**Seattle Indian Health Board**
*For the Love of Native People*
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Testimony of Esther Lucero, MPP
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House Committee on Appropriations – Subcommittee on Interior, Environment, and Related Agencies
Agency: Indian Health Service
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Chair Simpson, Ranking Member Pingree, and members of the House Committee on Appropriations – Subcommittee on Interior, Environment, and Related Agencies, my name is Esther Lucero. I am Diné, of Latino descent, the third generation in my family to be living outside of our reservation, and I strongly identify as an urban Indian. I serve 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 designed to serve the health needs of the 76% of American Indian and Alaska Native (AI/AN) people residing in urban areas.[1] 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 Council. I have had the privilege of serving SIHB for nine years. I am honored to have the opportunity to submit my testimony today.

**Uphold Tribal Sovereignty**

As the President & CEO of an organization, I recognize the value of efficiency in operating systems, and each year I have provided testimony to demonstrate how much SIHB has been able to achieve with so few resources. This only occurs with effective and efficient operating systems. Each year we have also discussed that the IHS system has always been grossly underfunded and in the more recent years we have made some progress to reconcile this issue (with a 10.59% increase from FY24 to FY25 passed by the Appropriations Committee), which I am grateful for. This year, I respectfully request this subcommittee to make the Indian Health Service System whole, to ensure that the Tribes and UIOs have resources necessary to provide vital health and human services for AI/AN people regardless of where they live. I often provide a gentle reminder of congress's fiduciary obligation to uphold the agreements defined by treaties, legislation and statute, which includes health care. This year, it will be important for congress to exercise its plenary authority to protect and uphold tribal sovereignty. It will require tireless education to help the new administration understand that while there is a desire to cut costs, tribal systems are prepaid benefits resulting from the cessation of land. It will also require strength from this committee and a unified voice to uphold the commitments you all have made to make decisions in the best interest of our people.

[1] U.S. Census Bureau. (2021). County Population by Characteristics: 2010-2020. Retrieved from: https://www.census.gov/programs-surveys/popest/technical-documentation/research/evaluation-estimates/2020-evaluation-estimates/2010s-county-detail.html

I respectfully ask you to continue our work to increase the overall IHS budget to $63 billion, and the Urban Indian Health line item $770.53 million.

**Traditional Health Services Reimbursement**

We are proud to share that our Indigenous Knowledge Informed System of Care (IndigiKnow) model has been fully instituted and that we now have a Traditional Indian Medicine Apprentice on every care team, employ 3 Traditional Medicine Practitioners, and have over 30 more on contract. This allows us to provide access to a diverse array of tribal specific healers. SIHB's traditional health services continue to provide promising outcomes. Between December 2021 and October 2024 we served 1502 relatives (patients), with 2915 encounters captured in our electronic health record system. We have worked in partnership with the Community Health Plan of Washington, a managed care organization, to develop a billing system which we tested this year. We have also developed a privileging/credentialing process that meets the western system's needs and remains culturally respectful for tribal communities. To my knowledge it is the only system of its kind. There were significant, promising results in the evaluation for this timeframe, the two most prominent of which were related to suicide risk and depression. 172 relatives were screened and identified at high-risk for suicide. After receiving traditional health services, we saw high-risk status decreasing by 71%. Of 212 relatives screened for depression severity, those with moderate severity saw a significant 22% reduction in severity. These outcomes are important because, according to the Centers for Disease Control and Prevention in a report released in July 2024, the Economic cost of U.S. suicide and Nonfatal Self-harm averaged $510 billion annually.[2] If cost reduction and efficiency is the goal, specifically in overburdened hospital systems, you can clearly see how a small investment in traditional health could not only improve the health outcomes for AI/AN people but also makes economic sense.

We have been pleased to see that 4 states were approved to pursue billing for traditional health services: Arizona, California, Oregon and New Mexico. We were not pleased to see the exclusion of UIOs in one of those demonstration projects. I urge this subcommittee to keep the IHS system of care intact, to be inclusive of the UIOs in any demonstration projects moving forward. I am also encouraging CMS to mandate the participation of MCOs, as many AI/AN beneficiaries receive coverage through an MCO. To keep moving forward on these issues, SIHB has been working on the White House National Science and Technology Subcommittee on Traditional Medicine and we are providing guidance for the integration through EHR systems. We also presented at the Traditional Medicine Summit hosted by the Department of Health and Human Services in November, and recently provided testimony to our state legislature to advocate for an amendment to Washington's 1115 waiver and to strongly advocate for the inclusion of UIOs.

