing, lack of transportation, geographic isolation, and insufficient economic mobility, which contribute to poor health outcomes. Historic and persistent underfunding of the Indian health system has resulted in problems with access to care and has limited the ability of the Indian health system to provide the full range of medications and services that could help prevent or reduce the complications of chronic diseases.

TRIBAL IMPACTS OF THE 2025 GOVERNMENT SHUTDOWN

[5] U.S. Commission on Civil Rights. "Broken Promises: Continuing Federal Funding Shortfall for Native Americans." December 2018. Available at: https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf

A federal government shutdown, even a partial shutdown, brings immense stress and uncertainty for Tribal Nations and the programs that serve Native communities. The I/T/U system relies directly on federal appropriations to sustain its day-to-day operations and to deliver culturally grounded, lifesaving care to AI/ANs. When that flow of funding halts, even briefly, the impact reverberates through every level of care, from clinic payroll to medication access to preventive health outreach.

While the 2025 shutdown has demonstrated progress for the Indian health system due to the availability of advance appropriations, persistent vulnerabilities remain. Through funding enacted in FY 2024, IHS clinical services and most operational accounts critical for front-line support remain funded, ensuring that hospitals, clinics, and pharmacies are open and care continues uninterrupted. This stability represents a historic success for Tribal advocacy and proves that advance appropriations work. This success should serve as a model for all federal programs serving Indian Country.

Vulnerable Tribal Health Funding Streams

However, not every IHS account was protected. Several key funding lines, including the Facilities Construction, Sanitation Facilities Construction, the Indian Health Care Improvement Act Fund, Electronic Health Records, Contract Support Costs (CSC), and Section 105(l) lease payments. These combined accounts represent more than $1.3 billion of IHS' FY 2025 budget, including approximately $979 million for CSC and $349 million for 105(*l*) leases.[6] These resources are essential for sustaining the infrastructure and operations that make healthcare delivery possible: maintaining safe water systems, repairing aging facilities, funding administrative costs for Tribally operated programs, and reimbursing lease obligations required under self-governance compacts. When funding for these lines lapses, Tribes face construction delays, halted sanitation projects, deferred maintenance, and gaps in lease payments that threaten operational stability. These shortfalls demonstrate that even within IHS, advance appropriations must be expanded to cover the full range of accounts that uphold patient safety, facility integrity, and Tribal self-determination.

The shutdown has also exposed vulnerabilities across other federal health agencies. HRSA and SAMHSA funds were delayed, jeopardizing behavioral health programs, maternal health initiatives, and suicide prevention services. The CDC and Environment Protection Agency (EPA) programs that fund Tribal public health infrastructure, environmental safety, and clean water projects were paused or slowed, disrupting vital community health operations. When their functions pause, the effects are immediate.

Supplemental Nutrition Assistance Program

The shutdown has also disrupted nutrition security, which is inseparable from health in Indian Country. The Supplemental Nutrition Assistance Program (SNAP) provides vital food assistance to roughly 170,000 to 500,000 Tribal citizens, including many who live outside areas eligible for the Food Distribution Program on Indian Reservations (FDPIR). With one in four Tribal citizens

[6] Continuing Appropriations and Extensions Act, H.R. 9747, 118th Cong. (2024)

experiencing food insecurity, any lapse in SNAP benefits would devastate families and deepen existing health disparities. According to the U.S. Department of Agriculture (USDA), SNAP funding will expire on October 31, 2025, without congressional action. To prevent this, Senator Josh Hawley (R-MO) introduced the Keep SNAP Funded Act of 2025 (S. 3024), which would extend flat funding for FY 2026 and restore any missed payments retroactively. NIHB strongly supports this legislation and urges swift action to ensure uninterrupted benefits. Food security is health security, and ensuring stable access to SNAP is an essential part of the federal government's trust responsibility and treaty obligations to Tribal Nations.

