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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

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

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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

WEDNESDAY, MAY 14, 2025

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 3:39 p.m. in room 628, Dirksen Senate Office Building, Hon. Lisa Murkowski, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. LISA MURKOWSKI, U.S. SENATOR FROM ALASKA

The CHAIRMAN. Good afternoon. Calling this oversight hearing to order.

We are here this afternoon to examine critical programs within the U.S. Department of Health and Human Services that are also essential to upholding the Federal Government's trust responsibility for the health and well-being of Native communities, but that are not under the Indian Health Service.

As we look broadly at the programs within HHS, we have to remember that for many Native communities, non-IHS programs are just as important as those under the IHS. From public health initiatives to social services, these programs often provide the only consistent access to basic supports for the most vulnerable members of Native communities.

So, what programs are we talking about? It is Tribal Head Start, that helps young children grow up healthy and rooted in culture, it is LIHEAP, that ensures tribal elders have heat in the winter and air conditioning in the summer. These aren't just Federal services, they are really critical components of the social safety net. My view is that these programs support family stability, child development and basic dignity.

So today, we are going to also hear about HHS programs like FVPSA, which is the Family Violence Prevention and Services Act. This is the primary Federal funding stream supporting vital crisis services and shelters for those experiencing family violence.

We will also hear about how tribes are reducing the risk of costly intervention and foster care removals through child welfare services and Tribal TANF. These programs help break intergenerational cycles of trauma, support safe housing and equip Native families with the tools to thrive.

Many tribes have built these effective programs over generations, investing their own resources, training their own workforce so that they better align with their culture and community needs. These are models of local innovation and sovereignty, and they deserve both protection and sustained support.

Given the scope and critical nature of these HHS programs, we are hearing growing concerns from tribes and Native communities about the executive order on optimizing the workforce across the Federal Government and the HHS announcements about reorganization and RIFs. I hear regularly from constituents that are asking, how do these proposals affect me and the delivery of essential services?

I want to acknowledge and thank Senator Kennedy for recognizing the importance of IHS very early on. He made clear that they were not going to be subject to those RIFs. Now we are asking for the same understanding for other programs at HHS. And that starts with tribal consultation at HHS on these programs. I think it has to occur early, be consistent and be meaningful.

We know that when tribes are truly engaged in shaping the policies and programs that serve their citizens, outcomes improve, trust deepens, and Federal resources are more effectively aligned with local priorities. These programs work best when they reflect the voices of the people that they are meant to serve.

Forums like this hearing are also important. This is your opportunity to formally make your case for these programs to the Legislative Branch. But we also know that HHS will take notice, too.

I was in a hearing that began at 1:30 before the Health Committee, and Secretary Kennedy was there. I had alerted him that we were having this oversight and he said, if he wasn't in that hearing he would be here as well, which I appreciate. And I think perhaps some of his team, if they are not here in the room, they might be watching or listening.

So I think what we learn today is not just going to be confined to this room, this audience, but broader.

I want to thank all of you for traveling with us to be here today or if you are here in D.C., your journey is a little bit easier. But I know your time and expertise are invaluable. The insights that you share will help inform our continued work to strengthen Federal programs and uphold the promises made to Native communities. So I am looking forward to your testimonies.

I now turn to Vice Chair Schatz for his comments.

STATEMENT OF HON. BRIAN SCHATZ,
U.S. SENATOR FROM HAWAII

Senator SCHATZ. Thank you, Chair Murkowski. I want to extend a special warm aloha to Dr. Sherri-Ann Daniels, CEO of Papa Ola Lōkahi. Papa Ola Lōkahi is the sole entity responsible for coordinating Native Hawaiian health care services, and is a leading voice

for health care across the State of Hawaii. Mahalo for your continued leadership on behalf of Native Hawaiian people.

Providing health care is one of the Federal Government's most fundamental trust and treaty responsibilities to American Indians, Native Hawaiians and Alaska Natives. And delivering on that promise depends on over a dozen HHS agencies, not just the Indian Health Service.

For Native Hawaiians in particular, HHS's trust responsibility extends far beyond just HRSA. But despite a lot of promises from the Secretary from the Secretary about strengthening Native health care and addressing longstanding issues, we have seen that this administration is engaging in staff layoffs, office closures, funding freezes and proposed budget cuts that will undermine the quality of care and overwhelm a health care system that, frankly, is already on the brink.

Native people are among the most vulnerable in health terms in the Country, falling behind on almost every metric. They experience some of the highest rates of cancer, heart disease, respiratory illness, diabetes, overdose and suicide, and their life expectancy is the lowest of any racial group in the United States and nearly 10 years below the national average.

So the status quo was insufficient to begin with. Then came the sweeping cuts at CDC, NIH, HRSA, SAMHSA, ACF, and other offices and programs. A CDC team supporting overdose prevention in tribal communities was reduced from seven staffers to a single human who is now responsible for managing millions of dollars in funding. The Healthy Tribes Program, which is focused on preventing certain chronic diseases, was gutted. Five HHS regional offices, which served 461 tribes in 22 States, terminated staff and were abruptly closed in March.

All of this means that Native communities have less support for job training, child care, domestic violence victim services, suicide and substance abuse prevention, and much more. These cuts are being carried out without any tribal consultation whatsoever in plain violation of our trust and treaty responsibilities.

This is not just a moral question of what we owe Native people; it is also a question of the law. Let's be clear: the status quo was already insufficient. The administration's proposed cuts of nearly $1 billion to Native health care will make matters worse.

There is bipartisan agreement on this Committee that these communities need more help. Now is the time to stand together to protect Native health care.

I want to thank our witnesses, and I look forward to the hearing.

The CHAIRMAN. Thank you, Senator Schatz.

We will now turn to the witnesses. I am going to turn to our colleague from South Dakota to do the first introduction.

STATEMENT OF HON. MIKE ROUNDS,
U.S. SENATOR FROM SOUTH DAKOTA

Senator ROUNDS. Thank you, Madam Chair and Vice Chair. I want to thank our witnesses as well for taking the time to attend today's hearing and share your perspectives.

Today I am proud to introduce my friend, Chairwoman Janet Alkire, of the Standing Rock Sioux Tribe.

After retiring as a staff sergeant in the U.S. Air Force, Chairwoman Alkire returned home to serve the Standing Rock Sioux Tribe. During this time, she oversaw the daily operations of tribal government programs while serving two terms as the Executive Director. In 2021, Janet became the first woman ever elected by the people as Chairwoman of the Tribe.

Chairwoman Alkire provides an important voice on several key tribal issues, including health care, public safety and economic development. In recognition of her leadership and advocacy, Chairwoman Alkire was named one of USA Today's women of the year in 2025. Not bad. Congratulations. Matter of fact, congratulations.

She continues to advocate for her people as a board member of the National Indian Health Board.

I want to again thank Chairwoman Alkire and all the other witnesses for attending today's hearing. Thank you, Madam Chair.

The CHAIRMAN. Thank you.

I will make full introduction of everyone, then we will begin with individual statements. Following Chairman Alkire, we have the Honorable Loni Greninger. She is the Vice Chair of Jamestown S'Klallam Tribal Council from Sequim, Washington.

We also have, from Fairbanks, Alaska, Melissa Charlie. Melissa is currently the Executive Director of Fairbanks Native Association. She is a tribal citizen of Minto, and has been involved in many, many leadership capacities in her region.

She is focused and committed to early childhood development and community wellness. We really appreciate the fact that you have traveled so far to be with us, Melissa.

Following Melissa, we have Lucy Simpson, the Executive Director for the National Indigenous Women's Resource Center from Lame Deer, Montana, as well as Dr. Sheri-Ann Daniels, who the Vice Chairman has already introduced. I am just going to try to say it, is the Chief Executive Officer of the Papa Ola Lōkahi, from Honolulu. It is good for us to be working through the names and doing them correctly to show that respect.

I want to remind everyone that we do have your full testimony that each member has. We would ask you to try to keep your comments to five minutes so that we can have questions following your statements.

So Chairman Alkire, you may begin with your testimony.

STATEMENT OF HON. JANET ALKIRE, CHAIRWOMAN, STANDING ROCK SIOUX TRIBE; REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD

Ms. ALKIRE. Good afternoon, Chairwoman Murkowski, Ranking Member Schatz, and distinguished members of the Committee. On behalf of the National Indian Health Board and the 574 sovereign federally-recognized tribal nations we serve, thank you for this opportunity to provide testimony today.

My name is Janet Alkire. I serve as the Chairwoman of the Standing Rock Sioux Tribe. I also serve as the Great Plains Representative for the National Indian Health Board. 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 in Indian Country.

The Department of Health and Human Services delivers vital programs to tribal nations and citizens from a part of the Federal Government's trust and treaty obligations. These services, many beyond Indian Health Service, are essential to the health and well-being of our citizens. As tribal leaders, we are deeply concerned about the ongoing HHS reorganization and its far-reaching consequences for serving tribal nations and their citizens.

Despite chronic underfunding, tribal nations, tribal organizations and Urban Indian Organizations rely on HHS resources to deliver lifesaving care. Tribes have long supported efforts to streamline Federal programs, reduce reporting burdens and direct funding to the Indian health system.

However, any reorganization must honor treaty and trust obligations, including meaningful consultation. We have urged HHS to hold consultations to ensure programs that serve tribal nations and citizens are protected. To date, the organization has reduced HHS staff by 24 percent, disrupting grant access, tribal advisory committees, and causing tribal program staff to leave.

This has already resulted in the cancellation of over $6 million in grants, jeopardizing critical infrastructure for the Indian health system. The Great Plains is experiencing a syphilis epidemic, with rates among Native people rising to 1,865 percent from 2020 to 2022, ten times the national average. The CDC played a key role in the response, but the recent restructuring cut nearly 20 percent of its staff, including those staff supporting our tribal epidemiology center.

OASH, Office of Infectious Disease, HIV/AIDS Policy also lost staff, ending a program that awarded $16 million to 18 tribal and Urban Indian Organizations, improved HIV outcomes by over 90 percent at the Phoenix Medical Center. This leaves us without essential Federal STI response support.

Additionally, the majority of the staff operating Healthy Tribes Program under CDC, which oversees several grants, including good health, wellness in Indian Country, grantees are receiving conflicting information about their grants and the programs are in limbo. One tribal grantee has already received notice of determination. A UIO has reported losing communication with their project officer and grants manager, leaving a critical gap in their program.

CDC's Division of Reproductive Health is a huge component for tracking maternal health and outcomes nationwide, including Native moms. These staff were also placed on administrative leave and updates to the pregnancy risk assessment monitoring system, one of the few national data sources that tracks Native maternal and infant health disparities, has been paused. Because of this, we are losing vital tools for identifying risks, interventions and saving lives.

SAMHSA's Center for Mental Health Services has seen major staffing cuts. Key tribal behavioral health grants have been terminated or left in limbo. Even when funding has been removed temporary disruptions in funding can destabilize programs.

The Great Plains Tribal Leaders Health Board is connecting with our youth program, which applies traditional Lakota values to reduce suicide through mentorship and culturally grounded education is at risk. This program reduced Native youth suicides in our area by 78 percent from 2019 to 2024. Successful outcomes like this shows what is at stake.

In conclusion, programs serving tribal nations and their citizens have a minimal fiscal impact, but are foundational to improving chronic health conditions in Indian Country. Tribes share a vision for a healthy America, but tribes must be consulted in the first instance.

Tribes want to work with HHS. I appreciate what the Secretary has done so far to protect our health. We want efficiency to reduce grant reporting, provide direct funding to tribes instead of reliance on State block grants, expand tribal self-governance outside the IHS.

We must avoid barriers such as DOGE Defend the Spend, which increased burdens and withheld funding from programs serving tribes and its citizens. We can be the solution to a more efficient HHS.

I thank the Committee for this opportunity to provide this testimony. Wopila.

[The prepared statement of Ms. Alkire follows:]

PREPARED STATEMENT OF HON. JANET ALKIRE, CHAIRWOMAN, STANDING ROCK SIOUX TRIBE; REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD

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 percent 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 profes-

[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.*

sionals. 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 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 percent 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 percent 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.

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

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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.

[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*)

adults/adolescents increased from 31 percent to 57 percent. In 2024, The Phoenix Indian Medical Center achieved viral suppression of over 90 percent 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 disproportionately impacted. HCV-related mortality is highest among Native people. Congenital syphilis has increased by over 5,000 percent 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 percent—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 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

[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.*

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 nonrenewed 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 been restored. However, even if such grants were restored—the act of terminating funding and restoring it in the

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[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).

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.

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

[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.*

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 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-togovernment 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 percent 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 Rec-

[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-ihsupdates-for-tribes-and-tribal-and-urban-indian-organizations/*.

ommendations 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-togovernment 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-togovernment 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, qualityimproving, 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.

The CHAIRMAN. Thank you, Chairman.

Next, we will go to Loni Greninger, the Vice Chair of the Jamestown S'Klallam Tribal Council.

STATEMENT OF HON. LONI GRENINGER, VICE CHAIRWOMAN, JAMESTOWN S'KLALLAM TRIBAL COUNCIL

Ms. GRENINGER. Thank you so much. [Phrase in Native tongue.]

Honored Leaders, Chair Murkowski, Vice Chair Schatz, thank you so much for the opportunity, and other members of the Committee that I know were here. I am grateful for their time as well.

I want to acknowledge the opening comments that you said earlier. You are going to be hearing me repeat probably many of the things that both of you have said already.

And for Vice Chair Schatz in particular, one of the things I have said at other tables before is, I hate being the first place in everything like that. Chronic disease, all these negative impacts, I hate being in first place. I want to be able to fix that.

So that is one of the reasons why I am here testifying before you today. So thank you for this opportunity.

For Chair Murkowski, I have family in the great State of Alaska, so I get to visit your great State often on the Kenai Peninsula. It is beautiful there.

So I am the current Vice Chair of the Jamestown S'Kallam Tribe. We are located in Squim, Washington, in the great State of Washington. I serve currently as the ACF Tech Chair, so I am pretty intimate with the ACF programs and how those programs are being implemented on the ground, especially within my region and in my State and in my community. The Jamestown S'Kallam Tribe actually has a few of the ACF programs, so I get to see what those things are doing to my families in the most positive way possible.

My service to my community comes very honestly. I have seven generations worth of tribal leadership in my blood, all going from educational services to child welfare. So for me to be a social services director at my tribe for five years is one of my passions. I currently serve as the chair of a few different tables in Washington State as an Indian policy advisory chair, serving not only just social services in maybe a traditional sense but also corrections, department of corrections and health care authority as well.

I am really glad to be able to be here to speak before you today.

In ancient times, we as tribes, we have had our own systems, so to speak, of how we addressed the community level needs, then the family level needs, then of course the individual needs. Most of that was addressed in our ancient times through communal living and also through spirituality. Because we believe that mental health and emotional health, that was made whole through the spirituality.

As the relationship between tribal governments and the United States was growing and it came to be, it was born, it has evolved over decades and decades and decades. So we have been learning how to evolve our systems, what does it mean to blend western systems with our indigenous perspective at the same time and being able to serve our people with these Federal services.

So this is why we are here testifying, we are here to try and figure out how do we blend that all together. And you mentioned tribal consultation, that is essential to us figuring out how do we blend these systems together and make these programs work for us. How do we make these programs fit our cultural needs and then translate them into Federal-speak so that we can access Federal funds?

The huge concern of the RIFs at HHS, as well as the proposed funding cuts, those are the things that are threatening our ability to be able to do that. These RIFs happened without tribal consultation. The budget proposal is happening without tribal consultation. I have lost connections to my staff in Region 10 at ACF, that means TANF contacts, that means my ACF regional administrator,

gone. Everybody is gone. And this was all done without consultation and with very little warning, not only to the tribes but also to the staff.

That also meant that we did not have any transition planning. There was nobody to tell us, hey, here is your next contact. For example, Regions 1, 2, 5, 9 and 10 have been consolidated, they have been eliminated and now they are being consolidated into the rest of the five.

So me in Washington State, my new regional office is in Denver, Colorado. And when you eliminate all of Region 10, just talking about Region 10 by yourself, that is all of Alaska's more than 200 tribes, Washington's 29, Idaho's 5, Oregon's 9, that is 250 plus tribes that now Denver is absorbing into their portfolio.

They don't know who we are, they don't know our lands. So we need to be able to have people on the ground who know our land, who know our intimate cultural nuances and our political nuances. That is what these HHS staff members have been for us, the technical advisor. They help translate our language into your language so we can access funds that are obligated to us through treaty and trust responsibility.

As I conclude here with my remarks, one of the things we want to see is just consultation. Consultation, consultation, consultation . We need HHS to understand the impacts that have already happened because of not having consultation. We know that there are regulation decisions to come, budget decisions to come, deregulation decisions to come. And we need to make sure that tribal voices are at the forefront, that we have our voices heard, our impacts are heard, so that we can minimize impacts and we can maybe find some different creative solution that meets both the Federal goal but also maintains trust and treaty responsibility for our tribes.

In conclusion, I do want to acknowledge that Secretary Kennedy, he seems to want to work with tribes, and I am glad for that. He has advocated for Head Start for us. And we saw that in the President's latest draft of the budget. So we are thankful for that. Thankful that LIHEAP is still also being chatted about as well.

Bu we want to see more. It is more than IHS, right? You mentioned this earlier. HHS programs as a whole, even if the word tribe, Native American or Indian isn't in the office name or in the grant name, it still serves tribes, and we want to be able to access that and make our communities healthy, so we continue to blend those systems together, and hopefully get us out of first place so we can be healthy again.

Thank you for the opportunity to speak before you today. I will look forward to any questions if you have any for me. Thank you.

[The prepared statement of Ms. Greninger follows:]

PREPARED STATEMENT OF HON. LONI GRENINGER, VICE CHAIRWOMAN, JAMESTOWN S'KLALLAM TRIBAL COUNCIL

Introduction

Chair Murkowski, Vice Chair Schatz, and members of the Senate Committee on Indian Affairs, thank you for the opportunity to testify in this oversight hearing regarding critical programs that serve tribal nations like mine, the Jamestown S'Klallam Tribe.

Tribal nations, as sovereign governments, have a government-to-government relationship with the United States. This relationship is based upon numerous treaties

between tribal nations and the U.S. government and is enshrined in the U.S. Constitution,[1] federal law, and numerous U.S. Supreme Court decisions. As part of the political relationship with tribal nations, the U.S. has a federal trust responsibility that is a legal obligation to protect tribal rights, lands, and resources, and to fulfill its obligations under treaties and federal laws. This includes providing for the well-being of tribal citizens through basic programs and services. Access to federal programs that support the basic needs of Native people is a critical element of the federal trust responsibility, which includes human services and behavioral health services provided by the Department of Health and Human Services (HHS), and an exercise of tribal sovereign authority to tailor programs to serve communities at the local level.

I have had the privilege of serving my tribe as Vice Chair since 2020 and have worked for my tribe's Social and Community Services Department from 2017–2022. I currently serve as the Chair of the Washington State Department of Social and Health Services Indian Policy Advisory Committee (since 2020), and the Washington State Governor's Tribal Leaders Social Services Council (since 2020). I also currently Chair the Administration for Children and Families (ACF) Tribal Advisory Committee (since 2022). In all of these roles, I am uniquely positioned to understand both the community impact of HHS's human and behavioral health services and the federal laws, policies, and implementation necessary to administer them.

In this testimony, I will focus on the role of human services and behavioral health services in tribal communities, identify federal programs that help tribal nations meet community needs, the role of HHS in providing support and assistance to tribal nations, and the impacts of recent reorganization efforts by HHS.

Tribal Human Services

Tribal human service programs administer a range of services that provide core support for tribal community members to meet their basic needs and improve their well-being to increase their quality and standard of living. Federal human service programs enable tribal nations to ensure every citizen can meet basic needs related to employment, food, housing, medical care, education, and childcare. They also provide support to ensure community members are protected from harm, can develop a healthy sense of belonging, have opportunities to have regular social contact, and more generally, find stability in their lives.[2] For people living in unstable and vulnerable conditions, these services can mean the difference between life and death in some cases. As tribal nations strive to create communities where children, families, and elders can thrive, human services play a vital role in supporting positive change that is accessible and sustainable.

While the types of human services vary widely, there are a number of key services that are contained within this category of services. They include, but are not limited to:

- prevention services,
- child, adult, and victims of crime protection,
- in-home family services,
- case management and service coordination,
- out of home placements for children,
- job training and education,
- childcare,
- housing and food assistance,
- participation in court hearings,
- intergovernmental coordination and service collaboration with federal, state or county partners, and
- referrals and coordination with other service providers, such as mental health, substance abuse treatment, child welfare, juvenile justice, employment assistance and training, education, food assistance, health care, childcare, housing, and law enforcement.

Examples of federal programs under ACF that support tribal human services include the following:

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[1] U.S. Constitution, Article VI states, "This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land. . ."

[2] Mayo Health Clinic Health System. (2021). Is Having a Sense of Belonging Important? *https://www.mayoclinichealthsystem.org/hometown-health/speaking-of-health/is-having-a-sense-of-belonging-important.*

- Title IV–B, Subpart 1, Child Welfare Services [3]
- Title IV–B, Subpart 2, Promoting Safe and Stable Families
- Title IV–E Foster Care, Adoption Assistance, Relative Guardianship, and Prevention Services
- Chafee Independent Living Program (youth aging out of foster care)
- Community Based Child Abuse Prevention grants
- Tribal Court Improvement Grant Program (tribal juvenile court proceedings)
- Social Services Block Grant (tribes receive pass-through of state allocations)
- Child Support Enforcement
- Temporary Assistance to Needy Families
- Tribal TANF-Child Welfare grant program (services integration and coordination)
- Native Employment Works grant program
- Family Violence Prevention and Services grant program
- Child Care and Developmental Fund
- Community Services Block Grant
- Affordable Housing and Supportive Services Demonstration grant program
- Rural Community Development grant program
- Low Income Home Energy Assistance Program grant program
- Community Economic Development grant program
- Head Start
- Tribal Personal Responsibility Education Program grants (adolescent pregnancy prevention)
- Demonstration Grants for Domestic Victims of Human Trafficking grants
- Runaway and Homeless Youth grant programs
- Administration for Native Americans social, economic development, and language preservation grant programs

Key to a well-functioning human service system is the integration of services from a variety of fields to create a system of programs and services that address families in a holistic manner. When programs or services are siloed and don't collaborate well, they struggle to communicate, adapt to changing client needs, and take advantage of opportunities to address issues early before crisis sets in. Tribal human service programs, by their nature, are well-adapted to developing program efficiencies and innovative ways to serving their citizens.

As an example, the Central Council of the Tlingit and Haida Indian Tribes of Alaska child welfare program understood many of the families that are involved with the tribal child welfare system are also involved with their Temporary Assistance to Needy Families (TANF) program. They also know that many of the families involved in their tribal child welfare system have been seen by the TANF program a year or more before they came to the attention of the tribal child welfare program. A number of years ago, the tribal child welfare and TANF programs outlined a strategy to improve the capacity of the TANF program to assess the risk for child maltreatment with their families and improve coordination with the child welfare program. The collaboration utilized an adapted child abuse and neglect risk assessment tool that TANF staff were trained to administer, which resulted in the identification of tribal families with child abuse and neglect risks earlier so they could receive child welfare services. This resulted in more families getting help earlier, reducing the risk of trauma to children and their families from foster care removal, and lowering the risks for more costly and intrusive interventions.

Tribal nations serve a critical role in providing these services not only for tribal citizens living within their tribal boundaries but also with state agencies that provide services to tribal citizens living off tribal lands. In child welfare, tribal assistance helps states reduce state costs and administrative burden, helps ensure appropriate and effective services are provided to Native families, and improves implementation of federal legal requirements, like those contained in the Indian Child Welfare Act. [4] In many cases, tribal human service programs also serve non-Native populations on or near tribal lands. Tribal programs like TANF, child welfare, and

[3] Title IV–B and Title IV–E refer to programs authorized under the Social Security Act.

[4] U.S. Government Accountability Office (2005). *Indian Child Welfare Act: Existing Information on Implementation Issues Could Be Used to Target Guidance and Assistance to States*. Washington, D.C.: Government Printing Office. *https://www.gao.gov/assets/gao-05-290.pdf*

childcare provide services and support to non-Native populations that would otherwise not be available in their area or would be much more challenging to access than state services. When tribal human service programs have adequate federal support, they are much more likely to be able to assist states and nearby non-Native communities, as well as tribal citizens living on tribal lands.

Tribal Behavioral Health Services for Children and Youth

Trauma is a key factor in the need for tribal human services. Threats to well-being like child maltreatment, substance abuse, domestic violence, and homelessness are highly linked to trauma. Exposure to trauma during childhood creates an adverse childhood experience (ACE). ACEs measurements help practitioners and researchers understand the impact of trauma in children and youth that are exposed to violence, abuse, or neglect. The impact of a traumatic event can occur through direct contact or by witnessing a traumatic event in the home or community.[5] Children and youth who have ACEs can often carry the negative effects, especially if untreated, into adulthood, which creates a higher risk for poor health, mental illness, and substance abuse.[6] Native populations have one of the highest rates of ACEs, in one study 2.3 times higher than any other racial group.[7] Another measure of the critical need to better address trauma in young Native people is the extremely high rate of suicide among Native youth between the ages of 15–19 years of age.[8] Behavioral health services are needed to treat existing trauma, prevent exposure to additional harm, and reduce the need for lengthy and repeated human services interventions.

In tribal communities, behavioral health services are provided through a combination of programs and services, such as mental health or substance abuse prevention and treatment. This can include services that are based on Western models of practice, tribal cultural models, or a combination of both. While the Indian Health Service (IHS) is one of the key providers of funding for tribal mental health services, and in a small number of tribal communities, directly provides mental health services, these funding streams are primarily designed for adults and not for children and youth. While the general number of professionally trained therapists in Indian Country is low, the number of child-trained therapists is even lower and well below what is needed to address at-risk children and youth. Access to state behavioral health services for Native children is also challenging, especially for Native children and youth that reside in remote areas of the country. Adding to this is the extremely limited availability of state-funded, child-trained therapists that have experience with Native children and youth. Federal programs, like those funded under the Substance Abuse and Mental Health Services Administration (SAMHSA), provide vital resources to tribal nations to develop their own community-based child and youth mental health and substance abuse prevention and treatment programs and services.

Examples of federal programs under SAMHSA that support tribal behavioral health services include the following:

- Tribal Behavioral Health Grants Program (two grant programs, mental health and substance abuse, that seek to prevent suicidal behavior and substance abuse among Native youth)
- Circles of Care grants (developing community based, children's mental health systems)
- Project Launch grants (promote wellness of children ages birth to eight years of age through positive mental, behavioral, and cognitive development)
- Children's Mental Health Services grants (operate and enhance community-based children's mental health systems)

Numerous tribal grantees that have received these federal funds have gone on to develop innovative children's mental health programming that provides children's mental health services in communities that previously had none and established fi-

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[5] Centers for Disease Control. (2024). What is Adverse Childhood Experiences? *https://www.cdc.gov/aces/about/index.html#:-:text=Adverse%20childhood%20experiences%2C%20or%20ACEs,attempt%20or%20die%20by%20suicide.*

[6] *Ibid.*

[7] Giano Z, Camplain RL, Camplain C, Pro G, Haberstroh S, Baldwin JA, Wheeler DL, Hubach RD. (2021). Adverse Childhood Events in American Indian/Alaska Native Populations. *https://pmc.ncbi.nlm.nih.gov/articles/PMC8098634/#:-:text=Results:,educational%20attainment%20reported%20lower%20scores.*

[8] Office of Minority Health. (2021). Mental and Behavioral Health—American Indians/Alaska Natives. *https://minorityhealth.hhs.gov/mental-and-behavioral-health-american-indiansalaskanatives.*

nancial sustainability by working collaboratively with states to leverage other federal and state funding.

HHS Reorganization Efforts and Impacts to Tribal Community Human and Behavioral Services Programs

While tribal human services programs have demonstrated their ability to design and operate effective services for their communities, they also need assistance from federal agencies to achieve their full potential. The National Indian Child Welfare Association, a leading tribal organization working to improve tribal human services, conducted 11 listening sessions with tribal leaders and tribal human service directors from October of 2023 through June of 2024, where many of the participants shared concerns regarding tribal human service programs being understaffed, lacking access to appropriate training, and needing improved support and technical assistance to access federal funding and ensure tribal programs can provide community-based programs that will meet federal requirements.

Beginning in February, numerous federal staff at ACF, both in the regional offices and central office in Washington, DC, had their positions eliminated based on HHS's reduction in force goals; the results were eliminating probationary staff, regional offices were closed, or staff took the buyouts being offered by the Administration. In some cases, staff who were considered probationary had been working for many years in another federal job within HHS but were considered probationary because they had been promoted or had taken a different job within HHS within the last two years. In ACF's central office in Washington, DC, there were five senior advisors on tribal engagement that advised ACF leadership on how to improve the agency's engagement with tribal nations and improve tribal participation in ACF programs. This team worked closely with regional ACF office tribal program leads and was improving ACF consultation and relationships with tribal nations across the country. As of May, only two staff in the central office tribal engagement team are still employed, and all but a few of the regional office tribal program leads have been let go as part of the regional office closures in five regions.[9]

In addition to elimination of staff in probationary status and buyouts, firings of whole teams of federal program staff have crippled program operations for certain ACF programs. For example, it is our understanding that the entire central office team for the Low Income Home Energy Assistance Program(LIHEAP) have been dismissed, creating a void for tribes needing help with the operation of their LIHEAP programs. This includes operating under their current grant and preparing for submission of year-end reports and funding applications for the next fiscal year.

Another facet of HHS staff reductions has been the timing and process used. According to reports by former federal staff, notice of staff reductions has occurred with less than 24-hour notice with staff being ordered to leave their office the same day. This doesn't allow for an orderly transition of work to other staff or managers and is demoralizing for both the staff that are fired and for those that remain. While HHS has talked about rehiring staff in some agencies, former staff that have experienced the first round of firings are reporting they are not feeling inclined to return to HHS. This has also eroded the desire of people new to the federal service to accept positions at HHS, especially those with higher-level skills and knowledge applicable to tribal nations.

The HHS regional office closures occurred abruptly causing tribal human service programs to scramble to find answers to program and fiscal issues and seek assistance as they develop their new applications for federal grant programs. The five regions that were closed served 80 percent of all federally recognized tribes in the United States. Many tribal human services directors have reported that even a month later, they haven't been able to talk to a person at ACF or have their voicemails or emails responded to. This comes at a particularly difficult time as hundreds of tribes are trying to fill out their funding applications for next fiscal year's funding and were in process with regional office tribal program leads to ensure they could submit a successful application (e.g. Child and Family Services Plans, Child Care Development Fund, LIHEAP, Title IV, Child Support, TANF, etc.). Other tribes were working with regional office tribal program leads to address training needs or develop strategies to address tribal-state concerns in service delivery.

While in some cases, ACF has referred tribes to other regional offices, they are often referred to regional staff that already have full workloads and can't respond to them in a timely manner or have little to no experience working with tribes and the federal programs they participate in. The strategy of "next man up" in assist-

[9] Five regional HHS offices were abruptly closed on April 1 and staff put on administrative leave pending their termination. The regional offices closed were regions 1, 2, 5, 9, and 10.

ance to tribes, trivializes the necessary skills and knowledge needed to work effectively with tribes and the years of professional development it takes to competently provide assistance to tribal nations. In this current environment, many tribal human services directors fear that federal assistance will become less focused on the values of supporting tribal self-determination and program effectiveness, and more on compliance and process.

Besides existing program work, ACF is also responsible for guiding implementation of new laws that are approved by Congress. Last year, in an overwhelming bipartisan show of support, Congress approved the Supporting America's Children and Families Act (P.L. 118–258). This new law reauthorized Title IV–B programs under the Social Security Act to accomplish a variety of goals, including streamlining administrative requirements for states and tribes, creating new technical assistance opportunities for states and tribes to improve implementation of the Indian Child Welfare Act, and improve tribal court participation in state court proceedings and data collection involving Native children and families. This historic law will require ACF's best efforts to develop guidance and provide assistance to states and tribes that will ensure a smooth and proper implementation. With fewer ACF staff with experience in tribal child welfare available, especially in areas where regional offices were closed, there are concerns about how this will impact the implementation and opportunities for tribal nations under the Supporting America's Children and Families Act.

An underlying concern in all of these changes at HHS was the lack of consultation with tribal nations. In almost every situation, tribal nations found out about these changes after the fact, usually in the media, well after the decisions had been made. While I and many other tribal leaders can appreciate your desire to improve the effectiveness and efficiency of the federal government, something that is important to tribal leadership too, respecting the nation-to-nation relationship requires adherence to formal government-to-government protocols, which begin with consultation before decisions are made that impact our communities.

Conclusion

While there is great appreciation for HHS's efforts to protect IHS programs and services from cuts and staff firings, attention also needs to be given to the implications of HHS's reorganization plans for human services and behavioral health services programs. None of these programs operate in isolation, just as our citizens don't live in isolation either. Our most vulnerable citizens and the programs that serve them need the assistance of fully qualified staff that understand their needs and have ongoing working relationships with our tribal communities. HHS's trust responsibility doesn't stop at IHS. It extends to all of the agencies of HHS and requires carefully planned consultation with tribal nations before policy decisions are made and the consideration of our rights as tribal people under our treaties and federal law. Consulting with tribal nations provides HHS with greater opportunities to identify and implement program efficiencies and establish more effective programs-in essence, tribal consultation will further our shared goals of achieving government efficiency and reduce federal bureaucracy, while maintaining the trust responsibility and continuing to empower tribal sovereignty.

Thank you for the opportunity to testify before you today.

The CHAIRMAN. Thank you very much. Well said.

Melissa, welcome to the Committee.

STATEMENT OF MELISSA CHARLIE, EXECUTIVE DIRECTOR, FAIRBANKS NATIVE ASSOCIATION

Ms. CHARLIE. Good afternoon, Chair Murkowski and Vice Chair Schatz and members of the Committee. Thank you for this opportunity to testify today. My name is Melissa Charlie, and I serve as the Executive Director of Fairbanks Native Association, FNA, a Native non-profit organization serving the Alaska Native community since 1967.

I am here today not only on behalf of FNA, but also to uplift the critical importance of Tribal Head Start and other U.S. Department of Health and Human Service programs that serve Native communities nationwide. At FNA, our Tribal Head Start program is the foundation of our investment in early childhood development, cul-

tural identity and family stability. Our program offers not only education but nourishment, cultural grounding, health and intervention while offering a healthy foundation for families who need it the most.

Our classrooms honor Native idendity and language, instilling pride in our community while preparing children for academic success. For many families, Tribal Head Start is the first point of connection for our broader network of services that address health, nutrition, wellness and family support. Moreover, our program, like many others, integrates traditional knowledge, language and values into every single classroom.

We know Tribal Head Start and child care programs across the Country integrate various programs and grants to stretch every dollar and create a system of comprehensive community based services. Many of these include utilizing Head Start with child care development funds or connecting programs with language work, at the Administration for Native Americans.

Indian Country is the most dynamic investment that the Federal Government can make. Our funding is no different. In addition to Head Start, FNA operates several other critical programs under HHS, including youth and adult behavioral treatment programs which provide services that integrate Native cultural values and practices with evidence based approach funding from SAMHSA, child welfare community based family prevention emergency youth shelter services and family and domestic violence prevention and services under ACF.

And we utilize funding under the current administration for community living such as Administration on Aging, Title VI funding, which fosters a healthy and connected elder community by providing nutrition, support services and caregiver services.

Yet, despite decades of success, Tribal Head Start and other programs remain under-resourced compared to other non-tribal counterparts. We face challenges recruiting and retaining qualified staff due to wage disparities. We need updated facilities and modern learning materials and a more robust professional development, which requires an increase in stable Federal investment and partnership with tribal organizations. Now is not the time to divest these programs; now is the time to invest in Indian Country, the same way the Federal Government hopes to reinvest in States.

These programs work to form a safety net for our tribal families who too often exist in a gap where they remain underserved by State and local communities. Importantly, tribal programs like these are a direct impact for fulfilling trust and treaty obligations to tribes.

In our area, the tribes and villages have done so through Native organizations like FNA. Whether a tribal nation or a Native organization, we are the best positioned to deliver these services, because we understand our communities, histories, strengths, and our needs.

Tanana Chiefs Conference, TCC, is our sister organization, providing a large array of prevention and clinical services for the Alaska Native population across interior Alaska. Either in complement of FNA services or in collaboration with FNA, TCC, like FNA, relies on Federal funding guaranteed under the Federal Govern-

ment's trust obligation to Alaska Natives and American Indians, which requires the United States to protect tribal lands, assets, resources, and treaty rights and to provide certain services such as health care, education, and housing.

The Federal trust obligation is not one that can simply be transferred to a State government. It is a legal and moral obligation of the Federal Government alone.

For FNA and the many tribes across the Country, HHS programs are not simply support services, they are an active nation-to-nation partnership, upholding the Federal trust responsibility to Native children, families and communities.

Today, I urge Congress to protect and maintain the Tribal Head Start program and other child care funding, and support such child care development funds, ensuring that these setasides go directly to tribes or Native organizations and that they are not rerouted through the States; to protect SAMHSA funding for tribes like the tribal behavioral health grants and ACF programs, including by protecting the Administration for Native Americans through streamlined funding which is directly provided to tribes and Native organizations; to support infrastructure investment so tribal providers can modernize facilities and expand reach.

We stand ready to work with the administration and Congress to streamline and strengthen these programs with quality investments.

Thank you for holding this important hearing and for your continued focus on the health and well-being of Native communities. I look forward to your questions. [Phrase in Native tongue.]

[The prepared statement of Ms. Charlie follows:]

PREPARED STATEMENT OF MELISSA CHARLIE, EXECUTIVE DIRECTOR, FAIRBANKS NATIVE ASSOCIATION

On behalf of the Fairbanks Native Association (FNA), a Native non-profit organization based in Fairbanks, Alaska committed to improving the quality of life for individuals and families by promoting justice, healing, and wellness in our community, thank you for the opportunity to provide written testimony on the critical services supported by the U.S. Department of Health and Human Services (HHS) and the profound impact these services have on our Alaska Native community.

My name is Melissa Charlie, and I am the Executive Director of FNA. In addition to my role at FNA, I serve on the Advisory Board of the Fairbanks North Star Borough Board of Education. I am Athabascan and Inupiaq, and I am a Tribal member of Minto, Alaska.

FNA was incorporated in 1967 in direct response to the social service needs of Alaska Natives in Fairbanks during a time when Native people were increasingly moving to the area from remote villages and Alaska Native soldiers were returning from military service. Access to basic health and social services was severely limited. Educational outcomes were extremely low, and life expectancy for Alaska Natives was alarmingly short. Because of the work of our early leaders, and thanks to increased investment in education and healthcare, our community has made substantial progress across quality-of-life indicators over the last sixty years.

FNA provides services within the Fairbanks North Star Borough, which has an Alaska Native and American Indian population of approximately 10,000 people. Working with our sister organization, the Tanana Chiefs Conference, our combined efforts serve more than 12,000 Alaska Natives across 42 communities in Interior Alaska.

With support from the U.S. Department of Health and Human Services, FNA serves our community through three major program areas: early childhood development, behavioral health services, and community services. The work we do at FNA is deeply rewarding. We assist individuals in times of great need—whether they are facing homelessness, substance abuse, mental health challenges, or grief. From the womb to the end of life, FNA is here to serve.

As our late founder, Poldine Carlo, often said: "There is no greater reward than serving our people."—Poldine Carlo, founding member of the Fairbanks Native Association

These programs are essential to addressing the needs of our Native population and strengthening the overall health, safety, and resilience of our community. Continued federal support for these HHS programs is critical to ensure we can meet these needs now and into the future.