[2] American Journal of Preventive Medicine. (2024). Economic cost of U.S. Suicide and Nonfatal Self-Harm. Retrieved from: Economic Cost of U.S. Suicide and Nonfatal Self-harm - American Journal of Preventive Medicine

**100% Federal Medical Assistance Percentage (FMAP) for Urban Indian Organizations**

To achieve health care parity, I urge this subcommittee to work towards permanently authorizing 100% FMAP for UIOs. 100% FMAP generates cost-savings for states and incentivizes them to work with high-cost populations. With efforts to supplement IHS with Medicaid, UIO eligibility for 100% FMAP can only help us achieve our mutual goal to make the IHS whole. It is important to note that states can reinvest the savings at their discretion. In some states, it would provide the revenue to support UIOs to receive reimbursement for Traditional health services.

**Workforce Development**

SIHB is proud to actively contribute to addressing the well understood healthcare workforce challenges. We operate 29 different workforce development programs, including our primary care residency, clinical social workers and substance use professionals. Our programs offer opportunities starting in high school and through medical school, including one-on-one time with providers, dedicated training space, mentorship opportunities and a fully integrated cultural experience. SIHB's programs have all been successful, making us a place where everyone, regardless of their education level, can fulfill their professional development goals within the health care field, but they are almost entirely self-funded. With the new threats to federal funding, it will likely be impossible to sustain these programs. I urge the members of this subcommittee to allocate workforce funding within the IHS system to sustain and establish training programs like ours. Your return on investment will be significant.

A budget neutral approach to addressing workforce challenges would be to have Congress authorize IHS to implement a system to offer cross-state credentialing for providers. This administrative solution was modeled and proven successful within the Veterans Affairs Department during the COVID-19 pandemic[3] and would increase access to substance use disorder (SUD) treatment professionals.

**Behavioral Health Services**

In Washington, SIHB continues to be a leader in behavioral health, and we are working to open our Thunderbird Treatment Center (TTC), which has 92 beds including 15 beds dedicated to serving pregnant and parenting people. TTC will increase King County's residential treatment capacity by 62%. The special services for parents where they will be able to bring up to two children with them (under the age of 5) will ensure SUD treatment does not perpetuate the dangerous cycle of children being removed from their homes and over burdening the foster care system. In the state of Washington, AI/AN are 1.9% of the overall population but represent 25% of the foster care system. Residential treatment services are critical as mental health conditions, including deaths by suicide and overdose or poisoning related to SUD, was the leading underlying cause

[3] Veterans Affairs Department. (2020). Authority of VA Professionals to Practice Health Care. Federal Register. Retrieved from: https://www.federalregister.gov/documents/2020/11/12/2020-24817/authority-of-va-professionals-to-practice-health-care

of pregnancy related death among AI/AN people in 36 states from 2017-2019,[4] and the fentanyl crisis may exacerbate adverse maternal and infant health outcomes among AI/AN people.

Additionally, if there is a true desire to address the intersection of homelessness, mental health disorders, and substance use, you must provide resources for residential treatment programs as this is a critical element of the continuum of care that has been neglected, resulting in an increase in citizens struggling with addiction in the streets of major cities and rural areas across the nation.

I appreciate your time and partnership this year and in every year into the future.

Sincerely,

Esther Lucero (Dine'/Latina), MPP
President & CEO

[4] Trost, S., Beauregard, J., Chandra, G., Njie, F., Harvey, A., Berry, J., and Goodman, D. Centers for Disease Control and Prevention. (2022). Pregnancy Related Deaths Among American Indian and Alaska Native Persons: Data from Maternal Mortality Review Committees in 36 States from 2017-2019. Retrieved from: Pregnancy-Related Deaths Among American Indian or Alaska Native Women: Data From Maternal Mortality Review Committees in 36 U.S. States, 2017–2019 | Maternal Mortality Prevention | CDC