Northern Valley Indian Health

YOUR HEALTH. OUR MISSION.

Testimony of Inder Wadhwa, CEO, Northern Valley Indian Health
"House of Representatives American Indian and Alaska Native Public Witness Hearings"
House Appropriations Subcommittee on Interior, Environment, and Related Agencies
February 25-26, 2025

Recommendations:

1. Protect the IHS from cuts, rescissions, sequestrations, and freezes.
2. Ensure mandatory funding for contract support costs and section 105(*l*) lease payments.
3. Reduce dependence on competitive grants for Indian Country.
4. Restore critical infrastructure investments for the Indian health system.
5. Address staffing shortages through adequate funding.
6. Increase funding and extend self-governance to the Special Diabetes Program for Indians.
7. Increase funding for behavioral and mental health programs.

Introduction: Thank you, Chairman Simpson, Ranking Member Pingree, and Members of the Subcommittee for the opportunity to share our funding priorities for the FY 2026 federal budget. My name is Inder Wadhwa and I serve as the Chief Executive Officer of Northern Valley Indian Health. Founded in 1971 by a group of American Indians seeking to reestablish Tribal health services in north-central California, Northern Valley Indian Health offers high-quality medical, dental, and pediatric services for Tribal members and the general public alike. We are a private, nonprofit Tribal corporation with clinics in Butte, Glenn, Colusa, Tehama and Yolo counties. Our leadership consists of four consortium Tribes—Grindstone Indian Rancheria, Kletsel Dehe Wintun Nation, Mechoopda Indian Tribe of Chico Rancheria, and Yocha Dehe Wintun Nation.

We would like to thank this Subcommittee for its recent, historic investments in the Indian health system. We are also grateful for your bipartisan effort to protect the IHS from cuts during the most recent fiscal years. To build off these victories, we urge you to remember that the trust and treaty responsibility to provide for the health and well-being of Tribal Nations exists irrespective of Congress' separate goal to balance the budget. This Subcommittee must appropriate the amounts necessary to fulfill its obligations. To that end, I offer the following recommendations for your consideration for FY 2026 appropriations for the IHS.

Permanently Exempt the IHS from Cuts, Sequestrations, Rescissions, and Funding Freezes: The IHS and its Tribal partners under the Indian Self-Determination and Education Assistance Act strive to provide Tribal people with access to high-quality and comprehensive medical services, in line with the federal government's trust and treaty obligations. However, chronic underfunding of the Indian health system has had detrimental impacts on our communities. American Indians and Alaska Natives are disproportionately affected by obesity, diabetes, heart disease, cancer, substance use disorder, and other largely preventable conditions.

Despite its chronic underfunding, the Indian health system is constantly at risk of additional budget cuts, sequestrations, rescissions, and funding freezes. As recently as January 2025, Tribal health

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programs like ourselves feared that our desperately-needed funding was frozen when the Office of Management and Budget issued a memorandum pausing federal financial assistance. Similarly, in FY 2024, Congress rescinded $350 million marked for public health infrastructure from the IHS. In fact, the IHS is the only federally funded service providing direct patient care that is not exempt from sequestration. This uncertainty greatly impacts our daily operations and ability to plan for the future, which in turn affects the quality of care we can provide our patients.

We respect the efforts of Congress and the Trump Administration to balance the federal budget. However, we ask you to remember that your trust and treaty obligation exists irrespective of these goals. 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 devastate Tribal Nations and their citizens. We urge Congress to ensure that any budget cuts, whether automatic or explicit, hold IHS and our patients harmless.

Continued Support for Advance Appropriations for IHS: We thank this Subcommittee for its commitment to advance appropriations for the IHS, and we continue to support it in all future fiscal years. This year's tumultuous appropriations cycle clearly demonstrates why advance appropriations are critical—IHS clinical services remained continuous throughout the volatile political process. We urge the Subcommittee to extend advance appropriations to all IHS accounts, including Electronic Health Records Modernization, Health Care Facilities Construction, and Sanitation Facilities Construction for FY 2027.

Mandatory Funding for Contract Support Costs and 105(*l*) lease payments: We appreciate the Subcommittee's commitment to ensuring that Contract Support Costs (CSC) and section 105(*l*) lease payments are fully funded. However, despite the obligatory nature of these payments, they remain in the discretionary budget, where they continue to take up a larger and larger percentage of overall IHS funding. In FY 2020, the Subcommittee found that "[o]bligations of this nature are typically addressed through mandatory spending, but in this case, since they fall under discretionary spending, they are impacting all other programs funded under the Interior and Environment Appropriations bill, including other equally important Tribal programs."

