National Indian Health Board

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AMERICAN INDIAN AND ALASKA NATIVE PUBLIC WITNESS DAY
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SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED AGENCIES
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Chairman Simpson, Ranking Member Pingree, and the distinguished members of this Subcommittee, thank you for the opportunity to provide testimony on Fiscal Year (FY) 2027 appropriations for the Indian Health Service (IHS). On behalf of the National Indian Health Board (NIHB) and the 575+ federally recognized American Indian and Alaska Native (AI/AN) Tribal Nations we serve, we appreciate this Subcommittee's longstanding commitment to improving health outcomes for AI/AN communities.

The United States maintains a fiduciary obligation to Tribal Nations' treaties, statutes, and the federal trust responsibility. Congress affirmed this duty through the Indian Health Care Improvement Act (IHCIA), declaring it the policy of the United States "to ensure the highest possible health status for Indians and to provide all resources necessary to effect that policy." [1]

Each year, the IHS National Tribal Budget Formulation Workgroup (NTBFW), through Tribal input from the twelve IHS Areas, develops the NTBFW Budget Book. The FY 2027 NTBFW Budget Book reflects Tribal priorities and outlines the resources necessary to fulfill the federal government's trust and treaty obligations. Despite this Subcommittee's partnership and progress in Tribal self-governance and Tribally-focused models of care, the Indian health system continues to face severe underfunding and Tribal communities continue to face persistent health disparities.

Congress established the IHS in 1955 to help fulfill the federal government's constitutional and treaty obligations to Tribal Nations. Today, health care for AI/AN communities is delivered through the Indian health system, a three-part network that includes IHS operated, Tribally-operated, and urban Indian organizations, collectively referred to as the "I/T/U system." These facilities deliver primary care, pharmacy, laboratory, and diagnostic services. When specialized services are unavailable within the IHS system, care is secured through the Purchased/Referred Care (PRC) program, allowing patients to receive specialty services from external providers.

FY 2027 Indian Health Service Budget

For FY 2027, the NIHB supports the request of the NTBFW for IHS in the amount of $73 billion for IHS, as a mandatory funded program. This includes full funding estimates for all services, facilities, and improvements needed to bring the Indian health system up to par with other federal health systems and the broader U.S. health care system. Top ranked priorities of the workgroup are Hospitals and Health Clinics ($18.49 billion), PRC program ($12.63 billion), Mental Health, the Indian Health Care Improvement Fund ($5.41 billion), and Alcohol and Substance Use ($4.24 billion). In Facilities, the workgroup prioritizes Health Care Facilities Construction ($2.54 billion), Maintenance and Improvement ($1.9 billion), and Sanitation Facilities Construction ($1.16 billion).[2] These investments are essential to ensuring Tribal communities have access to

[1] 25 U.S.C. § 1602
[2] The NTBFW's detailed request can be found here: legacy.nihb.org/resources/NIHB-FY26-Budget.pdf

safe facilities, adequate staffing, and modern health infrastructure.

Advance Appropriations

NIHB strongly supports the continuation and expansion of advance appropriations for the IHS and is grateful for this Subcommittee's work in protecting Indian health during the longest shutdown in American history. Advance appropriations allow IHS and Tribal health programs to receive funding one year in advance, providing the stability necessary for long-term planning and uninterrupted care delivery.

During the 43-day government shutdown in 2025, the IHS remained fully functional and responsive thanks to advance appropriations allowing clinics to stay open, employees receiving pay, and patients receiving care. These advance funds have directly allowed the I/T/U system to maintain services and critical programs which historically have been disrupted. During the 35-day federal shutdown in 2019, the IHS was the only federal healthcare delivery system without funding. While direct care services continued operating, providers did not receive pay, resulting in critical loss of positions and contracts.[3] In 2025, advance appropriations ensured this did not happen.

However, not every IHS account was protected, including the Facilities Construction, Sanitation Facilities Construction, the Indian Health Care Improvement Act Fund, Electronic Health Records, Contract Support Costs (CSC), and Section 105(l) lease payments. These combined accounts represent more than $1.3 billion of IHS' FY 2025 budget, including approximately $979 million for CSC and $349 million for 105(*l*) leases.[4] We urge Congress to continue providing IHS advance appropriations in FY 2027 and expand advance appropriations to all accounts within the IHS budget.

IHS Workforce

Workforce shortages remain one of the most urgent challenges facing the Indian health system. Many IHS facilities experience vacancy rates approaching over 30 percent, particularly in rural and remote Tribal communities. We appreciate the Administration's recent IHS hiring initiative, which recognizes the urgent need to strengthen the federal workforce supporting the Indian health system. Expanding recruitment and retention of staff across clinical and administrative positions will help ensure IHS facilities can meet the varying health needs of Tribal communities.

However, this monumental investment in workforce must be accompanied by funding from Congress. Addressing these shortages requires sustained investments in the Hospitals and Health Clinics account, which funds staffing packages and operational funding throughout the I/T/U system.

Strengthening the workforce must also extend beyond clinical positions. The Indian health system relies on a full array of professionals, including pharmacists, behavioral health specialists, engineers, information technology professionals, and administrative staff, who support the wholistic operation of hospitals, clinics, and public health programs.