The Special Diabetes Program for Indians

One of the most visible examples of how funding instability harms Tribal health is the Special Diabetes Program for Indians (SDPI). Established by Congress in 1997, SDPI remains the nation's most effective federal initiative for combating diabetes in Indian Country. Over nearly three decades, SDPI has achieved a 54 percent reduction in end-stage renal disease and a 50 percent decline in diabetic eye disease among American Indian and Alaska Native adults.[7] From 2000 to 2015, hospitalizations for uncontrolled diabetes among AI/AN adults dropped 84 percent, due in large part to SDPI innovative initiatives.[8] The program has also generated major federal savings, including saving Medicare an estimated $52 million per year and reducing broader HHS healthcare costs by $174–$520 million annually.[9]

Despite its success, SDPI was flat-funded at $150 million for more than 20 years before finally receiving a modest increase to $160 million in FY 2024 and 2025. However, the 2025 government shutdown has placed this critical program in jeopardy. As of October 1, 2025, the IHS has relied on unobligated balances to sustain operations temporarily. Lapses in funding, like the lapse created by this shutdown, and the ongoing cycle of temporary extensions and yearly renewals create significant uncertainty for the programs. Additionally, it leaves program administrators and participants in limbo. This instability makes it difficult for Tribal and urban Indian health programs to plan long-term strategies, retain skilled staff, and sustain vital diabetes prevention and treatment initiatives.

The NIHB strongly supports the permanent reauthorization of the SDPI at a minimum of $200 million annually, with automatic annual funding increases matched to the rate of medical inflation. Additionally, the NIHB supports amending the SDPI's authorizing statute, the Public Health Service Act, to permit Tribes and Tribal organizations to receive SDPI funds through self-determination and self-governance contracts and compacts. This change will establish the SDPI

[7] Indian Health Service. 2024 IHS Diabetes Care and Outcome Audit Results, available at https://www.ihs.gov/sites/sdpi/themes/responsive2017/display_objects/documents/factsheets/Audit2024FactSheet.pdf. Accessed on October 26, 2025.

[8] Agency for Healthcare Research and Quality (AHRQ). Data Spotlight: Hospital admissions for uncontrolled diabetes improving among American Indians and Alaska Natives. AHRQ Publication No. 18(19)-0033-7-EF. December 2018. https://www.ahrq.gov/sites/default/files/wysiwyg/research/ findings/nhqrdr/dataspotlight-aian-diabetes.pdf. Accessed on October 27, 2025.

[9] Department of Health and Human Service, *The Special Diabetes Program for Indians: Estimates of Medicare Savings*, ASPE Issue Brief, May 10, 2019, available at https://aspe.hhs.gov/sites/default/files/private/pdf/261741/SDPI_Paper_Final.pdf. Accessed on October 27, 2025.

as an essential health service and remove the barriers of competitive grants, which do not honor the Trust and Treaty obligations to Tribal nations. Self-governance also removes unnecessary administrative burdens that leaves more funding available for services. Self-governance Supports Tribal sovereignty by transferring control of the program directly to Tribal governments.

SUCCESS OF ADVANCE APPROPRIATIONS FOR THE INDIAN HEALTH SERVICE

For decades, the IHS was subject to the devastating impacts of government shutdowns. In 2022, after years of advocacy by Indian Tribes and NIHB, Congress provided the IHS with advance appropriations for the first time, ending its status as the only federal healthcare provider without advance funding.