Federal Obligations

The federal government's trust obligation to Alaska Natives and American Indians is a legal and moral commitment rooted in treaties, statutes, executive orders, and judicial decisions. It requires the United States to protect tribal lands, assets, resources, and treaty rights, and to provide certain services, such as healthcare, education, and housing. This obligation stems from the historical relationship between tribes and the federal government, in which tribes ceded large portions of land in exchange for these protections and services. The trust responsibility may seem to be carried out primarily by federal agencies like the Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS), but truly extends across the federal government, and outside of tribal-specific agencies. The trust obligation emphasizes the government's duty to act in the best interest of Tribal Nations and individuals with loyalty, care, and accountability.

FNA is only one of many Alaska Native and American Indian organizations providing services that are made available under the federal government's trust obligation. We work in lockstep with Tanana Chiefs Conference, our sister organization, to provide a large array of prevention and clinical services for the Alaska Native population across the Interior of Alaska. TCC's services either complement those offered by FNA or are provided in collaboration with FNA. Like FNA and many other Native entities, TCC too relies on Federal funding provided under federal trust obligations.

The federal government's trust obligation to Alaska Natives and American Indians involves a complex interplay of legal, financial, and social responsibilities. While progress has been made in certain areas—such as tribal self-determination and economic development—there are still significant challenges, particularly around underfunding, legal complexities, and the need for more meaningful, long-term investments in Native communities. The trust obligation is an ongoing process that requires constant attention, accountability, and respect for tribal sovereignty.

Despite this legal obligation, the federal government often fails to fully fund the programs and services essential to Native communities. This underfunding has led to significant disparities in health, education, and housing outcomes between Native and non-Native populations. Due to underfunding in the IHS, BIA, and Bureau of Indian Education (BIE), tribal organizations are relying on other federal funding like SAMHSA, HRSA, CDC and others to help support the provision of essential prevention, behavioral health and clinical services to decrease these disparities. Proposed cuts to many grants, programs and services currently provided through funding from these agencies, are of great concern to all of us and our partner organizations.

The federal government's trust obligation is not one that can be transferred to state governments. Again, it is a legal and moral obligation of the federal government alone, which should be honored in good faith and due diligence.

Tribal Head Start and Early Childhood

At FNA, one of the major services we provide is our Tribal Head Start Program. FNA's Head Start program promotes cultural identity of Alaska Native and American Indian families, while equipping all enrolled children with the educational, physical, and social skills and tools for a great head start towards school readiness. Students receive health screening for vision, dental, hearing, physical and cognitive development—an important early intervention to ensure any additional services are prioritized. Head Start works with families to connect with partnering community agencies for additional resources that they may need to succeed.

While many of these services are key lifelines that Head Start programs provide children nationwide, there are a few key differences between Tribal Head Start and other Head Start programs. The main difference lies in who administers them and the communities they are designed to serve.

Tribal Head Start programs are administered directly by tribal governments or tribal organizations. Our programs incorporate Native culture, language, and traditions into the curriculum and daily operations. We design our programs to support the cultural preservation and educational success of our children.

In short, Tribal Head Start is tailored for Native communities, while general Head Start serves the broader population of low-income families.

Our Head Start and Early Head Start programs are a strong example of how Alaska Native culture is thoughtfully woven into early childhood education. Our children are introduced to our Native languages throughout these programs through songs, simple phrases, and greetings. Elders and cultural bearers are regularly invited to share traditional stories, legends, and oral histories, passing down intergenerational knowledge.

FNA's program goes beyond education—it builds identity, pride, and connection to Native heritage from an early age, while meeting all federal Head Start standards. This is also true for Head Start programs in rural Alaska, including the Tanana Chiefs Conference regionwide programs, and other Tribal Head Start programs nationwide.

Other Critical HHS Programs

In addition to Head Start, FNA operates many other critical programs to fill gaps in services typically provided by state government for non-Tribal communities. These programs address the needs of our Native communities by providing the programs the federal government owes under trust and treaty obligations. Many of our services are funded under HHS outside of the Indian Health Service.

One program that has been considered for elimination by the Administration is the *Community Services Block Grant*. This grant, which FNA receives under the set-aside for Tribes and Tribal Organizations, provides services that remove obstacles to the achievement of self-sufficiency for low-income individuals, families, Elders, and homeless community members. By providing services that support self-sufficiency and that address emergency assistance needs, youth development, and health and nutrition, the program enhances the lives of low-income individuals with services that meet their needs and empower them with the resources, knowledge, and skills needed to achieve self-sufficiency. We urge Congress to protect this program for tribes. Unlike states, our communities do not have the tax revenue to pick up the services otherwise provided by the federal government.

Title VI funding through the Older Americans Act provides critical nutrition and supportive services for elders and caregivers, with 362 enrolled in the program. Through the congregate meals program, FNA serves approximately 800 hot lunches monthly on weekdays and provides group programming and information about a range of health, safety, and nutrition topics relevant to the population. This has been an area identified as a critical need in the Fairbanks North Star Borough, as an FNA survey of local elders in 2022 found that for 57.3 percent of respondents it was often or sometimes true that they could not afford to eat balanced meals. Additionally, three out of the five most common chronic conditions in the population are closely linked with nutrition: high blood pressure, diabetes, and osteoporosis. With more than one in five elders reporting that they eat alone most of the time, the congregate meal program also serves a critical function in helping to reduce isolation and promote social connection among this vulnerable population. Title VI funding also supports caregivers by connecting them to information and community resources and providing training, specialized support, and supplemental services. Given that current levels of programming are not able to meet the full degree of need for elder nutrition and support services, the funding that is provided under Title VI remains a critical resource for supporting the health of elders in the community.

We also receive funds from the *Family Violence Prevention and Services program*, which supports the prevention of and response to incidents of domestic violence, dating violence, family violence and their dependents. supports the prevention of and immediate response to incidents of domestic violence, dating violence, family violence by providing emergency shelter, supplies, and services to adult victims and their non-abusing dependents. Domestic and/or family violence continues to be an area of high need among FNA's service population, with 58.8 percent of consumers receiving victim services through FNA Community Services department reporting domestic and/or family violence in 2024. In Interior Alaska, where housing is limited and the cost of living is high, Family Violence Prevention and Services funding is especially critical in providing immediate access to temporary housing and resources that allow victims and their children to escape violent situations and meet their basic needs, a first step to achieving stability, security, and self-sufficiency.

Our *Tribal Maternal, Infant, and Early Childhood Home Visiting Program*, which FNA has operated since 2010, except in fiscal years 2015–2017 when funding was not available, uses the evidence-based Parents as Teachers (PAT) model to provide American Indian and Alaska Native children and families services that address their critical maternal and child health, development, early learning, family sup-

port, and child abuse and neglect prevention needs. Serving 30 expectant families and families with young children aged birth to kindergarten entry, the Tribal Home Visiting Program is a critical link in the continuum of early childhood education and family wellness that coordinates with other existing resources like AIAN Head Start to support healthy, happy, and successful children and families. As one of only a few providers offering services in the home for pregnant women and/or families with children younger than 5 years of age to the over 6,000 children ages 0–5 in the Fairbanks North Star Borough,[1] the Tribal Home Visting Program provides critical support for these children and families whose needs would otherwise go unmet.

FNA's *Domestic Violence Prevention program* provides primary and secondary domestic and sexual violence, trafficking, and abuse prevention programming for youth and adults. The DVP grant funds support community outreach and awareness events and evidence-based prevention programming for youth, in collaboration with the local school district. The DVP program facilitates coordinated community response to domestic violence prevention and intervention by emphasizing active collaboration between FNA's Community Services Department and the Fairbanks Police Department, the Alaska State Troopers, the District Attorney's Office, a local domestic violence shelter, and other service providers. Without access to this program, the community would lose important opportunities to learn about and connect with services through the many well-attended outreach and prevention events and activities it supports, and elementary and secondary aged youth throughout the Fairbanks North Star Borough would miss out on opportunities to build important life skills and trusting relationships that develop resilience and set them up for healthy and fulfilling lives. Through comprehensive prevention and skill-building programming, education and awareness activities, and community outreach events, the DVP grant reaches more than 600 youth and more than 1,200 adults annually.

Through its youth and adult services divisions, FNA's Behavioral Health Services (BHS) Department provides residential and outpatient, evidence-based prevention, intervention, and treatment services for more than 1,200 people annually through *18 population-specific programs funded by grants from the Substance Abuse and Mental Health Administration, Administration for Children and Families, and Indian Health Service*. Although multiple programs are intentionally designed to meet the needs of AIAN community members by integrating cultural values and practices with evidence-based mental and behavioral health strategies, many BHS programs provide community-wide services for anyone who needs them. These lifesaving and life-changing programs include projects funded by 19 active grants from the U.S. Department of Health and Human Services, including a one one-time Health Resources and Services Administration Community Project Funding/Congressionally Directed Spending grant for construction/renovation of the BHS Women's and Children's residential treatment facility.

FNA's *Women's & Children's Center* is a residential substance use disorder and mental health treatment facility for pregnant women and women with children ages 0–7 years old. Serving the entire state, it is a four- to six-month program providing individual and group treatment sessions. The primary outcomes of the program are that mothers learn how to interact with their children in a substance-free lifestyle, and that children who have suffered through traumatic incidences related to an environment of alcohol and drug abuse receive mental health services to ensure a healthy lifestyle for the entire family. With Community Project Funding/Congressionally Directed Spending funds administered through the Health Resources and Services Administration, FNA will be able to make much-needed updates to the residential facility so that this unique program can continue to meet the needs of the mothers and children who participate from across the state of Alaska every year.

Conclusion

The services provided by FNA are essential in promoting the independence and self-sufficiency of our community. Guided by our traditional values, we remain committed to serving our people in a respectful and meaningful way.

But, like other Alaska Native and American Indian tribes and organizations, FNA's ability to do this important work relies on the Federal government to uphold its trust responsibility. Adequate and consistent funding is essential to ensure that these critical services continue, as is a stable grant administration support infrastructure. Proposed and already executed DHHS restructuring actions such as closing and consolidating offices, dismissing federal program officers and grant managers, and/or converting existing direct grant programs into block grants administered by states, have very real impacts on tribes' and tribal organizations' abilities to implement federally funded programs and services and in turn, on the individ-

[1] U.S. Census Bureau and State of Alaska Department of Labor and Workforce Development

uals, families, and communities we serve. For a person who is experiencing an acute mental health crisis, grappling with addiction, trapped in a violent living situation, or struggling to keep a family fed and sheltered, a temporary lapse in availability of funds or a delay in processing a federally required grant approval action can mean life or death.

The loss of any FNA programs funded by DHHS would significantly harm both our community and the clients we serve. Since the pandemic, youth and social services have struggled to fully recover, and staffing continues to be a major challenge. Even if programs were cut, the underlying needs would persist. Gaps in victim services, behavioral health care, education for children, and family support would place additional strain on already limited community resources in Fairbanks.

FNA has operated these programs in good faith, relying in part on the federal government's trust responsibility to support essential services. These programs are vital to the well-being of families and the health of our community.

Thank you for this opportunity to share the important and rewarding work that FNA is doing with Health and Human Services funding. We believe it is reflective of the work that is being done across the nation by tribes and tribal organizations. This work is critical to meet the needs of families, children and communities.

I also want to thank the Alaska delegation, particularly Senator Murkowski, for their continued support of and advocacy for our work.

Basee'.

The CHAIRMAN. Thank you.

Next we turn to Lucy Simpson. Welcome.

STATEMENT OF LUCY R. SIMPSON, EXECUTIVE DIRECTOR, NATIONAL INDIGENOUS WOMEN'S RESOURCE CENTER

Ms. SIMPSON. Thank you, Madam Chair Murkowski, Vice Chairman Schatz, and members of the Committee, for the opportunity to testify today on the critical role of HHS programs serving Indian Country.

My name is Lucy Simpson. I am a citizen of the Navajo Nation and the Executive Director of the National Indigenous Women's Resource Center. We are a Native-led nonprofit dedicated to restoring sovereignty and safety for Native women and families. We serve as the National Indian Resource Center Addressing Domestic Violence and Safety for Indian Women and the Tribal Safe Housing Capacity Building Center under the Family Violence Prevention and Services Act, or FVPSA.

I first want to ground this testimony in what must remain the guiding principle of the Federal Government's work: its trust and treaty responsibility to tribal nations. This responsibility is not abstract; it is a legal and moral obligation.

HHS plays a crucial role in fulfilling this obligation, not only by providing public health services through the Indian Health Service, but also in providing services that address the public health crisis that is violence against Native people. Congress reaffirmed this obligation in the Violence Against Women Act reauthorization of 2005, stating that "Indian tribes require additional criminal justice and victim services resources to respond to violent assaults against women; and the unique legal relationship of the United States to Indian tribes creates a Federal trust responsibility to assist tribal governments in safeguarding the lives of Indian women."

By investing in tribal nations and Native-led organizations as they design and implement community-driven, culturally grounded services, HHS programs become instruments of tribal self-determination. Such programs include those funded by FVPSA, which for more than 40 years has been the cornerstone of our Nation's re-

sponse to family and domestic violence. It remains the only Federal funding source specifically dedicated to emergency shelter and related services for victims and their children and is especially important for tribal nations and American Indian and Alaska Native and Native Hawaiian victims of violence.

According to the National Institute of Justice, more than four in five American Indian and Alaska Native women have experienced violence in their lifetime, and more than half have experienced sexual violence and intimate partner violence. These statistics reflect a complex public health and safety crisis, which often involves jurisdictional confusion, a lack of law enforcement presence, geographic isolation, historical trauma, and distrust of systems.

Yet, despite the pervasive levels of violence, many tribal communities still lack access to the most basic safety services, with fewer than 60 Native-centered domestic violence shelters across all of Indian Country.

FVPSA provides essential funding to these tribal shelters, as well as counseling services, tribal domestic violence programs, the StrongHearts Native Help Line, and resource centers like ours, all of which ensure that culturally appropriate services are available where they are most needed.

But recent and abrupt changes within HHS, specifically the removal of experienced staff and leadership from agencies and programs that serve Indian Country, threaten to destabilize the progress made. Sudden changes in leadership, staffing and structure, especially without tribal consultation, can disrupt the continuity of services, erode trust, and delay funding for these life-saving programs.

At a time when Native women face the highest rates of murder, rape, and abuse in the Country, preserving institutional knowledge and maintaining stable, informed, and responsive leadership is not just a matter of continuity, it is a matter of life and death. Every day, we hear from frontline advocates who, with limited resources, are saving lives by creating safe homes, traditional healing circles, and language-based advocacy services that allow survivors to heal in ways that reflect their values and culture.

When we invest in Native women, we invest in the future of tribal nations. We respectfully urge Congress and HHS to fulfill your trust and treaty obligations by prioritizing, strengthening, and expanding all programs that impact the health and safety of Native peoples, and for HHS to engage in meaningful government-to-government consultation with tribal nations before making changes to program structure, leadership, or funding.

Thank you. [Phrase in Native tongue.]

[The prepared statement of Ms. Simpson follows:]

PREPARED STATEMENT OF LUCY R. SIMPSON, EXECUTIVE DIRECTOR, NATIONAL INDIGENOUS WOMEN'S RESOURCE CENTER

Thank you, Chairman Murkowski, Vice Chairman Schatz, and members of the Committee, for the opportunity to testify today on the critical role of Health and Human Services (HHS) programs serving Indian Country—particularly those programs that address the health and safety of Native women, families, and survivors of violence.

My name is Lucy Simpson. I am a citizen of the Navajo Nation and the Executive Director of the National Indigenous Women's Resource Center (NIWRC). NIWRC is

a Native-led nonprofit organization dedicated to restoring sovereignty and safety for Native women and their families. We serve as the statutorily mandated National Indian Resource Center (NIRC) Addressing Domestic Violence and Safety for Indian Women and the Tribal Safe Housing Capacity Building Center under the Family Violence Prevention and Services Act (FVPSA).

I first want to ground this testimony in what must remain the guiding principle of the federal government's work: its trust and treaty responsibility to Tribal Nations.

This responsibility is not abstract; it is a legal and moral obligation. HHS plays a crucial role in fulfilling this obligation, not only by providing public health services through the Indian Health Service, but also in providing services "which are necessary to raise the standard of living and social well-being of the Indian people to a level comparable to the non-Indian society," [1] including those programs that address the public health crisis that is violence against Indigenous people.

Congress reaffirmed this obligation in the Violence Against Women Act (VAWA) reauthorization of 2005, stating that "Indian tribes require additional criminal justice and victim services resources to respond to violent assaults against women; and the unique legal relationship of the United States to Indian tribes creates a Federal trust responsibility to assist tribal governments in safeguarding the lives of Indian women." [2]

By investing in Tribal Nations and Native-led organizations as they design and implement community-driven, culturally grounded services, HHS programs become instruments of self-determination.

Such programs include the Administration for Children and Families (ACF) Office of Family Violence Prevention and Services (OFVPS), which administers FVPSA. For more than 40 years, FVPSA has been the cornerstone of our nation's response to family, domestic, and dating violence. It remains the only federal funding source specifically dedicated to emergency shelter and related services for victims and their children. FVPSA programs are essential for Tribal Nations and American Indian, Alaska Native, and Native Hawaiian victims of violence.

According to the National Institute of Justice, more than 4 in 5 American Indian and Alaska Native (AI/AN) women (84.3 percent) have experienced violence in their lifetime, and more than half have experienced sexual violence (56.1 percent) and intimate partner violence (55.5 percent). [3] These statistics reflect a public health and safety crisis. One that is devastatingly complex, often involving jurisdictional confusion, a lack of law enforcement presence, geographic isolation, historical trauma, and distrust of systems.

Yet, despite the pervasive levels of violence, many Tribal communities still lack access to the most basic safety services. Fewer than 60 Native-centered domestic violence shelters exist across all of Indian Country, and access to specialized legal aid and programs aimed at improving the mental, emotional, physical, spiritual, and cultural health of survivors as they seek to rebuild their lives is extremely limited.

FVPSA funding is often the only lifeline preventing Native survivors from falling through the cracks. Through NIWRC's role as the National Indian Resource Center, since 2011, we have responded to nearly 15,000 requests for technical assistance, hosted more than 700 trainings and community engagement sessions, trained close to 100,000 individuals, and distributed more than 800,000 resources to support survivors, advocates, and programs nationwide. Our digital resources have been accessed more than 6 million times, a clear indication of both the reach and ongoing need for culturally specific, Native-led solutions.

With continued FVPSA funding, NIWRC leads national efforts to implement prevention strategies that address the root causes of violence, promote healthy relationships, and break cycles of intergenerational trauma—and we are not alone in this work.

FVPSA provides essential funding to Tribal shelters, counseling services, Tribal domestic violence programs, and resource centers like NIWRC, including the Alaska Native Tribal Resource Center on Domestic Violence and the Native Hawaiian Resource Center on Domestic Violence. These ensure that culturally appropriate services are available where they are most needed.

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[1] Administration for Native Americans. U.S. Department of Health and Human Services, Administration for Children and Families. Retrieved January 31, 2025, from *https://www.acf.hhs.gov/ana*

[2] Violence Against Women and Department of Justice Reauthorization Act of 2005, Pub. L. No. 109–162, § 901(6), 119 Stat. 2960, 3077 (2006).

[3] Rosay, André B., "Violence Against American Indian and Alaska Native Women and Men," NIJ Journal 277 (2016): 38–45, available at National Institute of Justice, *Violence against American Indians and Alaska Natives*, National Institute of Justice, *http://nij.gov/journals/277/Pages/violence-against-american-indians-alaska-natives.aspx.*.

Among the most vital efforts supported by FVPSA is the StrongHearts Native Helpline, a free, confidential, 24/7 service that connects Native survivors to advocacy, shelter, and support. Organizations like ours also fill critical data gaps by conducting research, evaluating program impact, and tracking trends that inform future prevention and response strategies. Data that too often does not exist elsewhere for Native communities.

In Fiscal Year 2024, FVPSA supported more than 230 Tribal domestic violence programs, most of which are the sole service providers in their communities. Yet, all but 36 of those programs received grants of just $58,000—barely enough to support one full-time advocate. The number of eligible Tribes has nearly doubled since 1993, but the Tribal set-aside has not meaningfully increased. We recommend raising the Tribal set-aside to 12.5 percent, both to reflect the expanded eligibility and to build on the proven success of existing programs.

Domestic violence, however, is never an isolated issue. Native survivors often face multiple overlapping challenges: housing insecurity, substance use disorders, chronic health conditions, poverty, and high rates of maternal and infant mortality, all of which are rooted in historical and intergenerational trauma.[4] Addressing this requires a coordinated federal response that bridges healthcare, social services, and justice systems, with Native voices leading the way.

Programs like the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, which includes a Tribal set-aside (TMIECHV) administered by ACF, are a critical part of that solution. TMIECHV offers culturally grounded, evidence-based strategies, including domestic violence screening and social support connections, that identify and address risk factors early in the lives of Native families.

In just four years, TMIECHV grantees have demonstrated measurable improvements across 17 performance indicators, including screening child injury prevention, maternal health, and domestic violence.[5] These outcomes underscore the deep connection between public health and safety—and the vital role of Native-led, community-based programs in advancing both.

HHS also provides funding for Tribal Nations and Tribal organizations to run programs such as the Low Income Home Energy Assistance Program (LIHEAP) and Temporary Assistance for Needy Families (TANF). These programs help strengthen Native families by assisting low-income households in meeting the costs of home energy and helping needy families care for their children in their own homes or in the homes of relatives. Funding integrated, culturally appropriate services such as these is essential to protecting Native women and families and building healthier, more resilient Tribal communities.

But recent and abrupt changes within HHS, specifically the removal of experienced staff and leadership from agencies and programs that serve Indian Country, threaten to destabilize the progress made by these services. These programs rely on staff who have cultivated trusted relationships with Tribal Nations, relationships that take years to build, alongside cultural competence, trauma-informed expertise, and a deep understanding of the complex realities facing our communities.

Sudden changes in leadership and staffing, especially without Tribal consultation, can disrupt the continuity of services, erode trust, and delay funding for life-saving programs. At a time when Native women face the highest rates of murder, rape, and abuse in the country, preserving institutional knowledge and maintaining stable, informed, and responsive leadership is not just a matter of continuity, but it is a matter of life and death.

Since time immemorial, Native women have been leaders, caregivers, knowledge keepers, and protectors of our cultures, languages, and traditions. Every day, we hear from frontline advocates who, with limited resources, are saving lives. They are creating safe homes, traditional healing circles, and language-based advocacy services that allow survivors to heal in ways that reflect their values and culture. Most importantly, survivors are able to disclose abuse and access support in spaces that feel safe, familiar, and trusted. This leads to better healing outcomes.

Given the unique historical, cultural, geographic, and socio-economic barriers facing Native people, the federal government must continue to expand, not scale back, its support for Native-led domestic, sexual, and family violence prevention and response programs. These programs are best positioned to foster healing, strengthen

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[4] Centers for Disease Control and Prevention, *Health disparities affecting American Indian/Alaska Native people*, Centers for Disease Control and Prevention, *https://www.cdc.gov/hearher/aian/disparities.html.*

[5] Administration for Children & Families, *Tribal Home Visiting Action Plan, 2020–2023*, Administration for Children & Families, *https://acf.gov/ecd/data/tribal-home-visiting-action-2020-2023.*

social support networks, and provide trauma-informed care that reflects Indigenous values and healing practices.

When we invest in Native women, we invest in the future of Tribal Nations. Continued federal funding for culturally grounded, community-led solutions is a trust and treaty obligation.

We respectfully urge Congress and the Department of Health and Human Services to continue to prioritize, strengthen, and expand all programs that impact the health and safety of Native peoples, and to engage in meaningful government-to-government consultation with Tribal Nations before making changes to program structure, leadership, or funding.

The National Indigenous Women's Resource Center is honored to support the life-saving work of Tribal programs across the country. Thank you for your commitment to safety, justice, and sovereignty. I welcome your questions.

The CHAIRMAN. Thank you.

And finally, Dr. Sheri-Ann Daniels.

STATEMENT OF DR. SHERI–ANN DANIELS, CEO, PAPA OLA LŌKAHI

Dr. DANIELS. [Greeting in Native tongue.] Aloha, Chairman Murkowski, and Vice Chairman Schatz. Thank you for the introduction, and members of the Committee.

Thank you for inviting me today to provide remarks on behalf of Papa Ola Lōkahi, the Native Hawaiian Health Board. We appreciate the Committee's legacy of strong bipartisanship in honoring the Federal trust responsibility. I am honored to hear and learn from other Native American leaders and communities on this panel, because the comments, stories and challenges that they shared are what we face as well.

Papa Ola Lōkahi was Congressionally and statutorily created in 1988 to improve the health status of Native Hawaiians, and the named entity in the Native Hawaiian Health Care Improvement Act. So I want to be really clear: we are statutorily named and created to support and uplift the health of Native Hawaiians.

And as a named entity, we have the statutory responsibility for the coordination, implementation and updating of a comprehensive health care master plan, the identification and research of diseases, establishment of a network of health resources, services and infrastructure through our five-island community based health organizations, as well as administer a scholarship for health care professionals.

On the topic of this oversight hearing today, it is in our written testimony, we highlight the following key messages. Federal trust responsibility to Native Hawaiians is based on our unique political status, not on our race. So let me say that again. There is a trust responsibility to Native Hawaiians, and that is through policy, funding and consultative practices, which we often don't get.

Our unique political status is recognized in other Congressional acts, not just the Native Hawaiian Health Care Improvement Act. And this is with a population that has grown 29 percent since between the 2010 and 2020 Census. That is huge.

For almost 40 decades, Papa Ola Lōkahi continues fulfilling our statutory responsibility including our Native Hawaiian health systems. We do this through funding with HHS.

We talk about IHS, and you are correct that we do not get any funding through IHS. So the bulk of our funding comes from HHS through HRSA. And that fulfillment of the Federal trust responsi-

bility for Native Hawaiians is in the way of programs and funding, again, primarily through HRSA.

The other HHS areas, including SAMHSA, we would be impacted through mental health and substance abuse. And we all know what those statistics are.

In addition to that, we also currently are supporting the Lahaina wildfires impacted families. So over the last two years, over 12,000 families, 34,000 people, 3,700 professionals, boots on the ground, and over 140 organizations had a role in that and continue to have a role in that.

We need to continue to focus on the most vulnerable of populations, programs that address the health, safety and self-sufficiency of Native Hawaiian families, and that is CMS. Our Native Hawaiian population in Hawaii is 21 percent. Yet for TANF families, 33 percent of them are Native Hawaiian. For victims of child abuse and neglect, 39.7 percent. Those are large numbers, greater than our population.

The total Hawaiian population currently receiving Medicaid equals almost 77,000. That is a lot. Thirty-four percent of them are children. That is not acceptable. If we talk about our cultural values and where we put our youngest as well as our oldest, that is culture. And when we remove those things, we create other impacts and other concerns down the line.

CDC, the prevention services, tobacco, chronic conditions, we all know diabetes. Diabetes does not discriminate. It is no longer just a Native issue. So cutting those services has huge impacts.

We also want to make sure we continue to advance the Missing and Murdered Native Hawaiian Women and Girls initiatives, but it is also with our tribal partners. We know that a quarter of the missing girls are Native Hawaiian.

We also want to recognize the reality of communities and the impact it has on health, that health policy should aim to reduce differences between rural and city areas. It is especially important because our Native communities, for many of us, tribes, everyone, our people live in rural areas, often with limited access to services.

Finally, we need to continue to strengthen our networks. In our written testimony, we highlight the Native Hawaiian health network collaborators across our eight major islands. It is not just us. We recognize it is our Native Hawaiian health systems, our federally qualified health centers, our community health centers, hospitals and especially our community based organizations. We are doing it with everyone, linking arms. And I think that is important to recognize.

And these are just some of the highlighted examples of the impacts that HHS in reduction and the things that are happening could have on our communities. I look forward to answering any further questions from the Committee.

Mahalo.

[The prepared statement of Dr. Daniels follows:]

PREPARED STATEMENT OF DR. SHERI-ANN DANIELS, CEO, PAPA OLA LŌKAHI

Aloha e Chairman Murkowski, Vice Chairman Schatz, and Members of the United States Senate Committee on Indian Affairs (“Committee”),

Mahalo (thank you) for inviting me to provide remarks on behalf of Papa Ola Lokahi (POL), the Native Hawaiian Health Board (NHHB). In the spirit of the Committee's legacy of strong bipartisanship in honoring the federal trust responsibility owed to American Indians, Alaska Natives, and the Native Hawaiian Community (NHC), collectively "Native Americans", thank you for convening the oversight hearing, and I'm honored to participate, and to share our collective support with Native American leaders and communities.

POL was congressionally and statutorily created in 1988 to improve the health status of Native Hawaiians, through the passage of the Native Hawaiian Health Care Act, which was later reauthorized as the Native Hawaiian Health Care Improvement Act (NHHCIA). The implementation of the NHHCIA provides for: 1) Coordination, implementation and updating of a comprehensive Native Hawaiian health care master plan (operationally known as "E Ola Mau"), including identification and research of diseases most prevalent among NH; 2) Establishment of a network of health resources, services, and infrastructure, through five island community based health organizations, commonly known and referred to as the Native Hawaiian Health Care Systems[1] (NHHCS or "Systems"); and 3) Administration of scholarships via the Native Hawaiian Health Scholarship Program (NHHSP).

We recognize and are grateful for the commitment and work of the NH Health Network (NHHN) collaborators across the eight major islands of the State of Hawai'i, including the Systems, federally qualified health centers (FQHCs), community health centers (CHCs), community-based organizations (CBO), and Native Hawaiian serving organizations (NHO), and the State of Hawaii (Department of Health, Department of Human Services).

POL's response to the Committee's Oversight Hearing focuses on examining Federal Programs serving NHs across the Operating Divisions at the United States Department of Health and Human Services (HHS), and is divided into the following three sections:

I—Federal Trust Responsibility, Unique Political Status & Declaration of Policy

II—Impact of Delivering Essential Public Health and Social Services to Native Hawaiians

A. Overview of POL's Unique Statutory Role

B. Impact re: Trust & Treaty Obligations, Policy Implementation for Native Hawaiians

C. Summary of Delivery of Essential Public Health and Social Services for Native Hawaiian Communities

D. Essential Public Health and Social Services: Via Native Hawaiian Health Care Systems

E. Essential Public Health and Social Services: During the Height of COVID–19 via HRSA

F. Essential Public Health and Social Services: For Communities Impacted by the Lahaina, Maui Wildfires via SAMHSA

G. Essential Public Health and Social Services: For Child Welfare, Domestic Violence, and Family Needs

H. Essential Public Health and Social Services: Via POL and Trusted Community Partners

I. Essential Public Health and Social Services: Via Cultural Healing Model

J. Essential Public Health and Social Services: Via Traditional Healers & Practitioners

K. Essential Public Health and Social Services: Via Native Hawaiian Health Professionals

L. Essential Public Health and Social Services: Via Education Collaborations

III—Continuing Needs, Implementing Master Plan Recommendations and the Native Hawaiian Health Network

A. Continuing Needs

B. Implementing Recommendations of E Ola Mau—Native Hawaiian Health Master Plan

C. Native Hawaiian Health Network

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[1] Comprised of Ho'ola Lahui Hawai'i—Kaua'i Community Health Center, a federally qualified health center; Ke Ola Mamo, island of O'ahu; Hui No Ke Ola Pono, island of Maui; Na Pu'uwai, islands of Molokai and Lana'i; and Hui Malama Ola Na 'Oiwi, Hawai'i Island

Chairman Murkowski and Vice Chairman Schatz, thank you for the longstanding commitment you have demonstrated individually, collectively and through your Committee work and leadership to ensure that the United States upholds its federal Trust and Treaty Obligations to Native Americans. We acknowledge the Committee's historic and bipartisan, work that has helped strengthen the overall well-being of Native Americans.

I—The Federal Trust Responsibility, Unique Political Status & Declaration of Policy

A. Federal Trust Responsibility

Similar to American Indians and Alaska Natives, Native Hawaiians never relinquished the right to self-determination despite the United States' involvement in the illegal overthrow of Queen Lili'uokalani in 1893 and the dismantling of our Hawaiian government. As such, Native Hawaiians are owed the same trust responsibility as all Native groups in the United States. The federal trust responsibility extends to all Native Hawaiians, a population that grew nationwide by 29.1 percent from the 2010 to the 2020 census data.[2] To meet this obligation, Congress—through landmark, bipartisan work of this Committee and its Members—created policies to promote education, health, housing, and a variety of other federal programs intended to build, maintain, and better conditions for the Native Hawaiian Community.

B. Unique Political Status

Hundreds of Acts of Congress expressly acknowledge or recognize a special political and trust relationship to Native Hawaiians based on our status as the Indigenous, once-sovereign people of Hawai'i. Among these laws are the Hawaiian Homes Commission Act, 1920 (42 Stat. 108) (1921), the Native Hawaiian Education Act (20 U.S.C. § 7511) (1988), the Native Hawaiian Health Care Improvement Act (42 U.S.C. § 11701) (1988), and the Hawaiian Homelands Homeownership Act codified in the Native American Housing Assistance and Self Determination Act, Title VIII (25 U.S.C. § 4221) (2000).

The first Congressional finding of the NHHCIA states, "(1) Native Hawaiians comprise a distinct and unique indigenous people with a historical continuity to the original inhabitants of the Hawaiian archipelago whose society was organized as a Nation prior to the first nonindigenous people in 1778."[3] Subsequent Congressional findings include: "(17) The authority of the Congress under the United States Constitution to legislate in matters affecting the aboriginal or indigenous peoples of the United States includes the authority to legislate in matters affecting the native Peoples of Alaska and Hawaii; (18) In furtherance of the trust responsibility for the betterment of the conditions of Native Hawaiians, the United States has established a program for the provision of comprehensive health promotion and disease prevention services to maintain and improve the health status of the Hawaiian people; and (22) Despite such services, the unmet health needs of the Native Hawaiian people are severe and the health status of Native Hawaiians continues to be far below that of the general population of the United States."[4]

C. Declaration of Policy

Congress declared that it is the policy of the United States in fulfillment of its special trust responsibilities and legal obligations to the indigenous people of Hawaii resulting from the unique and historical relationship between the United States and the Government of the indigenous people of Hawaii (1) to raise the health status of Native Hawaiians to the highest possible health level; and (2) to provide existing Native Hawaiian health care programs with all resources necessary to effectuate this policy.[5]

II—Impact of Delivering Essential Public Health and Social Services to Native Hawaiians

A. Overview of POL's Unique Statutory Role

For almost four decades, POL, the Native Hawaiian Health Board (NHHB), has consistently focused on raising the health status of Native Hawaiians, in executing its statutory charge to:

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[2] *https://www.census.gov/library/stories/2023/09/2020-census-dhc-a-nhpi-population.html,* retrieved May 7, 2025

[3] The Native Hawaiian Health Care Improvement Act (42 U.S.C. § 11701) (1988)

[4] Ibid

[5] The Native Hawaiian Health Care Improvement Act (42 U.S.C. § 11702) (1988)

1. Coordinate, implement and update a Native Hawaiian comprehensive master plan designed to promote comprehensive health promotion and disease prevention services to improve and maintain the health status of Native Hawaiians.

2. Conduct training for Native Hawaiian care practitioners, community outreach workers, counselors, and cultural educators to educate the Native Hawaiian population regarding health promotion and disease prevention.

3. Identify and perform research into diseases that are most prevalent among Native Hawaiians.

4. Develop an action plan outlining the contributions that each member organization of Papa Ola Lokahi will make in carrying out in the policy of the NHHCIA.

5. Serve as a clearinghouse for (1) collecting and maintaining data associated with the health status of Native Hawaiians; (2) identifying and researching diseases affecting Native Hawaiians; and (3) collecting and distributing information about available Native Hawaiian project funds, research projects and publications.

6. Coordinate and assist health care programs and services provided to Native Hawaiians.

7. Administer special projects.

B. Impact re: Trust & Treaty Obligations, Policy Implementation for Native Hawaiians

In responding to executive orders (EOs) and other policy statements by this Administration, HHS and the federal government, as a whole, must honor the federal **Trust & Treaty Obligations and Responsibilities** in policy, funding and consultation practices, specifically:

1. **Policy.** Follow other executive departments (e.g., Interior, Education, Agriculture), in articulating, via Secretary's Order, that diversity, equity, inclusion, accessibility and environmental justice policies do NOT apply to Tribal nations, tribal citizens and the NH Community and related programs. Most notably, the HHS Advisory Opinion 25–01, dated February 25, 2025, on "Application of DEI Executive Orders to the Department's Legal Obligations to Indian Tribes and Their Citizens" **excludes NHs**.

2. **Funding.** Recognize that federal Trust responsibility, policy implementation and program funding is: Congressionally and statutorily authorized and appropriated; NOT discretionary spending that Native Americans need to "apply" for; exists beyond Indian Health Services (IHS); and NOT a state obligation (i.e., state funding should supplement not supplant federal funding).

3. **Consultation Practices.** Implement meaningful consultation practices with Tribal nations, tribal citizens and the NHC, including announced HHS reorganization activities (e.g., consolidation, elimination of HRSA, SAMHSA).

In practice, and by observation, HHS' policy implementation activities in its related operating divisions, have not been explicit nor in alignment with the above.

C. Summary of Delivery of Essential Public Health and Social Services for NHCs

1. **Appropriations.** Current FY26 appropriations request for the Native Hawaiian Health Care Program is at $27 million, via HRSA, and historically funded:

a. Papa Ola Lōkahi, Native Hawaiian Health Board—Via HRSA[6], BPHC[7]—$10,000,000

b. Papa Ola Lōkahi, Native Hawaiian Health Board—Native Hawaiian Scholarship Program via HRSA, BHW[8]—$2,200,000

c. Papa Ola Lokahi, Native Hawaiian Health Board—Native Hawaiian Health Care Systems Via HRSA BPHC—$14,800,000

2. Program Commitments, Spending. Described in further detail below, the following table summarizes the financial program impacts by HHS operating divisions from 2022 to 2024 which may be at risk, pending further HHS' reorganization plan details—$16,572,000.

a. Papa Ola Lokahi, Native Hawaiian Health Board—American Rescue Plan Act (ARPA)—HRSA—$1,566,000

[6] Health Resources and Services Administration (HRSA)
[7] Bureau of Primary Health Care (BPHC)
[8] Bureau of Health Workforce (BHW)

b. Papa Ola Lokahi, Native Hawaiian Health Board—Community Health Workers, Perinatal Health—HRSA—$801,000

c. Papa Ola Lokahi, Native Hawaiian Health Board—Native Hawaiian Health Program (NHHP), including Native—HRSA, including BPHC, BHW—$9,576,000

d. Papa Ola Lokahi, Native Hawaiian Health Board—SAMHSA Emergency Response Grant (SERG)—SAMHSA,[9] via the State of Hawaii, Department of Health—$4,537,000

e. Papa Ola Lokahi, Native Hawaiian Health Board—Center of Excellence, Tobacco, Aging, Transportation Equity Working Group—Via the State of Hawaii, Department of Health—$92,000

Total HHS' Operating Divisions Related—$16,572,000

D. Essential Public Health and Social Services: Via Native Hawaiian Health Care Systems

1. **Overview.** The five NHHCS offer a range of health care and other services, including primary care, mental health, and fitness programs, in a way that reflects the culture and priorities of the island communities they serve. The work of the NHHCSs aims to build trust in the Native Hawaiian Community, serving as a bridge to Western medicine, while integrating medical care with traditional Native Hawaiian values, beliefs, and practices. In the past year, the five Native Hawaiian Health Care Systems have made a significant impact through their community outreach and traditional healing efforts.