Many direct service Tribes rely entirely on federal employees to deliver care within their

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

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

communities. These Tribal Nations exercise their sovereign right to receive services directly from the federal government under the trust responsibility. Ensuring that IHS can recruit and retain qualified personnel is therefore essential to honoring Tribal sovereignty and maintaining access to care for these communities.

Additionally, critical programs, such as the PRC program, depend on sufficient service units, Area Offices, and headquarters to manage referrals, coordinate specialty care, and process claims. Without these administrative and programmatic staff, access to specialty care is delayed and resources cannot be used efficiently.

Purchased/Referred Care

Congress established the PRC program to allow IHS and Tribally operated facilities to secure essential health care services from providers outside of the I/T/U system when such services, especially emergent and specialty care services, are unavailable within the Indian health care system. PRC funding has been essentially flat for years, not keeping pace with medical inflation, population growth, or increasing demand for specialty care. Without adequate funding, Tribal Nations are forced to absorb these costs, or worse, patients are forced to go without care. For the IHS Areas with few or no IHS-funded hospitals (PRC Dependent Areas),, specialty and tertiary care may be rationed because of a lack of financial resources. The consequences of rationing health care are devastating and unacceptable.

Facilities and Construction

The infrastructure needs across the Indian health system remain substantial. In fact, the IHS estimates that more than $26.5 billion is needed to address facility construction and modernization needs nationwide.[5]

Secretary Kennedy recently announced the U.S. Department of Health and Human Services (HHS) will reallocate $1 billion of unobligated HHS funding toward IHS facilities construction, specifically to address the 1993 facilities backlog list. This investment represents an important acknowledgment that modern health infrastructure is essential to delivering quality care and improving health outcomes for Tribal communities.

However, the magnitude of the need exceeds current funding levels. For FY 2027, Tribal Nations recommend $2.54 billion for health care facilities construction, along with continued investments in Facilities Maintenance and Improvement and Sanitation Facilities Construction. Investing in modern healthcare facilities is a long-term cost-saving measure for the federal government. Many IHS facilities are operating well beyond their intended lifespan, requiring frequent emergency repairs and increasingly expensive maintenance simply to remain operational. The Administration is prepared to tackle the backlog, we now need your continued commitment to bring IHS facilities into the 21st Century.

EHR Modernization

The NIHB requests $686.43 million to fully fund the modernization of Health Information Technology at the Indian Health Service through the Electronic Health Records (EHR) line item. For more than forty years, the IHS has relied on the Resource and Patient Management (RPMS), a legacy system identified by the Government Accountability Office (GAO) as one of the ten most critical systems in need of modernization[6] and older than any other currently in use across

[5] Indian Health Service. The 2021 Indian Health Service and Tribal Health Care Facilities Needs Assessment Report to Congress. December 2020. Page 1.

[6] GAO-21-524T, INFORMATION TECHNOLOGY: Agencies Need to Develop and Implement Modernization

the United States.

A modernized EHR is essential for improving patient care, data, and care coordination across the Indian health system. Modern health information technology is the backbone of efficient health care delivery. Implementing a new EHR will allow IHS hospitals and clinics to operate as a fully integrated health system, improving patient safety, information sharing, and enhancing continuity of care across Indian Country.

CSCs and 105(l)

Funding for line items like EHR has repeatedly fallen short because discretionary increases in the IHS budget are increasingly addressing rising CSC and 105(l) costs, which are legally obligated to be covered. Congress provides "such sums as may be necessary" to meet these obligations but does not account for them as mandatory spending in the budget.

However, the mandatory nature and rapid growth of these obligations means that they must be paid before other discretionary investments within the IHS budget. As a result, when overall increases to the IHS budget are limited by 302(b) allocations, much of the available funding is absorbed by CSC and 105(l) obligations. This dynamic is increasingly constraining investments in other critical priorities.

Realignment

It is widely recognized that there are structural challenges within the current IHS system, and thoughtful reforms could help improve care delivery and strengthen the IHS' capacity to support Tribal Nations. One solution proposed by IHS is realignment. If implemented thoughtfully and with the consensus of Indian Country, realignment could represent an important opportunity to strengthen the agency, improve direct service delivery, and expand IHS's ability to support Tribal Nations that choose to exercise their inherent right to assume operation of their health care systems under self-governance authorities. But it is essential this process takes place methodically and transparently, clarifies how every step improves outcomes, and is developed in meaningful and timely consultation with Tribal Nations.

Because realignment will shape how the agency delivers care and utilizes federal funding, continued congressional oversight is essential to ensure the process reflects Tribal priorities and strengthens the Indian health system. While elements of the proposal reflect ideas long raised by Tribal leaders, there remain areas that require consensus.

Conclusion

The Indian health system remains significantly underfunded compared to the federal government's trust and treaty obligations to Tribal Nations. Yet, Tribal Nations continue to lead innovative, culturally grounded health systems that improve health outcomes for their communities. Sustained investment in the IHS is essential to strengthening care delivery, modernizing health infrastructure, and ensuring that Tribal communities have access to the high-quality health care they deserve.

NIHB looks forward to continued work together with members of this Subcommittee to strengthen the Indian health system and ensure that the federal government fully meets its trust and treaty responsibilities.

Plans for Critical Legacy Systems https://www.gao.gov/assets/gao-21-524t.pdf