Northwest Portland Area Indian Health Board

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Testimony of Chairman Greg Abrahamson
Vice Chair of the Northwest Portland Area Indian Health Board
Before
House Appropriations Subcommittee on Interior, Environment, and Related Agencies
American Indian and Alaska Native Public Witness Hearing - FY 2026
February 27, 2025

Chair Simpson and Ranking Member Pingree, and Members of the Subcommittee. My name is Greg Abrahamson, and I serve as Chair of the Spokane Tribal Business Council, Vice Chair of the Northwest Portland Area Indian Health Board, Chair of the Direct Service Tribal Advisory Committee (DSTAC), and DSTAC Representative to the IHS National Tribal Budget Formulation Workgroup.

I provide the following testimony in my role as Vice Chair of the Northwest Portland Area Indian Health Board (NPAIHB). I thank the Subcommittee for the opportunity to provide testimony on the FY 2026 Indian Health Service (IHS) budget.

NPAIHB was established in 1972 and is a Tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638. NPAIHB provides support to the 43 federally-recognized Indians in Idaho, Oregon, and Washington on specific health care issues. The Board's mission is to eliminate health disparities and improve the quality of life for American Indians/Alaska Natives by supporting Portland Area Tribes in the delivery of high-quality health care. "Wellness for the seventh generation" is the Board's vision. This Subcommittee is critical to making this a reality.

For FY 2026, NPAIHB requests that this Subcommittee base its decisions on Indian Health Service funding through the lens of Tribal sovereignty, the Trust Responsibility, Treaty Obligations, Tribal Self-Determination, and Tribal Self-Governance.

Honor Tribal Sovereignty. Tribal sovereignty predates the formation of the United States[1] and is acknowledged in the U.S. Constitution. Respect for Tribal sovereignty, and a commitment to maintaining a government-to-government relationship with Tribal Nations has been supported by this Subcommittee.

As recognized by the Supreme Court, Tribal Nations are distinct political bodies with the inherent right to regulate their internal affairs according to their laws and customs, which includes addressing the health and well-being of their people. The Supreme Court upholds Indian-specific legislation, recognizing the political status of Tribes rather than a racial classification.[2]

Honor Trust Responsibility and Treaty Obligations. The Trust responsibility has been defined in numerous Supreme Court cases, Executive Orders, Statutes, Regulations and other policies. According to this doctrine, the United States has legal, moral and ethical obligations to Tribal Nations. Treaties are the contractual obligations of the United States to Tribal Nations and require the United States to provide healthcare to American Indians/Alaska Natives, among other agreements.

[1] *Worcester v. Georgia,* 31 U.S. 515, 581 (1832).
[2] *Morton v. Mancari*, 417 U.S. 535, 555 (1974); *see also Moe v. Confederated Salish & Kootenai Tribes of Flathead Reservation*, 425 U.S. 463, 479–80 (1976); *Washington v. Washington State Commercial Passenger Fishing Vessel Ass'n*, 443 U.S. 658, 673 n.20 (1979); *United States v. Antelope*, 430 U.S. 641, 645–47 (1977); *Am. Fed'n of Gov't Employees, AFL-CIO v. United States*, 330 F.3d 513, 520-21 (D.C. Cir. 2003).

Protect and Expand Tribal Self-Determination and Tribal Self-Governance. Portland Area Tribes support Tribal self-determination and Tribal self-governance Tribal self-governance, through the Indian Self-Determination Education Assistance Act (ISDEAA), has provided Tribes with the flexibility to tailor health care services to the meet the needs of their people and communities. Since ISDEAA was first enacted, numerous Tribes have entered compacts and contracts with the Indian Health Service. In Portland Area, there are thirteen Title 1 Tribes (contracts) and 25 Title V Tribes (compacts).

Portland Area Tribes have requested repeatedly that Tribes be given an option to receive grant funding through their Compact or Contract. Some of these grants include, the Special Diabetes Program for Indians, Behavioral Health Initiatives, opioid funding, etc., Moving this funding to a Tribe's compact or contract will streamline funding and allow Tribes the flexibility to maximize funding while reducing the administrative burden of grant requirements. We request that this Subcommittee direct the Indian Health Service to consult with Tribes on this broader systemic change.

