

Testimony of Esther Lucero, MPP (Diné)
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House Committee on Appropriations
Subcommittee on Interior, Environment, and Related Agencies
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Chairman 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 and of Latino descent. As part of the third generation in my family living outside of our reservation, I strongly identify as an urban Indian. I serve as the President & CEO of the Seattle Indian Health Board (SIHB), one of 41 Urban Indian Organizations (UIOs) nationwide designed to serve the health needs of the 76% of American Indian and Alaska Native (AI/AN) people residing in urban areas. I have had the privilege of serving as CEO of SIHB for ten years; additionally, I am 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 am honored to have the opportunity to submit my testimony today, including a request of \$1,152,520,000 for the Indian Health Service's Urban Indian Health line item.***

I have testified before this Subcommittee in eight of these hearings. Each year, I share my concerns about the chronic, gross underfunding of the IHS system. Last year, we were grateful for this committee's commitment to not go backwards, instead maintaining funding for the Indian healthcare system despite widespread budget cuts. As you enter another difficult budget cycle, I respectfully request that the subcommittee partner with us to expand funding so that we are adequately resourced to provide crucial, culturally attuned services for AI/AN people, wherever they live. It is important to underscore that health care for AI/AN is a prepaid benefit. The federal government established this fiduciary obligation through hundreds of ratified treaties; it is a trust and treaty obligation. I appreciate the resources you have invested into the Indian health care system in the past, and I ask you today to remain strong in these commitments. ***I urge the subcommittee to protect IHS by continuing advanced appropriations funding, and by moving IHS funding from discretionary to mandatory appropriations.***

Allow me to highlight what SIHB has achieved with so few resources. Our innovative initiatives demonstrate the resilience of the Indian health care system in the face of limited funding, and provide a preview of what we are capable of when properly resourced. I will also highlight opportunities for us to partner further with this subcommittee.

Behavioral Health & Thunderbird Treatment Center: We are proud to announce that on July 11th, we will hold the Grand Opening for the new site of our residential substance use disorder program, Thunderbird Treatment Center (TTC). This incredible project was made possible in part by the temporary extension of the Federal Medicaid Assistance Percentage (FMAP) for UIOs under the American Rescue Plan (2021). Through this two-year pilot, TTC received \$11



million, the project's principal funding source. We are grateful for the significant investment that the Appropriations Committee and this subcommittee made into the Indian health care system during this time, and we are proud of the investments that we made with this funding.

This facility will vastly enhance our ability to provide culturally-attuned mental health and substance use services to the AI/AN community in our region. With 92 new beds, we will increase King County's residential treatment capacity by 62%. This expansion is critical given the intersections of mental health, substance use, and homelessness. Additionally, 15 of our beds are reserved for pregnant and parenting people, in an effort to keep families together through their healing. Each parent can bring up to two children under the age of five to join them for the duration of the program. Through this strategy, we are combating the dangerous cycle in which seeking care leads to family separation and overburdens the foster care system. In the state of Washington, AI/AN are significantly overrepresented in the foster care system.¹

SIHB continues to be a leader in behavioral health, and your continued investment in our work aligns with this administration's stated priorities to address mental health and substance use.

Challenges remain to expanding inpatient services like ours. Currently, many federal funding opportunities focus disproportionately on outpatient services alone, and we continue to see a great need for additional support for programs that address the full continuum of care, including inpatient facilities, sober beds, transitional housing, and detox facilities. Additionally, Medicaid reimbursement rates rarely cover the full cost of residential care.

- *I ask that this subcommittee ensure that IHS disburse behavioral health funding specifically focused on inpatient programs.*
- *To protect and expand access to residential treatment for the AI/AN communities of Washington, I request additional support for operating costs, which would allow us to stabilize operations and reach sustainable occupancy.*

Traditional Indian Medicine: At SIHB, Traditional Indian Medicine (TIM) is the foundation of our Indigenous Knowledge Informed Systems of Care, the framework shaping every program we deliver. We believe TIM addresses cultural and service gaps that exist in other care systems. In 2021, we launched the nation's first TIM Reimbursement Pilot, creating an innovative billing, coding, and credentialing system that honors sacred knowledge while meeting Western clinical standards. We were guided throughout by our Advisory Council of 44 traditional practitioners. With three WA managed care organizations, we tested the TIM billing codes we modeled on CPT codes. Between 2021 and 2024, our Traditional Practitioners and Apprentices provided 2,915 encounters, including smudging, traditional medicines, counseling, and cultural classes.