Collectively, based on the most recent program funding year, the Systems distributed over 41,900 health education materials, hosted 376 events, and reached more than 39,400 individuals across Hawai'i. Traditional healing services played a vital role, with over 3,200 people receiving care rooted in Native Hawaiian cultural practices. For example, Hui Malama Ola Na 'Oiwi (HMONO) reached more than 17,000 individuals through just 3 major events, while Ho'ola Lahui Hawai'i (HLH) provided traditional healing services to 1,571 individuals across 131 events. Ke Ola Mamo (KOM), Na Pu'uwai, and Hui No Ke Ola Pono (HNKOP) also made notable contributions, with HNKOP engaging more than 15,400 community members through its 173 events, primarily a result of the Lahaina wildfires in August 2023. These efforts reflect a deep commitment to culturally grounded care and community engagement, strengthening health and wellness through Native Hawaiian traditions and values.

Indian Health Services (IHS) awarded a contract to KOM for alcoholism and related health care services and coronavirus activities in 2015 and 2020, respectively. POL is not aware of any other IHS related activities with the Systems or in the state.[10]

2. **HLH (Kaua'i)** provides comprehensive health services across Kaua'i County, including primary, dental, pharmacy (with delivery), behavioral health, substance abuse counseling, chronic disease management, physical activity and nutrition programs, health screenings, school-based services, mobile clinic care, family planning, and traditional healing. Services are delivered island-wide with central locations in Lihu'e, Kapa'a, and Waimea. In addition to its designation as a Native Hawaiian Health Care System, HLH operates as a Federally Qualified Health Center under Section 330 of the Public Health Service Act. Their culturally grounded approach emphasizes preventive care, cultural competence through local staffing, and integration of traditional practices with modern medicine. HLH's facilities include two clinics, mobile units, a pharmacy, and a fitness center.

3. **KOM (O'ahu)** is dedicated to improving the health and well-being of its clients, with a focus on Native Hawaiians while serving the entire O'ahu community. Becoming a client is simple and provides access to a variety of health and wellness programs. KOM offers comprehensive support, including medical and primary care, traditional healing such as lomilomi, fitness programs, cultural workshops, and health classes. Recognizing the disproportionate rates of heart disease, diabetes, stroke, and cancer among Native Hawaiians, Ke Ola Mamo integrates cultural values with healthcare to address these disparities. Services are delivered through one medical clinic, an administrative office, and four community-based health offices, ensuring care that honors the cultural and historical connections to health and well-being.

4. **Nā Pu'uwai**, founded on the pillars of Native Hawaiian health disparity and cardiovascular disease research, serves residents of both Moloka'i and Lāna'i. Nā

[9] Substance Abuse and Mental Health Services (SAMHSA)
[10] *KE OLA MAMO—Coronavirus Contracts—ProPublica*, retrieved May 12, 2025

Pu‘uwai is dedicated to delivering culturally responsive primary health, health education and health promotion that address the unique needs of these communities, its mission, informed by a foundation in research and advocacy, is to uplift and enhance the health of Native Hawaiians through an integrative healthcare delivery model grounded in Native Hawaiian culture, practices, tradition, and language. Services include primary health, in addition to traditional, complimentary and integrative medicine. Nā Pu‘uwai’s community engagement efforts are aimed at improving healthcare access by informing Native Hawaiians about available services, programs and resources.

5. **HNKOP (Maui)** is dedicated to improving the health of Native Hawaiians and the greater Maui island community by empowering clients to become their own health advocates, blending medical care with traditional Hawaiian values and practices. With an emphasis on health promotion and prevention, HNKOP, offers enabling and wrap-around services to help community navigate healthcare and connect with resources. Clinical services include adult primary care, oral health, and intensive cardiac rehabilitation, supported by wellness programs such as the Kaiaulu Wellness & Outreach, Hale Ho‘ōikaika gym, Simply Health Cafe, and career training through the Kealaho‘imai program. What distinguishes HNKOP is its Kūa‘ua‘u traditional healing program, which provides lomilomi, ho‘oponopono, and lā‘au lapa‘au. Strong community partnerships further enhance services, offering behavioral health training, medicinal plant access, and Native Hawaiian birth and parenting education.

6. **HMONO** (Hawai‘i Island) provides comprehensive, culturally grounded health services on Hawai‘i Island, including primary care, behavioral health, nutrition counseling, and chronic disease education. Services are offered at the Hilo-based Family Medicine Clinic, via telehealth, and through home visits—especially supporting kūpuna. HMONO emphasizes community wellness through traditional healing programs such as la‘au lapa‘au gardening and taro cultivation, health education including yoga, nutrition, and chronic disease management, and support groups for diabetes and cancer. HMONO also operates a transportation program with wheelchair-accessible vehicles to ensure access to medical appointments across the island. Community engagement is further supported through major events like the Mālama Nā Keiki Festival and Ladies’ Night Out.

E. Essential Public Health and Social Services: During the Height of COVID–19 via HRSA

1. **Overview.** The establishment of POL, the NHHB, as a non-profit organization allowed eligibility to pursue federal, State, county, and private sources of funding. Since the first shutdown in the State of Hawai‘i in March 2020, POL (both alone and in partnership with community organizations) successfully applied for or acted as fiscal agent for over $2 million dollars throughout various grants. These grant funds are in addition to the roughly $3.5 million of ARPA funds that POL distributed to community based organizations (CBOs). POL is committed to pursuing its mandates and mission through multiple funding mechanisms to expand opportunities for Native Hawaiian health. POL engaged its Congressional duties by providing the administration for the Hawai‘i COVID–19 Native Hawaiian & Pacific Islander Response, Recovery, and Resilience (NHPI 3R) Team, a coalition of over 60 partners engaged on behalf of communities throughout the State of Hawai‘i, from June 2020 to present.

2. **ARPA, Nā Makawai.** Nā Makawai is the name of the initiative that encompassed the work of the five NHHCS, POL, and fifteen Native Hawaiian serving health entities (20 organizations in total) that received ARPA funding to provide COVID–19 response and recovery services and resources throughout the State of Hawai‘i. ARPA funding was administered by HRSA. Notably, ARPA language allowed for funds to be applied towards health workforce, infrastructure, and community outreach and education—critical components of the Native Hawaiian Health Network (NHHN). Given the annual appropriations for federal fiscal years 2021 and 2022 ($20.5 and $22 million, respectively), a $20 million increase in funding across a two-year span increases the total funding to the NHHCIA by approximately half. The thoughtful flexibility and inclusivity of ARPA language and approved activities through HRSA allowed POL to partner with local organizations across a wide range of programs and services throughout the State of Hawai‘i, which included:

- Direct clinical COVID–19 services (vaccination and testing, mobile care, and mobile events);
- Indirect COVID–19 services (outreach, education, and surveillance; statewide referral hotline for various resources); and

- Increasing or maintaining resources needed to expand COVID–19 response (workforce, including community health workers; telehealth capacity and electronic medical records).

In addition, the Na Makawai partners' COVID–19 relief needs overlapped with preexisting needs in the Native Hawaiian community. These included: sustaining comprehensive primary health care; mental/behavioral health; serving rural youth; food insecurity and access programs; and maternal/childcare. POL connected with health factors that impact clinical needs, so Na Makawai partnerships have also supported a broadband infrastructure mapping project so that future telehealth projects and programs that rely on broadband accessibility can be informed by and based on high quality, locally collected data.

3. **NHPI 3R.** The Native Hawaiian & Pacific Islander Response, Recovery & Resilience Team (NHPI 3R) was established in May 2020 to collectively address the impact of COVID–19 and recommend and implement solutions. Established in May 2020, in alignment with the national response team, to improve the collection and reporting of accurate data, identify and lend support to initiatives across the Hawaiian Islands working to address COVID–19 among Native Hawaiians and Pacific Islanders, and unify to establish a presence in the decisionmaking processes and policies that impact our communities. **More than 60 agencies, organizations, and departments comprise the NHPI 3R Team.**

As the response to COVID–19 transitions, the NHPI 3R is pivoting toward priority issues impacting Native Hawaiian and Pacific Islander communities in Hawai'i. Capitalizing on the influence and impact such a collective can have, these working committees continue to meet regularly: Data & Research, Policy, Communication & Outreach, Health & Wellness Priorities and the Community Health Worker Collaborative.

F. Essential Public Health and Social Services: For Communities Impacted by the Lahaina, Maui Wildfires via SAMHSA

1. **SERG.** SAMHSA Emergency Response Grant (SERG) program is a SAMHSA-wide grant opportunity, inclusive of mental health and substance use prevention, response, and recovery services, that authorizes SAMHSA to act immediately under emergency circumstances that create a behavioral health crisis, where the crisis overwhelms the behavioral health system or creates behavioral health service needs that do not fit existing behavioral health resources. SERG funds are "funds of last" resort and cannot supplant existing resources. SERG funding enables public entities to address emergency behavioral health crises when existing resources are overwhelmed or unavailable. [11]

2. **Lahaina Wildfires & On the Ground Community Impacts.** In collaboration with SAMHSA grantee, the State of Hawai'i, Department of Health, the SERG collaborator network grew initially from 20 to over 30 providers, contractors, programs, serving the emotional, social and mental health needs of survivors of the August 2023 Maui

Wildfires. Maui SERG accomplishments, from the initial, on the ground delivery period February to September 2024: Community Served—7,298 families and 20,413 individuals; Clinical Care—8,152 urgent trauma and mental health clinical appointments; Community Outreach—452 events and 2,133 non-clinical appointments; Workforce Development—94 training sessions attended by 2,229 local professionals and; Collaborative Engagement—Strong partnerships with 14 local organizations ensured tailored and effective services, especially for under-served populations. [12] Year 2 of SERG grants began November 2024 and continue to be monitored.

3. **Programming.** Examples of urgent, on the ground, community customized programming include:

a. Family Resiliency toolkits rooted in the cultural values and wisdom of Aloha and focus on the 5 Protective Factors that support and strengthen families: Parental Resilience, Social Support, Concrete Support, Understanding of Child Development, and Social Emotional Competence of Children.

b. Via Radio, Newspaper, TV, Social Media—Developed culturally and linguistically appropriate materials and activities (e.g., family fair, youth empowerment/resiliency building activities); Provide bilingual community navigators to assist in seeking and applying for assistance; Conduct media campaigns (plac-

[11] *https://www.samhsa.gov/mental-health/disaster-preparedness/serg*, retrieved May 10, 2025

[12] *https://kawaiola.news/columns/i-ola-lkahi/collaborating-to-support-mental-wellbeing-on-maui/*, retrieved May 12, 2025

ing educational PSA and events announcements on the radio, social media, and Filipino community newspapers).

Disseminated information and resources through ethnic media and also strengthen promotion of services and resources offered by government and community organizations in Ilokano and Filipino/Tagalog. Develop culturally and linguistically appropriate materials and activities to promote health, wellness, and resiliency (e.g., family fair, youth empowerment, resiliency building activities, job fair). Conduct media campaigns (placing educational PSA and events announcements on the ethnic radio and TV, Facebook, Instagram, Filipino community newspapers and publications).

c. Workshops for Maui First Responders & Families (and partnered with 17 external partners).

d. Disaster Behavioral Health Curriculum & Training (and partnered with 15 SERG orgs and 33 external partners)

e. Cultural Healing & Recovery: Maui Wildfire Disaster (and partnered with 3 SERG orgs and 7external partners)

G. Essential Public Health and Social Services: For Child Welfare, Domestic Violence, and Family Needs

Often overlooked, but vital to NH and Hawai'i's health status include areas addressed by the State of Hawaii's Department of Human Services (DHS) in which HHS Divisions' funding flows, particularly Medicaid, covering a range of programming and funding for the most vulnerable of populations—children, pregnant women, parents of eligible children, low income adults, former foster care children, aged, blind and disabled individuals. [13]

1. **Benefit, Employment & Support Services**

a. Temporary Assistance for Needy Families (TANF)
b. Temporary Assistance for Other Needy Families (TAONF)
c. Employment & Training
d. Child Care Subsidy Program (Child Care Subsidy or Preschool Open Doors)
e. Child Care Regulation (also known as Child Care Licensing)
f. Homeless Programs
g. Aid to the Aged, Blind and Disabled
h. Supplemental Nutrition Assistance program (SNAP, formerly the food stamps program)
i. Hawaii Home Energy Assistance Program (HI–HEAP formerly LIHEAP)

2. **Social Services Division—Adult Protective and Community Services**

a. Adult Services and Programs: case management for elderly victims of crime program; chore services; adult foster care; senior companion; respite companion; foster grandparent program; transportation assistance; courtesy services.

b. Licensing and Certification: nurse aide training and re-certification.

3. **Social Services Division—Child Welfare Services**

Missing children website; mandated reporters; family connections; family court; foster and adoptive care; youth resources.

4. **Med-QUEST [14] Division**

The division is responsible for implementing the DHS responsibilities as the single state agency designated to administer the Hawaii Medicaid program under Title XIX of the Social Security Act. POL understands [15] the following about Native Hawaiian and part-Hawaiian members served by the Hawaii Medicaid Program: Total Hawaiian population currently receiving Medicaid equals almost 77,000 which represents 19 percent of all Med-QUEST members; almost 26,000 (34 percent), children including over 1,400 current and former foster care children; over 400 pregnant women; over 14,000 (18 percent) parents or caretakers; about 26,500 (34 percent) adults; about 8,800 (11 percent) aged, blind or disabled adults; and over 1,100 other individuals.

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[13] *What is Medicaid,* retrieved May 12, 2025
[14] QUEST stands for: Quality care; Universal access, Efficient utilization, Stabilizing costs; and Transforming the way health care is provided.
[15] State of Hawaii, Department of Human Services

H. Essential Public Health and Social Services: Via POL and Trusted Community Partners

1. **Overview.** Through presentations, demonstrations, workshops, kūkākūkā sessions and working closely with kūpuna (elders), POL seeks to improve awareness of and sensitivity to Hawaiian cultural processes and the philosophies of spiritual healing, thus assuring that they are included within the larger health and wellness arena. Whenever possible, POL collaborates and partners with NH community-based organizations.

2. **Cancer Prevention.** POL via ʻImi Hale, its research department is a part of the Native Hawaiian Cancer Network launched in 2000, ʻImi Hale collaborates with key local, state, national and international partners to reduce cancer incidence and mortality among Native Hawaiians through the establishment of a core organizational infrastructure that: Goal 1: Increase knowledge of, access to, and use of beneficial biomedical procedures in cancer prevention and control and co-morbid conditions of cancer patients. Goal 2: Develop and conduct evidence-based intervention research to increase use of beneficial biomedical procedures to control cancer and co-morbid conditions. Goal 3: Train and develop a critical mass of competitive researchers using community-based participatory research (CBPR) methods to reduce health disparities. ʻImi Hale is currently one of 23 Community Networks Program Center (CNPC) sites funded by the National Cancer Institute's Center to Reduce Cancer Health Disparities.

3. **Chronic Conditions.** Healthy lifestyles, disease prevention and health promotion are critical to reducing the impact of chronic disease and other conditions such as heart disease, hypertension, stroke, diabetes, kidney diseases, cancer and obesity. In many Hawaiian ʻohana (family), at least one family member is living with a chronic condition such as diabetes, heart disease, or stroke. Since Western contact, illnesses and the loss of resources have deeply affected the once-thriving lāhui of Kānaka Maoli, reshaping their way of life. Many Native Hawaiians in Hawaiʻi experience a higher prevalence of chronic disease due to a combination of genetic, environmental, and systemic factors. While lifestyle choices can influence health, access to resources, such as ʻaina for growing food, can be a significant barrier to making healthier choices.

There are many ways to support overall well-being and reduce the risk of chronic conditions. Engaging in physical activity, eating nourishing foods, breastfeeding, and avoiding tobacco are all beneficial steps. Fortunately, there are numerous resources and community support systems available to help individuals and families on their health journey.

POL coordinates, facilitates, contracts and sometimes direct delivers disease prevention and health promotion programming re: breastfeeding, nutrition, physical activity, tobacco use, kidney disease, heart disease, cancer, diabetes.

4. **Harm Reduction.** POL and the Hawaiʻi Health & Harm Reduction Center (H3RC) released a harm reduction toolkit for Native Hawaiians. This approach to harm reduction focuses on developing a community understanding of harm reduction, reducing the harms caused by colonization in Hawaiʻi, and introducing a cultural approach to reducing harm and promoting healing.

5. **Kūpuna Brain Health.** Aligned with POL's commitment to improve the health and well-being of Native Hawaiians and our families, inquiry into the brain health of kūpuna—elders, grandparents, adults 65 and older—and Alzheimer's Disease and Related Dementias (ADRD) has yielded insightful observations, a rich body of knowledge, and targeted recommendations to agencies that address the interests of elders in Hawaiʻi. The welfare of our kūpuna impacts the well-being and resiliency of the entire family.

6. **LGBTQIA+.** The Hawaiian ʻohana as well as our lāhui had roles for each person. Whether kane, wahine, or mahu, each person had a kuleana in the Hawaiian ʻohana. Māhū have long held an important traditional role as caretakers-of other ʻohana members, of cultural and historical knowledge, and as respected contributors to the lāhui. However, since Western-Colonial contact, we've seen a decrease in health outcomes for our māhū (aka LGBTQ) community.

Papa Ola Lōkahi includes our mahu ʻohana in our commitment to the health and well-being of Native Hawaiians and all our families. We are identifying the health disparities and through programs, public policy and partnerships, we are developing strategies to address: Increased risk for depression, anxiety and mental health challenges; Increased risk for substance use/misuse.; Increased societal stigma around care (e.g. HIV, MPOX, etc.); Limited, and sometimes prohibited access to gender-affirming care.

In 2023 alone, roughly 500 anti-LGBTQ bills were introduced within state legislatures across the United States, including six bills introduced in Hawaiʻi that would

limit and criminalize vital gender-affirming care that our trans and mahu ʻohana members need.

7. **Nutrition and Food Systems.** Promoting nutrition education, research, and policy related to food access, food sovereignty, and food systems. POL efforts build on the foundation established in *E Ola Mau*, Native Hawaiian Health Master Plan, emphasizing food sovereignty, community-based education, and sustainable nutrition practices to promote lifelong well-being. The 2023 *E Ola Mau* Update reaffirmed the commitment to these principles, incorporating contemporary research and community-driven solutions to further address nutritional health, chronic disease prevention, and overall wellness.

8. **ʻOhana (Family) Well Being.** From keiki (children) to kūpuna, this strand focuses on adverse childhood experiences, dental health, sexual and reproductive health.

9. **Substance Use, Recovery, and Behavioral Health.** This strand focuses on substance use, recovery, addictions, and related mental health and wellness. Disproportionate numbers of our Native Hawaiian population have been consistently over-represented among those who are seeking or thrust into Western treatment for substance use disorders and mental health issues. Existing systems of care continue to assign treatment within the same western frameworks that have led to this consistent over-representation, and do not account for the unique needs of the Native Hawaiian Community, and are not anchored in Hawaiian ways of knowing and being.

Research shows that this inequitable health status results from several complex and interconnected social determinants of health, including historical trauma, discrimination, and lifestyle changes. Research also indicates that re-envisioning treatment for the Native population, utilizing cultural re-connection and methodologies that speak to Native perspectives, is more influential in creating positive health outcomes for Native peoples

10. **Tobacco and Vaping Control and Prevention.** Taking action to lower tobacco and vaping rates among Native Hawaiians. Big Tobacco, or commercial tobacco, has historically ravaged Native Hawaiian communities, wreaking havoc and harm to our people from keiki to kūpuna. Seen as one of the top markets for menthol tobacco products since the 1960s, remnants still linger throughout our islands. In addition to combustible commercial tobacco, young people (minors and young adults) are being targeted by e-cigarette companies.

Although makahala (Native Hawaiian tobacco) has been used in laʻau lapaʻau, commercial tobacco as well as its subsequent nicotine-related products such as e-cigarettes (also known as ESD, ENDS), have been imported into Native Hawaiian communities since Western-Colonial contact. Since its import, tobacco, and more recently e-cigs, have infiltrated and ravaged through our kaiaulu (communities). The 2021 Youth Risk Behavioral Survey shows that Native Hawaiian youth are particularly vulnerable to the Tobacco Industry's targeted marketing.

I. Essential Public Health and Social Services: Via Cultural Healing Model

The Ahupuaʻa model emphasizes relationship among people and the environment, identifying protective and risk factors, and promoting collective healing. Recognizing Native Hawaiians' holistic worldview, which includes strong connections and reciprocal relationships between the land, community, and spirituality, is key to developing effective healing methods The ahupuaʻa model provides a framework for implementing these interventions or methods and fostering a thriving Native Hawaiian Community.

By embracing a culturally grounded approach, we can empower and uplift our lahui to reclaim and celebrate the unique cultural strengths that have kept our people healthy and thriving for generations, leading to more impactful and meaningful interventions for healing and growth.

J. Essential Public Health and Social Services: Via Traditional Healers & Practitioners

1. **Overview.** POL supports the efforts of kūpuna (elder) healing, and the organizing support of cultural masters and traditionalists toward the understanding, support and perpetuation of the Native Hawaiian healing knowledge, attitudes, values, beliefs and practices. POL advocates for the preservation of such traditions to ensure that the rights and cultural integrity of these practices are respected and appropriately protected.

2. **Approach.** Through community-based presentations, demonstrations, workshops, kūkākūkā (discussion) sessions and working closely with kūpuna (elder) of the geographic area, POL seeks to improve awareness of and sensitivity to Hawaiian cultural processes and the philosophies of spiritual healing, thus assuring that

they are included within the larger health and wellness arena. Whenever possible, POL networks and partners with organizations in the medical communities. The traditional healing program keeps apprised of both Hawai'i legislative and congressional actions impacting and affecting these practices, responds to requests and inquiries, and provides technical assistance to the Systems as well as other community-based organizations as requested.

POL welcomes kūpuna wisdom to provide the support for its cultural, spiritual and historical foundation. This foundation seeks the knowledge of the source of illness which lies within our ancestral past and environment. The wisdom of this knowledge understands that healing and wellness embraces the principles and protocols of our Native Hawaiian cultural and healing practices and compels respect for our kūpuna.

3. **Declaration of Practice, June 2024, Līhu'e, Kaua'i.** More than 70 practitioners and advocates of Native Hawaiian healing traditions gathered on Kaua'i to maintain the integrity of Hawaiian healing knowledge. The chairs of five elder councils of Hawaiian healing practitioners signed *Ke Kuahaua Mauli Ola*, a *Declaration of Practice* to preserve, protect and perpetuate the cultural integrity and ancestral traditions passed down through generations of healers. The declaration is a response to the growing appropriation of Hawaiian healing knowledge and practices by usurpers who don't genuinely understand the protocols, the genealogy, the community recognition, the continued lineage of healers, and most importantly, that healing is a spiritual practice.

K. Essential Public Health and Social Services: Via Native Healthcare Professionals

1. **Native Hawaiian Health Scholarship Program**

a. **Overview.** Established within the Native Hawaiian Health Care Act, the NHHSP provides awards to Native Hawaiian students seeking degrees in the health care professions. The purpose is to increase the number of Native Hawaiians in health and allied health professions, thereby increasing access to health care delivery for those who seek it. The program recruits and nurtures professionals in-training for primary health care disciplines and specialties most needed to deliver quality, culturally competent health services to Native Hawaiians throughout the State of Hawai'i. The merit-based program awards scholarships dedicated to providing primary health services to Native Hawaiians and communities in Hawai'i.

b. **Impact by the Numbers.** Over the past almost three decades, 318 scholars via 347 scholarships awarded resulted in 244 program alumni in the fields of clinical psychology, dentistry, dental hygiene, dietetics/nutrition, nursing, medicine, physician assistant and social work. Fifty-one (51) scholars are supported by NHHSP staff, thru three primary phases of their journey to serving communities—-education, in-service and in community placement.

c. **Impact via Native Voices.** Hear the voices of in-education, in-service and alumni scholars below:

(i) **Scholar A, In-Education, Physician's Assistant (PA), Community Area: TBD:** "The Native Hawaiian Health Scholarship equips me with the financial stability necessary to excel as a physician's assistant and effectively serve the rural communities of Hawai'i. The scholarship alleviates my financial concerns, ensuring that I can pursue my studies without the burden of part-time employment after attending classes Monday to Friday, 8 a.m. to 4 p.m., to cover my living expenses. While the financial support is substantial, the most valuable aspect of this program is the opportunity to connect and learn from esteemed and future leaders in Hawaiian healthcare. The I Ola Lahui lecture series provided me with invaluable insights into the path to leadership as a Native Hawaiian in healthcare. This scholarship not only benefits me personally but also contributes to the greater well-being of the lahui by enabling me to serve the community as a physician's assistant upon completion of my studies."

(ii) **Scholar B, In-Service, Registered Nurse (RN), Community Area: Maui** "The NHHSP helped me obtain my nursing license to serve my rural community of Hana, Maui. The financial, emotional, and mental support allowed me to focus on my education and complete my program successfully. It also lifted the financial burden, allowing me to focus on my family."

(iii) **Scholar C, Alumni, Family Nurse Practitioner (FNP), Community Area: Kaua'i** "The Native Hawaiian Health Scholarship Program has been invaluable to me and my family. Without this scholarship I would not have pursued my Master's degree and would never have become a nurse practitioner serving as a primary care provider and hospice/palliative care provider for my

community. Had I not received this scholarship I would have had to decline my acceptance to the Master's program because it was going to be near impossible to afford my tuition as I would have had to quit my full time job and become a full time student. I was also making a choice between purchasing a home (remaining an RN) and pursuing my education (becoming an APRN). When I received the notification of my acceptance for the Scholarship program my family and I were overjoyed as we felt that the decision was made for us and my education was what I was meant to pursue. The scholarship program afforded me the ability to become a full-time student and still be able to help care for my then 3 year old son. The primary challenge I had with the scholarship program was related to taxes the years following my award. However, through the help of an accountant I was able to file correctly and was able to afford the taxes in the end. This was such a small bump in the road compared to the hurdles I faced going to school and being able to afford to provide for my family as well as afford my tuition. I am grateful for this program and feel blessed to continue to be able to be a part of the community it helped me to find."

(iv) **Scholar D, Alumni, Masters in Nursing (MSN), Community Area: Molokaʻi** "The NHHSP assisted my Masters In Nursing Program from 2011–2013. Because of the assistance of this program, I was able to obtain a management position as a Branch Coordinator of the only Home Care Agency on the island of Molokai serving a majority of the Hawaiian Population. I am fortunate to serve the people on a rural island and community who lack the medical resources other islands are privileged to. Because of this scholarship, I have been able to make a difference in my community."

(v) **Scholar E, Alumni, Bachelor of Science in Nursing (BSN), Community Area: Maui, Molokaʻi:** "I was a registered nurse working at Hui No Ke Ola Pono, Inc. The NHHSP allowed me to pursue my BSN degree while continuing to work full time. I continued to work for Hui No Ke Ola Pono, Inc. serving the Native Hawaiian community. The BSN degree allowed me to move back home to Molokaʻ and serve the community that helped to raise me. I had the privilege and honor to work with Dr.Aluli, the person who had been instrumental in obtaining the Native Hawaiian Health funding and testified in Washington DC to advocate for the health of our lahui. In my current position, I am able to advocate for our island and help to find solutions for our island's health needs. All this was possible first to Ke Akua for opening the doors and providing the open door to the NHHSP.

2. **Department of Native Hawaiian Health, John A. Burns School of Medicine, University of Hawaii—Mānoa** [16]

a. **Overview.** For the past five decades, Hoʻonaʻauao, the medical education division, has been dedicated to developing physicians who are committed to improving the health of Hawaiʻi through the ʻĪmi Hoʻōla Post-Baccalaureate Program and the Native Hawaiian Center of Excellence. Over 350 physicians (38 percent NH) who serve communities across Hawaii, the Pacific, and the continental U.S., were produced by the program and in the current year, 52 medical students currently enrolled, 47 pre-medical students preparing to apply to medical schools and 2,300 K–12 students engaged through recruitment and outreach events.

b. **Executive Order Impacts.** The following information was shared with the Board of Trustees at the Office of Hawaiian Affairs:

Already Lost

Stop order on 20yr+ NIH longitudinal grant on diabetes ($208K/year)
Discontinuation of biomedical sciences mentorship pathway program ($2SOK/year)
Minority Health Training Grant for students in health sciences (New—$270K/year)
Loss of data infrastructure and specialized research staff

At Risk

Current Funding: $5.4M
Pending Funding: $6.6M
Disruption/halt of health research for Native Hawaiians
Reduced support for NH students pursuing medicine, behavioral health, and health science careers

[16] Presentation to the Board of Trustees of the Office of Hawaiian Affairs by DNNH, JABSOM, May 1, 2025

Disruption of partnerships with NH communities

Future Outlook
Declining rates of NH student recruitment into health fields
Reduction of community-based clinical and health science outreach
NH will experience widening health inequities without a voice in academic medicine
Loss of informed health policy regarding Native Hawaiians

L. Essential Public Health and Social Services: Via Education Collaborations

POL collaborates with other sectors, including education, resulting in the United States Department of Education, Native Hawaiian Education Program,[17] award in 2001, a grant to POL, totaling $1.879 million for the Resilient Communities, Families and Schools project. Also known as the 'Ohana (Family) Resilience Program, approximately 20 community-based vendors were contracted, serving sites included in communities near community health centers on the islands of Hawai'i (in the communities of Mountain View, Honaunau, West Hawaii, East Hawaii) and O'ahu (in the communities of Waianae, Waimanalo) to ensure equitable access to disadvantaged communities by strengthening community partnerships, promoting trauma sensitive practice and enhancing coordination of wrap-around prevention/intervention services for children and families.

POL, Native Hawaiian Health Care System, Hawai'i Department of Education, University of Hawai'i Hilo Center for Place-Based Socioemotional Development, Hawai'i Afterschool Alliance, Ceeds of Peace, and HawaiiKidsCAN committed to support five (5) Title I elementary schools located in rural and remote communities where poverty, substance abuse and unemployment are pervasive with limited access to health and further education. On average, 69 percent of students identify as Native Hawaiian or Pacific Island ancestry and 90 percent of students are eligible for free and reduced lunch.

Accelerating the unique challenges of rural and remote places, COVID–19 exacerbated existing stressors on youth, family and communities. In response to the impacts of COVID–19, the purpose of the resiliency hubs for communities, families and schools, was to promote equitable access to education by empowering schools in disadvantaged and/or rural communities to strengthen community partnerships, promote trauma sensitive practice and enhance coordination of wraparound prevention/intervention services for children and families.

III—Continuing Needs, Implementing Master Plan Recommendations and the Native Hawaiian Health Network

A. Continuing Needs

Despite Congress' declaration that it is the policy of the United States in fulfillment of its special trust responsibilities and legal obligations to the indigenous people of Hawaii, health disparities persist and programming needs in the following areas are at risk:

1. SAMHSA Emergency Response Grants (HHS>SAMHSA)

Currently in Year 2 of the implementation of SERG grants (beginning November 2024), and the six-month period reporting in progress, emerging data includes (pending final review and confirmation): over 5,400 families served in the community, associated with almost 14,400 individuals; about 4,400 urgent trauma and mental health clinical appointments; almost 475 events, over 3000 non-clinical appointments; over 90 training sessions attended by almost 1,700 local professionals; and over 140 unduplicated organizations.

2. Rural Health Disparities in Hawai'i'—Native Hawaiian Health Systems (HHS, HRSA>BPHC, Federal Office of Rural Health Policy)

The following plain language summary is provided by the Economic Research Organization at the University of Hawai'i report "Rural Health Disparities in Hawai'i",[18] published in August 2024:

"Health can be different in rural and city areas for many reasons. For example, rural places might not have as many healthcare services. This makes it harder for people to get good care. But rural areas are closer to nature and often have close communities. This can be good for health. Studies on how rural living affects health

[17] To address and support the educational needs of Native Hawaiians, as demonstrated through the 1983 Native Hawaiian Educational Assessment Report, Congress enacted the Native Hawaiian Education Act (NHEA)

[18] *Rural Health Disparities in Hawai'i—UHERO*, retrieved May 12, 2025

in the US have shown mixed results. There have not been any studies for Hawai'i before. This report looks at health differences between rural and city areas in Hawai'i. We used data from a health survey done in June 2023: the UHERO Rapid Survey. We looked at things like age, gender, race/ethnicity, income, education, and disability to see how they relate to health and rural living. We found some big differences in health between rural and city residents in Hawai'i. Living in a rural area was strongly linked to overall health. The effect was bigger for physical health than mental health. People with disabilities and people with low incomes in rural areas faced the biggest health differences. Our findings suggest that health policies should aim to reduce differences between rural and city areas. It is especially important to help groups like people with disabilities and people with low incomes in rural areas. These groups need additional support."

Continuing supports via NHHN organizations (POL, Systems, FQHCs, CHCs, CBOs, NHOs, universities, State of Hawaii) can collectively address rural health disparities.

3.Disproportionate Representation in Programs that Address the Health, Safety and Self-Sufficiency of Native Hawaiian Families [19] (HHS>CMS)

a. 33 percent of Temporary Assistance for Needy Families (TANF) clients in June 2024 were Native Hawaiian. This is higher than Hawaiians' proportion of the total state population of 21 percent.

b.In State Fiscal Year (SFY) 2024, 39.7 percent of confirmed victims of child abuse or neglect were Hawaiian.

c.In the same year, 41.6 percent of children in foster care are Native Hawaiian.

d.42.8 percent of incarcerated youth were Hawaiian.

e.Total Hawaiian population currently receiving Medicaid equals almost 77,000 which represents 19 percent of all Med-QUEST members; almost 26,000 (34 percent), children including over 1,400 current and former foster care children; over 400 pregnant women; over 14,000 (18 percent) parents or caretakers; about 26,500 (34 percent) adults; about 8,800 (11 percent) aged, blind or disabled adults; and over 1,100 other individuals.

4.Missing and Murdered Native Hawaiian Women and Girls [20] (HHS>HRSA)

Pursuant to H.C.R. 11, the Hawai'i State Commission on the Status of Women (CSW) convened a Task Force to study Missing and Murdered Native Hawaiian Women and Girls (MMNHWG). The Missing and Murdered Native Hawaiian Women and Girls Task Force (MMNHWG TF) was administered through the Hawai'i State CSW and the Office of Hawaiian Affairs and was comprised of individuals representing over 22 governmental and non-governmental organizations across Hawai'i that provide services to those who are impacted by violence against Kanaka Maoli.

The MMNHWG TF had the responsibility of understanding the drivers that lead to Kanaka Maoli women and girls to be missing and murdered, to propose solutions, and to raise public awareness about violence against Kanaka Maoli.

The findings and recommendations in the report were provided to members of the MMN–HWG TF for review and their insights were included. Any disparate agreement with the findings and recommendations will be noted.

a. 21 percent of Hawai'i's total population (N= 1,441,553) identifies as Native Hawaiian (U.S. Census Bureau, 2021).

b. 10.2 percent of the total population of Hawai'i identifies as a Native Hawaiian female, with 47.6 percent of this population identified as females under the age of 18 (U.S. Census Bureau, 2021).

c. More than a quarter (1/4) of missing girls in Hawai'i are Native Hawaiian (JJIS, 2001 2021).

d. Hawai'i has the eighth highest rate of missing persons per capita in the nation at 7.5 missing people per 100,000 residents (Kynston, 2019).

e. The average profile of a missing child: 15 year old, female, Native Hawaiian, missing from O'ahu (MCCH, 2022).

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[19] Audit, Quality Control & Research Office Research Staff. (2024). Databook. State of Hawaii Department of Human Services. *https://humanservices.hawaii.gov/wp-content/uploads/2025/04/DHS-Databook-FY2024.pdf*

[20] Cristobal, N. (2022). Holoi a nalo Wahine 'Oiwi: Missing and Murdered Native Hawaiian Women and Girls Task Force Report (Part 1). Office of Hawaiian Affairs; Hawai'i State Commission on the Status of Women: Honolulu, HI.

f. The majority (43 percent) of sex trafficking cases are Kanaka Maoli girls trafficked in Waikiki, Oʻahu (Amina, 2022).

g. 38 percent (N= 74) of those arrested for soliciting sex from a thirteen-year-old online through Operation Keiki Shield are active-duty military personnel (Hawaiʻi Inter net Crimes Against Children Task Force, 2022).

h. In 2021, the Missing Child Center Hawaiʻi (MCCH) assisted law enforcement with 376 recoveries of missing children. These cases are only 19 percent of the estimated 2,000 cases of missing children in Hawaiʻi each year (MCCH, 2021).

i. On Hawaiʻi Island, Kanaka Maoli children ages 15–17, represent the highest number of missing children's cases, with the most children reported missing in area code 96720, Hilo (Hawaiʻi Island Police Department, 2022).

j. From 2018–2021, there were 182 cases of missing Kanaka Maoli girls on Hawaiʻi Island, higher than any other racial group (N= 1,175) (Hawaiʻi Island Police Depart-ment, 2022).

k. 57 percent of participants served through the Manaʻolana Program at Child & Family Services are Native Hawaiian females who have experienced human trafficking (Ma naʻolana, CFS, 2021–2022).

Continued collective, systemic and community-based efforts are needed to address MMINHWG issues.

B. Implementing Recommendations of E Ola Mau—Native Hawaiian Health Master Plan (HHS, HRSA)

1. **E Ola Mau 2023 Recommendations Overview**.[21] The E Ola Mau (EOM) report (NHH Master Plan) provides comprehensive recommendations aimed to address and improve the overall well-being of the Native Hawaiian community. It is generated through the efforts and commitment of a multidisciplinary collective of practitioners across the pae ʻaina. The structure of the 2023 report followed the key areas of health and well-being covered in the earlier report, including the new addition of recommendations made in the racism, data governance, and workforce development chapters. The recommendations emphasize the importance of integrating Native Hawaiian culture with modern healthcare systems to create a holistic approach to well-being. This includes increasing the availability of culturally appropriate services and resources, and supporting community-based efforts.

Additionally, the report advocates for a strengths-based approach to wellness, increased monitoring and evaluation of the recommendations, and interdisciplinary collaboration. The overarching goal of these recommendations is to reduce health disparities and promote a healthier, more vibrant future for Native Hawaiians.

2. **Racism & Well-Being.** EOM teams reviewed the literature connecting racism with each chapter (e.g., oral health, behavioral health, historical and cultural context) that existed in previous EOM reports and identified specific recommendations for each section. While this chapter is new to the 2023 report, racism has been implicit in the previous reports. Recommendations from 1985 called for culturally sensitive approaches to health programs and interventions and the need to address Native Hawaiian concerns relating to land, urbanization, the justice system, self-determination, economic self-sufficiency, environmental protection, education, housing, transportation, energy, historical and archaeological sites, lawaiʻa ʻana (fishing), mahiʻai ʻana (farming), and language and culture. The 2019 report called for disaggregated data, Kanaka workforce development, and more culturally grounded ways of supporting Native Hawaiian health There are recommendations for: Racism: Historical & Culture Perspectives; Mental and Behavioral Well-Being; Medicine; Nutrition, Oral Health, Data Governance, Workforce Development, Resilience; and Mental & Behavioral Wellbeing; Nutrition, Policy & Advocacy; and Community Education.