The continuity of services and normal operations provided by advance appropriations at IHS during this shutdown reveals the critical need for advanced funding for the I/T/U system. Before the enactment of advance appropriations, the IHS was subject to the full impact of government shutdowns, disrupting all levels of care delivery. During the 35-day government shutdown in 2019, the IHS was the only federal healthcare entity without funding. While direct care services remained non-exempt, providers did not receive pay. In addition, administrative and technical staff responsible for scheduling patient visits, processing referrals, and managing health records were furloughed. Contracts with vendors for sanitation services and facilities upgrades went weeks without payment, prompting many Tribes to exhaust alternative resources to stay current on these bills. Many Tribes reported losing physicians to other hospitals and health systems unaffected by the shutdown. At the height of the budget instability, some Tribal governments were forced to reconcile their budgets up to 21 times in a single fiscal year due to successive short-term continuing resolutions, each lasting anywhere from a single day to several months.[10] This constant uncertainty strained cash flow and, in some cases, triggered credit downgrades for Tribes financing critical health facilities.

While it is impossible to measure the full scope of adversity brought on by the 35-day government shutdown, one reality remains clear: Indian Country was both unequivocally and disproportionately impacted. Through advance appropriations, the difference is clear. Advance appropriations have helped maintain stability during uncertain times. While Native communities are still affected, the IHS remains functional and responsive during the second-longest shutdown in US history. The IHS remains open thanks to the members of this Committee, as advance appropriations allow clinics to stay open, payroll to continue, and patients to receive care today. These advance funds have directly allowed IHS direct service facilities to maintain services and critical programs, while also planning for the future.

Advance appropriations also helped Tribal health systems respond to unexpected emergencies. On October 11, 2025, eleven days into the federal shutdown, Western Alaska was slammed by remnants of Typhoon Halong, which brought hurricane-force winds and life-threatening floods.

[10] US Senate Permanent Subcommittee on Investigations. "The True Cost of Government Shutdowns." February 2019. Available at: https://www.hsgac.senate.gov/wp-content/uploads/imo/media/doc/2019-09-17%20PSI%20Staff%20Report%20-%20Government%20Shutdowns.pdf. Accessed on October 27, 2025.

In southwestern Alaska, the Yukon-Kuskokwim Health Corporation (YKHC) assisted in coordinating response efforts and aiding in the rescue mission. Initial reports from YKHC indicated that Tribal leaders requested that medical providers and prescription medications be provided to Kwigillingok, Kipnuk, Tuntutuliak, and Chefornak. YKHC immediately coordinated with medical teams to assist these remote locations. Through available funds, YKHC provided services for community members in need and funded other relief efforts.

IMPACTS OF THE REDUCTIONS IN FORCE

Ongoing RIFs, early retirements, and hiring freezes across the HHS have created serious instability for Tribal Nations and the federal programs that serve them. These are not abstract bureaucratic changes; they directly weaken the government's capacity to fulfill its trust and treaty obligations to Tribal Nations. Since early 2025, workforce reductions and hiring freezes within HHS, particularly at the IHS, HRSA, SAMHSA, and CDC, have significantly reduced the personnel supporting Tribal programs. The uncertainty surrounding these actions has devastated morale, driving experienced staff and clinicians to leave the Indian health system altogether.

The IHS already operates with severe shortages, including a 30 percent overall provider vacancy rate and a 36 percent physician vacancy rate. Many facilities are so thinly staffed that losing just one physician-level provider could force closure; 43 percent of IHS facilities would have to shut their doors if that occurred. These shortages are not new. A 2018 Government Accountability Office report found that IHS clinics often lack enough doctors and nurses to deliver timely, quality care. [11] Staffing is not a bureaucratic detail—it is literally a matter of life and death in many Tribal communities.

When workforce reductions intersect with funding instability, it means lives are at risk. These losses of personnel and capacity translate into preventable deaths in Tribal communities, from precipitous births, cardiac events, untreated diabetes complications, and preventable suicides. We know these impacts because we have lived them. Before IHS had advance appropriations, during previous government shutdowns, members of our families died from exactly these kinds of emergencies.