This is especially concerning given the recent ruling in *Becerra v. San Carlos Apache Tribe*, which found that the IHS is required to pay CSC on third-party revenues. As you know, this will cause a drastic escalation in the CSC budget, and we are very worried that Congress will cut into other essential Tribal programs to pay for these increases. Indeed, in FY 2024, this Subcommittee approved cuts to Electronic Health Records Modernization, Health Care Facilities Construction, and Sanitation Facilities Construction in part to offset the increases to CSC and section 105(*l*) leases. To permanently protect the rest of the IHS budget, we ask you to continue to advocate with your colleagues on authorizing committees to enact mandatory appropriations for CSC and 105(*l*) lease costs.

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In addition, we ask the Subcommittee to include language in its Committee Report requiring the IHS to pay section 105(*l*) leases in full, even if the space is used to serve Tribal members and non-beneficiaries alike. Currently, the IHS will only pay a percentage of the lease, claiming that it is not obliged to pay for the facility space used to serve non-beneficiaries. This argument implies that Tribal health providers segregate their facilities by eligibility for IHS services, but this could not be farther from the truth. All 100% of facility space is used to serve Tribal patients, so in recognition of the trust and treaty obligation to those patients, the IHS should pay 100% of the lease costs.

Reduce Dependence on Federal Grants: We also support moving away from competitive grants for federal funding mechanisms. Grants unfairly pit Tribes against each other for resources we are all deserving of. The federal trust responsibility does not require that we jump through a myriad of hoops and onerous applications to see that services are provided to our citizens. Too often, Tribes are too under-resourced to apply for federal grants and comply with their reporting requirements. Our staff must divert time to apply and report, thereby diluting the usefulness of the resources. Instead, we request widespread, formula-based funding across all programs. Tribes must also be granted the flexibility needed to respond to the specific needs of their own communities, not those prescribed by federal grants. This also means appropriating enough resources so funds are provided in meaningful amounts across all Tribes. We join other Tribal leaders in calling for broad-based funding for Indian Country.

Adequately fund critical infrastructure investments: We were excited to see that this Subcommittee proposed advance appropriations for Health Care Facilities Construction and Sanitation Facilities Construction in its draft FY 2025 bill. This is a meaningful step toward addressing the severely outdated conditions common in the Indian health system. We also appreciate Congress' investment in IHS sanitation facilities through the Bipartisan Infrastructure Law. Yet, with a multi-billion-dollar backlog and growing inflation, funding to close out the list is not keeping pace with need. This creates situations where facilities are unfit and unsafe. Therefore, we recommend increases for Health Care Facilities Construction and Sanitation Facilities Construction in FY 2026.

That being said, we were disappointed to see that this Subcommittee has proposed to drastically cut the Electronic Health Records modernization account. Such a cut would effectively halt modernization efforts, which is untenable given the already extremely outdated system the IHS is currently using. Therefore, we request that this Subcommittee restore this account with $217 million for FY 2026.

Address Staffing Shortages. The Indian health system is chronically understaffed due to a variety of challenges including underfunding and rural location. We face difficulties recruiting and retaining critical staff because we must compete with the larger non-Tribal health systems nearby.

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We thank this Subcommittee for proposing a 12% increase to the Hospitals and Health Clinics line item, which will help ensure Tribal health programs have the funding to offer competitive salaries and benefits. We also urge this Subcommittee to ensure this increase is included in the final bill, also with additional direct resources for staff housing.

Extend Self-Governance Funding Options to the Special Diabetes Program for Indians (SDPI) and increase funding to $200 million/year: While we understand that SDPI is not under the jurisdiction of the Subcommittee, we appreciate that Congress has continued to include short-term extensions of SDPI throughout this fiscal year at a $160 million annualized rate. We recognize that these are among the first increases given to SDPI in two decades. Communities like ours across Indian Country rely on these resources to address the alarming rates of diabetes and diabetes-related health complications among our people. SDPI's success rests in the flexibility of its program structure that allows for the incorporation of culture and local needs into its services. Consistent with this model, Congress should authorize SDPI participants the option of receiving their federal funds through either a grant (as currently used) or self-governance funding mechanisms under the Indian Self-Determination and Education Assistance Act.

Additionally, SDPI has not had a meaningful increase in funding since FY 2004 despite its overwhelming success. Short-term reauthorizations continue to destabilize this program and make staffing and program continuity difficult. For this reason, we recommend permanent reauthorization for SDPI at a minimum base of $200 million per year with annual adjustments for inflationary increases. This is consistent with that which was included in the first continuing resolution released on December 17, 2024, before the pared-down version passed. We urge you to work with your Congressional colleagues to enact this important priority.

Behavioral Health: Our communities, like all of Indian Country, have been devastated by the ongoing fentanyl and opioid epidemic. Nevertheless, funds for these services are extremely limited. For example, in FY 2024, Congress only appropriated $2 million to fund essential detoxification-related services. That's less than $1 per IHS patient. We urge the Subcommittee to dedicate resources to detoxification and reemphasize the importance of protecting funding for the following accounts— Health Care Facilities Construction, Alcohol & Substance Use, and Mental Health.

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