C. Native Hawaiian Health Network (HHS>HRSA, SAMHSA, CMS)

Continuing the work of the collective, the Native Hawaiian Health Network (NHHN), is vital for raising the health status of Native Hawaiians and Hawaiʻi, and POL, the NHHB, acknowledges the following organizations and the long standing commitment to Hawaiʻi's communities:

1. The Native Hawaiian Health Care Systems

a. Hoʻola Lāhui Hawaiʻi—Kauaʻi Community Health Center, also a federally qualified health center.
b. Ke Ola Mamo, island of Oʻahu;

[21] *https://www.papaolalokahi.org/wp-content/uploads/E-Ola-Mau-2023–Recommendations-all-workgroups.pdf*, retrieved May 12, 2025

c. Hui No Ke Ola Pono, island of Maui;
d. Na Pu'uwai, islands of Molokai and Lana'i; and
e. Hui Mālama Ola Na 'Oiwi, Hawai'i Island.

2. Federally Qualified Health Centers (island), alphabetically and with multiple sites and modes within their communities [22]

a. Community Clinic of Maui (Maui)
b. Hamakua-Kohala Health (Hawai'i Island)
c. Hana Health (Maui)
d. Kalihi Palama Health Center (O'ahu)
e. Ko'olauloa Health Center (O'ahu) f. Kokua Kalihi Valley Comprehensive Family Services (O'ahu)
g. Lanai Community Health Center (Lana'i)
h. Molokai Ohana Health Care (Molokai)
i. Wahiawa Center for Community Health (O'ahu)
j. Waianae Coast Comprehensive Health Center (O'ahu)
k. Waikiki Health Center (O'ahu)
l. Waimanalo Health Center (O'ahu)
m. West Hawaii Community Health Center Inc. (Hawai'i Island)
n. WHCHC Hawaii Island Community Health Center (Hawai'i Island)

3. Community Health Centers
CHCs are the cornerstone of the health care system in Hawai'i, providing essential services to the most vulnerable populations. CHCs are non-profit organizations, and exist in federally-recognized areas, where residents have barriers to getting health care. They also actively reinvest in the development of the communities they operate in. A comprehensive array of services including: primary medical care, behavioral/mental health care, dental services, diagnostic services, prescription drugs, case management, language assistance, culturally-competent and sensitive care, health education, including nutrition counseling, and assistance with program applications, including housing and cash assistance. [23]

4. State of Hawaii, Department of Health and Department of Human Services
Both department are integral to working with each other and the community at large to accomplish public health goals and objectives.

5. Native Hawaiian Organizations
POL, the NHHB, recognizes the almost 200 NHOs currently on the U.S. Department of the Interior, Office of Native Hawaiian Relations' Notification List [24] which are vital, community and cultural connections to the Native Hawaiian community.

6. Community Based Organizations
Too numerous to name organizationally, the network of CBOs intersect with all of the above named and includes community collaborators in education, health, housing, social services, land and ocean at all governance levels—community, county, state, federal, international.

POL, the NHHB, acknowledges all who have been and/or are a part of the NHHN, individually and organizationally, and welcome all and commits to strengthen the health status of NHs and Hawai'i.

The CHAIRMAN. Thank you very much, all of you. We appreciate your testimony and what you bring to the conversation here today.

I want to start with tribal consultation, because it has been mentioned by Chairwoman Alkire and Loni Greninger as well. I think all of you reference it, and again, we are seeing changes that are going on. I believe it was you, Chairwoman, that indicated that a letter had been sent urging tribal consultation in light of the reductions in staffing and the cuts.

I am assuming that if there has been response to that, that initial consultations have yet not been made. Can you clarify for me where we are on that?

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[22] *https://npidb.org/organizations/ambulatory__health__care/federally-qualified-health-center-fqhc__261qf0400x/hi/*, retrieved May 12, 2025
[23] *https://www.hawaiipca.net/what-is-a-chc, retrieved May 12, 2025*
[24] *https://www.doi.gov/sites/default/files/documents/2025–04/nhol-complete-list-final-web.pdf*, retrieved May 12, 2025

Ms. ALKIRE. Yes. I just want to say thank you to the ladies here also. We come here to make these statements, and thank you, Committee, for hearing what we have to say.

But we know really what we have to say has to come from our heart. Our people have always struggled with the fact of consultation. And I think all our organizations, we send these letters but we haven't heard anything yet. And I think that is the issue. And that is the issue I think all of America is dealing with, with all these issues that we have these are saving lives.

The consultation for tribal leaders and those involved with these grants that are receiving these grants and implementing these programs out in the rural communities, that is the voices that need to be told how important these programs are that save the lives for our people.

The CHAIRMAN. And that is why we are having this conversation with you, representing the many voices within, from your tribes, tribal communities, your regions. As I mentioned, Secretary Kennedy was before the Health Committee today and it is very important for him to be there to be presenting the budget as we know it at this point in time.

But this feedback is so necessary. We have talked about, we are seeing what is happening with the proposals for consolidation, the Administration for a Healthy America will consolidate the Office of Assistant Secretary for Health, HRSA, SAMHSA, ATSDR, NIOSH, and so many of these agencies that are really very critical to the services that are provided to our tribal communities.

So what I am hearing is they are acting first, you are responding, saying we need to know what is going on, and true consultation is not a responsive action. It is being there at the beginning so that some of this input, the imperative of Tribal Head Start, the imperative of FVPSA, the imperative of LIHEAP, that that is factored in before the decisions are being made.

So I want to make sure that for the record, what we are hearing from you as leaders in your respective areas is that that outreach is yet to be had. Is that probably correct? I see everybody nodding their heads.

Vice Chair Greninger, I want to ask, because you have great detailed insight into the ACF Tribal Advisory Committee, given your role there. Given the reduction of tribal engagement staff that we are seeing there at ACF, going from five to now just two, and then the loss of the regional tribal program leads, what is this meaning on the ground for you? You mentioned the consolidation within the regions, so Alaska, Washington, and some of the other impacted areas are now reporting into Denver.

Just quickly, what is the impact of all of this? What do you think is needed to restore effective tribal advisory functions during this reorganization? Because we have a reorganization going on. It is just pretty public here. Tribal advisory role is pretty key.

How do we make this more effective?

Ms. GRENINGER. Those are great questions. So the effect of what we are seeing now with the RIFs, those particularly five advisory staff that you are talking about come from the ACYF within ACF. So they were the ones who were actually helping ACF leadership-

wide be able to understand tribal nuances, what does it take for us to participate in grants.

It was also helpful in the consultation setting where we could help form agendas together, make it a collaborative process rather than just it is a one-sided Federal process. Consultation is both of us coming together, right?

So with the RIFs of those particular staff, what is walking out the door is tribal nuance knowledge, institutional knowledge and then intimacy with the tribes. All of that, all of the advisory is walking out the door, unfortunately. So we are left behind with staff who maybe have minimal knowledge or no knowledge, and they are learning it as they go. And it takes a long time to understand tribes.

So that is one of the areas that I have a huge concern about.

But what can it take in the meantime? Gosh, if we could get those staff back. I don't know what process that would take. But if we can get those particular staff back, that would be wonderful.

And having the consultation process may be ACF specifically with tribes, HHS broadly with tribes, each branch of HHS with tribes, so we can dig into those particular programs and those nuances, that is going to be most helpful, because we have lost those advisory staff.

The CHAIRMAN. I know I am over my time, but I think this is a question that my colleagues would agree is worth drilling down on. Because the Secretary has said to individuals within HHS that have been RIFd, terminated, that if they so desire, they can move over within the IHS sphere. Does that make sense? Or are you talking about levels of expertise where a body just isn't a body?

Ms. GRENINGER. That is a great question. I would be concerned that IHS becomes all things Indian for HHS because IHS is strictly about health. When HHS programs in tribes, it is all HHS offices. So I need expertise in each branch of HHS.

The CHAIRMAN. Very good. Thank you.

Vice Chair?

Senator SCHATZ. Thank you, Chair Murkowski. It occurs to me, obviously you are the Chair and you can tell us how to work together on a bipartisan basis, but it seems to me this hearing is calling for some follow-up and using the convening authority of the Senate Committee on Indian Affairs. Because nobody is talking to anybody.

We could suppose how things might work better and we might have some pretty good ideas, but it starts with you knowing who to call and that person having any authority or knowledge at all. So I am not a believer of, just get everybody into a room and it is going to work out, but I do think that is probably a necessary condition for success, that we start to have a dialogue and know who our points of contact are and kind of what the path forward is.

I commit to you, Chair, I do my fair share of partisan fighting, this is not the place for that. I will try to make sure that we keep it on the substance of the matters. Thank you for your leadership here.

Dr. Daniels, welcome. Papa Ola Lōkahi is authorized to coordinate health care programs and services for Native Hawaiians, subcontracting with Native Hawaiian and community health organiza-

tions. Are there any other entities authorized to do this work under the statute?

Dr. DANIELS. There are no other entities.

Senator SCHATZ. So as the only entity coordinating care for Native Hawaiians across the State, what is your service population and what happens if HRSA's funding gets cut?

Dr. DANIELS. Our service population is targeting Native Hawaiians, although because we get Federal dollars, we cannot limit access. So it is community.

Just in our five Native Hawaiian health care systems, we are serving over 70,000 individuals at touch points. That is clinical, non-clinical, that is outreach. We know in our communities face to face going out to where they are, that is what we know we have to do. Traditional practices, all of those things roll up into those numbers.

That does not include our network partners. So it is not just the five systems. Papa Ola Lōkahi actually reaches out and we contract with other FQHCs. So we recognize we can't be the do-all and be-all, that our community doesn't only see one type of provider. So reaching out to the FQHCs, our community health centers, our hospital and institutions, we are creating bridges, we are partnering with them. But also our community based organizations across the State.

So adding those numbers in, those touch points grow. And we know that that is how our community gets help, and accesses care. And to adjust that to already be fearful about cuts in funding, people are scared and nervous.

And having those reach-outs allow us to one, keep a pulse on what is happening with our community, so that we can report back. But also then we can get the stories, which we did provide in our written testimony, from communities in all different areas.

Senator SCHATZ. Thank you.

Everyone is tracking that there is a House bill that will cut Medicaid by about $700 billion. There are carve-outs for Alaska Native and Indian tribes. There are no carve-outs for Papa Ola Lōkahi or for Native Hawaiian health. I am wondering if you could speak to the impact of Medicaid cuts for Native Hawaiians.

Dr. DANIELS. Good question, Senator. I want to say this, because I think that one comment was, we speak from our heart. The fact that there is an exclusion of Native Hawaiians is unacceptable. That should stir something in all of us, that we talk about being Native communities, yet we exclude. And that is not acceptable.

So just at the offshoot, the exclusion of Native Hawaiians in that House carve-out, it perpetuates the belief that within departments and agencies that we do not exist. And I am sure some of our other tribal communities might feel that way, these moments of not existing. And we cannot perpetuate that.

But I think the biggest pieces is in passing these, imposing these new hurdles, that is what I am going to call them. It is just that, they are hurdles. They impact eligibility, they slow access to identification of needs, they slow access to services. We don't need any more slowdowns.

And specifically, if you talk about the work requirements, employment is one of the social determinants of health. And if we are

talking these things, we are saying these things, all of this adds to our community and the people we work with.

Already, Native employment rates are among the lowest in our State. And you couple that with the highest health disparities. Doesn't look good, it doesn't fit. And so basically health plus employment are seen as separate issues, and they are not. They are tied in together. Employment equals health and health equals employment.

Senato Schatz. Thank you. There are a lot of very valid complaints about the health care system. I have never met a single soul who has asked for more paperwork, and that is a lot of what the House bill does.

The CHAIRMAN. So, Senator Luján was actually here first, but he just kind of walked in. If you want to catch your breath and let Senator Smith go.

STATEMENT OF HON. TINA SMITH,
U.S. SENATOR FROM MINNESOTA

Senator SMITH. Thank you, Chair Murkowski, and Vice Chair Schatz, for this hearing today. And thank you so much to all of you for being here and for providing your testimony.

I think that now is a very good time to be talking about HHS programs and how they should be benefiting Naïve people as part of our trust and treaty responsibilities, and to acknowledge that what the Trump administration is doing, what Secretary Kennedy is doing, and gutting and reorganizing, the department is directly hurting communities, Native communities in this process.

I think it is so ironic, because during his confirmation process, Secretary Kennedy talked a lot about being a champion for Native people. He talked about his own father; he worked hard to build his reputation for being a leader who was going to keep Native people in his mind. But yet in his role so far the reality has been very different.

I am really struck by the stunning lack of consultation that you all have described in your testimony. And again, we all know here that that tribal consultation is not an optional thing to do because it is nice to do, it is part of our legal trust and treaty responsibilities, recognizing your sovereign nation status to do that.

So whether it comes to suicide prevention or HIV prevention or ICWA or elder programs, all of these are vital to the health and well-being of Native communities. God knows, IHS needs reform and improvement and more funding. But to be clear, that is not all that we are talking about here.

So I am grateful for this hearing and the opportunity to talk about this. Because I think in many cases, I know from the nations that I represent in Minnesota that these are issues of life or death and have such direct consequences on what happens to people and their lives.

So I want to follow up, I appreciated very much the question that Chair Murkowski sneaked in at the end of her time, I want to just follow up on that. There has been this information about how senior career officials who are tobacco regulators, research scientists and others at NIH, as those jobs are being eliminated, have been offered jobs in far-flung locations in IHS. As I was reading this, I

found this offensive to the individuals who don't have, and these are clinical jobs for the most part, I think. And that these clinical jobs would be offered to be filled where we already have such a great shortage of staff and people with folks that don't have clinical experience.

So I want to just ask any witness if you could comment on this, what impact do you see this has? And how do you view this from your perspective? I will just open that up to anybody. Chair Alkire, would you like to take this?

Ms. ALKIRE. Yes. In preparation for coming here, all of us ladies here, we all have an area. One of the things in my regard was to talk to our CEO at our IHS facility, and talk about the impact that it has had in regard to staffing and the loss of providers. I am glad that Secretary Kennedy is going ahead and letting up a little bit on the hiring freeze, but it needs to be across the board, especially for those types of providers that we need, to provide that health care.

The staffing is so important for these facilities. It is even like, if we can't even hire a maintenance janitor, that means the hospital is not safe. These kinds of basic things.

Senator SMITH. Of course.

Ms. ALKIRE. So yes, I think all the ladies could agree on that. There is a huge need.

Senator SMITH. And sending a research scientist who specializes in tobacco cessation research to an IHS facility when what is needed is not research but clinical care doesn't really solve any problem, does it?

Ms. GRENINGER. May I?

Senator SMITH. Yes, please.

Ms. GRENINGER. I think one thing we also need to remember is when we are eliminating researchers, tribal researchers in particular, now we are talking about another historical issue of concern.

Senator SMITH. Yes.

Ms. GRENINGER. Research has been used against tribes and in unethical ways, it has been implemented in our communities. So if we are going to be eliminating positions of research that have that tribal nuance and that knowledge —

Senator SMITH. That is right, it is kind of a double whammy.

Ms. GRENINGER. Absolutely. And the nexus for programs and ACF, I have actually, in this last budget consultation last month with HHS, I was wondering, how can I make a better connection between NIH and ACF programs? Because data is huge. That is a huge issue for us. Child welfare data, especially when we have children in the State systems.

Senator SMITH. Right.

Ms. GRENINGER. And in our own systems. So to hear that those particular positions were also being eliminated, just because I am not in NIH intimately doesn't mean I am not concerned and I don't see the connection to other programs across HHS and my tribal community.

Senator SMITH. Thank you very much. Thank you very much, Chair Murkowski.

The CHAIRMAN. Thank you. Senator Cortez Masto?

STATEMENT OF HON. CATHERINE CORTEZ MASTO, U.S. SENATOR FROM NEVADA

Senator CORTEZ MASTO. Thank you, Madam Chairwoman.

Can I jump back, Dr. Daniels, I want to touch on something that you were, a conversation you were engaging with Senator Schatz. FQHCs. Medicaid funding to FQHCs is in jeopardy. If they don't get their funding, they could close their doors. Most people don't realize, in Nevada we have 28 federally recognized tribal communities. Not every one of my tribal communities has a health center. They just can't afford it. They just can't do it.

So they rely on FQHCs. And sometimes those FQHCs are a two-hour drive for them.

So we are not just, a carve-out, which we talked about, is not enough. It is really important that we provide a system of health care for our tribal communities, indigenous communities, that the can not only access, that is reliable, that is affordable.

So can you talk a little bit about these Medicaid cuts? It is not just the impact to tribal communities themselves, but surrounding communities where there is a system of health care that could be devasted, particularly in our rural communities. If you would touch on that?

MS. Daniels. Absolutely. I think you brough up a very good point, that it is just not the Medicaid. Because if FQHCs or others are impacted, it also includes the retention and recruitment of staff. But then they can't, we have several FQHCs that are in high rural areas that they supplement housing for those providers.

We have one island that access to it is on little nine-seater planes. And providers are coming in. Those things are all going to be impacted.

So then, where does our community go? Off-island? We already have health deserts. Not the same way as I think South Dakota, but similar. We have water between the islands, but when pregnant women can't give birth on the islands, how does that—so we already now are eliminating another access point.

Senator CORTEZ MASTO. That is right.

Dr. DANIELS. That is a challenge.

The one thing that we recognize is the network. So I think oftentimes FQHCs and other health entitles are siloed. We do what we do in our community and that is it. And we have recognized that we no longer can do that. That if resources go down, we are going to need each other, and to support and pool our resources so we can continue to serve our community.

But when those keep getting like pinned off, it is really hard to keep doing that. Then our communities grow. And our providers don't grow. There is still only a handful. But the number that is coming grows.

So I think it is all of these domino effects, when we start picking up, and it might seem very minimal that we are going to adjust or take off on Medicaid on things, but then we might not see it today or tomorrow, but we are going to see it as people start having to close, not even close doors, but close services. Maybe they are not doing the five types of services, maybe it is only two. And that becomes a problem.

For us, then we start looking at if that service isn't provided on their island, where do they go? And do they have access to pay for a $200 ticket to fly to the next island?

Senator CORTEZ MASTO. Right. And it is the same, listen, it is the same in rural communities as well. In Nevada, sometimes you have to drive four hours just to get access to health care. That is if you have a car, and you can get off work to be able to access it.

So it is a system that will shut down that is essential for providing health care that quite honestly, you have worked so hard to put together because of a lack of resources and a lack of providers and a lack of geography that brings everybody together like you have in an urban area.

I appreciate this. I want to touch on—my time is running out—mental health. Mental health. I cannot stress this enough. I am so concerned about the cuts to mental health services that we fought for in our communities.

There is a program called Native Connections. I know about it because in my State, I have talked with so many of my Native community members, there is a nine-year old girl in Nevada, Urban Indians, who is struggling with mental health. She did not, could not get the care from the school or a pediatrician. But it was the Native Connections program that, according to her father, got his daughter back. It is a Native Connections program.

So I don't know if any of you are familiar with it or if you could talk about it. But please stress the importance of why funding for programs, particularly on this mental health and Native Connections, is so important.

Ms. ALKIRE. Thank you. I am so glad you brought that up. So, it is clear to me that programs like Native Connections save lives. Thank you for that. From my tribal community, two last week, two suicide ideations happened with a fifth and sixth grader. These programs are so important right now to save lives.

So suicide rates for Native youth are four times higher than any other racial or ethnic group. Native Connections allows awardees to tailor culturally appropriate programming to reduce suicide, substance use, and impact of trauma in tribal communities. Native Connections empowers Native youth by strengthening community ties and providing, as I said, culturally responsive support.

Through this program, youth engage in models that promote, through protective factors, like personal wellness and positive self-image, and a strong sense of cultural identity. Without this funding, intervention and support services for Native youth will become even more limited.

This puts Native youth, many of whom experience discrimination, trauma, and loss of loved ones, at greater risk for resources available for them to heal. So I think it is so important, life-saving. So thank you for that question.

Senator CORTEZ MASTO. Thank you. Thank you, Madam Chair.

The CHAIRMAN. Senator Luján?

STATEMENT OF HON. BEN RAY LUJÁN,
U.S. SENATOR FROM NEW MEXICO

Senator LUJÁN. Thank you, Madam Chair. And thank you and Vice Chair Schatz for this important hearing.

To each of our honorable and distinguished witnesses, thank you for taking time to be here away from other responsibilities, and especially from home. I know that this is not easy.

Madam Chair, before I begin, being more aware that Secretary Kennedy would have liked to have been here and that his staff may be here, or may be watching, I want to point out what a disappointment I believe this administration has been to the Indian Health Services. Recently, when Secretary Kennedy was in Winter Rock, Arizona and in Gallup, New Mexico, he was just minutes away from one of the oldest IHS centers in Gallup, New Mexico.

If he would have gone there, he would have seen this. What it says is, do not drink the water. Do not use the water for consumption. Failure to follow this advisory could result in illness. Do not use the ice, and then "made from tap water" for drinking and patient care. Don't use it for baby formula, for brushing teeth, for making ice, care, until further notice.

The way that I was raised is you make time for what is important. And he didn't make time.

The other thing I would share with Secretary Kennedy is, it has been over 60 days that members of the United States Senate sent you a letter about the measles outbreak in America where many of our constituents are not just sick but some have died.

Respond to the letter. Keep your word. When you were asked in Committee if you would respond to letters sent by members of the United States Senate, you took an oath and said yes. Keep your word. I am just very disappointed there.

Ms. Charlie, as an alum of Head Start, I am one of only two in the United States Senate that went to Head Start. I often joke I thought everybody went to Head Start. I didn't know you got to be poor enough to go.

I believe in early childhood education. I believe the United States Senate, this is a place that Head Start can get you, in addition to other responsibilities we have around the world. Research has demonstrated that high quality early childhood education programs increase child educational achievement later in life and significantly reduce the likelihood of adult poverty.

Right now, there are conversations taking place about going after one program or another. There are statements on social media that are later redacted and things of that nature. What can you share with us about the importance of early childhood education and programs like Head Start to the livelihoods of kids and others that you are honored to represent and speak for?

Ms. CHARLIE. Head Start is critical for the kids that we serve. At FNA we serve 224 kids. We provide interventions, we work with the school district, with the special education department. We do the 45–90 days dental health screenings. We provide referrals with health care and other specialists needed.

So we provide early intervention for the kids so when they get into school, they are not delayed. The school doesn't have the capacity to do what we do. They don't even screen for IEPs until third grade.

They don't have the capacity to provide the services that we do at Head Start. So it is critical, it provides structure for them, it de-

velops routines for them. So they are ready when they get into school.

Not only that, it supports the whole family. Our program supports grandparents coming in and volunteering, we are culturally based, we do a lot of cultural activities. We created a book with Denaka [phonetically] lesson plans. We were working on a digital app to give access to that, to anybody who wanted it.

So it is important. And the school just doesn't have the capacity or resources to do what we do.

Senator LUJÁN. I appreciate that strong testimony.

I would argue, all of us on this dais, including those that are not present right now, we all care greatly for Native American mothers and for babies, which is why I am outraged by the fact that 92 percent of Native American women that die from pregnancy related deaths are considered preventable. Just let that sit for a second.

And that the CDC has seen a 20 percent reduction in staffing, leaving more vulnerabilities out there, this could all be preventable.

Ms. Alkire, can you speak to how the reduction in force at IHS and the reorganization in programs like the Pregnancy Risk Assessment Monitoring System will have on people going forward, namely moms and babies?

Ms. ALKIRE. [Remarks off microphone.]

Senator LUJÁN. In the area of maternal health, with moms and especially with babies, with looking at 92 percent of those that we lose, it is all preventable.

Ms. ALKIRE. Right.

Senator LUJÁN. And there are more conversations around programs like the Pregnancy Risk Assessment Monitoring System getting financial support or not, some of the layoffs at HHS. Do you have any thoughts of taking those programs away or making it harder, what kind of impact would that have on moms and babies?

Ms. ALKIRE. Yes, actually there are several, and we provide a lot of this in the testimony, because this is such an important issue for us.

The investments from HRSA, this is one of the conversations I had with the CEO in regard to young moms, where I come from. She said the issue is that a lot of them, these programs fill the gaps, because IHS does provide services. But these programs that HHS provides, they fill the gaps for a lot of our tribes with these grants.

And one of them is to help young moms get some prenatal care, get some education. Because the issue, I think, in having such scary statistics that we have is that a lot of these are young moms, and they don't come to the hospital until they are going to have the baby.

So a lot of them need this education. They need these programs, these grants that are out there, to provide that connection for them to learn what is coming, even to see the baby's growth. And that way it provides more of a connection for the mom to see how important it is to take care of themselves and take care of the baby. That is what these grants provide.

So HRSA is an investment in Healthy Start that saves lives. By supporting tribally tailored programs, it helps reduce infant mor-

tality and address adverse perinatal conditions in American Indian and Alaska Native populations. Healthy Start is a vital lifeline for rural and remote communities. It provides essential services like health screenings, nurse visits and support through tribal home visiting programs, which I think is so important right there, to ensure new and expecting mothers receive the care they need.

Programs like this help bring knowledgeable staff into our communities, so expecting mothers and new moms do not have to drive, as we said, three or four hours away to get support for pre- and post-natal care. Without HRSA funding, the tribal maternal and health safety net is at risk.

Losing these dedicated resources would weaken critical support for Native families at a time when these services are essential, more than ever. Many young mothers, as I said, don't show up until they are ready to have their baby. So perinatal care is often not even sought.

This program puts babies on the radar, so home visits can be conducted. As I said, it helps connect them. These programs are successful of collaboration and also culturally appropriate programs, because I think it just helps with identity issues for the mother and the baby and just the family. Super important.

Senator LUJÁN. Thank you.

Madam Chair, just in closing, thank you for your leadership, for putting a face on the people across the Country that we are so honored to represent and for fighting for them. More of that is what we need. I want to say thank you to you and to Vice Chair Schatz for that. Thank you.

The CHAIRMAN. Thank you, Senator Luján.

Significant issues that we are talking about, maternal mortality, how we are able to ensure that the programs that are so important for, again, so many that are so vulnerable.

We talked about mental health. I want to talk about domestic violence for just a moment. This is a matter that I raised with the Secretary at the hearing at 1:30. I mentioned FVPSA. This is the primary Federal funding source for our domestic violence shelters and our support services and our tribal communities. Obviously, essential for emergency shelter, crisis intervention. We understand all too well up north why these are priorities.

I received a letter back, it was dated April 2nd from the Alaska Native Women's Resource Center, about the impacts of the layoffs at the FVPSA office the concerns about what it means to have the director of that placed on administrative leave.

I am going to enter this into the record, as well as an attached letter that was directed to Secretary Kennedy about the same subject.

When I mentioned this to the Secretary, he indicated his clear support for making sure that when it comes to domestic violence, shelters for women and the most vulnerable, that it is not his intention to be cutting programs. And I don't recall his words specifically, but it was something along the lines of he didn't think that they had cut programs.

But I also recognize that in budgets that are proposed, that is one thing. But sometimes you can effectively eliminate the effectiveness of a program if you don't have people there, right? If there

is nobody there to process the grant application, if there is nobody there to answer the phone or to respond to your email about what the status of your grant is.

So let me direct this one to you, Ms. Simpson. Can you describe how the Office of Family Violence and Prevention has been key in implementing FVPSA in our tribal communities and then what happens when you don't have, okay, let's just say the program is still there, but you don't have the folks to implement it? What happens to those you are trying to serve?

Ms. SIMPSON. Thank you for the question. The Office on Family Violence Prevention and Services, we call it OFVPS, the OFVPS office under former director Dawson's leadership has been instrumental in recognizing the need for culturally grounded and Native led programs for survivors of violence. The OFVPS office ensures that over 230 tribes and tribal domestic violence programs receive FVPSA formula grants that allow them to provide emergency shelter and crisis intervention services.

OFVPS also partners with Native led organizations like NIWRC to provide training and technical assistance and resources to tribal grantees and advocates that can build the capacity of tribal organizations so that our communities have access to long-term and specialized care that meets their unique needs. In this way, OFVPS helps to carry out the Federal trust obligation.

When Director Dawson was abruptly placed on administrative leave, not only did that impact the office's ability to move forward, but that was felt all the way down to the individual tribal grantees. There was a significant gap of communication, silence between program officers and the tribal programs in terms of what the new, what this was going to mean for ongoing funding.

There was a lot of uncertainty from grantees, because none of the new solicitations have gone out. The continuation applications that normally are released in March haven't been released yet, so programs are unsure what the funding is going to be. So it is good to hear that Secretary Kennedy has assured that those programs will maintain funding. But that hasn't been expressed to any of the programs yet.

There are a lot of questions about what is now allowable and what is not allowable. That information that we haven't gotten guidance; tribal programs haven't gotten guidance yet. So it has caused many programs to kind of feel the need to halt services, because they are worried that they might do something wrong and then lose their funding and get their grants terminated the way things have happened at the Department of Justice.

So it creates a lot of uncertainty and stress and fear within these tribal programs. The substantial reductions in force will, if there are more, it will surely interrupt the essential functions of these prevention efforts across Indian Country. These RIFs threaten decades of improvements in the public health response.

Tribal programs rely on OFVPS staff who have cultivated trusted relationships with the tribal nations. This can take years to build. The institutional knowledge is immense.

This long-term relationship building has also led to many OFVPS staff developing cultural competence, significant cultural competence, trauma-informed expertise and a deep understanding of

the complex realities that face our Native communities. So when we lose those staff, when we lose the communication with those staff, then we are resulting in gaps of silence and tribes unable to be able to move forward with their domestic violence programming.

So it is pretty significant. Also, I think that the loss of leadership, a direct result of that is the funding delays that tribes have experienced. It resulted in many programs where the possibility of being forced to shut down or lay off staff, and we do know that there have been programs that have had to lay off staff, because of the long gap in receiving their funding through drawdowns as well as the uncertainty of being able to maintain funding into the future.

The CHAIRMAN. We have heard some of that, where the uncertainty with the funding coming, let's just say it has been put on a pause, or a freeze, or just the uncertainty, and in so many of these, with so many of these programs, if you have a shelter that you are trying to run, usually you don't have a lot of cushion. You are able to pay your staff salaries that month and maybe the following month. You are able to get the food, the supplies for maybe that month, maybe the following.

But there is not, again, a cushion in the event that these funds don't come through. And if you can't provide the services, you can't open the doors and you can't provide the safety that is sought.

Ms. Charlie, I know that there at FNA you utilize the FVPSA funding to help those that you serve in doing everything from temporary housing and safety for survivors. So I am going to ask you a question that kind of ties into FVPSA but goes just a little bit more. Because I mentioned the issue of LIHEAP, the Low Income Heating and Energy Assistance. This is a program that has been zeroed out, and for us in Alaska, it makes a difference. You need to stay warm in the winter. I would imagine that in some of the areas that you represent, it is about air conditioning in the summer, in order for your elders to be safe in their own homes.

One of the things that we have heard is that the assumption with this proposed budget was that the greater focus on energy production, it would lower the cost of energy to people's homes and so thus the LIHEAP assistance would not be necessary.

That may be true in the future. I don't know that we have an easy button on this to reduce energy costs around the Country, much less in a place that is as expensive as Alaska or Hawaii. But Melissa, if you can just share for the Committee record the expense that a family basically faces in staying warm in a place like Fairbanks, Alaska, and what it would mean if you weren't able to access this LIHEAP funding.

Ms. CHARLIE. Like you said, the cost of living in Fairbanks and Alaska is extremely high. There are places in Alaska that one gallon of heating fuel can run from $5 to anywhere over $10 a gallon. And that is for heating fuel.

We do have an elders program; we do a lot of case management. We do deal with a lot of elders who not only have food insecurity but can't pay their energy bill. They can't pay their rent. So this is the case management that we provide. We also do it with the FVPSA funds for emergency shelter, because as women leave a domestic violence situation with just the clothes on their back, they

can't afford temporary housing, not in Fairbanks and especially in Remo, Alaska. So it is really critical.

For the energy assistance, it is a huge impact on all of the families we serve, not just the elders, but the families in Head Start. The cost of living in Fairbanks is extremely high, and the surrounding areas is much higher. So it would be devastating to everybody we serve, across all of our programs.

The CHAIRMAN. Thank you.

Senator Luján, do you have follow-on questions?

Senator LUJÁN. No, thank you, Chair Murkowski.

The CHAIRMAN. Okay. I am just going to keep going here for just a few more minutes, because I think one of the things that we share as members of this Committee when we think about the many challenges that we see across Indian Country, and the barriers to things like economic opportunities and strong education, is the issue of mental health, behavioral health, and the lack of services that are then made available.

We have had a little bit of conversation about some of the statistics related to suicide, and I agree with you, Vice Chair Greninger, we are tired of being number one in so many of these really awful, awful statistics.

So, SAMHSA's Center for Mental Health Services has faced pretty significant RIFs, and now with this proposed elimination of SAMHSA overall, I would like to hear from you about the impacts on the delivery of culturally responsive programs to tribal communities.

Ms. GRENINGER. Thank you for the question. SAMHSA is important in particular because when you look at SAMHSA mental health programs compared to IHS programs, IHS does have mental health dollars but it is focused on adult mental health. And SAMHSA has children and family mental health.

So that is where it is super critical for us tribes to have those dollars so that we can specifically tailor our mental health to our children and our young families.

So I would highlight Circles of Care as one of those particular programs.

The other great thing about SAMHSA mental health programs is tribes don't have to compete for them. In other programs, we have to, which is really sad for us. We hate competing against our brother and sister nations.

So those are the two biggest things, to be able to focus on youth and the non-competitiveness of SAMHSA. So the ability for us to even have culturally relevant services, that kind of flexibility within SAMHSA grants is what allows us to get to that spirituality piece that I was talking about in my comments, where we can bring in the songs and the language and are filling in that emotional and spiritual piece of the holes in our hearts that frankly, medical care from the western perspective cannot touch.

That is why we are always going after those dollars, bringing in drum-making kits, bringing in regalia-making kits, teaching our kids language, bringing in the language teachers. That is all part of mental health, as well as doing, I am going to say, more traditional forms of treatment, such as counseling and things like that. That is all essential too.

But bringing in those spiritual healers as well to teach us the songs and to help heal our hearts and spirits in that way, those SAMHSA dollars can help us in those ways as well.

The CHAIRMAN. Important point about not having to compete, which is significant.

Dr. Daniels, you looked like you were wanting to say something.

Dr. DANIELS. You mentioned the Center of Excellence. I think we all have part of that. So at Papa Ola Lōkahi, we actually are a pass-through with the State for the center of excellence, and ours is called the Ohana Center of Excellence, which is an AANHPI Center of Excellence.

What has been happening is with the RIFs and the changes, that program has been asked to scrub the information that they have put on for communities to access. So things around webinars or culturally appropriate programming that goes onto those websites are at risk.

So our communities cannot access it. And it is not just communities; it is the professionals that are working within those communities that it is a TA type of opportunity for them. So that center of excellence is at risk.

Then also, SAMHSA also funds Emergency The Surge, which is the Lahaina Wildfire Disaster monies, same thing, that those kinds of opportunities to get creative and really focus in on communities are being kind of shifted off. So I agree with the SAMHSA kind of understanding and how they support communities.

The CHAIRMAN. I think part of what we were hoping to accomplish today was again to remind not only those in the administration but just to remind all of us of the many, many programs that are available that are critically important to Native people, whether you are in Hawaii, Alaska or elsewhere around the Country, that are outside of the IHS system. We have talked about SAMHSA, we talked about young people, early Head Start.

We really haven't had that much of a discussion about elders. Clearly, the Older Americans Act, while it doesn't say anything about Natives in the title, but clearly, those services, whether it is the congregant meal services, the caregiver support, these are vitally important. I don't know, I know Melissa, probably FNA does a fair amount with the Title VI, the tribal program there within the Older Americans Act. Do you want to speak to how important these programs are for our elders?

Ms. CHARLIE. Yes. At FNA, we do have an elders program at community service. We do receive Title VI funding. We provide 800 meals a month, Monday through Friday. And we also assist with food boxes. They have a garden for food insecurity.

And we serve over 300 elders in our program. We do a lot of case management, if they can't pay their rent, if they can't pay their fuel bill.

But what I really love about our elders program is they are really integrated into everything that we do at FNA. They are at the school tanning moose hide, they are at our Head Start program teaching them how to make fire bread and cut berries. They are at certain schools that they are the grandparents for certain classrooms. They are teaching them how to jig; they are doing songs and dance.

They are just really involved in everything that we do at FNA. I really love that program, because it is important that we take care of our elders. We are all going to be elders one day.

And so it is a really amazing program. They love the program; they love to come together and congregate and eat and just be together. Otherwise, they would be home alone.

Every time we invite them to talk at our annual meeting, they are there, they are speaking. And they own their program. They develop their agendas and meeting and topics that they want to do. It is a really amazing program. It really builds and makes them happy to be able to come together.

The CHAIRMAN. I love the fact that they are there with the kids as well.

I want to ask a question about efficiency. Because we are operating in an administration that has taken a very keen eye toward efficiency and we all know that we can and should do more when it comes to more efficient operations.

So I think we have something to advertise when we are talking about the 477 program. I look at that as a model for tribal self-governance. It really demonstrates how tribes can exercise their sovereign authority. It is the integration of employment, of training, of human services into one just efficient, streamlined plan.

So I think this is probably directed to you, Vice Chair Greninger, about how, I guess the progress that we have made over the years in expanding HHS program participation in tribal 477 plans. And how important you think it could be in this administration, again, one that is really keenly focused on how we can do a better job in reducing inefficiencies and eliminating kind of the overlap and the overlay. If we have multiple programs here, consolidation is good, let's make sure we are consulting on it all, let's make sure it makes sense.

But talk a little bit for the Committee here about the value of the tribal 477 program.

Ms. GRENINGER. Absolutely, thank you for the question.

I think I am going to steal the words from my chairman, Ron Allen. He said if there is anyone who understands how to run things efficiently, it is the tribes, because we are all wearing multiple hats, smaller governments and trying to stretch the dollar as far and wide as possible.

So 477 is really critical to tribes because it allows us the flexibility to self-govern, we can take these funds from the Federal Government and we can issue them into our community the ways that we see fit.

The other important part of that is we are talking about efficiency, is the reporting structures. Data and reporting is much more streamlined. It is a reduced burden for us, especially the smaller tribes, such as Jamestown. We aren't 477 per se, but we will advocate for it. I am more of a 638 tribe.

But when we talk about HHS programs in particular, we have been working with ACF specifically to increase those particular programs. What we would love to see is if all of HHS programs and ACF programs could be in 477 because of that streamline factor, and it gives us that self-governance benefit.

ACF has worked with us, and I think we are up to about five, five programs in 477. I would like to highlight for this Committee that there are going to have to be conversations to talk about the barriers, probably, with some of the regulations and maybe part of the statutory pieces of this.

With Head Start, we have had some concerns about that. Head Start was able to be put into 477. But there was discussion on, are we meeting statutory requirements when we put Head Start under 477 when we are really seeing some of these data burdens, reporting burdens, statutory burdens, health and safety burdens, things like that.

But I think that those are conversations that tribes want to have, and if there is statutory requirements we need to look at and evaluate those, I think those conversations should be happening.

So we are hoping that HHS will remain open to adding more programs into 477.

The CHAIRMAN. So let me ask on that, do you think, or maybe it is too early to know whether there is somebody within HHS that is dedicated, I guess, to be able to support tribes in integrating HHS programs into their 477 plans?

Ms. GRENINGER. I think I will need to follow up with you on that. I want to say that ACF has like maybe two or three staff that are dedicated to 477 right now. But I can follow up with you on that.

The CHAIRMAN. The reason I ask, and I think the Vice Chair noted it at the beginning of his questions, or maybe it was the end of them, that this input that we are getting from you today is really important that it be an iterative process, that it not just be this conversation today but that we build on this, that as you are bringing information to us, we are able to feed that up to let them know it is going to be really important that you have somebody within your department that is tasked to these things.