The ripple effects extend throughout the IHS system. Area and Service Unit offices report bottlenecks in supply orders, personnel actions, and reimbursements for CSCs and Section 105(l) leases, forcing Tribes to deplete reserves or reduce services. As remaining staff shoulder impossible workloads, burnout and attrition accelerate. These reductions are especially damaging for Direct Service Tribes, who rely on IHS-operated care as an expression of sovereignty and trust responsibility. When federal staffing cuts eliminate positions or defer replacements, those Tribes are unfairly penalized, deprived of resources that would otherwise be available through self-governance contracts or compacts.

[11] 3 U.S. Government Accountability Office, Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies, GAO-18-580, published August 15, 2018, available at: https://www.gao.gov/products/gao-18-580, accessed on: January 27, 2025.

Beyond the clinical impact, RIFs have also eroded institutional knowledge and broken coordination and communication channels critical to Tribal consultation and intergovernmental collaboration. While NIHB appreciates Secretary Kennedy's efforts to protect Tribal Affairs offices, countless other federal staff—grant managers, liaisons, and technical assistance providers—play indispensable roles in connecting agencies to Tribal governments. Their departures have delayed grant awards, slowed decision-making, and disrupted key programs like HRSA's Rural Tribal Maternal Health Initiative, SAMHSA's Tribal Behavioral Health Grants, and CDC's various public health programs.

Impacts on the Administration for Community Living

When the 2025 HHS reductions went into effect, Tribes lost the bridge between federal policy and community well-being. The Regional Administrators (RAs) within the Administration for Community Living and Administration on Aging served as the direct point of contact for all 574 federally recognized Tribes. The RAs provided application guidance, training, and consistent support that enabled Tribal programs to connect resources with real people — ensuring Elders received meals, caregivers had help, and communities could prevent unnecessary institutional care. Their removal has left Tribal programs, especially smaller and under-resourced ones, to navigate complex systems alone.

The result is not administrative efficiency, but a loss of access to quality of life and positive healthcare outcomes, as Elders and people with disabilities are unable to receive meals, caregiving, and other community-based services that keep them independent in the places they call home. People who once remained safely in our communities are now at higher risk of institutional placement. The financial impact is significant considering the national average cost of nursing home care is $111,324 per year compared to $49,900 for home- and community-based care[12]. When Tribes administer these programs, these costs are often reduced further yet the outcomes remain positive with reported high rates of care satisfaction.

Title VI of the Older Americans Act remains the only federal funding stream dedicated exclusively to Tribal aging and disability services. Yet, only about half of Tribes are current grantees, and the absence of ACL technical assistance has made access increasingly fragile. These programs are vital—according to the National Resource Center on Native American Aging (NRCNAA), 42.5 percent of Elders rely on Title VI food programs for nutrition support[13] or would otherwise go hungry.

Across Indian Country, more than 945,000 Elders age 60 and older now depend on these programs. The "Baby Boomer" generation's aging will triple the number of Elders 65 and older in the coming years. Among them, 36.7 percent report a disability, including Veterans with service-related disabilities. Locally administered, tribally operated programs remain the most efficient and fiscally responsible model. Every dollar invested in these home- and community-based

[12] Genworth Financials Care Scout "Cost of Care" calculator, accessed at *https://www.carescout.com/cost-of-care*
[13] NRCNAA triennial survey of Title VI Elders, Cycle VII 2020-2023, accessed at https://www.nrcnaa.org/assets/5727-27214/cycle-8-data-book.pdf

services stays in the community, supports local jobs, and reduces downstream costs to Medicare and Medicaid. Yet coordination between ACL/AoA and Tribal health programs has been hindered by staff reductions that have slowed communication, impeded program operations, and increased administrative burdens.

To restore function and strengthen partnerships, the NIHB supports reinstating ACL/AoA Regional Administrators to restore technical assistance, training, and communication with Tribal grantees. Additionally, the NIHB recommends extending HHS deadlines for Tribal Title VI applications to prevent service interruptions and avoid more costly nursing-home spending, as well as engaging Tribal Leaders in consultation before any further changes to staff or programs impacting Native communities.