Protect Direct Service Tribes Nations from Harm. While many Tribal Nations have moved to ISDEAA compacts or contract to operate programs, functions, services and activities, many Tribal Nations continue to rely on the Indian Health Service to provide health care to their people. Unfortunately, there has been a 30% vacancy rate at IHS-operated facilities. Long-standing vacancy rates compounded by recent Administrative Actions, such as, hiring freezes, reductions in workforce, including layoffs, destabilize services to many Direct Services Tribes. Because of the hiring freeze, one Tribe in the Portland Area has been unable to hire a Janitor for their Indian Health Service facility. This is unconscionable. While the layoffs of Indian Health Service employees were rescinded on February 15 by the new Department of Health and Human Services Secretary, other Administrative Actions related to the Federal workforce reductions must exempt the Indian Health Service.

Continue Meaningful Tribal Consultation. The Federal government must honor Tribal sovereignty and engage in meaningful Tribal consultation on all initiatives impacting the Indian Health Service and American Indian/Alaska Native people.

Protect Medicaid -- It Protects Funding for IHS and Tribally-Operated Facilities. Exempt the Indian Health Service, Tribes and Tribal Organizations from any funding decreases being proposed for HHS in budget resolutions and/or budget reconciliation processes. IHS-operated facilities and Tribally-operated facilities rely heavily on Medicaid. Medicaid makes up 30-40% of funding that the Indian Health Service falls short on every year in annual appropriations. Portland Area Tribes request protection of 100% FMAP for services to American Indians/Alaska Natives received through IHS and Tribally-operated facilities. Retaining 100% FMAP keeps the Trust responsibility with the Federal government. Portland Area Tribes also request exemption from per cap capita or block grants being proposed and Medicaid work requirements.

NPAIHB's Recommendations for FY 2026

For FY 2026 IHS funding, NPAIHB makes the following recommendations:

Protect Funding to IHS and AI/AN people. The Indian Health Service has continually been significantly underfunded. In FY 2024, the Indian Health Service was funding at $6.9 billion when the actual need was identified as $53.8 billion by the IHS National Tribal Budget

Formulation Workgroup.[3,4] This has resulted in poor health and significant health disparities among American Indian/Alaska Native people. Given this significant shortfall in funding, IHS funding for IHS-operated facilities and Tribally-operated facilities must not be reduced in FY 2026. Continuing Resolutions in FY 2025, with level funding, result in decreases for much of Indian Health Service when medical inflation or population growth are not included. Moreover, the rising costs of 105(l) Leases and Contract Support Costs (CSC) continue to decrease programmatic and facilities funding.

Full Funding for IHS. The National Tribal Budget Formulation Workgroup recommended, and Portland Area Tribes support, the request of $55.9 billion to fully fund the IHS in FY 2026.[5]

Expand Advance Appropriations to All IHS Accounts. Continue and expand advance appropriations for the Indian Health Service to every account in the budget. There must also be increases to adjust for medical inflation, population growth and program increases.

Mandatory Funding for IHS. Portland Area Tribes requests support from this Subcommittee to work with Tribal Nations on moving Indian Health Service funding from discretionary to mandatory funding through Tribal consultation. We also request that Contract Support Costs (CSC) and ISDEAA 105(l) Lease funding be moved from discretionary to mandatory before other IHS subaccounts be considered. While we appreciate the Subcommittee's support in securing an indefinite appropriation for 105(l) lease agreements and CSC, we request that this Subcommittee commit to moving 105(l) leases and CSC to mandatory appropriations accounts to ensure that these appropriations are funded year after year without impacting programmatic increases to IHS-operated facilities and Tribally-operated facilities. Portland Area Tribes are experiencing decreases in funding annually due to the rising annual cost of 105(l) leases and CSC.

Increase Funding for Purchased and Referred Care (PRC). Every year Portland Area Tribes set Purchased and Referred Care (PRC) as the top priority for Indian Health Service funding in the budget formulation process. Portland Area Tribes purchase all specialty and inpatient care because there is no Indian Health Service or Tribal 638 hospital in the Portland Area. The PRC program makes up over one-third of the Portland Area Indian Health Service budget. From FY 2023 to FY 2024, there was no increase to PRC. No increase to PRC is a decrease in funding to Portland Area Tribes because of medical inflation and population growth. Level funding means that Portland Area Tribes are forced to cut access to specialty care and inpatient care because they cannot stretch PRC dollars to meet increased needs. Areas with IHS hospitals can absorb these costs more easily because of their infrastructure and large staffing packages.