Then further, that that individual that has been named, you all know who is on point there. We can be that intermediary. But it shouldn't be for more than just the fact of getting a name and then being able to pass that on.

So I think it is going to be important again that we are working with the folks at HHS, the folks in the Secretary's office, in recognizing and acknowledging the many, many, many programs within HHS that have implications for our tribal citizens and Native people.

So how we do this going forward, we are going to kind of rely on those of you, the many that you represent. There is still much that is going on within this reorganization that we are all just learning about.

And the fact that we don't have yet a full president's budget, we just have a skinny budget, we are operating off of a continuing resolution and we are hoping that the departments are going to be following their operational plan, and if not, that there is reprogramming.

There is just so much that is just uncertain. I think the message that I would like to leave with all of you is, amidst this uncertainty, know that we all have to kind of link arms and get through this together, even though the frustration at times may be really, really hard to deal with, because you can't seemingly get answers.

I know we want to try to give benefit of the doubt as administrations are getting stood up. We are very, very slow in moving these nominations through the Floor. It is a process. It could be made easier, but we are where we are.

So you may be the Secretary that is accountable, but you might not have your full teams in place to do the execution, to do the kind of consultation that I think we are talking about that you need and demand, and rightly demand.

So, not making excuses for the administration, they have to answer on their own. But I do know that the Secretary has indicated to me that these matters are priorities to him. We want to take him at his word for that. And that he will assign teams that work with us to better the lives of our Native peoples, wherever they may be.

So I am really appreciative for what you have brought here today. If there are additional matters that the Committee needs, I know that questions for the record will continue to come in. We would ask you to try to help us out with that.

I started off my morning with the Administrator of the EPA and we were asking him about various grants that have been paused or frozen or are still under review. And I just told him that we would like a list. We want to know from your perspective where things are.

Because if something has been terminated, that is one thing. If something is still under review, that is another thing. Maybe you can hold on and keep your folks on it, your shelter for another month, if you know that there is still a likelihood that that funding is going to come through.

But if it has been terminated, then decisions are being made for you. So if you have specifics that you want to share with us that we can then elevate, know that we also can perform that role as well.

Thank you to each of you for making the trip and thank you for the leadership that you provide respectively.

With that, the Committee stands adjourned.

[Whereupon, at 5:17 p.m., the hearing was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF DONNIE GARCIA, CHAIRMAN, ALBUQUERQUE AREA INDIAN HEALTH BOARD, INC.

Thank you, Chairman Lisa Murkowski, Vice Chairman Brian Schatz and respected members of the Committee for the opportunity to provide this written testimony on behalf of the member tribes of the Albuquerque Area Indian Health Board, Inc. (AAIHB). As Congress knows, Indian tribes have a unique political and legal status recognized by the U.S. Constitution. Elimination or disruption of federal funding for Indian country has a huge impact on the ability of tribes and tribal organizations to provide essential services to American Indians and Alaska Natives. Indeed, the problems that face communities nationwide are far more severe for Indian communities, with tribes having far fewer resources to address basic health care needs and larger problems like substance abuse, mental health and other issues. AAIHB acknowledges and appreciates that there has been broad bi-partisan Congressional support for addressing health and wellness issues facing Indian 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 in the surrounding Albuquerque area. 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 funded—about 86 percent—through various programs under the U.S. Department of Health and Human Services. Approximately two-thirds of that funding falls outside of the Indian Health Service (IHS).

For example, our health programs significantly rely on funding directly from the National Institutes of Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC). While we receive a small amount of state and private foundation funding, the loss of our federal funding would force us to reduce or completely terminate health care services and related educational and research programs. A summary of these non-IHS programs that AAIHB receives is set forth below.

- CDC Healthy Tribes Program:

—Approximately $1.2 million for Good Health and Wellness in Indian Country
—Approximately $990,000 for Tribal Epidemiology Center Public Health Infrastructure

- CDC Division of Injury Prevention:
  —Approximately $200,000 for alcohol impaired driving prevention
  —Approximately $671,000 for tribal opioid prevention
- CDC Division on HIV Prevention:
  —Approximately $1.3 million
- SAMSHA Tribal Opioid Response:
  —Approximately $1.5 million
- NIH Native Collective Research Effort to Enhance Wellness (N Crew):
  —Approximately $497,000
- NIH Community Partnerships to Advance Science for Society:
  —Approximately $989,429

[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.

Some of our funding streams noted above provide much needed research within Indian country to address addiction, substance abuse and pain, including for related factors like mental health and wellness. Understanding and addressing these issues is critical to a Healthy America for tribal communities. Secretary Kennedy recently testified that "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, [is] a top priority."[2]

Eliminating or reducing those funding streams because they appear to be duplicative or too small for national impacts, ignores the uniqueness and size of Indian country compared to the country as a whole. For example, funding from N Crew for tribes and tribal organizations was a direct result of tribal consultation and the need for tribally led research as it relates to substance abuse and pain in Indian country. AAIHB receives other funding that may seem duplicative, but it is not and the funding is needed in Indian country. AAIHB for instance also receives federal grants that focus on opioid addition from the CDC and SAMSHA, but unlike the N Crew funds used for research, the CDC grants focus on surveillance and public health practice while the SAMSHA grant is issued directly to tribes to strengthen capacity of tribal behavioral health programs, as noted below.

We urge Congress to protect all of these funding streams and recognize that tribes and tribal organization receive funding from many sources and while it may seem duplicative it is not and all of the funding is needed to address health issues throughout Indian country. Indeed, Congress acknowledges the chronic underfunding of health and wellness related programs throughout Indian country. Rather than eliminating or reducing funding streams for research within Indian country, these funding streams must be protected and could even be consolidated—without reduction to tribes and tribal organizations—to eliminate the need to seek funding from multiple grant sources.

The Community Health Education and Resiliency Program (CHERP) at AAIHB provides trauma-informed and strengths based capacity building in STI/HIV prevention, opioid and substance use prevention, positive youth development, and mental health. Our program tailors to community needs to equip tribal public health professionals with the skills, resources, and tools to implement effective interventions and services. This program is funded mostly through SAMHSA and CDC grants. CHERP hosts a Wellness Conference, which is the only conference of its kind devoted to addressing HIV prevention, testing, and biomedical treatments, along with harm reduction strategies and substance use disorders within tribal communities. This allows for education and capacity building that is uniquely geared towards Indian country.

Within AAIHB is the Albuquerque Area Southwest Tribal Epidemiology Center (c), which is 1 of only 12 tribal epidemiology centers nationwide. More than half of the funding for AASTEC comes from non-IHS programs. For example, AASTEC operates a Good Health and Wellness in Indian Country Program with funds provided by the Centers for Disease Control and Prevention—*Healthy Tribes Program*. Through that program AASTEC provides leadership, technical assistance, training, and other health resources to AAIHB's 27 tribal communities to promote community level changes that support health and wellness and prevent and manage type 2 diabetes, heart disease, and stroke and their associated risk factors, such as commercial tobacco use, physical inactivity, and unhealthy diet. More specifically for example, AASTEC provides 10 direct tribal sub-awards for community projects that are critical to improving health and wellness in tribal communities. We have significant concerns regarding this funding moving forward. All CDC staff within this program have been subject to a reduction in force (RIF) and the CDC Division of Population and Health, which is the division that oversees this program, is being proposed for elimination as part of the Administration's reorganization plan.

Similarly, as noted above, AASTEC receives important funding from the CDC Division of Injury Prevention. This funding assists with (1) building important collaboration among and between tribes and external partners, (2) building public awareness aimed at educating tribal communities on the burdens of motor vehicle accidents and alcohol-impaired driving, as well as risk reduction strategies, (3) strengthening the capacity ability within the tribal public health workforce to implement best practices, and (4) improving data collection and access to data. These evidence-based programs are essential for our tribal communities because unintentional inju-

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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.*

ries remain the leading cause of mortality for American Indian and Alaska Natives nationwide from birth through middle age. We are concerned about this funding because all staff within the CDC Division of Injury Prevention have been RIF'd. It is also important to note that the various RIFs that are occurring are concerning not only with respect to the status of funding moving forward, but the RIFs also result in the loss of institutional knowledge and result in the diminished capacity of federal staff who not only understand Indian country but provide important expertise and technical assistance with tribes and tribal organizations.

Heavy reliance on non-IHS funding streams to serve our tribal communities is not unique to AAIHB. Tribes throughout Indian country rely on these funding streams as well. Eliminating funding streams that tribes and tribal organizations, like AAIHB rely on will only further exacerbate the health disparities that American Indian and Alaska Natives face. While we understand that programs may be consolidated, any such consolidation should not result in less funding for Indian country. As Congress considers the FY 2026 Budget we urge you to protect all non-IHS funding sources depended on by tribes and tribal organizations. Thank you.

PREPARED STATEMENT OF THE AMERICAN INDIAN HIGHER EDUCATION CONSORTIUM

The American Indian Higher Education Consortium (AIHEC) is comprised of 34 accredited Tribal Colleges and Universities (TCUs) in the United States (U.S.). On behalf of the TCUs, the following comments are submitted to the U.S. Senate Committee on Indian Affairs in regard to their May 14, 2025, oversight hearing on examining Federal programs serving Native Americans at the U.S. Department of Health and Human Services (Department) programs. AIHEC's mission is to provide leadership and influence public policy on American Indian higher education issues, including promoting and strengthening Indigenous languages, cultures, communities, and Tribal Nations.

About Federal Trust and Treaty Obligations

Rooted in treaties and authorized by the United States Constitution, the federal government's unique responsibilities to Tribal Nations have been repeatedly reaffirmed by the Supreme Court, legislation, executive orders, and regulations. [1] The trust responsibility establishes a clear relationship between Tribal Nations and the federal government. [2]

This legal duty and trust responsibility applies across all branches of the federal government. These trust and treaty obligations are owed to Tribal Nations and their citizens and do not have an expiration date. Health and Education are central components of the federal trust and treaty obligations promised to Tribal Nations, Tribal citizens, and Tribal communities. The federal government has long endeavored to uphold this duty through the appropriations process and through the enactment of laws such as the Snyder Act of 1921, the Indian Self-Determination and Education Assistance Act of 1975, and the Tribally Controlled Colleges and Universities Assistance Act of 1978.

About Tribal Colleges and Universities

In a bold expression of sovereignty, Tribal Nations began chartering their own institutions of higher education—Tribal Colleges—in the 1960s. The first Tribal College, like all that followed, was established for two reasons: the near complete failure of the U.S. higher education system to address the needs of—or even include—American Indians and Alaska Natives; and the need to preserve our culture, our language, our lands, our sovereignty—our past and our future. The guiding vision of the Tribal College Movement is an education system founded on traditional knowledge and focused on a prosperous future through job creation and strengthening our communities.

Currently, TCUs operate more than 90 campuses and sites in 16 states, which make up over 80 percent of Indian Country. These institutions serve students from over 250 federally recognized Tribal Nations and embody a vital component of Tribal higher education. All TCUs offer certificates and associate degrees; 22 offer bachelor's degrees; 9 offer master's degrees; and one offers a doctoral degree. Programs

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[1] The Court has consistently held that the federal government has a trust responsibility to Tribes, which has formed the foundation for federal/Tribal relations. See *Seminole Nation v. United States*, 316 U.S. 286 (1942), *United States v. Mitchell*, 463 U.S. 206, 225 (1983), and *United States v. Navajo Nation*, 537 U.S. 488 (2003).

[2] In *Worcester v. Georgia*, 31 U.S. 515 (1832), the Supreme Court explicitly outlined that the relationship between the federal government and the Tribes is a relationship between sovereign nations and that the states are essentially third-party actors.

range from liberal arts to technical and career programs and are created to address the needs of Tribal Nations and rural economies. TCUs train professionals in high-demand fields, including early childhood education, law enforcement, agriculture, natural resources management, information technology, and healthcare. By teaching the job skills most in demand in our communities, TCUs are laying a solid foundation for Tribal economic growth, with benefits for surrounding communities and the nation as a whole. As open enrollment, community-based institutions, Tribal Colleges welcome all students and proudly became a part of the nation's land-grant university family in 1994.

TCUs provide accessible and affordable options for higher education for Tribal citizens and other rural students by offering low tuition rates and fees; 97 percent of TCU graduates are debtfree. Additionally, most TCU students are first-generation and low-income, with 78 percent relying on Pell grants-far above the national average. [3]

TCUs also serve other community members through various community-based programs and services each year, such as library services, job training, High School equivalency program instruction and testing, health promotion, Head Start and K–8 immersion programs, financial literacy, community gardens, youth and college prep, summer camps, and civic programs.

Key Program Within the U.S. Department of Health and Human Services

Administration for Children and Families—Office of Head Start: Tribal Colleges and Universities Head Start Partnership Program. The TCU-Head Start Partnership program was re-established in FY 2020 at $4,000,000 and has been flat-funded at $8,000,000 for FY 2023 and FY 2024 (funding for FY 2025 has yet to be disbursed). The purpose of the TCU-Head Start Partnership Program is to increase the number of qualified education staff working in American Indian and Alaska Native Head Start programs. The program accomplishes this goal by increasing access to higher education degrees in early childhood education. Through this unique and successful partnership, TCUs lead and are able to build a larger network through their subawardees by:

1. Building Early Childhood Education Career Pathways in Tribal communities;
2. Addressing the employment needs of American Indian and Alaska Native Head Start Programs while being responsive to the cultures and languages of Tribal Nations through a "Growing Our Own" Approach; and
3. Meeting the unique needs of individual Tribal communities and supporting staff in American Indian and Alaska Native programs to acquire the competencies that ensure children's academic development while also supporting cultural identity.

This program reaffirms the mission of TCUs by increasing self-determination and providing services to their respective Tribal community. Through this program, TCUs have been able to successfully train early childhood educators and Head Start teachers in high-demand areas across Indian Country. In 2021, 71.7 percent of Head Start teachers nationwide held a bachelor's degree, but only 42 percent met this requirement in Indian Country (Head Start Region 11). Additionally, only 39 percent of assistant teachers in Region 11 met the associate-level requirements, compared to 76 percent nationally. TCUs offer a cost-effective solution to this gap. From 2000 to 2007, the program provided scholarships and stipends to help Head Start teachers enroll in TCU Early Childhood Education programs.

Currently, this program is able to fund six TCUs to increase access to both entry-level credentials and early childhood education degrees for teachers working in American Indian and Alaska Native Head Start Programs. As an example, Navajo Technical University (NTU), located in Crownpoint, New Mexico, offers a Bachelor of Science degree that specializes in early childhood multicultural education. Since the Fall of 2020, NTU has been able to confer over 50 degrees or certificates in early childhood multicultural education. [4] Additionally, as of the Spring of 2024, the University had over 85 students enrolled in the program, which includes both fulltime and part-time students.

Another example, Salish Kootenai College (SKC), located in Pablo, Montana, offers a wide range of early childhood education degrees and certificates such as Early Childhood (birth to age 8), Early Childhood P–3 (preschool–grade 3), Elementary

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[3] American Indian Higher Education Consortium (2023). Retrieved from: *American Indian Measures of Success (AIMS)*

[4] Navajo Technical University. *Bachelor of Science: Early Childhood Multicultural Education.* Retrieved from: *https://www.navajotech.edu/wp-content/uploads/2024/11/Early-Childhood-Mult-Edu-BS-Enrollment-Data.pdf*

(K–8), Secondary programs (grades 5–12) in Science and in Mathematics, and a Master's program in Curriculum and Instruction. These degree programs provide an opportunity for candidates to become highly qualified professional educators who serve students in diverse school settings. At SKC, students are held to high standards, where the goal is excellence—not simply completion. Their student cohorts live, study, and work closely with each other and form personal and professional relationships that last far beyond the college classroom.

AIHEC's Concerns on the Potential Termination of the Head Start Program for Fiscal Year 2026

AIHEC and other organizations were alarmed to learn that the budget pass back from the Office of Management and Budget to the Department contemplates completely doing away with Head Start altogether for FY 2026. This would not only be catastrophic in the immediate term for the individual Tribal communities served, but it would have long-lasting and cascading effects throughout all of Indian Country for years to come.

The need for degree or certificate programs is vital to Head Start Region 11, which represents Indian Country. As mentioned previously, in 2021, only 42 percent of primary teachers met the requirement of holding a bachelor's degree, and only 39 percent of assistant teachers held an associate's degree in the region. TCUs are closing this gap as 24 institutions offer certificates, associates, or bachelor's in early childhood education, which represents 11 different states. According to the National Indian Health Start Association, through the TCU Head Start Partnership, it is expected that the program will confer over 700 graduates with an early childhood education degree by 2028.

Students who attend Tribal Colleges are most often non-traditional and potentially have families. As TCUs provide a wide range of student services, such as childcare services through their Head Start programs, students are able to partake in available support services that assist with decreasing any financial and economic burdens outside of their education. If Head Start programs are shut down, the enrollment numbers will significantly decline for these older, nontraditional students. As Region 11 of Head Start is comprised of the American Indian and Alaska Native programs, which are most often the only daycare or childcare facilities located within the region. These programs not only provide childcare or early childhood education services, but they also impact the community through cultural and language reclamation, economic stability, and long-term positive outcomes for Native children and families. Therefore, the elimination of Head Start would be detrimental to Tribal communities, along with the nation's TCUs, as they provide vital degree programs and professional development as it relates to early childhood education.

Conclusion

TCUs provide thousands of American Indian and Alaska Native students with access to highquality, culturally appropriate postsecondary education opportunities, including critical early childhood education programs. The modest federal investment in TCUs has paid significant dividends in employment, education, and economic development. AIHEC appreciates the Committee for hosting this vital oversight hearing. AIHEC remains committed to working collaboratively with the Committee as a trusted resource to ensure that Tribal Nations and Tribal citizens have a say in shaping their education and their future.

PREPARED STATEMENT OF STEPHANIE KNOWLTON, PROGRAM COORDINATOR, FORT PECK TRIBAL COURT

AI/AN Head Start Programs

Good Morning.

I am a community member, a tribal member, and an employee of Fort Peck Indian Reservation. It has come to my attention that we may lose our Head Start programs in Indian Country. This is very sad that political issues are now affecting our ability to educate our native children on Fort Peck.

This program has been the most successful program for our children teaching not only the fundamental foundation but basic life skills that are detrimental to our community and their self growth. As you know, children are our future, and they need to be nurtured and placed on the highest level of care and support. Without our Head Start, this will set us back decades and remind us that we are controlled by people who have not lived our lives or walked in our trenches.

I have worked in the schools. As an advocate. BIA Social Services Child Protection worker and now a program coordinator with the Fort Peck Tribal Court.

I have seen first hand the benefits of our Head Start programs. Knowing that this may come to an end is heartbreaking and very disappointing for our children and the people who have worked hard in their careers to lead by example for successful children.

Head Start is important because it provides low-income families with high-quality early childhood education , health, and family support services, leading to improved school readiness, cognitive and social emotional development, and long term success for children and families. It also addresses systemic issues that can hinder a child's development, such as poverty, limited access to health care, and lack of parenting resources.

Thank you for taking the time to read my concerns for our children. Your attention and time are greatly appreciated and I am hopeful for some positive outcome.

PREPARED STATEMENT OF EILEEN J. LUJAN, BOARD MEMBER, NATIONAL INDIAN COUNCIL ON AGING

Dear Senators. Congressman,

My name is Eileen J. Lujan Pueblo Indian from Taos Pueblo , Southwest Region of New Mexico. I serve on the National Indian Council on Aging (NICOA) as a board member. On May 22nd–23rd, 2025 NICOA board members were present in several of Senators offices. Expressing our concerns about very unsettling decisions being made by President Trump and his staff. Sorry to say but you have no idea how an Indian Pueblo or reservation lives day to day. This does not sit well with me as an elderly voting member. It is very alarming to the elderly population that certain services will be cut or wiped off. Such as with in the Affordable Care Act, Medicaid, Health Insurance. Other services Medicare, Social Security, SNAP. Other departments, Indian Health Service, Bureau of Indian Affairs, Natural Resources, Education Department. Older Americans Act which affects the Title VI nutrition services, Senior Community Service Employment Program (SCSEP).

We can no longer accept this treatment. Where did the TRUST RESPONSIBILITY, and GOVERNMENT to GOVERNMENT RELATIONSHIP GO. United States Government you are not upholding your responsibility. We as Indian people are not going anywhere we are here to stay. Please take a closer look and hear yourself talk when making these decisions. I thank you for being able to write this today.

PREPARED STATEMENT OF FRANCYS CREVIER, ALGONQUIN/CEO, NATIONAL COUNCIL OF URBAN INDIAN HEALTH (NCUIH)

My name is Francys Crevier, I am Algonquin and the Chief Executive Officer of the National Council of Urban Indian Health (NCUIH), a national representative for the 41 Urban Indian Organizations (UIOs) contracting with the Indian Health Service (IHS) under the Indian Health Care Improvement Act (IHCIA) and the American Indians and Alaska Native patients they serve. On behalf of NCUIH and these 41 UIOs, I would like to thank Chairman Murkowski, Vice Chairman Schatz, and Members of the Committee for your leadership in improving health outcomes for American Indian and Alaska Native people and for the opportunity to provide testimony in response to the Senate committee on Indian Affairs May 14 hearing titled, "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"

Overview of Urban Indian Organizations

The term "urban Indian" refers to any American Indian or Alaska Native person who is living in an urban area, either permanently or temporarily. UIOs were created by urban American Indian and Alaska Native people with the support of Tribes, starting in the 1950s in response to severe problems with health, education, employment, and housing.[1] Congress formally incorporated UIOs into the Indian Health System in 1976 with the passage of IHCIA. UIOs are an integral part of the Indian health system, comprised of the Indian Health Service, Tribes, and UIOs (collectively I/T/U), and provide essential healthcare services, including primary care, behavioral health, and social and community services, to patients from over 500 Tribes in 38 urban areas across the United States.

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[1] Relocation, National Council for Urban Indian Health, 2018. *2018__0519__Relocation.pdf(Shared)-Adobe cloud storage*

UIOs only receive funding from one line item in the IHS budget, the Urban Indian Health line item, which accounts for approximately 1 percent of the IHS budget. As such, UIOs rely heavily on funding from grants in various Health and Human Services (HHS) agencies to ensure they are able to provide their communities with the quality of care they require.

Proposed Health and Human Services Restructuring and Funding Cuts

Many UIOs rely on funding and partnerships through key HHS divisions such as the Health Resources and Service Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS), and various Division of Tribal Affairs (DTA) offices. These divisions play a critical role in supporting programs and services vital to urban American Indian and Alaska Native populations. The value of HHS programs outside of IHS cannot be overstated, as they are essential for UIOs in fulfilling the federal trust and treaty obligation to provide health care services to American Indian and Alaska Native people.[2] The proposed reorganization and restructuring of HHS, combined with the administration's recommended 26.6 percent cut in agency funding,[3] will bring significant changes to several operating divisions, with potentially serious consequences for UIOs.

It is particularly concerning that, to date, HHS has not held Tribal consultation or urban confer on the HHS restructuring. The lack of tribal consultation and urban confer is a failure to fulfill the U.S. Government trust and treaty obligations to Tribal Nations and programs serving Tribal citizens. Given the scope and potential impact of this restructuring, it is imperative that HHS engage in meaningful consultation with both Tribes and UIOs to ensure transparency and to address serious concerns about the consequences of such a significant public health and policy shift.

Health Resources and Services Administration

The Health Resources Services Administration (HRSA) plays a vital role in delivering healthcare to geographically isolated, economically disadvantaged, and medically underserved populations. Presently, there are 11 UIOs that receive HRSA Community Health Program funding through the 330 grant program.[4] The proposed dissolution of HRSA and its integration into the new Administration for a Healthy America (AHA) raises serious concerns about the future of these essential programs. It remains unclear whether the programmatic support provided by HRSA will be preserved or diminished during this transition, which poses a direct threat to the continuity of care for UIO patients.

Additionally, recipients of the 330 grant program are required to provide care to non-American Indian and Alaska Native patients. As such, NCUIH, on behalf of UIOs, has requested guidance and clarification from HRSA on complying with the recent Executive Orders (EOs) on diversity, equity, and inclusion (DEI).[5] This guidance and clarification is especially important in light of the recent Advisory Opinion from HHS Office of the Secretary General Counsel (OGC) which states that the recent EOs do not apply to HHS' legal obligation to provide healthcare for American Indian and Alaska Native people.[6] While the Advisory Opinion provides some clarity on how the Administration applies the DEI EOs to American Indian and Alaska Native health, it is still unclear how agencies within HHS, including HRSA, will apply this guidance in practice when enforcing these EOs, particularly as it relates to UIOs who receive HRSA Community Health Program funding. UIOs require this guidance to ensure their programs can operate effectively and without interruption as implementation of EOs could impact or affect HRSA funding if the UIO is not in compliance. HRSA has yet to respond to the request for guidance and clarification.

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[2] 25 U.S.C. § 1601(1)

[3] Office of Management and Budget, Fiscal year 2026 Discretionary Budget request (May 2025), retrieved from: *https://www.whitehouse.gov/wp-content/uploads/2025/05/Fiscal-Year-2026-Discretionary-Budget-Request.pdf*

[4] Tribal/Urban Indian Health Centers, HEALTH RES. & SERV. ADMIN, *https://www.hrsa.gov/about/organization/offices/hrsa-iea/tribal-affairs/tribal-urban-indian-health-centers* (last visited Mar. 11, 2025).

[5] Exec. Order No. 14151, 90 Fed. Reg. 8,339 (Jan. 29, 2025), *https://www.govinfo.gov/content/pkg/FR-2025-01-29/pdf/2025-01953.pdf*; Exec. Order No. 14168, 90 Fed. Reg. 8,615 (Jan. 30, 2025), *https://www.govinfo.gov/content/pkg/FR-2025-01-30/pdf/2025-02090.pdf*; Exec. Order No. 14173, 90 Fed. Reg. 8,633 (Jan. 31, 2025), *https://www.govinfo.gov/content/pkg/FR-2025-01-31/pdf/2025-02097.pdf.*

[6] Dep't of Health & Human Serv., Advisory Opinion 25–01, Application of DEI Executive Orders to the Department's Legal Obligations to Indian Tribes and Their Citizens (2025), *https://ncuih.org/wp-content/uploads/HHS-Advisory-Opinion-25-01.pdf.*

Substance Abuse and Mental Health Services Administration

American Indians and Alaksa Native people experience disproportionately high rates of alcohol, substance use and mental health disorders, suicide, violence, and behavior-related morbidity and mortality compared to the rest of the U.S. population. [7] In fact, American Indian and Alaska Native people experience serious psychological distress at a rate 2.5 times more than the general population over a month's time. [8] These poor outcomes impact American Indian and Alaska Native people no matter where they live. For example, according to a 2020 report from the Centers for Disease Control and Prevention, non-Hispanic American Indian and Alaska Native people had the highest rates of drug overdose deaths in both urban and rural counties compared to other races, at 44.3 per 100,000 and 39.8, respectively. [9]

SAMHSA programs play a critical role in addressing these outcomes, saving lives and improving behavioral health outcomes across Indian Country. However, both the reorganization and the President's proposed budget include substantial cuts to SAMHSA's three major centers: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT), and the Center for Substance Abuse Prevention (CSAP).

Notably, CMHS funds several Tribal behavioral grant programs, including the Native Connections program. The Native Connections program is youth-focused behavioral health grant, with 17 UIOs as recipients of the grant. The programs have been influential in reducing suicides among American Indian and Alaska Native youth. Unfortunately, many UIOs have heard from SAMHSA staff that their Native Connections grants will not be renewed in the 2026 grant year. This expected loss of funding is deeply concerning, as it would undermine efforts to address the behavioral health crisis facing our communities.

Centers for Disease Control and Prevention

The recent reorganization efforts and reduction in force at the Centers for Disease Control and Prevention (CDC) have had a significant negative impact on Tribal and Urban programs, including the Healthy Tribes initiative, which provides a culture-first approach to health promotion/disease prevention in American Indian and Alaska Native communities and funds key grants for UIOs through the Tribal Practices for Wellness in Indian Country (TPWIC) and Good Health and Wellness in Indian Country (GHWIC) programs.

For example, one UIO recipient of both TPWIC and GHWIC has indicated that all their Project Officers, Grant Managers and Indigenous subject matter experts have been put on administrative leave. The UIO has not received any communications or guidance relating to these changes, leaving the UIO unclear about the status of their current funding, as well as the their ability to plan, implement, or forecast for essential public health initiatives.

While TPWIC and GHWIC represent only a small fraction of federal spending, they provide essential support for chronic disease prevention, increased physical activity, and reduction of commercial tobacco use in Tribal and urban American Indian and Alaska Native communities. The loss or interruption of these culturally responsive programs threatens to further exacerbate already poor health outcomes for and undermines the federal trust responsibility to American Indian and Alaska Native people.

Office of the Assistant Secretary for Health

American Indian and Alaska Native people have the highest rate of undiagnosed HIV cases compared to other racial/ethnic groups in the U.S., [10] and according to IHS, as many as 34 percent of the American Indian and Alaska Native people living with HIV infection do not know it. [11] UIOs are an important resource for urban

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[7] Fact Sheet: Behavioral Health, INDIAN HEALTH SERV. (2023), *https://www.ihs.gov/sites/newsroom/themes/responsive2017/display__objects/documents/factsheets/BehavioralHealth.pdf.*

[8] *Id.*

[9] Merianne Rose Spencer et al., Urban-Rural Differences in Drug Overdose Death Rates, 2020, NAT'L CTR. FOR HEALTH STAT. (July 2022), *https://www.cdc.gov/nchs/data/databriefs/db440.pdf.*

[10] IHS Awards New Cooperative Agreements for Ending the HIV and HCV Epidemics in Indian Country. (2022, September 27). Retrieved January 5, 2023, from *https://www.ihs.gov/sites/newsroom/themes/responsive2017/display__*objects/documents/HIV-Funding-PressRelease09272022.pdf

[11] Indian Health Service, HIV/AIDS in American Indian and Alaska Native Communities. Retrieved August 8, 2023, from: *https://www.ihs.gov/hivaids/hivaian/#:-:text=The%20IHS%20National%20HIV%2FAIDS,Get%20tested%20for%20HIV.*

American Indian and Alaska Native people for HIV/AIDS testing and referral to appropriate care.

The Office of Infectious Disease and HIV/AIDS Policy (OIDP), housed within the Office of the Assistant Secretary for Health (OASH), administers key programs such as *Ending the HIV Epidemic in the U.S.* and the *Minority HIV/AIDS Fund*, which are primary sources of support for IHS HIV and sexually transmitted infection (STI) response efforts.

Alarmingly, OASH is currently slated for elimination under proposed restructuring plans. The loss of this office would endanger critical programmatic support for UIOs working to combat HIV/AIDS in urban American Indian and Alaska Native communities. Continued funding and programmatic support are essential to preventing the spread of HIV and STIs. Without sustained investment, our communities face a heightened risk of worsening health outcomes.

Indian Health Service

Although IHS staff have not been subject to recent Reduction in Force actions, the broader pattern of abrupt terminations and staffing changes across HHS has created uncertainty and unease. This has compounded the long-standing recruitment and retention challenges within IHS, particularly for providers and clinical personnel, especially since IHS continues to operate under a hiring freeze with extremely limited exemptions, making it difficult to fill critical vacancies.

While IHS was exempted from the Deferred Resignation Program, it was not exempt from the Voluntary Early Retirement Authority or the Voluntary Separation Incentive Program. As a result, staff have departed and cannot be replaced under current restrictions. Many of these vacancies are essential to supporting operations. For instance, one Area Office has an urban coordinator vacancy that remains unfilled due to the freeze, which is now affecting the efficiency and effectiveness of health care delivery for urban American Indian and Alaska Native people across the region. The ongoing instability regarding staffing authority and exemptions pose real risks to IHS's ability to maintain and improve service delivery in Indian Country.

Centers for Medicaid and Medicare Services Office of Minority Health (CMS OMH)

As part of the restructuring efforts, CMS OMH has been eliminated. The shuttering of this office will impact revolutionary research that's been done in support of American Indian and Alaska Native people. For example, CMS OMH supported research on Traditional Healing and Medicaid [12] prior to the newly approved Medicaid waivers. [13] Data on American Indian and Alaska Native people is already scarce, and we can't afford cuts to critical research.

Conclusion and Request

In conclusion, the proposed restructuring and funding cuts across HHS operating divisions represent a significant threat to the health and well-being of urban American Indian and Alaska Native communities. UIOs rely on critical support from HRSA, SAMHSA, CDC, OASH, CMS OMH, and other HHS divisions to fulfill the federal trust responsibility and provide culturally competent, life-saving care to their patients. The lack of Tribal consultation and urban confer surrounding these changes is deeply concerning and undermines the government's obligation to engage meaningfully with the communities these policies affect. NCUIH urges the Committee to hold HHS accountable for its trust and treaty obligations to American Indian and Alaska Native people and to ensure UIOs are fully included in decision-making processes. We respectfully request that Congress protect and strengthen funding for UIOs across all HHS divisions and ensure HHS provides transparency and collaboration before moving forward with any reorganization that would jeopardize the health of American Indian and Alaska Native people.

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[12] Nat'l Council of Urban Indian Health, Recent Trends in Third-Party Billing at Urban Indian Organizations: Thematic Analysis of Traditional Healing Programs at Urban Indian Organizations and Meta-Analysis of Health Outcomes (2023), *https://ncuih.org/research/third-party-billing/#tab-id-11.* Urban Indian Organizations (UIOs) rely on reimbursement from third-party payers to sustain operations and provide necessary health services to American Indians and Alaska Natives (AI/ANs) living in. . .

[13] Press Release, Ctrs. for Medicare & Medicaid Serv., Biden-Harris Administration Takes Groundbreaking Action to Expand Health Care Access by Covering Traditional Health Care Practices (Oct. 16, 2024), *https://www.cms.gov/newsroom/press-releases/biden-harris-administration-takes-groundbreaking-actionexpand-health-care-access-covering.*

PREPARED STATEMENT OF ANDREA PESINA, PRESIDENT, NATIONAL INDIAN HEAD START DIRECTORS ASSOCIATION (NIHSDA)

Chairman Murkowski, Vice Chairman Schatz, and Members of the Committee:

Thank you for the opportunity to submit testimony on behalf of the National Indian Head Start Directors Association (NIHSDA) regarding the delivery of essential public health and social services to Native communities. We deeply appreciate the Committee's attention to the role that federal programs administered by the U.S. Department of Health and Human Services (HHS) play in supporting the health, development, and well-being of American Indian and Alaska Native (AIAN) children and families.

NIHSDA represents over 150 Tribal Head Start and Early Head Start programs across the United States, serving more than 20,000 Native children annually. These programs are not only early education services—they are comprehensive, community-driven systems of care that provide critical health screenings, nutrition support, mental health services, and family engagement in a culturally rooted and sovereign framework.

They are essential public health and social service providers, uniquely situated to meet the needs of Native children and families in Tribal communities. Core services include:

- **Comprehensive Health Screenings:** Including vision, hearing, developmental, dental, behavioral, and immunization checks, ensuring early detection and follow-up care.
- **Preventive Health and Nutrition Services:** Programs provide healthy meals, growth monitoring, and nutrition education tailored to local and cultural dietary needs.
- **Mental and Behavioral Health Services:** On-site mental health consultation, trauma-informed supports, and social-emotional learning integrated into the classroom environment.
- **Family Services and Case Management:** Programs conduct family needs assessments and provide referrals to housing, food assistance, substance abuse recovery, and domestic violence services.
- **Parent and Caregiver Support:** Services include parenting education, goal setting, and advocacy to promote self-sufficiency and strengthen family well-being.
- **Emergency and Wraparound Support:** Assistance with transportation, clothing, and other urgent needs, especially in crisis situations.
- **Culturally Responsive and Sovereignty-Driven Approaches:** AIAN programs partner with Tribal health departments, incorporate traditional practices and healing, and reflect the values, governance, and priorities of their communities.

These essential services not only support children's immediate development but also address long-standing disparities in health access, educational outcomes, and economic opportunity. AIAN Head Start programs are often one of the few consistent providers of preventive health and social services in Tribal communities.

Head Start is an Essential Health and Social Service

Head Start is a cornerstone public health and social service in Tribal communities. AIAN programs have long addressed deeply rooted disparities in access to healthcare, early intervention, and early education. Head Start's two-generational model strengthens families, improves long-term outcomes, and helps fulfill federal trust obligations to Native peoples.

Despite this, Tribal programs often face disproportionate challenges, including:

- **Limited and Constrained Funding:** NIHSDA remains deeply concerned about the future of Head Start in light of recent federal actions and the release of the administration's "skinny" budget on May 2, 2025. While the budget did not explicitly propose eliminating Head Start, it offered no reassurance about sustained or increased funding—and the full FY 2026 budget, expected later this month, may still include harmful cuts. These omissions are troubling and risk destabilizing nearly 60 years of investment in children, families, and communities. The stakes are especially high for American Indian and Alaska Native (AI/AN) programs, which could face significant consequences.

AI/AN communities already face some of the highest rates of poverty, housing insecurity, limited healthcare access, and educational disparities in the country. Reductions in Head Start services would exacerbate these inequities and risk undoing

decades of progress achieved through community-driven, culturally grounded programs. These services are a lifeline for Native children and families, and any cuts would disproportionately affect the most vulnerable populations.

Today, 481 AI/AN Head Start centers operate in 26 states, providing vital services to children and families and employing thousands—teachers, family service workers, bus drivers, cooks, and more. These programs serve as economic engines in Tribal communities, enabling 73 percent of participating families to work, attend school, or complete job training. Without sustained federal investment, these families risk losing both child care and jobs—further weakening Tribal economies. This would have devastating consequences, not only for the children and families directly impacted but also for the broader community and economy.

NIHSDA strongly urges Congress to continue funding Head Start at robust levels, ensuring that both the base program and the Tribal set-aside are maintained and increased. We recommend that the federal government include a 3.2 percent Cost of Living Adjustment (COLA) in FY 2026 to help programs retain qualified staff, manage rising operational costs, and ensure the delivery of high-quality services. These investments in Head Start are critical to improving educational outcomes, promoting self-sufficiency, and addressing the deep-seated disparities in AI/AN communities.

- **The Critical Role of the AIAN Regional Office (Region XI):** The separate Regional Office for AIAN Head Start programs within the Office of Head Start (Region XI) is vital to ensuring culturally competent, responsive, and respectful oversight. This office supports Tribal sovereignty by working government-to-government with Tribal Nations and is uniquely positioned to navigate the complexities of operating Head Start programs in diverse and sovereign Tribal contexts. NIHSDA strongly supports the continued operation—and strengthening—of this dedicated regional structure.
- **Dedicated AIAN Training and Technical Assistance (TTA):** Tribal Head Start programs benefit from a separate, culturally grounded TTA system that understands the historical, cultural, and logistical context in which these programs operate. Maintaining a dedicated AIAN TTA system is critical to building Tribal capacity, supporting continuous quality improvement, and ensuring that Tribal programs are not expected to conform to models that do not reflect their community values or realities.

Recommendations for HHS and Congressional Action

We respectfully urge the Committee to champion the following actions:

1. Retain and Strengthen the Tribal Head Start Set-Aside

—Maintain the Tribal set-aside and increase the overall Head Start appropriation to ensure that it reflects actual need and cost in Native communities.

2. Protect and Support Region XI and AIAN TTA

—Continue funding and support for the AIAN Regional Office at the Office of Head Start (Region XI), and maintain a dedicated TTA system to serve AIAN grantees with culturally grounded, community-specific expertise.

3. Center Tribal Voices in Policy and Program Design

—Require meaningful and consistent Tribal consultation in the development of federal policies and systems impacting Tribal early childhood programs, and invest in Tribal-led innovation, evaluation, and system-building efforts.