I am excited to tell you about our promising results. During this period, 172 relatives identified

¹ Washington State Department of Children, Youth & Families, "Tribal Foster Care," accessed March 11, 2026, <https://dcyf.wa.gov/tribal-relations/tribal-foster-care>

as high-risk for suicide received TIM services; after care, high-risk status decreased by 71%. Of 212 relatives screened for depression severity, those with moderate severity saw a significant 22% reduction in severity. These results highlight TIM's potential not only to improve mental health for AI/AN people, but also to reduce emergency department utilization and lower costs in overburdened hospital systems.

We are pleased that 4 states have utilized Medicaid 1115 waivers to secure reimbursement for TIM. However, it has been a battle to ensure that UIOs are included in states' 1115 waiver. Washington current draft 1115 waiver excludes UIOs on the grounds that we do not receive 100% FMAP. This omission disregards SIHB's leadership as the first to develop and implement a TIM billing system. Nevertheless, we continue to advocate for TIM implementation and provide national leadership through presentations to DHHS, testimony to the state legislature, and technical assistance to partners across the country. We would like to extend a special thank you to Representative Ellzey for championing access to TIM, and to the American Indian Health Commission for supporting UIO inclusion in TIM reimbursement.

- *In keeping with this subcommittee's charge to keep the IHS system of care intact, I urge you to advocate for the inclusion of UIOs in 115 demonstrations.*
- *I reiterate the importance of extending 100% FMAP to UIOs, so programs like this can be sustainably reimbursed.*

Workforce Development: SIHB continues to invest in addressing the severe shortage of healthcare workers in Indian country and beyond. Currently, we operate 32 workforce development programs, spanning from shadowing experiences for high schoolers, to social work practica, to a medical residency program in family medicine. A central aim of these programs is to increase the supply of providers dedicating their careers to serving AI/AN communities, and we are succeeding. For example, in our family medicine residency program, over 50% of participants stay in Indian country; 75% continue working in "underserved" communities.

Currently, federal funding offers insufficient support for workforce development, resulting in the shortchanging of the relatives we serve, and the overburdening of those providers we do have.

- *I urge the members of this subcommittee to direct additional IHS funding toward workforce development.*
- *I also ask you to advocate for the inclusion of UIOs in all federal workforce funding opportunities, including by amending the Indian Health Care Improvement Act, Sec. 111 to include us as eligible participants in the IHS Community Health Aide Program.*

Housing: We continue our work to address housing insecurity, a key determinant of health for our relatives. AI/AN people experience housing insecurity at higher rates than any other race or ethnicity in King County, Washington. Among the elders who visit our clinic, 40% report that they are unhoused.

Our programs span the housing continuum, from rent support and financial assistance, referrals

to housing programs and wraparound services, to rapid rehousing. I would like to reiterate the importance of all components of the spectrum of housing programming; each type is a crucial piece to the puzzle of addressing housing disparities for AI/AN individuals and families. I have already spoken to you today about how inpatient SUD treatment beds, such as those we have at Thunderbird, also fill an important gap in this broader strategy. Recognizing that housing support systems for our communities remain inadequate, we plan to build new housing units to support programming through Medicare's Program for All-Inclusive Care for the Elderly. This is just one component of our planned clinic redesign, which will also include expansion of specialty services, including dental and physical therapy services.

- *I ask that this subcommittee ensure that IHS funding opportunities support culturally attuned inpatient facilities, sober beds, transitional housing, and detoxification facilities.*

Infrastructure: We thank the committee for its attention to improving the physical infrastructure of the Indian health care system. As described throughout this testimony, we have strategically directed resources to invest in infrastructure that enables the delivery of our critical services and programs.

As Congress considers how to improve the physical infrastructure of the Indian health care system, we would like to see consideration for the fact that UIOs need these same updates. While we are in full support of 105(l) leases in IHS funding, UIOs are not currently eligible.

- *I ask that IHS infrastructure funding opportunities include UIOs as eligible entities.*
- *I ask that IHS appropriations increase proportionally to 105(l) leases, to ensure that other line items like the UIO line item are not decreased.*

Healthcare Parity: I will close by once again urging this subcommittee to support our work towards permanently authorizing 100% Federal Medicaid Assistance Percentage (FMAP) for UIOs. Securing health care parity into the future would supplement IHS's limited resources, enabling projects like the ones that I have shared with you today. Moreover, it will enable your states to reinvest these cost savings.

- *While I recognize that this committee does not hold direct jurisdiction over shaping FMAP rates, I ask you to use your voice and influence to help us achieve our shared goal of strengthening the Indian health care system through the addition of these resources.*

Thank you for your consideration of these requests, and for your continued partnership. I appreciate this subcommittee's commitment to honoring federal trust and treaty obligations to provide healthcare services to AI/AN people. I look forward to our work together in this year and the years to come.