Impacts on the Health Resources and Services Administration

HRSA's maternal health funding and corresponding programs provide critical public health funding to Tribal nations across the US. However, the current government shutdown and the resulting RIFs have exacerbated HRSA's inability to properly provide technical assistance to grantees, leaving many Tribal nations struggling to implement grant programs. For example, Healthy Start, the nation's longest-running federal program dedicated to infant and maternal health, has been severely disrupted, with major staffing and funding impacts. The Healthy Start initiative enrolls pregnant women, partners, and infants up to 18 months of age for care coordination, education, health referrals, and social supports. This is a critical program for Tribal nations as AI/AN mothers experience some of the highest maternal death rates in the US while also facing numerous barriers to accessing care. The chronic underfunding of the IHS and lack of care access across rural settings, leave many AI/AN mothers and infants in care deserts.

Additionally, administrative bottlenecks have also emerged within HRSA's regional offices, where staff reductions have limited the agency's ability to provide technical assistance and monitor grantee performance. Tribal programs that depend on HRSA's guidance, such as health workforce development and health clinic support, are now experiencing gaps in oversight, communication, and program evaluation. These disruptions have real consequences for Tribal populations. Fewer HRSA staff mean fewer resources to recruit and retain clinicians in shortage areas, less support for maternal and child health programs, and reduced capacity to respond to public health emergencies. For Tribal Nations that already face workforce shortages and infrastructure challenges, the cumulative effect is a decline in access to timely, quality care. Moreover, uncertainty surrounding future funding and staffing has weakened morale across HRSA's workforce. Experienced grant officers and program specialists have departed, taking with them years of institutional knowledge that are not easily replaced. This loss of expertise undermines HRSA's long-standing ability to provide technical assistance to Tribal Nations as Tribes seek to improve the health of their people.

Ultimately, the RIFs have triggered a crisis of confidence in the federal commitment to Indian Country. Every lost or unfilled position represents diminished capacity to uphold treaty and trust obligations. At a time when Native communities continue to experience some of the nation's

most severe health disparities—from suicide and overdose to chronic disease—weakening the federal health infrastructure that supports them is not only short-sighted; it is a retreat from decades of bipartisan progress toward Tribal self-determination and improving the health and well-being of American Indian and Alaska Native people.

CONCLUSION

Government shutdowns and reductions in force are not administrative inconveniences; they are breaches of the United States' trust and treaty obligations to Tribal Nations. Every time federal operations are halted, or federal positions are eliminated, it forces Tribal Nations to bear the cost of broken promises. According to the Senate Permanent Subcommittee on Investigations, the last three shutdowns alone cost the federal government $3.7 billion in back pay and at least $338 million in lost revenue, late fees, and administrative waste. Those figures capture not only the fiscal waste but the human cost to Indian Country is far greater.

When the federal government shuts down or sheds its workforce, the consequences are immediate. Clinics lose providers, programs lose oversight, and communities lose lifelines. The recent RIFs, early retirements, and hiring freezes across HHS and IHS have compounded this instability, hollowing out the very systems that sustain Tribal health and safety. In small, rural communities, the loss of even one provider, grant manager, or emergency responder can mean the difference between stability and crisis—or between life and death.

Even after funding is restored or staffing plans are rewritten, the damage lingers. The uncertainty erodes trust, drives away skilled staff, and disrupts essential services that cannot easily be restarted. The trust responsibility is not subject to political cycles or budget impasse—it is a binding and moral duty that must be honored in both policy and practice.

As Congress and the Administration work to restore stability to the federal budget and workforce, they must ensure that the federal commitment to Tribal Nations is protected from disruption. The federal government's trust and treaty obligations do not shut down, and they cannot be reduced in force. Tribal Nations deserve consistency, respect, and a government that keeps its word. Our sovereignty does not shut down. Our people cannot wait.

Thank you for your time, and for this opportunity to address the committee and answer your questions.