Conclusion

For 60 years, Tribal Head Start and Early Head Start programs have served as foundational systems of care and opportunity for Native children and families. These programs honor cultural identity, promote educational success, and strengthen Tribal communities. The federal government must uphold its trust responsibility by ensuring equitable, stable, and culturally grounded support for these services.

NIHSDA strongly opposes any proposals to eliminate or reduce funding for AI/AN Head Start programs in the FY 2026 budget or future fiscal years. Any such cuts would have a catastrophic impact on Native communities, dismantling critical services for children and families and violating the federal trust responsibility to Tribal Nations.

We thank the Committee for its commitment to oversight and for recognizing the vital role of Tribal Head Start in delivering essential health and social services to Native children and families.

PREPARED STATEMENT OF ROBYN SUNDAY-ALLEN, CEO, OKLAHOMA CITY INDIAN CLINIC (OKCIC)

My name is Robyn Sunday-Allen, I am Cherokee and the Chief Executive Officer of the Oklahoma City Indian Clinic (OKCIC), the largest Urban Indian Organizations (UIO) in the continental US serving only American Indian and Alaska Natives. OKCIC contracts with the Indian Health Service (IHS) under the Indian Health Care Improvement Act (IHCIA) and the American Indians and Alaska Native patients they serve. On behalf of OKCIC, I would like to thank Chairman Murkowski, Vice Chairman Schatz, and Members of the Committee for your leadership in improving health outcomes for American Indian and Alaska Native people and for the opportunity to provide testimony in response to the Senate committee on Indian Affairs May 14 hearing titled, "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"

Proposed Health and Human Services Restructuring and Funding Cuts

The Oklahoma City Indian Clinic relies on funding and partnerships through key HHS divisions such as the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC) and various Division of Tribal Affairs (DTA) offices. These divisions play a critical role in supporting programs and services vital to urban American Indian and Alaska Native populations. The value of HHS programs outside of IHS cannot be overstated, as they are essential for UIOs in fulfilling the federal trust and treaty obligation to provide health care services to American Indian and Alaska Native people.[1] The proposed reorganization and restructuring of HHS will bring significant changes to several operating divisions, with potentially serious consequences for UIOs.

It is particularly concerning that, to date, HHS has not held Tribal consultation or urban confer on the HHS restructuring. The lack of tribal consultation and urban confer is a failure to fulfill the U.S. Government trust and treaty obligations to Tribal Nations and programs serving Tribal citizens. Given the scope and potential impact of this restructuring, it is imperative that HHS engage in meaningful consultation with both Tribes and UIOs to ensure transparency and to address serious concerns about the consequences of such a significant public health and policy shift.

Substance Abuse and Mental Health Services Administration

American Indians and Alaska Native people experience disproportionately high rates of alcohol, substance use and mental health disorders, suicide, violence, and behavior-related morbidity and mortality compared to the rest of the U.S. population.[2] In fact, American Indian and Alaska Native people experience serious psychological distress at a rate 2.5 times more than the general population over a month's time.[3] These poor outcomes impact American Indian and Alaska Native people no matter where they live. For example, according to a 2020 report from the Centers for Disease Control and Prevention, non-Hispanic American Indian and Alaska Native people had the highest rates of drug overdose deaths in both urban and rural counties compared to other races, at 44.3 per 100,000 and 39.8, respectively.[4]

SAMHSA programs play a critical role in addressing these outcomes, saving lives and improving behavioral health outcomes across Indian Country. However, both the reorganization and the President's proposed budget include substantial cuts to SAMHSA's three major centers: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT), and the Center for Substance Abuse Prevention (CSAP).

Notably, CMHS funds several Tribal behavioral grant programs, including the Native Connections program of which the Oklahoma City Indian Clinic is an awardee. The Native Connections program is a youth-focused behavioral health grant. This program has been influential in reducing suicides among American Indian and Alaska Native youth. Unfortunately, many UIOs have heard from SAMHSA staff

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[1] 25 U.S.C. § 1601(1)

[2] Fact Sheet: Behavioral Health, INDIAN HEALTH SERV. (2023), *https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/BehavioralHealth.pdf.*

[3] *Id.*

[4] Merianne Rose Spencer et al., Urban-Rural Differences in Drug Overdose Death Rates, 2020, NAT'L CTR. FOR HEALTH STAT. (July 2022), *https://www.cdc.gov/nchs/data/databriefs/db440.pdf.*

that their Native Connections grants will not be renewed in the 2026 grant year. This expected loss of funding is deeply concerning, as it would undermine efforts to address the behavioral health crisis facing our communities.

Centers for Disease Control and Prevention

The recent reorganization efforts and reduction in force at the Centers for Disease Control and Prevention (CDC) have had a significant negative impact on Tribal and Urban programs, including the Healthy Tribes initiative, which provides a culture-first approach to health promotion/disease prevention in American Indian and Alaska Native communities and funds key grants for UIOs through the Tribal Practices for Wellness in Indian Country (TPWIC) and Good Health and Wellness in Indian Country (GHWIC) programs.

For example, the Oklahoma City Indian Clinic, which receives both TPWIC and GHWIC funding, is currently running these programs without the support of Project Officers, Grant Managers, and Grant Evaluators. These positions were eliminated due to a Reduction in Force. As a result, we have received very little communication or guidance about these changes, leaving us uncertain about the status of our current funding. This lack of clarity also hinders our ability to plan, implement, and forecast essential public health initiatives. Additionally, the absence of key staff makes it difficult to report project outcomes to Congress in a clear and effective manner, which could impact future funding decisions.

While TPWIC and GHWIC represent only a small fraction of federal spending, they provide essential support for chronic disease prevention, increased physical activity, and reduction of commercial tobacco use in Tribal and urban American Indian and Alaska Native communities. The loss or interruption of these culturally responsive programs threatens to further exacerbate already poor health outcomes for and undermines the federal trust responsibility to American Indian and Alaska Native people.

Office of the Assistant Secretary for Health

American Indian and Alaska Native people have the highest rate of undiagnosed HIV cases compared to other racial/ethnic groups in the U.S.,[5] and according to IHS, as many as 34 percent of the American Indian and Alaska Native people living with HIV infection do not know it.[6] UIOs are an important resource for urban American Indian and Alaska Native people for HIV/AIDS testing and referral to appropriate care.

The Office of Infectious Disease and HIV/AIDS Policy (OIDP), housed within the Office of the Assistant Secretary for Health (OASH), administers key programs such as *Ending the HIV Epidemic in the U.S. and the Minority HIV/AIDS Fund*, which are primary sources of support for IHS HIV and sexually transmitted infection (STI) response efforts. Located in Oklahoma and serving the American Indian population, both identified as a high risk state or population for the EndHIV initiative, the Oklahoma City Indian Clinic is particularly concerned about the ramifications of budgetary cuts to such an important program.

Alarmingly, OASH is currently slated for elimination under proposed restructuring plans. The loss of this office would endanger critical programmatic support for UIOs working to combat HIV/AIDS in urban American Indian and Alaska Native communities. Continued funding and programmatic support are essential to preventing the spread of HIV and STIs. Without sustained investment, our communities face a heightened risk of worsening health outcomes.

Indian Health Service

Although IHS staff have not been subject to recent Reduction in Force actions, the broader pattern of abrupt terminations and staffing changes across HHS has created uncertainty and unease. This has compounded the long-standing recruitment and retention challenges within IHS, particularly for providers and clinical personnel, especially since IHS continues to operate under a hiring freeze with extremely limited exemptions, making it difficult to fill critical vacancies.

While IHS was exempted from the Deferred Resignation Program, it was not exempt from the Voluntary Early Retirement Authority or the Voluntary Separation Incentive Program. As a result, staff have departed and cannot be replaced under

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[5] IHS Awards New Cooperative Agreements for Ending the HIV and HCV Epidemics in Indian Country. (2022, September 27). Retrieved January 5, 2023, from *https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/HIV-Funding-PressRelease09272022.pdf*

[6] Indian Health Service, HIV/AIDS in American Indian and Alaska Native Communities. Retrieved August 8, 2023, from: *https://www.ihs.gov/hivaids/hivaian/#:-:text=The%20IHS%20National%20HIV%2FAIDS,Get%20tested%20for%20HIV.*

current restrictions. Many of these vacancies are essential to supporting operations. For instance, one Area Office has an urban coordinator vacancy that remains unfilled due to the freeze, which is now affecting the efficiency and effectiveness of health care delivery for urban American Indian and Alaska Native people across the region. The ongoing instability regarding staffing authority and exemptions pose real risks to IHS's ability to maintain and improve service delivery in Indian Country.

Centers for Medicaid and Medicare Services Office of Minority Health (CMS OMH)

As part of the restructuring efforts, CMS OMH has been eliminated. The shuttering of this office will impact revolutionary research that's been done in support of American Indian and Alaska Native people. For example, CMS OMH supported research on Traditional Healing and Medicaid[7] prior to the newly approved Medicaid waivers.[8] Data on American Indian and Alaska Native people is already scarce, and we can't afford cuts to critical research.

Conclusion and Request

In conclusion, the proposed restructuring and funding cuts across HHS operating divisions represent a significant threat to the health and well-being of urban American Indian and Alaska Native communities. The Oklahoma City Indian Clinic relies on critical support from SAMHSA, CDC, OASH, CMS OMH, and other HHS divisions to fulfill the federal trust responsibility and provide culturally competent, lifesaving care to their patients. The lack of Tribal consultation and urban confer surrounding these changes is deeply concerning and undermines the government's obligation to engage meaningfully with the communities these policies affect. The Oklahoma City Indian Clinic urges the Committee to hold HHS accountable for its trust and treaty obligations to American Indian and Alaska Native people and to ensure UIOs are fully included in decisionmaking processes. We respectfully request that Congress protect and strengthen funding for UIOs across all HHS divisions and ensure HHS provides transparency and collaboration before moving forward with any reorganization that would jeopardize the health of American Indian and Alaska Native people.

PREPARED STATEMENT OF SHAWN M. KANA'IAUPUNI, PH.D., PRESIDENT/CEO, PARTNERS IN DEVELOPMENT FOUNDATION (PIDF)

Thank you, Chairman Murkowski, Vice Chairman Schatz, and members of the Committee for the opportunity to provide testimony on behalf of Partners in Development Foundation (PIDF) in support of programs at the U.S. Department of Health and Human Services (HHS), that support the Native Hawaiian community, including funding for programs that support Native Hawaiian children and youth through the Administration for Native Americans (ANA), an office within the Administration for Children & Families (ACF).

Background about PIDF

Partners in Development Foundation (PIDF) is an IRS Section 501(c)(3) public charity incorporated in the State of Hawai'i in 1997 to inspire and equip families and communities for success and service using timeless Native Hawaiian values and traditions. Since inception, PIDF has provided free programs for at-risk communities across our state in the areas of multi-generational education (early education through adult), strengthening families and communities (full-service community school programming, workforce development, and a safehouse for adjudicated teens), and island resiliency (natural farming project providing training and youth mentoring for opportunity youth).

In our years of experience providing our ten programs to keiki, young people and families, we see the challenges our community faces in trying to address the needs of their families while struggling to find positive solutions to the crises in education,

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[7] Nat'l Council of Urban Indian Health, Recent Trends in Third-Party Billing at Urban Indian Organizations: Thematic Analysis of Traditional Healing Programs at Urban Indian Organizations and Meta-Analysis of Health Outcomes (2023), *https://ncuih.org/research/third-party-billing/#tab-id-11.* Urban Indian Organizations (UIOs) rely on reimbursement from third-party payers to sustain operations and provide necessary health services to American Indians and Alaska Natives (AI/ANs) living in. . .

[8] Press Release, Ctrs. for Medicare & Medicaid Serv., Biden-Harris Administration Takes Groundbreaking Action to Expand Health Care Access by Covering Traditional Health Care Practices (Oct. 16, 2024), *https://www.cms.gov/newsroom/press-releases/biden-harris-administration-takes-groundbreaking-actionexpand-health-care-access-covering.*

housing, and managing the high cost of living in this state. Therefore, at PIDF, every program we offer is more than an educational service—it is an act of aloha, deeply rooted in Hawaiian cultural values such as mālama ʻāina (caring for the land), kuleana (responsibility), and ʻike kupuna (ancestral wisdom). Our journey over the last 28 years, touching more than 175,000 lives, has shown us that meaningful, culturally responsive education can break the cycle of poverty, trauma, and marginalization. One such notable program is *Ka Paʻalana* in which young infants and toddlers experiencing homelessness gain stability and school readiness through Ka Paʻalana's accredited early learning program, delivered directly on beaches/shelters/transitional housing alongside vital caregiver education and support.

The Importance of USDHHS: Administration for Native Americans

For decades, HHS has provided essential funding to organizations like PIDF, supporting the advancement and well-being of Native Hawaiian children and youth, through ACF's ANA funding programs. Without programs like these, communities across Hawaii will lose access to federal support for the planning, designing, restoration, and implementing of native language curriculum and education projects to support Hawaiian language preservation goals; the development of self-determining, healthy, culturally and linguistically vibrant, self-sufficient communities; community-driven projects designed to revitalize the Hawaiian language to ensure its survival and continuing vitality for future generations; culturally appropriate strategies to meet the social service needs and well-being of Native Hawaiians across the state; and the creation of a sustainable local economy to enhance the economic independence of Native Hawaiians.

Like many organizations in Hawaii predominantly serving Native Hawaiian children and youth, PIDF leverages federal grant programs administered by ANA, which have included language revitalization and immersion programs, as well as social and economic development programs. PIDF has received ANA grant funding for years to provide services in various areas of need:

- language access for the first and original written Hawaiian language resource which has been foundational for Native Hawaiian families but was previously out-of-print (CFDA 93–587, Grant 90NL0248, *Baibala Hemolele*, 09/30/02–02/28/06),
- recruitment, training and preparation of 144 Native Hawaiian foster parents across the state to meet the needs of the large number of Native Hawaiian children in foster care (CFDA 93–612, Grant 90NA7748, *Kokua Ohana*, 09/30/04–09/30/06),
- creation of a culturally-sensitive math and science curriculum delivered through a mobile computer lab serving houseless families in conjunction with the *Ka Paʻalana* Homeless Family Education Program (CFDA 93–612, Grant 90NA7931, *ʻIke Noʻeau*, 09/30/07–09/29/10),
- development of Native Hawaiian culture-based toddler and preschool curriculum that meets national standards and empowers 30 homeless Native Hawaiian fathers through a Native Hawaiian parent education curriculum focused on the role of fathers (CFDA 93–612, Grant 90NA8188, *Ka Paʻalana* Homeless Family Education Program, 09/30/11–09/29/14),
- development of a Native Hawaiian health curriculum called Ola Mau for 0–5 year olds and their caregivers/families in the *Ka Paʻalana* Program (CFDA 93–612, Grant 90NA8259, *Ka Paʻalana* Homeless Family Education Program, 09/30/14–09/29/17),
- expansion of *Ka Paʻalana* services in Keaukaha (East Hawaii on Hawaii Island) (CFDA 93–612, Grant 90NA8366, *Ka Paʻalana* Family Education Program in Keaukaha, 09/30/19–09/29/22), and
- delivery of the *Ka Paʻalana* program including emergency preparedness for East HI Island and Leeward Oahu's Malama Mobile outreach sites (CFDA 93–612, Grant 90NA8474, *Makaukau Ka Paʻalana*, 09/30/22–09/29/25).

Data: Demonstrating Effectiveness of ANA-funded Programs

Some data highlights from the most recent of these critical and relevant ANA grants have demonstrated positive impact and an increase in knowledge and family wellness.

- While 67.9 percent agreed or strongly agreed that they did not know very much about the topic before the parent education class, 94.5 percent agreed or strongly agreed that they had a better understanding of the topic after the class. Topics covered Parenting tips, child development, preschool engagement, STEAM curriculum, literacy strategies, mental health support, discl

- While 74.7 percent agreed or strongly agreed that they did not know very much about the topic before the adult education classes (including classes on how to take of health for caregivers and their family), 99.3 percent agreed or strongly agreed that they had a better understanding of the topic after class.
- The Hawaii State School Readiness Assessment indicates to what extend the child is ready for Kindergarten with primary focus on literacy skills. On a scale from 1 to 4, with 4 being a perfect score, the overall mean score of the 33 participants was 3.76 which indicates most of these children have mastered literacy skills. There were 22 (66.7 percent) participants that scored a 4 for all four measures.
- As part of the Emergency Preparedness curriculum, 38 (84.4 percent) adult participants improved their knowledge of fire safety after attending the class, and 28 (82.4 percent) adult participants improved their knowledge of hurricane preparedness after attending the class.

Conclusion

It is imperative that programs at HHS that serve Native communities continue to provide necessary support for these important activities that serve and support the Native Hawaiian families and communities. Thank you for the opportunity to provide testimony to the Committee's hearing on federal programs across HHS that serve Native Americans. I look forward to working with the Committee on this important issue.

PREPARED STATEMENT OF JENNIFER ROWLAND

We Need Headstart In Native Country

Federal budget discussions have raised concerns for Native early childhood education. Considerations for a restructuring of HHS have proposed the elimination of Head Start, which includes a set-aside for Tribal Nations and Tribal organizations.

For nearly 60 years, AI/AN Head Start programs have provided early learning, family support, and community-driven services to Native children from birth to age five. These programs help families access health care, support school readiness, and preserve Tribal languages and traditions. In Tribal communities, Head Start and Tribal programs are frequently the only childcare available.

If this program is eliminated:

- Nearly 20,000 Native children could lose access to critical early education
- More than 6,000 Head Start staff may lose their jobs
- Tribal Nations could face setbacks in community-based efforts to support families and preserve culture

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PREPARED STATEMENT OF ESTHER LUCERO, MPP, PRESIDENT/CEO, SEATTLE INDIAN HEALTH BOARD

Chairman Murkowski, Vice Chairman Schatz, and members of Senate Committee on Indian Affairs (SCIA), my name is Esther Lucero, and I am of Diné and Latina descent, currently living in an urban Indian community in Seattle, Washington. I am the third generation in my family living outside our reservation. Since 2015, I have served as the President & Chief Executive Officer of the Seattle Indian Health Board (SIHB), one of 41 Indian Health Service (IHS) designated urban Indian organizations (UIO) nationwide, a network designed to serve the health needs of the 76 percent of American Indian and Alaska Native (AI/AN) people residing in urban areas. Over the past 16 years, I have dedicated my professional career in healthcare to serving AI/AN communities.

I am also a delegate to the Washington state American Indian Health Commission, a member of the King County Board of Health, the City of Seattle Indigenous Advisory Council, and the AstraZeneca Health Equity Advisory Councill. I am honored to have the opportunity to submit my written testimony today for the SCIA Oversight Hearing.

Seattle Indian Health Board

SIHB is a UIO and Federally Qualified Health Center (FQHC) and serves over 5,000 people living in the Greater Seattle, Washington area with specialized services for AI/AN people. We are part of the IHS/Tribal 638/UIO healthcare system (I/T/U) and honor our responsibilities to work with our Tribal and federal partners to serve all Tribal people, regardless of where they reside. Urban Indian Health Institute

(UIHI) is the research division of SIHB, a public health authority, and one of twelve Tribal Epidemiology Centers (TEC) in the country—the only one that serves UIOs nationwide. UIHI conducts research and evaluation, collects and analyzes data, and provides disease surveillance for Tribes and the 41 UIOs nationwide. As a UIO and TEC, our role is to address the community health and public health needs of the over 76 percent of AI/AN people who live in urban areas.

Fully Fund the Indian Health Care System

To truly fulfill its trust and treaty obligations, the federal government must fully fund the I/T/U system. The National Tribal Budget Formulation Workgroup calculates that to meet this goal in FY 2026, Congress must appropriate $63.04 billion to the Indian Health Service, including $770.53 million for the Urban Indian Health line item and $474.47 million for the Hospitals and Health Clinics: TECs line item.

However, until full funding for IHS is achieved, Congress must continue to invest in the critical programs that supplement the IHS budget but are not administered by IHS. For example, Healthy Tribes, a Centers for Disease Control and Prevention (CDC) program, supports chronic disease prevention in Indian Country. While not administered by IHS, its funding is crucial for the health of AI/AN communities. Numerous other programs administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institutes of Health, the Health Resources and Services Administration, and other divisions of the U.S. Department of Health and Human Services (HHS) directly benefit AI/AN communities and cutting their funding also has a direct negative impact on AI/AN communities. The proposed $33.3 billion, or 26.2 percent, reduction in the HHS budget, including a proposed reduction of $139.8 million to SAMHSA programming will disproportionately harm Indian Country. I urge Congress to maintain funding for HHS and its divisions.

Advance Appropriations

I urge you to once again support advance appropriations for the I/T/U system. It is the only federal healthcare system without mandatory appropriations, and failure to include advance appropriations jeopardizes the health and wellbeing of AI/AN communities relying on IHS, Tribal, and UIO facilities for their health care needs.

Protect Medicaid

Congress must protect Medicaid expansion for AI/AN communities. Medicaid is a critical component to the fulfillment of the federal government's trust and treaty obligations to AI/AN people. In 2023, 31.3 percent of AI/AN people including 48.7 percent of AI/AN children aged 0–19 years old were enrolled in Medicaid.[1] Medicaid funding helps bridge chronic shortfalls in funding for IHS. For many Indian health facilities, Medicaid funding accounts for 30–60 percent of total revenue, underscoring its vital role in supporting health care services for AI/AN populations. In 2024, 50 percent of our relatives (patients) seen at SIHB were Medicaid beneficiaries, and our facilities' Medicaid revenue was $4.9 million, or, 47 percent of our third-party revenue. Clinical services paid for by Medicaid accounted for $1.5 million, while pharmacy Medicaid payments accounted for $3.4 million. As an FQHC we are required to re-invest these revenues back into our health service system—and we do that in innovative ways, such as traditional medicine, that we know reduce the rates of chronic diseases. Medicaid ensures that all eligible members of the AI/AN community receive health care services critical to their well-being no matter where they live and I urge you to oppose any cuts to this important program.

Missing and Murdered Indigenous Women and People

As I am aware of your deep commitment to addressing the crisis of Missing and Murdered Indigenous Women and People, I would also like to bring attention to the President's proposed reduction of $107 million in funding for U.S. Department of the Interior law enforcement programming currently supporting Tribal operations. This is counter to efforts, including those carried out under Trump's first administration, to combat one of the greatest crises affecting Indian Country.

I thank you for your continued leadership on issues affecting Indian Country and remain a committed partner with you in this regard.

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[1] Davis, W. (2025), AI/AN Medicaid Enrollment & Funding, National Indian Health Board (NIHB).

PREPARED STATEMENT OF HON. MELVIN J. BAKER, CHAIRMAN, SOUTHERN UTE INDIAN TRIBE

Greetings, Chairman Murkowski, Vice Chairman Schatz, and members of the Committee. My name is Melvin J. Baker. I am the elected Chairman of the Southern Ute Indian Tribe ("Tribe") on the Southern Ute Indian Reservation in southwestern Colorado. Thank you for the opportunity to provide written testimony concerning the need to fully fund Health and Human Services (HHS) programs serving Indian Country. Given the critical impact Tribal health programs have on communities like ours, the Tribe strongly urges Congress to protect funding for HHS. Without adequate HHS funding, the Tribe's ability to serve its members and other Native Americans living within our community is severely diminished.

The Tribe is one of two federally recognized Tribes in the State of Colorado. Our Reservation is home to thousands of Native Americans, including Tribal members, first descendants, and those affiliated with other federally recognized Tribes, who are eligible to receive health services through the Indian Health Service (IHS). The federal government has a legal and moral trust obligation to provide health and social services to the Ute people and other Natives in our community. This obligation is grounded in long-standing treaties, statutes such as the Indian Health Care Improvement Act and the Indian Self Determination Act, executive orders, and judicial precedent. HHS is the principal federal agency responsible for fulfilling this trust. The federal trust responsibility to provide healthcare to Tribes must extend not only to the IHS but to all HHS agencies that support tribal health. As you noted in your May 9 letter to HHS Secretary Kennedy, threats to these programs or "termination of staff responsible for managing these programs threatens the health, safety, and well-being of Native communities," [1] including the Tribe's. Funding and staffing cuts would disrupt care, reverse hard-won public health gains, and violate sacred trust obligations to Tribes that the United States is required by law to meet.

Upholding this trust obligation is critical as Native Americans already suffer serious disadvantages in the healthcare space. We have long experienced significant and unacceptable health disparities when compared with other Americans. [2] These discrepancies remain prevalent today, but they find their roots in historical trauma that flows from forced relocation and assimilationist policies. Such trauma contributes directly to higher rates of poverty, unemployment, and lack of access to quality education and healthcare experienced by Native communities today. [3] These socioeconomic inequities in turn lead to higher rates of chronic conditions such as heart disease, diabetes, cancer, and obesity. [4] Life expectancy for Native Americans is 10 years lower than the United States average. [5] Not only is life expectancy shortened, but these disparities operate to reduce quality of life for Native Americans while alive. For example, Native Americans experience disproportionately higher rates of mental health and substance abuse issues. [6] Suicide rates are significantly higher among American Indian youth than other youth populations. [7] Many of these health disparities were exacerbated by the COVID–19 pandemic and have long been made

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[1] Letter to HHS on non-HIS RIFs and reorganization, Senators Lisa Murkowski and Brian Schatz, May 9, 2025, at 1, available at: *Letter to HHS on non-IHS RIFs and reorganization*

[2] Tribal Public Health Week 2025: Health Equity Starts Here—In Truth, Action, and Sovereignty, National Indian Health Board, April 9, 2025, available at: *Tribal Public Health Week 2025: Health Equity Starts Here—In Truth, Action, and Sovereignty—National Indian Health Board*

[3] National Indian Council on Aging, Inc., American Indian Health Disparities, last accessed on May 21, 2025, available at: *American Indian Health Disparities*

[4] Indian Health Service, Disparities, October 2019, available at: *Disparities/Fact Sheets*; U.S. Department of Health and Human Services Office of Minority Health, Obesity and American Indians/Alaska Natives, last edited Feb. 13, 2025, available at: *Obesity and American Indians/Alaska Natives/Office of Minority Health*

[5] National Vital Statistics Reports, Vol. 74, Number 2, at 50, April 8, 2025, available at: *https://www.cdc.gov/nchs/data/nvsr/nvsr74/nvsr74-02.pdf*

[6] American Addiction Centers, Alcohol and Drug Use Among Native Americans, updated May 2, 2025, available at: *Substance Abuse Statistics for Native Americans*; A Path Forward to Fully Fund Tribal Nations by Embracing the Trust Responsibilities and Promoting the Next Era of Self-Determination and Health Care Equity and Equality, Victor Joseph and Andrew Joseph, Jr., at 31, April 2024, available at: *NIHB=FY26-Budget.pdf*

[7] Tribal Public Health Week 2025: Health Equity Starts Here—In Truth, Action, and Sovereignty, National Indian Health Board, April 9, 2025, available at: *Tribal Public Health Week 2025: Health Equity Starts Here—In Truth, Action, and Sovereignty—National Indian Health Board*; NMSU study finds high suicide rates among American Indian, Alaska Native children, Carlos Carrillo Lopez, Dec. 9, 2024, available at: *NMSU study finds high suicide rates among American Indian, Alaska Native children*

worse by the persistent, chronic underfunding of Indian health care—a problem that dates back decades. [8]

Despite the health imbalances that have plagued generations of Native Americans, Indian Country has seen significant and real progress in closing these gaps and providing Tribal communities with better-quality healthcare. Much of this progress is thanks to funding from HHS and other federal programs given directly to Tribes so that we may direct how we treat the health needs of our communities. Empowering Tribes to operate their own health programs through self-governing contracts or compacts is a critical tool for achieving better health outcomes for our people. As Tribes, we know best how to care for our members.

By law, the federal government must continue to empower us to provide culturally sensitive and quality care for our patients. Federal funding opportunities like those provided by HHS honor Tribal sovereignty by allowing the Tribe's governments to be an equal partner in shaping the public health systems and policies that affect our people. The Tribe takes this partnership seriously.

As a result, our Tribal Health Department operates a robust health program pursuant to a Title I self-determination contract. The Tribe's patients are included in the one million Native Americans who rely upon coverage by Medicaid and the Children's Health Insurance Program. [9] The Tribe's programs depend upon HHS funding and Medicaid reimbursement for health services to function and provide basic services to its patients. The proposed massive cuts to Medicaid funding would devastate Native communities and risk severe reductions in essential health care for Tribal members. [10] Medicaid funding has allowed the Tribe to make major strides in adequately addressing disparities in Tribal healthcare and to provide Tribal members with culturally competent healthcare that is aimed at tackling the unique health challenges faced by the Ute people and other Native Americans in our communities.

As a result of this funding, the Tribe's Health Department can provide all-inclusive, high-quality health care to over 2000 Native Americans in our community and the surrounding areas with the goal of elevating the health status of all Native people served by the Department. In operating a modern, sophisticated health clinic, the Tribe offers comprehensive and integrated direct care programs, including mental health and substance abuse treatment, referred services, and public health initiatives. Through these programs, the Tribe provides a multitude of critical health services to its patients, including: adult and pediatric primary care; adult and pediatric immunizations; dental and optometry care; physical therapy; urgent care and nurse triage appointments; 24/7 triage phone lines; lab and x-ray services; pharmacy services; women's health and reproductive services; referrals and consultations to specialist care; and specialty clinics for nephrology, gastroenterology, rheumatology, and audiology. Additionally, the Tribal Health Department provides home health care nurses and community health workers to eligible patients and provides medical care for Tribal inmates at our Detention Center.

Without HHS funding, the Tribe would be unable to sustain essential programming or meet the unique needs of its patients. For example, the Tribe routinely receives grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), such as Tribal Opioid Response and Native Connections grants. SAMHSA grants allow the Tribe to fund programs to address the high rates of suicide, substance use, and intergenerational trauma that continue to persist in our community—efforts that are vital to the Tribe's ability to safeguard the health of our people. These funds also allow the Tribe to support the continuum of prevention, harm reduction, treatment, and recovery support services for opioid use disorder and co-occurring substance abuse disorders. These programs are critical as Native Americans continue to suffer the highest rate of fatal opioid overdoses in the United States. [11] The Tribe's Behavioral Health Division further relies on SAMHSA grants to pay salaries for many of the Tribe's behavioral health staff. Without this funding, the Tribe will not have the personnel it needs to address critical behavioral health conditions prevalent in its patient population. An inability to address these conditions would have disastrous consequences for the health of Tribal patients because adequate behavioral health treatment is directly linked to positive health out-

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[8] Am. J Public Health June 2014, Donald Warne and Linda Bane Frizzell, available at: *American Indian Health Policy: Historical Trends and Contemporary Issues—PMC*

[9] Medicaid.gov, Indian Health & Medicine, last visited May 21, 2025, available at: *Indian Health & Medicaid/Medicaid*

[10] Medicaid cuts would decimate Native American programs, tribal health leaders say, CBS News, Jazmin Orozco Rodriguez, March 14, 2025, available at, *Medicaid cuts would decimate Native American programs, tribal health leaders say—CBS News.*

[11] NCHS Data Brief No. 457, December 2022, Merianne Rose Spencer, M.P.H, Arialdi M. Miniño, M.P.H., and Margaret Warner, Ph.D, at 3, available at: *https://www.cdc.gov/nchs/data/databriefs/db457.pdf*

comes overall. When we fail to treat these conditions, we fail our patients. Lack of adequate funding must never be the cause of such failures.

Additionally, the Tribe works closely with the Albuquerque Area Indian Health Board and the Southwest Epidemiology Center. These organizations receive federal grants and distribute subawards to the Tribe to address substance use issues and to provide technical assistance. We also use HHS funding to operate Shining Mountain Health and Wellness program—a fully grant funded community and clinic-based program that has a primary focus on chronic disease management and prevention, including for diabetes, women's health, and maternal-child health. Shining Mountain offers dynamic services, including nutrition education, cooking classes, foot care education and exams, membership at SunUte Community Center—the Tribe's state-of-the art fitness facility, and meal planning assistance, all based on the fluctuating and unique needs of the Tribal community. The Tribe's ability to continue providing these services is conditioned on its ability to receive HHS grants. These include the Special Diabetes Program for Indians coordinated by the IHS Division of Diabetes, and Center for Disease Control (CDC) grants, such as the Good Health and Wellness in Indian Country funding which is coordinated through the Healthy Tribes program and aimed at delivering holistic, culturally responsive, community-driven interventions for preventing, managing, and controlling chronic diseases like diabetes. Cuts to the CDC's Healthy Tribes program have already reverberated throughout Indian Country and have halted culturally tailored public health initiatives that the Tribe relies upon to serve its members. Further cuts to similar programming through IHS would negatively impact the Tribe's ability to maintain its public health capacity and would limit its ability to prevent or treat manageable health conditions.

The Tribe also needs key agencies that serve Tribal communities, including the Health Resource and Services Administration (HRSA), to receive adequate funding. HRSA's loan repayment program allows the Tribe to compete for providers with nearby communities that are located in less remote areas. The Tribe's Reservation is relatively isolated in southwestern Colorado. It is hard enough to recruit qualified providers to deliver vital healthcare services to the Tribe's patients. As a result, the Tribe is already short on providers. Cuts to programs like HRSA would make this situation even worse.

The Tribe's ability to operate these vital, life-saving programs and provide critical healthcare to Tribal patients is dependent on the federal government meeting its obligation to fund Indian healthcare. Cuts to HHS, Medicaid, or other essential federal programs—including any staff cuts that impact the federal government's ability to process Tribal funding in a timely manner—comes with real human costs. As a matter of human dignity, the Tribe's patients deserve to be treated by high-quality professionals operating in robustly funded programs. But the reality is, the Tribe, like many Native communities, is forced to operate on an extremely thin margin due to decades of federal underfunding of Tribal health programs. Cutting already inadequately funded HHS programs risks reversing the significant gains the Tribe has made in achieving long-lasting healthy outcomes for its patients.

As a sovereign government, the Tribe's primary responsibility—and one I take seriously as the Chairman—is to ensure the health and safety of our people. As a separate sovereign who has a legal responsibility to provide health care to Native Americans, the United States must coordinate with the Tribe to help us meet this responsibility. This means that Congress must preserve and strengthen HHS funding for Tribal health programs. These programs are not discretionary—they uphold federal legal commitments and are vital for public health equity and Tribal sovereignty.

As such, we urge HHS to prioritize the protection and sustainment of funding and programming to support Tribal health and wellness across all HHS agencies and ensure this funding is flexible and responsive to Tribal priorities. We further request that HHS reinstate personnel and preserve key HHS programs that provide vital support to Tribes and Tribally designated organizations. And we urge HHS to protect and expand Tribal eligibility for funding through HHS programs and to create a funding mechanism that supports long-term sustainability rather than short-term projects.

The Tribe greatly appreciates its partnership with HHS and our joint efforts to protect critical funding, services, and staff that allow Tribes to deliver quality healthcare to Tribal patients. We remain committed to our shared vision of a healthy America that must include a specific focus on Tribes. Tribal patients are often the most vulnerable among us and they need continued commitment from the federal government to fully fund the programs and staff that serve their unique needs. At the very least, that requires meaningful and proactive consultation with

Tribes when considering HHS program changes, budget and workforce cuts, or new initiatives. The federal government's trust responsibility permits nothing less.

In closing, I strongly urge HHS to support Tribal sovereignty and uphold HHS's Tribal Consultation Policy, which necessitates that HHS work in partnership with Tribes to ensure they have unfettered access to the critical resources needed to address current and future public health challenges that will support, strengthen, and sustain the health and wellness of our people. We look forward to working with you to meet these challenges head on for the betterment of our people.

Thank you for the opportunity to submit this written testimony.

PREPARED STATEMENT OF THE UNITED SOUTH AND EASTERN TRIBES SOVEREIGNTY PROTECTION FUND (USET SPF)

On behalf of the United South and Eastern Tribes Sovereignty Protection Fund (USET SPF), we write to provide the Senate Committee on Indian Affairs with testimony for the record of the oversight hearing "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" (HHS) held on May 14, 2025. As the Committee is aware, this is a chaotic and confusing time for the Health and Human Services System, including the Indian Health System, which together have the responsibility of fulling trust and treaty obligations to Indian Country. Recent HHS reorganization and reduction in force (RIF) efforts, potential threats to funding and programs, and an overall lack of Tribal consultation on any of these issues have caused significant confusion and greatly impacted the ability of Tribal Nations to provide programs and services to our communities. This testimony focuses on the urgent need for Congress to exercise its oversight authorities over HHS and protect the various funding and resources provided to Indian Country.

USET SPF is a non-profit, inter-tribal organization advocating on behalf of thirty-three (33) federally recognized Tribal Nations from the Northeastern Woodlands to the Everglades and across the Gulf of Mexico.[1] USET SPF is dedicated to promoting, protecting, and advancing the inherent sovereign rights and authorities of Tribal Nations and in assisting its membership in dealing effectively with public policy issues.

Introduction

USET SPF is deeply concerned by recent Administration actions and reorganization efforts at HHS and their collective impacts on Tribal Nations. Across the Department, Tribal programs continue to be reduced or eliminated unexpectedly and federal employees that provide services to Tribal Nations continue to be terminated without Tribal consultation. This is despite Secretary Kennedy's commitment during his confirmation hearing to "make sure that all the decisions [at HHS] are conscious of their impacts" on Tribal Nations. Unfortunately, while many of these actions and policies are not directed at Indian Country specifically, we have been inadvertently harmed because the Administration's implementation actions have been so broad and, often, have not accounted for the legal obligations of the United States in its relationship with Tribal Nations.

As a result of the cession of vast land and natural resources by Tribal Nations to the United States—oftentimes by force—the United States is legally obligated to provide certain benefits and services, including healthcare, to Tribal Nations and Native people in perpetuity. The delivery of Tribal programs and services, the provision of federal funding to Tribal Nations and Tribal organizations serving Tribal Nations, and the federal employees necessary for the provision of those programs and services are integral to the delivery of federal trust and treaty obligations. These

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[1] USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chickahominy Indian Tribe (VA), Chickahominy Indian Tribe-Eastern Division VA), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Monacan Indian Nation (VA), Nansemond Indian Nation (VA), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Pamunkey Indian Tribe (VA), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Rappahannock Tribe (VA), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), Upper Mattaponi Indian Tribe (VA) and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

resources provided to Indian Country are not discretionary—they are legal obligations rooted in the trust and treaty relationship, the U.S. Constitution, and longstanding federal statutes. Despite this truth, at no point has the United States every fully delivered upon this sacred promise and responsibility. The actions to the HHS system serves to further exacerbate data supported heath disparities experienced across Indian Country.

Despite some of the messaging we have heard from the Administration, we are not "all the same," nor are we mere stakeholders. Rather, as the Committee is well aware, the United States has unique obligations to Tribal Nations and Native people that necessitates our disparate treatment. As the Administration implements its priorities, it is necessary for Congress to fulfill these obligations by protecting funding and resources for the Indian Health System in the budget and appropriations processes.

Exercise Oversight Authority to Ensure Proper Tribal Consultation at HHS

At the root of many of the issues Tribal Nations are facing from HHS reorganization and reform efforts is the overall lack of proper Tribal consultation at HHS. Part of the federal trust and treaty obligations is a duty to engage in government-to-government consultation with Tribal Nations during the development and prior to the enactment of any federal actions that may have Tribal implications. Despite this legal obligation, HHS has failed to engage in meaningful Tribal consultation while proposing and enacting drastic changes to agency budgets, programs, and staffing.