Nationally, PRC is also the second rated priority of the National Tribal Budget Formulation Workgroup. Year to year it receives zero to a nominal increases. In FY 2026, we request that this Subcommittee honor the request of the National Tribal Budget Formulation Committee and fund PRC at $10.2 billion or ensure that it is the second highest funded priority in IHS appropriations for FY 2026 by this Subcommittee.

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[3] National Tribal Budget Formulation Workgroup Recommendation. *Indian Health Service Fiscal Year 2026 Budget*. 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 .(Last visited Feb 18, 2025).

[4] Indian Health Service. Indian Health Service Operating Plan for FY 2024. Accessed January 30, 2025.

[5] National Tribal Budget Formulation Workgroup Recommendation. *Indian Health Service Fiscal Year 2025 Budget*. Honor Trust and Treaty Obligations: A Tribal Budget Request to Address Tribal Health Inequity Crisis. (Last visited Feb 18, 2025).

Increase Funding for Alcohol and Substance Use, including Prevention Services.

In August 2023, the NPAIHB organized a National Tribal Opioid Summit that convened over 1,000 Tribal leaders, providers, community member, including Federal and State officials, to discuss opioid prevention, care and treatment, data, and law and justice policy priorities in Tribal communities. Several priorities for Portland Area Tribes were identified through the Summit for IHS Alcohol and Substance Use subaccount.

Portland Area Tribes have long recognized how deeply opioid and substance use disorders impact their Tribal communities and the healing that can occur when our relatives receive effective treatment and support on their recovery journeys. Indian Health Service Alcohol and Substance Use funding is used to provide a comprehensive array of preventive, educational, and treatment services that are community-driven and Tribally-specific. These collaborative activities strive to integrate substance use treatment into primary care. However, not enough funding has been allocated to this subaccount to allow IHS and Tribally-operated facilities to fully address the need.

In addition, more funding must be focused on substance use prevention services. Prevention is the key to reducing substance use and treatment services over time. Focusing on creating healthy children and youth has shown to be successful in Iceland. The Iceland Prevention Model is a long-term prevention model that has been proven to reduce substance use among Icelandic youth. Several Washington Tribes are currently implementing this model so funding must be available to support upstream prevention efforts.

For FY 2026, the IHS Tribal Budget Formulation Workgroup recommends $4 billion for Alcohol & Substance Use subaccount.

Increase Funding for Mental Health In our Area and nationwide, there are high rates of depression and anxiety in our communities. Portland Area Tribes need funding to address mental health provider shortages and expand services. NPAIHB is particularly concerned about American Indian/Alaska Native youth with suicide being the second leading cause of death of Native adolescents and young adults. For FY 2026, the IHS Tribal Budget Formulation Workgroup recommends $4.8 billion for the Mental Health subaccount.

Fund Expansion of Community Health Aide Program. NPAIHB has successfully established a Community Health Aide Program (CHAP) in the Portland IHS Area. CHAP is one of the solutions to addressing workforce shortages at IHS and Tribal facilities. However, stable funding is necessary to ensure that the programs are accessible to our students and can best meet the health care needs of the Tribes they will serve. For FY 2026, we request $60 million for continuation of the national expansion with $10 million for Portland Area to continue to expand CHAP.

Increase Small Ambulatory Program and Joint Venture Construction Program Funding. For FY 2026, Portland Area Tribes recommend continuation of vital resources for the Small Ambulatory Program (SAP) and recommend expansion of the Joint Venture Construction Program (JVCP) with funding for staffing and equipment.

Thank you for this opportunity to provide recommendations on the Indian Health Service budget. I invite you to visit IHS, tribal health programs, and urban Indian organizations in the Northwest to learn more about the utilization of IHS funding and the health care needs in our Area. I look forward to working with the Subcommittee on our requests.[6]

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[6] For more information, please contact Laura Platero, NPAIHB, at lplatero@npaihb.org or (503) 416-3277.