Tribal Nations support this Administration's efforts to alleviate burdensome regulations and other barriers that hinder Tribal self-governance and economic development, but these efforts must be developed in close consultation with Tribal Nations to ensure there are no unintended consequences on us. This is particularly important at this juncture as HHS considers its proposed agency reorganization plan and other efforts to reform how programs and services are delivered through HHS. Tribal Nations are served by programs and staff across HHS, not just by the Indian Health Service (IHS); therefore, all efforts to reorganize HHS must start with and include robust Tribal consultation. Without Tribal consultation on reorganization, it is unclear how HHS intends to protect Tribal programs and resources and ensure there are no disruptions to service delivery. HHS has stated that its activities are not meant to affect its legal obligations to Tribal Nations, but it is impossible to know how a reorganization effort of this magnitude could affect delivery of those obligations without Tribal consultation. USET SPF shares important goals with HHS and this Administration such as reducing chronic disease prevalence and increasing access to healthy foods, but existing programs and resources that support those goals are being threatened by HHS reorganization efforts and our focus on shared priorities is being necessarily redirected to address these threats.

USET SPF and other advocates in Indian Country have repeatedly called on HHS to fulfill its Tribal consultation obligations as this Administration engages in government reform efforts. During the most recent HHS Secretary's Tribal Advisory Committee (STAC) meeting in April 2025, a senior advisor to the Secretary committed to holding at least one Tribal consultation on the recent HHS reorganization efforts. However, in the month since the STAC meeting, HHS has yet to schedule or provide any information on this Tribal consultation. We appreciate Committee Chair Murkowski and Vice Chair Schatz for their May 9, 2025, letter to HHS reiterating that meaningful consultation on any changes to HHS that may impact Tribal healthcare is "crucial to ensure that health disparities are not further exacerbated" and we urge the Committee to continue exercising its oversight authorities over HHS to hold the Department accountable for its commitments and obligations to conduct robust Tribal consultation.

HHS Reorganization and Reduction in Force Concerns

Beyond the lack of Tribal consultation on these actions, USET SPF is concerned by the recent efforts at HHS to drastically reduce the federal workforce, radically reorganize the Department and its divisions, rescind funding, and alter or eliminate federal programs. We remind Congress and the Administration that any Tribal program or funding delivered to Tribal Nations—including through Tribal organizations serving Tribal Nations—is provided in furtherance of the United States' trust and treaty obligations. The federal employees necessary for the functioning of those Tribal programs and the disbursement of those Tribal funds are also part of the trust and treaty obligations. The loss of numerous federal employees who supported Tribal Nations in HHS Regional offices and across the Department has had serious impacts on the delivery of programs and services in Indian Country.

The closure of HHS Regional offices 1 (Boston) and 2 (New York), which collectively served nearly half of USET SPF's member Tribal Nations, eliminated critical

support for program delivery and technical assistance in Tribal communities. Elimination of these employees has also created communication gaps between Indian Country and HHS, creating uncertainty and confusion around grant and program resources. These issues have, in turn, forced some Tribal Nations and organizations to pause or cancel programs in our communities to try to avoid endangering our funding and resources. The loss of these employees also means the loss of years of relationship building and knowledge sharing between Tribal Nations and HHS at the regional level. With these employees goes vast institutional knowledge and cultural competency that will likely take years to rebuild. USET SPF requests that the Committee reinforce our concerns with HHS reorganization and reduction in force efforts as they relate to the Department's trust and treaty obligations to Tribal Nations and the need for a regional HHS presence to execute on those obligations.

Increased Efficiency Through Tribal Self-Governance Expansion

We understand that these reorganization and reduction in force efforts at HHS are part of the Administration's goals to increase government efficiency. The Indian Self-Determination and Education Assistance Act (ISDEAA) has been an important tool that puts federal funding into Indian Country's hands so that we may run federal programs more efficiently and effectively to serve our own communities. However, ISDEAA contracting and compacting is currently limited to certain federal agencies and programs.

Self-governance expansion beyond IHS at HHS has been a long-standing priority in Indian Country. Tribal Nations have successfully administered complex healthcare programs for decades, but self-governance limitations at HHS have prevented us from taking over other aspects of our health systems from the federal government. A feasibility study conducted in 2013 found that self-governance expansion at HHS is possible, but would require Congressional action, and efforts to advocate for this change with HHS and Congress have stalled over the years.

With the Administration's current focus on government efficiency and increased local control over programs and services, it is the perfect opportunity to renew Tribal self-governance expansion efforts at HHS. USET SPF urges the Committee to work with Tribal Nations and HHS to extend ISDEAA authorities to all agencies and programs at HHS at serve Tribal Nations, Tribal citizens, or Tribal communities.

Threats to Indian Country in Budget and Appropriations

USET SPF remains concerned about FY 2026 appropriations for the Indian Health System, given a leaked proposal in the Office of Management and Budget (OMB) HHS 2026 Discretionary Budget Passback to substantially reduce funding for the IHS and other HHS offices and programs that deliver crucial services to Indian Country and the subsequent lack of detail on the IHS budget in the President's Skinny Budget Request. The HHS System that serves Indian Country is already chronically underfunded, understaffed, and under-resourced; therefore, any reduction in resources has the potential to create dire consequences for the health of Tribal Nations and our communities.

In the leaked OMB Passback, for IHS alone, the Administration proposed a nearly 30 percent reduction to the IHS base allocation for FY 2026—a cut that would dismantle essential services and affect service quality and access across Indian Country—and proposed to eliminate advance appropriations for the agency. IHS is currently underfunded by 90 percent or more according to some estimates, has a staff vacancy rate of 30 percent, and operates out of significantly older facilities than other U.S. health systems. If the IHS budget were to be cut by the proposed $896 million, these issues would only be exacerbated. Fortunately, advocacy opposing the IHS budget cuts was possibly successful, as the fact sheet for the President's skinny budget request stated that "The budget preserves federal funding for the [IHS]." However, the Skinny Budget Request offers no detail on the IHS budget, creating continued uncertainty.

The Skinny Budget Request is also silent on whether the Administration will propose to maintain advance appropriations for the IHS or continue to support its earlier proposal in the Passback to eliminate this practice. Advance appropriations have provided critical budgetary certainty for the IHS and its enactment in FY 2024 marked a historic shift in the nation-to-nation relationship between Tribal Nations and the federal government. Prior to FY 2024, IHS was the only federal healthcare provider without advance or mandatory appropriations, subjecting Tribal citizens to increased risk of harm or death from delays in the annual appropriations process. The elimination of advance appropriations would be a violation of the federal government's obligations to Tribal Nations and a massive step backwards in federal Indian policy. USET SPF urges Congress to maintain IHS advance appropriations, re-

gardless of whether the proposal is included in the forthcoming President's budget request.

Beyond IHS, the Administration is proposing to eliminate key HHS agencies and programs that provide critical services to the most vulnerable populations in Indian Country. Tribal behavioral health grants and the Circles of Care Children's Mental Health Program at the Administration for Children and Families (ACF) and other resources for combatting opioid use disorders at the Substance Abuse and Mental Health Services Administration (SAMHSA) are proposed to be cancelled, despite the disproportionate prevalence and mortality rates of mental health issues, substance use disorders and suicidality in Tribal communities. Other programs slated for elimination or reduction like Head Start, the Low-Income Home Energy Assistance Program (LIHEAP), Community Services Block Grants, and Temporary Assistance for Needy Families (TANF) are all lifelines for Tribal Nations. These programs are essential to maintaining healthy communities and economies in Indian Country, where the rural and remote nature of many of our communities often results in a lack of early childhood education and employment opportunities.

Tribal Nations are already forced to operate with vastly insufficient resources due to decades of chronic underfunding, especially for the essential services provided through the annual appropriations process. By nearly every measure and indicator, Tribal Nations, our citizens, and communities face a lower quality of life than others in the U.S. The proposed disruption of what little resources are flowing will only exacerbate these issues and deepen the divide between Indian Country and the rest of the country. Unless dedicated Tribal set-asides, Tribal funding, and Tribal Advisory Committees are preserved, either through existing agencies, new departments, or new mechanisms (such as an expansion of self-governance authority), underfunded Tribal programs will face compounding reductions that will require large-scale service cuts. History has shown those cuts will inevitably increase health disparities and negative outcomes in Indian Country. USET SPF calls upon Congress to uphold its trust and treaty obligations and, at minimum, protect the limited resources already provided for the Indian Health System, which includes the IHS budget as well as other programs and services at HHS that support Indian Country.

Protect Resources for Chronic Disease Prevention and Mitigation in Indian Country

USET SPF supports this Administration's goals to reduce chronic disease prevalence and severity in Indian Country, as AI/AN people experience the highest rates of chronic disease prevalence and mortality among all U.S. populations, but proposed cuts to chronic disease prevention and mitigation programs threaten the success of this goal.

For example, HHS is currently proposing to eliminate the Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention (CDC). If the Center for Chronic Disease Prevention is eliminated, so will 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, all of which play critical roles in reducing chronic disease prevalence in Indian Country. Further, HHS has terminated most of the staff within the Healthy Tribes Program (HTP) at CDC, which includes the Good Health and Wellness in Indian Country (GHWIC) program, Tribal Practices for Wellness in Indian Country (TPWIC) program, and the Tribal Epidemiology Centers Public Health Infrastructure program. Through its various programs, the HTP supports holistic, culturally responsive methods for preventing and managing chronic diseases like type 2 diabetes and high blood pressure, supports food access and nutrition education services, and supports Tribal Nations' public health capacity and infrastructure, among others—all of which are supposedly priorities for this Administration. The HTP provides critical, cost-saving chronic disease prevention and mitigation resources each year, but the elimination of program staff puts the HTP and its work at risk. If the HTP program is eliminated or otherwise limited by staffing constraints, vitally important chronic disease prevention programs at hundreds of Tribal Nations could be at risk of being eliminated or limited as well, which is of major concern for a population that suffers disproportionately from chronic disease.

USET SPF also urges Congress to protect and increase support for the Special Diabetes Program for Indians (SDPI), one of the most successful chronic disease reduction and prevention programs in the U.S. In the decades since its creation, SDPI has greatly reduced diabetes prevalence, severity and mortality in Tribal communities while diabetes prevalence in the general population has only increased. This has saved millions of dollars in health care costs for diabetes-related complications. However, despite SDPI's proven, evidence-based success, the program has only received meager and insufficient funding increases over time. Prior to 2024, SDPI had

been flat funded at $150 million for the last 20 years, and the slight increase to $160 million annually is negligible due to inflation and rising costs from the program's expansion. USET SPF requests that Congress significantly increase SDPI funding and permanently reauthorize this critical and exceedingly successful program. Additionally, we urge Congress to implement Tribal Nations' authority to receive SDPI funds through self-determination and self-governance contracts and compacts. Currently, program dollars are delivered through grant mechanisms which fail to honor the federal trust obligation by treating Tribal Nations as grantees rather than sovereign governments. With the authority to receive SDPI funds directly through Indian Self-Determination and Education Assistance Act (ISDEAA) contracts and compacts, Tribal Nations will be able to use SDPI dollars more efficiently as less staff time will be needed to complete grant-related tasks and can be dedicated to program delivery.

We urge Congress to not only protect but expand support for and access to critical programs like the SDPI and HTP that work to reduce chronic disease prevalence in Indian Country. USET SPF is strongly supportive of the Administration's goals to reduce chronic disease prevalence, but these goals cannot be achieved without the programs and resources that are relied on and proven successful in Indian Country.

Preservation of Medicaid as Fulfillment of Trust and Treaty Obligations

Medicaid is one of the major programs through which the federal government fulfills its trust and treaty obligation to provide for AI/AN healthcare. It serves a third or more of the AI/AN population in the United States, and reimbursements from the Medicaid program constitute a significant portion of IHS and Tribal health care program budgets. While the Indian Health System makes up less than 1 percent of overall federal spending on Medicaid, it is also estimated that Medicaid billing constitutes from 30 percent up to 60 percent of the operating budgets at most IHS and Tribal health facilities. These funds provide a critical bridge in funding between the underfunded IHS and other health care systems; therefore, any limitations or reductions in Tribal access to Medicaid—including work requirements, per capita funding caps and block granting—could have dire consequences for the Indian Health System. Any effort to reduce federal spending on Medicaid must not impact AI/AN eligibility and access or quality of care within the Medicaid program for AI/AN people.

The federal government has an obligation to protect Tribal access to Medicaid resources and provide appropriate exemptions from work requirements and per capita funding caps for AI/AN Medicaid beneficiaries. USET SPF has urged HHS to ensure that states include these exemptions in any state plan amendments to Medicaid and have advocated with Congress to include statutory exemptions in any legislation intended to reform Medicaid to more concretely preserve AI/AN access to the program.

USET SPF was pleased to see that the current reconciliation bill text contains a clear exemption for AI/AN beneficiaries from Medicaid work requirements. The bill also does not impose annual per capita caps or block granting on the Medicaid program, which would have created significant issues for the Indian Health System. USET SPF is strongly supportive of this exemption and these provisions must be maintained in any final version of the bill containing work requirements or other limitations on Medicaid.

Conclusion

Congress has a responsibility to protect the HHS System from harmful rescissions, budget cuts, and program eliminations and to ensure increased, sustainable resources for AI/AN healthcare. Our people prepaid for our healthcare through the cession of vast lands and resources to the United States, which created the federal government's trust and treaty obligations that exist in perpetuity. The proposed cuts to the IHS and other parts of the HHS budget that support service and program delivery in Indian Country are not only inappropriate but also a direct violation of the U.S.'s obligations to provide for AI/AN healthcare. Congress must exercise its oversight and appropriations authorities to ensure that Indian Country is not wrongfully harmed in the efforts to reform the federal government and budget. USET SPF stands ready to support Congress and the Administration in its priorities to reduce disease prevalence and promote healthier communities, but these efforts must honor the federal trust and treaty obligations to Tribal Nations.

ALASKA NATIVE WOMEN'S RESOURCE CENTER
April 2, 2025

Dear Senator Murkowski,

I am writing today to express our concerns regarding the recent placement of Shawndell Dawson, Director of the Office of Family Violence and Prevention Services (OFVPS), on administrative leave as of March 31, 2025. We are very worried about this unexpected leadership change and its potentially devastating impact on critical services for survivors.

The Alaska Native Women's Resource Center (AKNWRC) is the OFVPS-designated Alaska Tribal Resource Center and works closely with Tribes and communities across our state. Through this work, we have witnessed firsthand how OFVPS, under Director Dawson's leadership, has been instrumental in addressing the disproportionately high rates of violence experienced by our people. Director Dawson has demonstrated an undeniable commitment to honoring our Tribes and, in particular, honoring Tribal sovereignty, while ensuring that federal resources reach our most needed and historically underserved communities. Her dedication to meaningful engagement and consultation with our Tribes has led to programs that are both culturally appropriate and effective.

The impact that this leadership change will have on our Tribes and Tribal communities is very unsettling. As you know, Alaska Native communities face unique challenges in addressing domestic violence and sexual assault due to our geographic isolation, limited infrastructure, and limited funding opportunities. The OFVPS is crucial in supporting our communities through specialized funding, culturally responsive training, and technical assistance that acknowledges these unique challenges.

Additionally, the OFVPS has been instrumental in implementing critical provisions of the Family Violence Prevention and Services Act to Tribal communities. Through dedicated funding streams for Tribal shelters, advocacy services, and culturally specific prevention initiatives, the OFVPS has created a network of support that honors our traditional healing practices while providing essential resources for survivors. Director Dawson's guidance has ensured these programs operate with cultural sensitivity and meaningful Tribal engagement and consultation. The disruption in leadership threatens to undermine the trust and partnership that has been carefully nurtured and developed between OFVPS and Tribes across Alaska, and any interruption or change in direction could have devastating consequences for survivors, their families, and their communities.

As a longtime advocate and champion for survivors of domestic violence and sexual assault and as a Senator who has consistently demonstrated your commitment to Alaska Native issues, you understand the critical importance of stable, informed leadership in addressing these complex challenges.

We respectfully urge you to:

- Inquire into the circumstances surrounding Director Dawson's placement on administrative leave and advocate for transparency in this process;
- Utilize your position as Chair of the Senate Committee on Indian Affairs and other committees to ensure that the OFVPS maintains its commitment to Tribes and culturally appropriate, trauma-informed approaches;
- Work to ensure that funding for Tribal programs remains robust and that implementation proceeds without unnecessary disruption; and
- Request information about any transition plan and qualifications of incoming leadership, particularly regarding their experience working with Tribal nations.

Finally, I have included a copy of a letter sent to the Secretary of Health and Human Services yesterday, signed by 72 organizations, including Tribal coalitions and nonprofit organizations, state coalitions, national organizations, and specialized groups focused on domestic violence and sexual assault prevention and response, urging the Secretary to change course, reinstate Director Dawson, and ensure the stability of the work of the OFVPS.

The safety and well-being of Alaska Native survivors and families experiencing violence must remain a priority. Leadership changes should never come at the expense of those who depend on these essential services or undermine the progress made in recognizing the sovereign right of our Tribes to address violence in ways that align with our cultural values.

Thank you for your continued dedication to these critical issues affecting Alaska Native communities. I welcome the opportunity to discuss these concerns with you or your staff in greater detail and look forward to hearing your response and learning how you plan to address these concerns.

With gratitude,

TAMI TRUETT JERUE, EXECUTIVE DIRECTOR

APRIL 1, 2025

The Honorable Robert F. Kennedy, Jr.,
Secretary, Health and Human Services,
U.S. Dept. of Health & Human Services,
Washington, DC.

Dear Secretary Kennedy,

We understand that Shawndell Dawson, Director of the Office of Family Violence Prevention and Services (OFVPS), was placed on administrative leave on March 31. The undersigned organizations are calling on you to reinstate Director Dawson and express our grave concern about the impacts this will have on the nation's response to domestic violence and sexual assault.

This goes far beyond a personnel issue or individual position in terms of its potential to disrupt an essential leadership function of this work but instead threatens decades of a successful public health response to domestic violence.

The work of the OFVPS office is specialized. OFVPS administers the Family Violence and Prevention Act (FVPSA), which is at the heart of our nation's response to domestic violence and supports lifesaving services, including shelters, hotlines, counseling, and domestic violence programs throughout the states and territories. OFVPS has more recently administered funds for sexual assault programs that are essential to keeping their doors open. The functions of the OFVPS office are unique to the field and leadership requires broad expertise of both domestic violence and sexual assault. Moreover, Director Dawson and the OFVPS office have had a critical role in addressing the intersections of domestic violence and sexual assault with other health issues.

We must ensure the stability of the work and consistent leadership is essential to any efforts to pursue efficiency. Losing that consistency will hamstring efforts to respond to domestic violence and sexual assault. The field, made up of over 2000 local domestic violence and sexual assault agencies, will be closing out a billion dollars of grants in the next several months and is currently awaiting grant awards. OFVPS administers over $250 million a year. These dollars would be in jeopardy without experienced leadership. This effort requires leadership with a history and understanding of the grantees and services.

We urge you to change course and prevent the potentially devastating impacts on the domestic violence and sexual assault service delivery system.

Sincerely,

Alaska Native Women's Resource Center
Alaska Network on Domestic Violence and Sexual Assault
Alliance of Tribal Coalitions to End Violence
American Samoa Alliance Against Domestic and Sexual Violence
Arizona Coalition to End Sexual and Domestic Violence
Arkansas Coalition Against Sexual Assault
Asian Pacific Institute on Gender-Based Violence
ASISTA
Battered Women's Justice Project
California Partnership to End Domestic Violence
Caminar Latino
Colorado Coalition Against Sexual Assault
Delaware Alliance Against Sexual Violence
Delaware Coalition Against Domestic Violence
End Domestic Abuse Wisconsin
Esperanza United
First Nations Women's Alliance
Florida Council Against Sexual Violence
Futures Without Violence
Georgia Coalition Against Domestic Violence
Georgia Network to End Sexual Assault
Hawaii State Coalition Against Domestic Violence
Idaho Coalition to End Sexual and Domestic Violence
Illinois Coalition Against Domestic Violence
Illinois Coalition Against Sexual Assault (ICASA)
Indiana Coalition Against Domestic Violence
Indiana Coalition to End Sexual Assault

Iowa Coalition Against Domestic Violence
Iowa Coalition Against Sexual Assault
Jane Doe Inc.
Jewish Women International
Just Solutions
Legal Momentum
Louisiana Foundation Against Sexual Assault
Louisiana Coalition Against Domestic Violence
Maine Coalition Against Sexual Assault
Maryland Coalition Against Sexual Assault
Maryland Network Against Domestic Violence
Michigan Coalition to End Domestic and Sexual Violence
Minnesota Indian Women's Sexual Assault Coalition
Montana Coalition Against Domestic and Sexual Violence
National Alliance to End Sexual Violence
National Organization of Asians & Pacific Islanders Ending Sexual Violence
National Center on Domestic Violence, Trauma, and Mental Health
National Congress of American Indians—Violence Against Women Taskforce
National Indigenous Women's Resource Center
National LGBTQ Institute on IPV
National Network to End Domestic Violence
National Organization of Sisters of Color Ending Sexual Assault
National Resource Center on Domestic Violence
Native Women's Society of the Great Plains
Nevada Coalition to End Sexual and Domestic Violence
New Mexico Coalition of Sexual Assault Programs
New Mexico Coalition Against Domestic Violence
New Jersey Coalition to End Domestic Violence
New York State Coalition Against Domestic Violence
North Dakota Domestic and Sexual Violence Coalition
Ohio Alliance to End Sexual Violence
Ohio Domestic Violence Network
Oregon Coalition Against Domestic and Sexual Violence
Pennsylvania Coalition Against Domestic Violence
Pouhana O Nā Wāhine
Puerto Rico Coalition Against Domestic Violence and Sexual Assault
Respect Together
Rights4Girls
Rhode Island Coalition Against Domestic Violence
StrongHearts Native Helpline
Tahirih Justice Center
Texas Association Against Sexual Assault
Ujima, The National Center on Violence Against Women in the Black Community
Vermont Network Against Domestic and Sexual Violence
Violence Free Colorado
Washington State Coalition Against Domestic Violence
West Virginia Coalition Against Domestic Violence
Wyoming Coalition Against Domestic Violence and Sexual Assault
VALOR
ZeroV, Kentucky United Against Violence

RURAL ALASKA COMMUNITY ACTION PROGRAM, INC., (RURAL CAP)
May 12, 2025

Senator Lisa Murkowski, Chairman of the Senate Committee on Indian Affairs:

Since its founding in 1965, Rural Alaska Community Action Program, Inc., (RurAL CAP) has been a cornerstone for low-income Alaskans to access economic opportunity, both directly providing essential services in early education, housing, and health and well-being and partnering with statewide leaders on system building opportunities. Our programs offer innovative, community-driven solutions that are crucial for the sustainable development of Alaska—for us, a vision of Alaskans benefiting from Alaskan economic potential and an improved quality of life in our state.

The grants and technical support provided by Health and Human Services (HHS) enable us to provide critical services to Alaskans. While we are a private, non-tribal entity, the majority of our service recipients are Alaska Native from communities both urban and rural, reflecting Alaska's unique composition of more tribes than

any other state in the US. Today, we would like to focus on our operational relationship with HHS using our Head Start programs' 60-year history as an example.

Since 2020, RurAL CAP Head Start and Early Head Start has provided the following to Alaskan families:

Services to Alaskan Families

- 1,903 children in RurAL CAP Head Start and Early Head Start received critical cognitive, social, and educational development

  —1,570 of those children are Alaska Native (82.5 percent)
- 1,416 Alaskan families received Head Start and Early Head Start services
- 76 families experiencing housing insecurity enrolled in Head Start and Early Head Start
- 1,856 children received age-appropriate developmental screenings
- 1,713 health screenings were conducted
- 279,316 meals served

Employment and Local Workforce Development

- 285 Alaskans employed serving in their own communities through Head Start

  —These are Alaskan jobs, staffed by Alaskans, often in rural communities where opportunities for employment can be hard to come by
- 173 Staff members are former Head Start graduates

Innovations in Workforce Development

- 1 Teacher Apprentice at Homer Head Start
- 6 more apprentices scheduled to begin next year in 6 rural, off-road communities

  —Teacher Apprenticeships help address the ongoing childcare crisis in Alaska while creating pathways to long-term, self-sufficiency through on-the-job training in rural communities

Impact Story

> "After unexpectedly losing my husband three years ago I was left alone with our two babies. I was unable to work. I was grieving and honestly just trying to survive in any way that I could. Head Start gave us socialization, new friendships. They offered speech services to my daughter Jade who has now surpassed her goal by 13 percent, and she's even started reading before going to kindergarten. I cannot stress enough how vital Head Start has been in helping my tiny broken family find our new normal, and I hope that Head Start is available for families just like mine for many years to come."
>
> —Turena, Homer Head Start parent

RurAL CAP remains committed to efficiently creating pathways to self-sustainability, workforce development, and finding innovative solutions to the challenges facing Alaska. Thank you for the opportunity to highlight the significance of our Head Start programming in improving the lives of working Alaskans.

Best regards,

TIEL SMITH, CEO

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LISA MURKOWSKI TO HON. JANET ALKIRE

Question 1. Staffing reductions have affected the ability of Tribal Epidemiology Centers (TECs) to maintain vital surveillance tools and data sets, such as Pregnancy Risk Assessment Monitoring System. How can Congress ensure that TECs maintain their capacity to collect and analyze critical public health data that informs tribal health decisionmaking particularly during this period of reorganization?

Answer. In order to maintain TECs capacities to collect and analyze critical public health data, Congress should ensure that TECs are recognized and treated as public health authorities, as required by HIPAA (25 U.S.C. § 1621m(e)). Additionally, HHS must continue to manage and respond to TECs requests for any data held or administered by any division at HHS, in accordance with this statutory mandate.

Question 2. What are the specific health outcomes CDC Healthy Tribes programs were achieving in Tribal communities and what alternatives might exist to maintain these critical public health initiatives current funding structures are dismantled?

Answer. The CDC Healthy Tribes programs are widely successful in improving a wide range of health outcomes for Tribes with a program. The Healthy Tribes programs enable Tribes to customize each program to fit the needs of each individual Tribe. This flexibility allows each site to create programming that meets local cultural and traditional values. In Oklahoma, the Southern Plains Tribal Health Board has utilized funding to invest in a Caring Van that offers preventative health care and health education offering immunizations, dental screenings, and HIV/AIDS screenings. In one year, the Caring Van completed 294 screenings.

As part of Culture is Prevention, the Great Lakes Inter-Tribal Epidemiology Center is partnering with the Great Lakes Inter-Tribal Council to offer resource gathering and development of a 36-bed Adolescent Recovery and Wellness Center.

Healthy Tribes is irreplaceable. No other federal or state program provides the comprehensive community-driven support that Healthy Tribes delivers. It is the only federal initiative that invests in the day-to-day multi-sector needs of Tribal communities which focuses on disease identification and prevention.

Question 3. Public Health Service Commissioned corps officers assigned at CDC have historically provided temporary duty assistance in Tribal communities during public health emergencies. Given their critical role in addressing urgent issues like sexually transmitted infection outbreaks in the Great Plains region, what strategies would most effectively preserve this rapid response capability while ensuring officers receive appropriate cultural competency training for effective service in Tribal communities?

Answer. This type of surge staffing with Commissioned Corps Officers is critical to our communities. Because of the underfunding and high vacancy rates, surge staffing is frequently the only process to get sufficient response during a public health crisis. Federal employees who provide services to Tribal Nations should be exempted from the Reduction in Force (RIF) and hiring freezes. Tribal leaders continue to make this request known to Secretary Kennedy. These employees are critical to delivering legally mandated services to American Indian and Alaska Native beneficiaries and are essential extensions of the government-to-government relationship. Once assigned to Tribal communities, officers receive education on local cultural values and traditions, with cultural competency defined by each Tribal Nation.

Question 4. Recent staff reductions at the Public Health Service Commissioned Corps Headquarters have raised concerns about essential support functions including payroll processing, officer assignments, and special pay administration. These changes potentially impact not only the approximately 1,200 PHS officers serving at Indian Health Service and Tribal facilities but also the nearly 6,000 officers serving across critical public health programs at HHS and non-HHS agencies. How might these administrative disruptions affect the Corps' ability to recruit, retain, and deploy qualified healthcare professionals to address ongoing health disparities in Tribal communities and what measures could be implemented to stabilize this critical workforce?

Answer. Public Health Service Commissioned Corps Officers are critical to providing services at the IHS and Tribal health care facilities and assisting the federal government in meeting the Trust and Treaty obligations. Instability in the program and in federal hiring have caused a lot of chaos, which drives potential new officers away. Additionally, the number of Public Health Service Officers has decreased in recent years, which has severely limited staff for the public health process in Indian Country.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BRIAN SCHATZ TO HON. JANET ALKIRE

Question 1. Secretary Kennedy has taken steps to "overhaul" agencies across HHS—including those that serve Native communities. We heard from several witnesses that because many grants have been canceled and HHS regional offices abruptly closed, Tribes have been left without assistance with implementing critical programs, including those that support victims of domestic violence. Did HHS engage in consultation with Tribes regarding any of the changes that have been implemented, including its RIF or reorganization efforts?

Answer. No, the Department of Health and Human Services did not engage in consultation with Tribes regarding any of the changes that have been implemented, including HHS' reduction in force or reorganization efforts.

Question 2: Earlier this month, I sent a letter with Chair Murkowski and Senator Merkley to Secretary Kennedy about our concerns with the continued hiring freeze and staff reductions at IHS which are exacerbating existing staffing issues and the

delivery of healthcare services. What impacts have you seen at IHS facilities? Please be specific.

Answer. The hiring freeze and staff reductions have had many impacts on the Indian Health Service. First, the IHS has a vacancy rate for physicians at 36 percent and 44 percent for behavioral health providers. These providers are critical to delivering services and have some exemption from the hiring freeze. Furthermore, 43 percent of our IHS facilities would need to close their doors if they lose a single provider. With that said, the exemption for hiring has been capped by DOGE to less than 500 for the agency. This is not enough to meet the demand of the IHS. IHS has experienced staff attrition of 4–5x the typical rate, which is exacerbating current understaffing within the agency and we expect without a change in course on the current hiring freeze, facilities will likely need to at least temporarily close in the near future.

Additionally, other key positions are not exempt from the hiring freeze, such as janitorial staff, administrative reception, or coders, billers, and Purchased and Referred Care (PRC) staff. These positions must be included in a broader exemption for the IHS. These key positions not only help IHS facilities meet accreditation requirements, but our PRC staff pay medical bills owed by IHS and ensure Tribal citizens can get the referred care they need. Without them, our citizens face lack of care or worse bill collections for debts owed by the federal government.

Question 2a. In your opinion, how will these impacts and/or continued staffing uncertainties affect federal agencies' ability to provide legally required health care for Native communities?

Answer. In addition to the loss of staff at the Indian Health Service, many Tribal Offices and Tribal Support Teams have been reduced or eliminated impacting Tribal grants and communication with federal agencies. These offices and staff serve as a lifeline for Tribal citizens and their dismissal will harm public health programs serving Native communities. The number of HHS regional offices has been reduced from 10 to 5, placing over 400 Tribes under the jurisdiction of a single office in the Western United States.

Additionally, the termination of staff working with the Great Plains Tribal Epidemiology Center has directly halted critical public health response efforts. OASH staff who oversaw HIV/AIDS programming have also been terminated impacting local efforts to provide lifesaving care and prevention efforts for American Indian and Alaska Native individuals living with or at risk of HIV/AIDs. Due to uncertainty in funding for Head Start, one Tribe reported the loss of three staff causing them to close their facility. Finally, dismissal of staff from the CDC's Healthy Tribes and SAMHSA's Circles of Care harms local behavioral health initiatives that provide prevention, intervention, and treatment efforts.

Question 3. During a May 14th House appropriations hearing, Secretary Kennedy called distribution of ultra-processed foods in Indian Country a "genocide" against Native Americans. But this rhetoric doesn't match the Trump administration's actions, *e.g.* gutting the Centers for Disease Control and Prevention (CDC)'s Healthy Tribes program, which focuses on chronic disease prevention through nutrition, its proposed massive funding cuts to HHS, and staffing reductions, including at the Administration for Community Living (ACL), which administers Title VI funding through the Older Americans Act. How does the CDC's Healthy Tribes program support chronic disease prevention? Please be specific.

Answer. The CDC Healthy Tribes programs are widely successful in improving the prevention of chronic diseases. The Healthy Tribes programs able to customize each program to fit the needs of each individual Tribe. This flexibility allows each site to create programming that meets local cultural and traditional values. In Oklahoma, the Southern Plains Tribal Health Board has utilized funding to invest in a Caring Van that offers preventative health care and health education offering immunizations, dental screenings, and HIV/AIDS screenings. In one year, the Caring Van completed 294 screenings. The Alaska Native Tribal Health Consortium collaborates with regional Tribal health organizations to increase colorectal cancer screening. This partnership has resulted in an increase of screening from 46 percent in 2020 to 62 percent in 2024 in Alaska Native populations.

Question 3a. How do ACL programs, including Title IV programs authorized by Older Americans Act, support nutrition services and health promotion across Indian Country?

Answer. The Administration for Community Living funds and administers a wide range of nutrition services and health promotion programs across Indian Country. They provide transportation services, home-delivered nutrition services, congregate nutrition services, information, referral, and outreach services, in-home services, caregiver counseling and support group services, and caregiver respite services.

These are all essential to ensuring Native Elders can remain and thrive in their own communities. The Native Elder programs within ACL's OAA Title VI administration are the only federally funded wrap around services for Native Elders and are offered in conjunction with other Medicaid services that support keeping our Elders in community.

Question 3b. What do the administration's current and proposed funding cuts mean for Tribal health, specifically related to chronic disease prevention and health promotion?

Answer. The Administration's current and proposed funding cuts will mean many Tribal chronic disease prevention and health promotion programs will shut down. Tribes will be limited in their scope of services and may eventually need to ration resources, like limiting prevention services to provide more urgent levels of care. Lack of funding, staff, and data will make it harder to specifically address disease disparity in our communities.

Question 4. Federal agencies were directed to take down critical health data to comply with President Trump's DEI Executive Order. Although HHS issued an advisory opinion clarifying that the President's Executive Orders regarding DEI do not apply to programs serving American Indian and Alaska Natives (AI/AN), AI/AN data has been deleted from public view, including data on how many Native youth are struggling with mental health and thoughts of suicide, where disease outbreaks are happening, what's making moms and babies less healthy, and how we can combat chronic health issues. How does losing this kind of data and information (now and in the future) impact HHS' ability to deliver health care services to Native communities?

Answer. The Department of Health and Human Services has issued an Advisory Opinion which clearly states that Tribes and their citizens are not DEIA and that the obligations to Tribes should not be abridged. Under this opinion, American Indian and Alaska Native data should not be impacted. However, this is not reality and we must work to get data back online. Losing access to critical data sources significantly hinders Tribal communities' ability to effectively respond to emerging health challenges. Without timely and accurate data, Tribes would be unable to identify and address rising health issues, let alone implement health education and prevention programs. The inability to access and analyze data would also undermine Tribe's ability to secure resources and funding, as data is essential for justifying requests for support and demonstrating a need. Without critical information, it weakens Tribal leaders' ability to make informed decisions and our ability to protect the health and well-being of our communities.

Question 5. For the first time ever, in FY23, IHS received advance appropriations following years of advocacy from Tribes and Tribal Organizations. An initial pass back of the President's proposed FY26 Budget (the "skinny budget") threatened to end advance appropriations while decimating IHS funding by 30 percent compared to FY25. Why is it important that the federal government maintain advance appropriations for IHS?

Answer. IHS Advance Appropriations has been critical to creating stability for IHS, Tribes, and urban Indian organizations. The predictable funding helps Tribes plan long-term for programs and staff and provide a guarantee that health programs will not be subject to stops in funding or reductions. Advance appropriations is important because it meets the treaty and trust obligations to tribes and secures stability for our programs, communities, providers, and our health.

Question 5a. If the President's proposed FY26 Budget is adopted, and funding cuts are implemented across HHS, what impacts should Indian Country brace for?

Answer. Indian Country will need to brace for severe impacts if the President's proposed budget for FY26 is adopted. Most urgently, Tribes could lose millions of dollars from critical programs at HHS. Additionally, the IHS would no longer have funding certainty, which is provided by advance appropriations.

Question 5b. Could Tribes meet their communities' needs as proposed in the skinny budget?

Answer. No, Tribes would not be able to meet their communities' needs as proposed in the skinny budget or the President's Budget without reduction to programs.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN RAY LUJÁN TO HON. JANET ALKIRE

Question 1. How will the reduction in workforce and Health and Human Services (HHS) reorganization impact Pregnancy Risk Assessment Monitoring System (PRAMS) and other key public health programs?

Answer. In addition to the Indian Health Service, several other departments within the Department of Health and Human Services provide critical healthcare services to Tribal communities. A reduction in force would result in many key public health programs, including the Pregnancy Risk Assessment Monitoring System (PRAMS) to halt efforts. The PRAMS data set is one of the few points of information on AI/AN pregnancy risk which is critical to identifying and addressing pregnancy risks and disparities in our communities. It is critical that all programs serving Tribal communities are protected from the reduction in force, so that they can continue providing key public health services to Indian Country.

Question 2. Implementing reduction in force measures, like eliminating the Office of Minority Health and other key Medicare and Medicaid services goes against their promise and their federal legal responsibilities to Tribes—can you discuss how the Center for Medicare and Medicaid Services supports critical Tribal programs?

Answer. Since IHS is already severely underfunded, Medicaid serves as a critical funding stream for Indian health care providers, including Urban Indian Organizations. Medicaid is essential to sustaining Tribal health care services. For some clinics, it accounts for 30–60 percent of their operating budgets, making it a critical source of funding to sustain services for our Tribal citizens. IHS's projected Medicaid is only 0.21 percent of total federal Medicaid spending. We are encouraged by bipartisan efforts to protect Tribal citizens in Medicaid reform, including the House Energy and Commerce text exempting Tribal Citizens from work requirements, and we urge the Senate to maintain these protections.

We also have seen the Administration re-instate offices like the CMS Office of Minority Health understanding the statutory requirements to keep such offices open within HHS agencies under the Patient Protection and Affordable Care Act (P.L. 111–148). We hope this will continue in relation to programs supporting our Tribal communities.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BRIAN SCHATZ TO MELISSA CHARLIE

Question 1. Secretary Kennedy has taken steps to "overhaul" agencies across HHS—including those that serve Native communities. We heard from several witnesses that because many grants have been canceled and HHS regional offices abruptly closed, Tribes have been left without assistance with implementing critical programs, including those that support victims of domestic violence. Did HHS engage in consultation with Tribes regarding any of the changes that have been implemented, including its RIF or reorganization efforts?

Answer. I can only speak on behalf of the Fairbanks Native Association. No consultation was offered regarding these changes. One day, our federal grant administrators were accessible; the next, they were no longer available. We have historically maintained strong, collaborative relationships with our federal partners, working together to deliver meaningful services to our members. The abrupt termination of this relationship-without prior notice-was both unsettling and counterproductive for everyone involved.

Question 2. Secretary Kennedy frequently touts that HHS exempted the Indian Health Service from the hiring freeze in place across the federal government. However, not only is the exemption limited to only certain clinical positions, it is still in place across other HHS agencies that serve Native communities' health care needs. In addition, HHS has engaged in a series of staff layoffs, and additional Reductions in Force (RIFs) are looming. Your testimony stated that staffing uncertainties are crippling programs for children. How do efforts to reduce federal staff affect Head Start programs serving Tribes, and how will future reductions exacerbate existing challenges?

Answer. As grant recipients, particularly for Head Start programs, we are required to navigate an increasingly uncertain fiscal landscape, often without clear insight into what changes may come from the federal level day to day. In good faith, we submitted grant modifications designed to enhance services for the children and families we serve while maximizing the use of federal funds. These changes were approved shortly before the recent reduction in federal staffing.

Like many others, we have been addressing workforce shortages since the pandemic and are only now beginning to rebuild, with an increase in both teachers and associate teachers that will enable us to expand enrollment. This recovery strategy was developed collaboratively with our Head Start grant management team.

Unfortunately, that team is no longer functioning cohesively due to hiring freezes and job uncertainty. Reductions in the federal workforce risk undermining the trust-

ed relationships built over time and will inevitably disrupt service delivery to those most in need-our children and their families.

Question 3. During a May 14th House appropriations hearing, Secretary Kennedy called distribution of ultra-processed foods in Indian Country a "genocide" against Native Americans. But this rhetoric doesn't match the Trump administrations actions, e.g., gutting the Centers for Disease Control and Prevention (CDCYs Healthy Tribes program, which focuses on chronic disease prevention through nutrition, its proposed massive funding cuts to HHS, and staffing reductions at the Administration for Community Living (ACL), which administers Title VI funding through the Older Americans Act. What do the administration's current and proposed funding cuts mean for Tribal health, specifically related to chronic disease prevention, nutrition services, and health promotion?

Answer. Our Title VI program provides nutritious meals to our elders—often the only complete meal they receive each day. These meals include fresh fruits and vegetables, which can be difficult to afford for those on fixed incomes. This service is a vital preventive health measure that supports the overall well-being of our elders and helps reduce avoidable medical visits.

In addition to promoting physical health, the program offers valuable opportunities for social interaction, helping to combat isolation and support mental health.

Eliminating or reducing this program, or any of its related services, would likely result in increased costs in other areas, such as healthcare, due to the adverse effects on the physical and emotional well-being of our elder community members.

This one example is representative of the impacts any funding cuts would have on Tribal health services across the board.

Question 4. For the first time ever, in FY23, IRS received advance appropriations following years of advocacy from Tribes and Tribal organizations. An initial pass back of the President's proposed FY26 Budget (the "skinny budget") threatened to end advance appropriations while decimating IHS funding by 30 percent compared to FY25. Why is it important that the federal government maintain advance appropriations for IHS?

Answer. Maintaining advance appropriations for the Indian Health Service (IHS) is critically important to ensure the continuity and stability of health care services for American Indian and Alaska Native communities.

Historically, IHS funding was subject to delays and disruptions caused by the annual federal budget process and government shutdowns. These disruptions directly threatened access to essential health services, compromised staffing and retention, and undermined long-term planning.

Advance appropriations, which provide funding one fiscal year ahead of time, allow IHS programs and tribal health systems to operate without interruption, regardless of delays in the federal budget process. This stability is essential for maintaining:

- Continuity of care for chronic and acute health conditions
- Reliable staffing and recruitment of health professionals
- Timely procurement of medical supplies and services
- Tribal self-governance and planning under self-determination agreements

Most importantly, advanced appropriations honor the federal government's legal and moral obligation to provide health care to tribal nations, as established through treaties, statutes, and trust responsibilities. They uphold the federal trust responsibility and support the delivery of consistent, quality care in Native communities.

Question 4a. If the President's proposed FY26 Budget is adopted, and funding cuts are implemented across HHS, what impacts should Indian Country brace for?

Answer. While I can only speak on behalf of Fairbanks Native Association (FNA), it is clear that such drastic funding reductions would severely compromise our ability to provide essential services. The Indian Health Service (IHS) is already significantly underfunded, and any further cuts would force impossible decisions about which critical services to eliminate—despite the persistent and growing unmet health needs in our communities.

It is important to emphasize that IHS funding is not discretionary funding. It is a legal and moral obligation of the federal government, grounded in treaties, federal statutes, executive orders, and the federal trust responsibility to American Indian and Alaska Native peoples. This obligation must be honored with consistent and adequate funding, not subject to arbitrary reductions.

Question 4b. Could Tribes in Alaska meet their communities' needs as proposed in the skinny budget?

Answer. This question would be more appropriately addressed if the essential needs of our people were already being met. However, defining what constitutes an

"essential need" is complex. Are immunization services more critical than diabetes management? Is treating a broken bone more urgent than providing behavioral health related services? These are not either-or choices, all are vital, and all are currently underfunded.

Each tribe must determine its own priorities based on the specific needs of its community. For the Fairbanks Native Association (FNA), any reduction in funding would have a deeply negative and far-reaching impact on the health and well-being of those we serve.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN RAY LUJÁN TO MELISSA CHARLIE

Question 1. How has federal funding for Indian Head Start programs improved school readiness and mental health outcomes for Native American children?

Answer. Since its inception in 1965 as part of the federal government's War on Poverty, the Head Start program has provided critical early childhood education and comprehensive support services to millions of children and families across the nation, giving them a "head start" in life.

At Fairbanks Native Association (FNA), our Head Start program goes beyond traditional classroom instruction. We offer a holistic, child-centered approach that includes individualized support tailored to each child's developmental needs. Our goal is to ensure every child is fully prepared to transition into kindergarten with confidence and readiness.

In addition to educational programming, we provide essential health and wellness services, including referrals to behavioral health support, vision and dental screenings, and regular developmental assessments. We also actively engage families as partners in their child's learning, recognizing that strong family involvement is key to long-term success.

I will also add that as a Tribal Head Start program, FNA integrates a strong cultural component that honors and fosters the cultural strengths of the children and families we serve. We incorporate Alaska Native languages, teach traditional dances, and celebrate cultural heritage in meaningful ways throughout our curriculum and activities.

This culturally responsive approach promotes a sense of identity, belonging, and pride, which supports the overall well-being of our children and their families—socially, emotionally, and spiritually. By grounding our program in culture, we empower families and help children thrive in all areas of life.

Through these coordinated efforts, FNA Head Start helps lay a strong foundation for lifelong learning, well-being, and success.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BRIAN SCHATZ TO DR. SHERI-ANN DANIELS

Question 1. Secretary Kennedy has taken steps to "overhaul" agencies across HHS-including those that serve Native communities. We heard from several witnesses that because many grants have been canceled and HHS regional offices abruptly closed, Tribes have been left with assistance with implementing critical programs, including those that support victims of domestic violence. Did HHS engage in consultation with POL or the Native Hawaiian Community regarding any of the changes that have been implemented, including its RIF or reorganization efforts?

Answer. HHS did not engage in consultation with POL regarding its RIF or reorganization efforts. We have conferred with a number of Native Hawaiian Organization partners who receive funding from the Administration for Native Americans and Administration for Children and Families. These partners also reported that they were not consulted. We are not aware of any other organizations or individuals in the Native Hawaiian community that were consulted by HHS.

Question 2. House Republicans are proposing devastating Medicaid cuts. In Hawai'i, about 1 in 4 Native Hawaiians rely on Medicaid, and while the House bill includes a carve out for American Indians and Alaska Natives, it does not include any exemptions for Native Hawaiians in clear violation of the federal government's trust responsibility. How will imposing new hurdles, such as work requirements and additional cuts to Medicaid, affect Native Hawaiian health care in Hawai'i?

Answer. The work requirements "hurdle" indeed will be a "hurdle" impacting Native Hawaiians, without the same carve out as American Indians and Alaska Na-

tives. As noted by HHS's Office of Disease Prevention and Health Promotion,[1] social determinants of health ("SDOH") are the conditions in the environments where people are born, live, learn, work, play, worship and age, that affect a wide range of health functioning, and quality-of-life outcomes and risks. The SDOH domain of Economic Stability indicates the following goal:[2] Help people earn steady incomes that allow them to meet their health needs. The unemployment rate in Hawai'i in 2025 and 2026 is projected to be 2.9 percent, declining to 2.8 percent in 2027 and then 2.7 percent in 2028.[3] Native Hawaiians on Medicaid in Hawai'i are caught in a viscous circle of needing employment to enable access to healthcare services for management of individual chronic disease conditions plus dependents who are overrepresented in special health and social services needs (0–3 years old), early childhood (3–5 years old), and special education (5 to 22 years old).

The poverty rate of Native Hawaiians in Hawaii is relatively high, even though they are employed at about the same rate as the state's total population.[4] Over 144,000 Native Hawaiians and Pacific Islanders are below the 138 percent poverty threshold for Medicaid.[5]

POL understands the following about Native Hawaiian and part-Hawaiian members served by the Hawai'i Medicaid Program administered by the State of Hawaii's Department of Health: More than 70,000 individuals that identify as Native Hawaiian are enrolled in Med-QUEST, which represents approximately 17 percent of total Medicaid enrollees (and 20 percent of those who chose to identify their ethnicity); Almost 26,000 (34 percent) children which includes more than 1,400 current and former foster care children; more than 400 pregnant people; over 14,000 (18 percent) parents or caretakers; about 26,500 (34 percent) adults; and about 8,800 (11 percent) aged, blind or disabled adults.

While these statistics indicate that Native Hawaiians are generally represented in Medicaid enrollment at rates comparable to our representation in the state's population. Medicaid enrollment is more pronounced on the rural islands.[6] On O'ahu, 26.5 percent of the total population is enrolled in Medicaid. In contrast, nearly half—43 percent—of Hawai'i Island and over half—56 percent—of Moloka'i are enrolled in Medicaid.[7] Each of these islands also have the highest percentages of Native Hawaiians, with Hawai'i Island's population made up of 29.6 percent Native Hawaiian and Moloka'i's population comprised of 65.1 percent Native Hawaiians.[8] Given these numbers, it is clear that hurdles, barriers and cuts to Medicaid will have a pronounced impact on Native Hawaiian Medicaid enrollees, especially those in rural communities.

In addition to the high representation of Native Hawaiians and Medicaid enrollees, these islands tend to be considered more rural with significant barriers to accessing health care. Hawai'i Island residents often face long drives (60 to 100 miles one way) just to access primary and urgent care services. Moloka'i has significant healthcare professional and facilities shortages with many residents needing to go off island to receive the care they need. This is exacerbated by commuter air transportation options for disabled and elderly being severely limited or non-existent for flights to and from Moloka'i. Again, additional hurdles and disruptions to Medicaid coverage will only exacerbate the significant health care access issues on each of these and other islands.

Question 3. After federal agencies were directed to take down critical health data to comply with President Trump's DEI Executive Order, data regarding American

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[1] Office of Disease Prevention and Health Promotion. "Social Determinants of Health." Healthy People 2030, Office of Disease Prevention and Health Promotion, *odphp.health.gov/healthypeople/priority-areas/social-determinants-health*. Accessed 1 June 2025.

[2] Healthy People 2030. "Economic Stability—Healthy People 2030." *Health.gov, odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability*. Accessed 1 June 2025

[3] "DBEDT Economists Lower Hawaii Economic Growth Projections." *State of Hawaii Department of Business, Economic Development & Tourism*, 2025, *dbedt.hawaii.gov/blog/25–20/*. Accessed 1 June 2025.

[4] Hofschneider, Anita. "Poverty Persists among Hawaiians despite Low Unemployment." *Honolulu Civil Beat*, 19 Sept. 2018, *www.civilbeat.org/2018/09/poverty-persists-among-hawaiians-despite-low-unemployment/*. Accessed 1 June 2025.

[5] Karthick. "By the Numbers: Economic Hardship—*AAPI Data*." AAPI Data, 7 Mar. 2025, *aapidata.com/featured/by-the-numbers-economic-hardship/*. Accessed 1 June 2025.

[6] Audit, Quality Control & Research Office Research Staff. *State of Hawaii Department of Human Services Databook*. Dec. 2024. Percentages of island population covered by Medicaid are as follows: 34 percent Kauai, 26.5 percent Oahu, 43 percent Hawaii Island, 33.8 percent Maui, 56 percent Molokai, 29 percent Lanai)

[7] *Id.*

[8] Office of Hawaiian Affairs. "Native Hawaiian Data Book: Population." *Ohadatabook.com*, 2025, *www.ohadatabook.com/go__chap01.23.html*. Accessed 19 June 2025.

Indian, Native Hawaiian, and Alaska Health Native health was deleted from public view, including data on how many Native youth are struggling with mental health and thoughts of suicide, where disease outbreaks are happening, what's making mothers and babies less healthy and how we can combat chronic health issues. How does losing this kind of data and information (now and in the future) impact HHS' ability to deliver health care services to Native communities?

Answer. Losing the data negatively impacted HHS' ability to deliver health care services to Native communities because the actions: incorrectly conflated Trust responsibilities with DEI policy; intentionally created a vacuum of community-based implementation data, sharing and learning; and paternalistically prevented Native communities from being solution partners and providers.

A. Trust Responsibilities are based on Political Relationships and not DEI Initiatives

1. **Federal Trust Responsibility.** Similar to American Indians and Alaska Natives, Native Hawaiians never relinquished the right to self-determination despite the United States' involvement in the illegal overthrow of Queen Lili'uokalani in 1893 and the dismantling of our Hawaiian government. As such and as established by more than 150 federal laws, Native Hawaiians are owed the same trust responsibility as other Native groups in the United States. The federal trust responsibility extends to all Native Hawaiians, a population that grew nationwide by 29.1 percent from the 2010 to the 2020 census data.[9] To meet this obligation, Congress—through landmark, bipartisan work of this Committee and its Members—created policies to promote education, health, housing, and a variety of other federal programs intended to build, maintain, and better conditions for the Native Hawaiian Community.

2. **Unique Political Status.** More than 150 Acts of Congress expressly acknowledge or recognize a special political and trust relationship to Native Hawaiians based on our status as the Indigenous, once-sovereign people of Hawai'i. Among these laws are the Hawaiian Homes Commission Act, 1920 (42 Stat. 108) (1921), the Native Hawaiian Education Act (20 U.S.C. § 7511) (1988), the Native Hawaiian Health Care Improvement Act (42 U.S.C. § 11701) (1988), and the Hawaiian Homelands Homeownership Act codified in the Native American Housing Assistance and Self Determination Act, Title VIII (25 U.S.C. § 4221) (2000).

3. **Declaration of Policy.** Congress declared that it is the policy of the United States in fulfillment of its special trust responsibilities and legal obligations to the indigenous people of Hawaii resulting from the unique and historical relationship between the United States and the Government of the indigenous people of Hawaii (1) to raise the health status of Native Hawaiians to the highest possible health level; and (2) to provide existing Native Hawaiian health care programs with all resources necessary to effectuate this policy.[10]

B. Intentionally Created a Vacuum in Community-based Implementation Data, Sharing and Learning

Billions of dollars, over the past five decades, have been and continue to be invested in Native community health professionals and providers, facilities, interventions, strategies, and initiatives. Community data, particularly that, which disaggregates Native populations, triangulates the researched native community with researchers and research organizations and the health care professional community, to recognize and understand problems as well as co-construct, community-based solutions. The data vacuum hinders HHS' ability to deploy resources and programs and meet the Federal Treaty and Trust responsibilities, effectively, including consultation practices.

C. Paternalistically Prevented Native Communities from Being Solution Partners and Providers

1. **E Ola Mau.** The Native Hawaiian Health Needs Assessment (1985) was a landmark report that provided a comprehensive assessment of Native Hawaiian health, offering recommendations related to the health needs of Native Hawaiians. It provided the initial roadmap to local, state, and federal agencies on how each could contribute to the health and well-being of Native Hawaiians, was foundational in the passing of the Native Hawaiian Health Care Act of 1988, and the establishment of Papa Ola Lōkahi. The assessments conducted in the original E Ola Mau

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[9] US Census Bureau. "Chuukese and Papua New Guinean Populations Fastest Growing Pacific Islander Groups in 2020." *Census.gov*, 21 Sept. 2023, *www.census.gov/library/stories/2023/09/2020-census-dhc-a-nhpi-population.html*. Accessed 7 May 2025.

[10] The Native Hawaiian Health Care Improvement Act (42 U.S.C. § 11702) (1988)

and subsequent versions of the document since then are not possible without current and reliable data. The availability of data has enabled Papa Ola Lōkahi and other Native Hawaiian-serving agencies to monitor the health status of Native Hawaiians, allowing us to identify areas of need and growth, as well as strengths and resiliencies. Chapter topics in E Ola Mau have expanded over the years to address these needs, now including recommendations for workforce development, health education, and data governance.

E Ola Mau has not only been used to create policy change, but it has also had an impact at the community level, and this would not be possible without the availability of data. E Ola Mau is heavily referenced among community leaders and Native Hawaiian-serving organizations as evidence of need in grant funding applications, establishment of services, and in academic literature. E Ola Mau has been a catalyst for change for Papa Ola Lokahi, as well as other Native Hawaiian-serving organizations, communities, and individuals, all of which have been made possible by the availability of reliable data.

2. **COVID–19.** One key example of the ways in which data that focuses on native communities helps community and government partners identify and address issues that have impacts on the broader population is the data collected and used during the COVID–19 pandemic. By May 2020, data indicated that Native Hawaiians and Pacific Islanders (NHPIs) had higher rates of confirmed COVID–19 cases.[11] These important data points drove a coalition of organizations and government agencies to allocate resources and develop tactics to address the high rates of infection and mortality. Papa Ola Lōkahi is proud to have helped these efforts, which became known as NHPI 3R for Response, Recovery and Resilience. NHPI 3R mobilized efforts to ensure the State Department of Health was collecting and analyzing accurate and relevant data. From there, NHPI 3R was able to work with government agencies to identify immediate needs of the community and deliver community-based and networked assistance, including testing, educational materials and social supports.

In March 2021, the CDC identified that NHPIs had the highest death rate of any racial or ethnic group in 18 of 20 states that reported deaths of our communities.[12] At the same time, the State of Hawai'i Department of Health was not yet regularly reporting vaccination rates broken down into racial or ethnic groups. NHPI 3R, along with other community members, pushed the Department of Health for relevant data reporting. When data was available, our state saw that Native Hawaiians and Pacific Islanders had the lowest vaccination rate coupled with the highest infection rate.[13] NHPI 3R worked with the Department of Health and other community partners to build messaging and programming that would resonate with our communities. Papa Ola Lōkahi partnered with the Department of Health to help disperse funds to increase vaccination rates among NHPIs. Further, these efforts spurred organizing and capacity-building of community health workers, which has continued to positively impact our communities.

The data at both state and federal levels that focused solely on Native Hawaiians and Pacific Islanders was vital for Papa Ola Lokahi and our partners, including the NHPI 3R coalition, to understand what our communities needed to address COVID–19 in our communities. Further, these data also allowed both the State of Hawai'i and the federal government to allocate resources in more effective ways. These data helped not just to move needed investments into Native Hawaiian communities. The targeted allocation of resources helped to reduce COVID–19 infections across Hawai'i and in Hawaiian communities across the other 49 states.

3. **Maternal Mortality.** Another prime example of the way in which disaggregated data yields powerful insights is the maternal mortality rate. For years, Black American birthing people were known to have the highest rates of maternal mortality. This allowed for HHS and other organizations to tailor programs, resources and services to address the disparity. It was not until the last couple of years that Asian American, Native Hawaiian and Pacific Islander populations were

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[11] Kaholokula, Joseph Keawe'aimoku, et al. "COVID–19 Special Column: COVID–19 Hits Native Hawaiian and Pacific Islander Communities the Hardest." *Hawai'i Journal of Health & Social Welfare*, vol. 79, no. 5, May 2020, p. 144, *pmc.ncbi.nlm.nih.gov/articles/PMC7226312*. Accessed 19 June 2025.

[12] Seto, Brendan K. et al. "Differences in COVID–19 Hospitalizations by Self-Reported Race and Ethnicity in a Hospital in Honolulu, Hawaii." Preventing Chronic Disease, vol. 19, 2022, *www.cdc.gov/pcd/issues/2022/22__*0114.htm#:-
:text=As%20of%20March%202021%2C%20Native, retrieved June 16, 2025

[13] Hofschneider, Anita. "Pacific Islanders, Including Hawaiians, Disproportionately Missing out on Vaccines." *Honolulu Civil Beat*, 17 Mar. 2021, *www.civilbeat.org/2021/03/pacific-islanders-including-hawaiians-disproportionately-missing-out-on-vaccines/*. Accessed 19 June 2025.

disaggregated that our community was forced to face the harsh truth that our communities faced the highest maternal mortality rates in the nation from 2017 to 2019—more than 50 percent higher than Black Americans.[14] In years since, Native Hawaiian and Pacific Islander populations have not yet been disaggregated, but we have seen multiple years where American Indian and Alaska Native communities also have the highest rates of maternal mortality.[15] These data sets are critical for our communities as well as the federal government to identify problems and address them effectively. For us to develop solutions after all, we must first understand the problem and its root causes.

Mahalo hou (thank you again) for providing the opportunity for POL, the NHHB, to respond to the three questions for the record from Vice Charman Schatz, as a follow up to the above referenced Committee Oversight Hearing; and we stand ready and available to provide any follow up information.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LISA MURKOWSKI TO HON. LONI GRENINGER

Question 1. As of 2022, there are seventy-six approved Tribal Temporary Assistance for Needy Families (TANF) programs operating across the United States. These programs serve more than 285 Federally recognized Tribes and Alaska Native Villages, providing culturally tailored services that promote self-sufficiency and community wellbeing. What is the critical role of Tribal TANF programs in supporting the most vulnerable in your communities and how is the flexibility of Tribal TANF key in achieving self-sufficiency?

Answer. Tribal TANF programs provide much more than employment and training resources in Tribal communities. They often are actively engaged with child welfare, health, youth services, education, and behavioral health programs. As one of the four main purposes of TANF, these programs focus on services and support to ensure needy children can be cared for in their homes. A number of Tribal TANF programs have regular engagement with these other service providers to identify risk factors early on for children and families that can lead to greater crisis and involvement in service systems like child welfare. TANF often sees at risk families long before other service systems identify the families and with proper support can engage multiple systems to identify concerns that threaten family stability and ensure that services that promote economic self-sufficiency contribute to the strengthening of families and community wellness overall. TANF's flexibility to respond quickly, utilize culturally based services, and engage various systems effectively is key to serving children and families in need in Tribal communities. Operating a Tribal TANF program empowers us with flexibility and autonomy to design and administer a culturally relevant program that better serves the specific needs of our Tribal citizens strengthening Tribal sovereignty, Self-Determination, and improving overall community well-being.

Question 2. One of the critical functions of ANA is to provide language grants. Preserving and revitalizing Native languages is critical to sustaining Native history, culture, and philosophy. There are significant impacts from the teaching of Native languages on academic outcomes, social indicators, and community wellbeing. Alaska has three active Ester Martinez Immersion grants currently, spanning Southeast, Southcentral, and Western Alaska. Two of these grants support language immersion through early childhood education, serving children ages 0–5. What is the role of ANA Native Language Grants like Ester Martinez Immersion in enhancing child development and building strong communities?

Answer. Language is crucial to a child's development of their sense of self and their relationship to their family, community, and the world around them. Our languages are structured to show our relationships with those around us, and express concepts unique to our communities and cultures. The Federal Indian boarding school era wiped out much of our Indigenous language knowledge, and COVID–19 has claimed the lives of many of the remaining elders that were fluent speakers of our languages. It is impossible to fully describe the impact that losing our language and elders has had on our community. The generational trauma of Indigenous language loss is well documented, and we live and observe this trauma every day in our Tribal communities. ANA Native Language grants, such as the Esther Martinez Immersion Grant, provide essential funding to Tribal Nations to develop and imple-

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[14] CDC. "Data from the Pregnancy Mortality Surveillance System." *Maternal Mortality Prevention*, 29 Apr. 2025, *www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance-data/index.html?cove-tab=1.* Accessed 19 June 2025.

[15] *Id.*

ment language learning models that incorporate family and elders into methods-based curricula and assessments to revitalize our language in pre-Kindergarten aged children. Indigenous language use and revitalization is well understood to improve health disparities in Tribal communities, as well as improve mental health outcomes. Tribal communities have always known that culture is healing, and ANA Native Language grants empower our sovereignty to rebuild the loss of our language, culture, and community, starting with our youngest, most vulnerable members.

The Jamestown S'Klallam Tribe has actively revitalized our Klallam language through various initiatives, including documentation, education, and community engagement. The Tribe established the Klallam Language Program in 1992, recording our elders and transcribing the language. This foundational work provided a basis for creating teaching materials and curricula. The program has since expanded to include language classes in local schools for pre-school to high school aged children. These programs are vital to ensure that our younger generations learn the language. Adult language classes and online resources contribute to language learning beyond high school. Some positive impacts of the Klallam Language Program are increased language proficiency, improved academic success for Tribal students and community empowerment. It has helped create local networks and employment opportunities. The Tribe's efforts have influenced education of surrounding non-Native communities and others who visit our area with the introduction of bilingual street and Tribal campus signs. There is a system in place for training and certifying Klallam language teachers as qualified instructors that can continue to ensure the language's survival and transmission to future generations. This is essential because while our Klallam language is undergoing revitalization, it is still critically endangered. The Jamestown S'Klallam Tribe's commitment to language revitalization demonstrates a dedication to preserving our cultural heritage and ensuring our language continues to thrive.

Question 3. What is the importance of the CDC's Tribal Practices for Wellness in Indian Country funding and how has this funding benefitted the Jamestown S'Klallam Community?

Answer. The CDC Healthy Tribes program is important to the Jamestown S'Klallam Tribe because it provides a framework and resources that support the Tribe's goal of enhancing the health, social strength, and self-reliance of our citizens and community members. Traditional lifestyle and healing practices are essential to the overall well-being of our Tribe and our citizens, and these programs provide us with the opportunity to re-engage our ancient ways and utilize them in contemporary time. The CDC program prioritizes cultural values, traditions, and practices as central to health and wellness and this aligns with our Tribe's mission to serve the unique needs of our community with cultural sensitivity. Our identity as Tribal people is healed and strengthened and our bodies and physical health is improved with the healthy foods that we harvest, hunt, and cultivate on our Tribal homelands and in our ancestral waters. The Healthy Tribes Program recognizes the disproportionately high rates of chronic disease and shorter life expectancy faced by American Indian/Alaska Native (AI/AN) people often linked to historical trauma and lack of resources. By promoting community-led, culturally responsive interventions, we can address the root causes of these health disparities and improve health outcomes. We have been able to lower the incidence of disease and lower stress through traditional dancing, traditional foods, and harvesting activities.

Funding and resources are used in various ways:

- Salaries for staff that have the expertise needed to plan both small- and large-scale events, teach classes, and coordinate the First Foods Ceremony and all food harvesting and preparations.
- Stipends are provided to Tribal cultural and spiritual leaders, usually our Tribal elders and wisdom keepers who teach classes, lead songs and teach and facilitate sacred traditional ceremonies.
- Supplies include seeds and tools needed to help grow and support our community garden and seasonal feasts. We create safe pathways for citizens and community members of all abilities to come to the garden and participate and actively contribute to harvesting activities and the cooking of meals. The garden serves as an intergenerational gathering place for a plethora of activities including physical education, nutritional and medicinal education, a learning space for singing, drumming and dancing, and Ceremony, and a place for cultural education of traditional harvest practices, food preservation methods, and proper harvesting seasons. Garden activities and opportunities for learning are offered on a weekly basis. Food education includes harvesting, preparing, preserving, cooking and storing. We teach our citizens and community members various

food preservation methods such as how to freeze dry, dehydrate, smoke and can foods.

Cultural classes have specific themes and are hosted frequently, usually on a quarterly basis. For example, every January we focus on winter wellness and teach our citizens and community members about the healing and nutritional properties of various plants and animals—we make natural cough and cold medicines such as cough honey (a natural throat coat and cough suppressant), Devils Club Tea (a natural expectorant), Cedar steams (natural sinus cleanser) and healthy and nutritious soups like duck soup where we gain health benefits from the meat, bones and vegetables.

The First Food Ceremony is our largest garden event of the year with at least seventy participants ranging in age from our youngest Tribal citizens to our elders. During the Ceremony, a variety of activities take place, and individuals may participate in a variety of roles from assisting staff with harvesting, preparing the foods for cooking, cooking the meal, singing and drumming, speaking the names of our food in our language, and the act of gift giving. During the Ceremony we celebrate the beginning of our traditional seasonal calendar that includes only three seasons as we combine both fall and winter into a single season that begins in November. We provide samples of the major food groups and listen to the language speakers teach us the Klallam words for deer, duck, berry, water, crab, camas, and fish. Then we share the seasonal feast together and celebrate with songs.

The Tribe hosts multiple cooking classes, clam digs, seaweed and forest plant harvests throughout the year. There are a number of inter-Tribal events where we gather with our sister Tribes and learn about their ancient harvest and cooking practices like cooking pits for camas bulbs and using watertight bentwood boxes with hot stones to cook soup. Our staff learn these traditional practices and bring that knowledge back to our community to share with our citizens and community members.

These grants are essential for cultural preservation and because they play a significant role in helping us learn ancient methods and knowledge systems that are not known in western cultures. Holistic and traditional health and education systems touch our hearts and revitalize our soul in a deeper and more meaningful way than western systems due to our belief in the interconnectedness of body, mind, and spirit.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BRIAN SCHATZ TO HON. LONI GRENINGER

Question 1. Secretary Kennedy has taken steps to "overhaul" agencies across HHS—including those that serve Native communities. We heard from several witnesses that because many grants have been canceled and HHS regional offices abruptly closed, Tribes have been left without assistance in implementing critical programs, including those that support victims of domestic violence. Did HHS engage in consultation with Tribes regarding any of the changes that have been implemented, including its RIF or reorganization efforts?

Answer. There was no Tribal consultation on HHS reorganization efforts or decisions ahead of implementation. HHS has just scheduled a listening session on this topic on July 16–17, 2025, but a listening session is not the same as robust, Nation-to-Nation consultation with transparent information-sharing and engagement with Tribal leaders.

Question 2. Secretary Kennedy frequently touts that HHS exempted the Indian Health Service from the hiring freeze in place across the Federal government. However, not only is the exemption limited to only certain clinical positions, it is still in place across other HHS agencies that serve Native communities' health care needs. In addition, HHS has engaged in a series of staff layoffs, and additional Reductions in Force (RIFs) are looming. Your testimony stated that staffing uncertainties are crippling programs for children. How do efforts to reduce Federal staff affect services for Native children and families, and how will future reductions exacerbate these challenges?

Answer. Tribal Nations take seriously the program requirements and expectations that come with Federal programs, but they work to utilize available flexibility within Federal programs to create functional and responsive programs that work in their communities. In order for Tribal Nations to successfully balance the need to meet requirements, administrative and programmatic, that come with Federal funds and create effective programming, they rely on HHS staff to partner with them to discuss, design, and implement programs with Federal funding. This is particularly

true in child welfare and behavioral health services, where many Federal programs have limited recognition of Tribal needs or service delivery systems. The relationship between Federal agencies and Tribal Nations is an ongoing relationship with ongoing needs that require collaboration throughout the year. Tribal Nations invest significantly into developing positive and meaningful relationships with Federal staff, which in turn become more knowledgeable and helpful in helping Tribal Nations meet Federal requirements and develop effective programs. Most of this work occurs between Federal staff in the regional offices and Tribes in their region. Beginning in February with the prohibition of external communication in HHS, loss of Tribal staff within the Central Office in DC, and the closing of five regional HHS offices, hundreds of Tribes have been scrambling for months to complete and submit their Federal program reports and applications and make contact with Federal staff that can provide meaningful assistance to them. The impacts to Native children and families if Tribal Nations cannot submit their materials on time to ensure they will receive funding in the future are profound. For example, recipients of Title IV–B child and family services funding are required to submit certain reports by June 30 of each year, but due to the communications freeze, loss of staff, and regional office closures, many Tribes that are new to the program have not received sufficient technical assistance to complete the required reports. As a result, these Tribes are at risk of losing access to these vital child and family services funds in FY 2026. In addition, many Tribal Nations will have to lay off staff in sensitive program areas, like child welfare, and will have to make hard decisions about whether they can participate in state child welfare cases involving their member children and families. When Tribal Nations have to pull back from their work, states will also suffer, because they rely greatly on Tribal expertise and services to support Native children and families who are in state systems.

Question 3. For the first time ever, in FY23, IHS received advance appropriations following years of advocacy from Tribes and Tribal Organizations. An initial passback of the President's proposed FY26 Budget (the "skinny budget" threatened to end advance appropriations while decimating IHS funding by 30 percent compared to FY25.

a. Why is it important that the Federal government maintain advance appropriations for IHS?

b. If the President's proposed FY26 Budget is adopted, and funding cuts are implemented across HHS, what impacts should Indian Country brace for?

c. Could Tribes meet their communities' needs as proposed in the skinny budget?

Answer. Advance appropriations have been a truly life-changing improvement for our clinic and patients. It has allowed us to provide more consistent day-to-day care, as well as plan for a future expansion of our healthcare services. Without advance appropriations, we return to a time when shutdowns forced us into financial hardship. Across Indian Country, clinics would drastically reduce or discontinue services indefinitely, while our patients go without healthcare. This is inconsistent with the trust and treaty responsibility. It is a violation of Tribal sovereignty because we cannot fully exercise our Self-Governance if our funding is held back by unrelated political disputes in Washington, D.C. Simply put, the cuts proposed in the draft "skinny budget" would be devastating to our clinic and our patients who rely on us for consistent, high-quality healthcare. We would be forced to roll back essential services, and our patients would not have the same access to comprehensive healthcare services. Furthermore, this would force us into the impossible situation of determining which services must be pared back. In short, we would not be able to meet community needs if any cuts were enacted.

We were relieved to see that the final FY 2026 President's Budget Request did not propose widespread cuts to the IHS, but the proposed flat-funding of most accounts is still concerning to us. As you know, this is effectively a cut when you take increased patient needs and high medical inflation into account. This Indian health system is already so chronically underfunded, leading to Tribal communities being disproportionately impacted by obesity, diabetes, heart disease, cancer, substance use disorder, and other preventable conditions. In our communities, the life expectancy is ten years shorter than that of the rest of the United States. The trust and treaty obligation demands that we receive increases to our budget, not flat-funding or cuts.

We understand that this year, Congress is dealing with a tight budget environment. However, the trust and treaty obligation exist irrespective of the goal to limit Federal spending. In fact, the IHS budget remains so small in comparison to the Federal budget that cuts, rescissions, sequestrations, and freezes do not result in any meaningful savings in the national debt, but they do harm Tribal Nations and our citizens.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN RAY LUJÁN TO HON. LONI GRENINGER

Question 1. Despite Nationwide efforts to improve access to behavioral health services in Indian country, Native Americans still have one of the highest suicide rates in the country, can you talk about how Federal programs like Substance Use and Mental Health Services Administration (SAMHSA) has made an impact in addressing these disparities in Tribal communities? How will cuts to SAMHSA harm Tribal communities?

Answer. Federal funding for behavioral health services, particularly for Native children and youth services, has been extremely limited for many years. In addition, Tribal Nations have struggled to find Federal behavioral health funding that is flexible enough that Tribal traditional healing services can be supported. SAMHSA, while not having only a few programs that address the behavioral health needs of Native children and youth, has created a number of programs that have provided some of the first Federal funding for Tribes to plan for and implement traditional healing services in connection with more mainstream interventions to address historic and intergenerational trauma. The Circles of Care grants, Children's Mental Health Services grants, and Tribal Behavioral Health Programs (two programs, one focused on preventing youth suicide and other on addressing substance abuse) have provided Tribal funding that is child and youth specific and allows Tribal communities to utilize Tribal traditional healing methods. The combination of these grant programs has helped Tribal grantees establish greater stability and resources in an area where there have historically been few and raise the capacity to address mental health and substance abuse risks. These programs have been helpful in creating Tribal models in behavioral health that future Tribal grantees can draw upon in developing programs for their communities. Cuts to these programs and Federal staff that support Tribal grantees will extinguish much of the important work that Tribal Nations have done to decrease disparities and likely increase risk levels for suicide and substance abuse in affected communities.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. LISA MURKOWSKI TO LUCY R. SIMPSON

Question 1. As of 2022, there are 76 approved Tribal Temporary Assistance for Needy Families. (TANF) programs operating across the United States. These programs serve more than 285 federally recognized Tribes and Alaska Native villages, providing culturally tailored services that promote self-sufficiency and community wellbeing. What is the critical role of Tribal TANF programs in supporting the most vulnerable in your communities and how is the flexibility of Tribal TANF key in achieving self-sufficiency?

Answer. Tribal TANF programs not only address the immediate economic needs of low income families, many of which are survivors of violence, but also promote long-term self-sufficiency of these families. Due to the high rates of violence and lack of safe housing and economic opportunity in Indian Country, some families need help meeting their basic needs and many are faced with rebuilding their lives after escaping abuse. Tribal TANF allows Tribes to design and administer their own programs that reflect the unique needs of their communities. This flexibility has made TANF highly successful in providing services that are culturally relevant, trusted, and effective, making it an excellent example of Tribal self-determination and the federal government's trust and treaty obligation at work.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BRIAN SCHATZ TO LUCY R. SIMPSON

Question 1. Secretary Kennedy has taken steps to "overhaul" agencies across HHS—including those that serve Native communities. We heard from several witnesses that because many grants have been canceled and HHS regional offices abruptly closed, Tribes have been left without assistance with implementing critical programs, including those that support victims of domestic violence. Did HHS engage in consultation with Tribes regarding any of the changes that have been implemented, including its RIF or reorganization efforts?

Answer. No, the Department of Health and Human Services has not engaged in consultation with Tribes regarding any of the changes that have been implemented, including its Reductions in Force and reorganization efforts.

Question 2. Secretary Kennedy frequently touts that HHS exempted the Indian Health Service from the hiring freeze in place across the federal government. How-

ever, not only is the exemption limited to only certain clinical positions, it is still in place across other HHS agencies that serve Native communities' health care needs. In addition, HHS has engaged in a series of staff layoffs, and additional Reductions in Force (RIFs) are looming. Your testimony stated that staffing uncertainties are crippling programs for children. How do efforts to reduce federal staff affect Tribal services to support victims of domestic violence, and how will future reductions exacerbate these challenges?

Answer. The reductions in force (RIFs) issued by HHS have interrupted essential functions of sexual assault and domestic violence prevention efforts, threatened decades of improvements to our public health response to these issues, and risked the loss of vital institutional knowledge. Tribal programs rely on federal staff who have spent years cultivating trusted relationships with Tribal Nations, as well as developing their cultural competence, trauma-informed expertise, and a deep understanding of the complex realities Native communities face. Additional RIFs will cause a monumental loss of institutional knowledge concerning Tribes and Native victims and destabilize the work that has been done to make Native communities safer over the last four decades.

Changes to leadership within HHS have also created uncertainty for Tribal grantees due to the abrupt nature and lack of consultation and communication. Notably, Shawndell Dawson, Director of the Office of Family Violence Prevention and Services (OFVPS), was placed on administrative leave on March 31.

The OFVPS office, under Director Dawson's leadership, has been instrumental in recognizing the need for culturally grounded and Native-led programs for survivors of violence. Over 230 Tribes and Tribal DV programs receive Family Violence Prevention and Services Act (FVPSA) formula grants to provide emergency shelter and crisis intervention services. OFVPS, which administers FVPSA grants, also partners with Native-led organizations like NIWRC to help build the capacity of and provide training and technical assistance to Tribal grantees and advocates so Native communities can access long-term, specialized care. Director Dawson's abrupt placement on administrative leave was felt within the OFVPS office and down to individual Tribal grantees, causing deep uncertainty as they attempted to move forward in their work. The issuance of Non-Competing Continuations—the funding continuation for programs with multi-year grants or cooperative agreements—and new funding for grants that terminate at the end of this fiscal year have been significantly delayed, with little to no communication with the programs relying on this funding. Programs continue to face concerns about laying off staff or closing entirely if this funding is not received, which would have a disastrous impact on the number of resources available to victims in Indian Country.