Spokane Tribe of Indians
P.O. Box 100 • Wellpinit, WA 99040 • (509) 458-6500 • Fax (509) 458-6575

Testimony of Chairman Greg Abrahamson,
Chair of the Spokane Tribal Business Council and
Vice Chair of the Northwest Portland Area Indian Health Board
Before the
House Natural Resources Committee, Subcommittee on Indian and Insular Affairs
December 11, 2025

Chair Hurd and Ranking Member Leger Fernandez, 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 (NPAIHB), and former Chair of the Direct Service Tribal Advisory Committee (DSTAC).

The Spokane Tribe is located in Northeast Washington State. We have around 3,030 enrolled Tribal citizens, with about 55 percent living on the reservation and 35 percent in Eastern Washington. About 50 percent of our people are 30 years and younger with over 1,500 females and 1,400 males. While our ancestors inhabited much on Northeast Washington's approximately 3 million acres, today our reservation is close to 160,000 acres with lands in Stevens and Spokane counties.

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.

I thank the Subcommittee for the opportunity to provide testimony on "Modernizing the Implementation of 638 Contracting at the Indian Health Service". Since the Indian Self-Determination and Education Assistance Act was signed into law, the self-determination contracting process has allowed Tribes to carry out functions and activities according to their own needs, customs, and desires, ushering in a sea change from the traditional direct service model.

As such, the Spokane Tribe recently elected, via a 638 contract, to assume control of our health center, which has provided some immediate benefits to our Tribal citizens. Today, I'm here to tell you about this experience so that the process might become easier and more streamlined for other Tribes who also choose to pursue self-governance contracting with the Indian Health Service (IHS).

I respectfully request that any recommendations out of this Subcommittee related to modernizing the implementation of 638 Contracting at the Indian Health Service be made with core considerations of: (1) Tribal sovereignty; (2) Trust Responsibility and Treaty Obligations; (3) Tribal

self-determination and self-governance; (4) Protect Direct Services Tribes from Harm; (5) Meaningful Tribal Consultation:

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]

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.

Tribal Self-Determination and Self-Governance. Many Portland Area Tribes were some of the early implementers of the Indian Self-Determination Education Assistance Act (ISDEAA). In Portland Area, there are 24 Title 1 Tribes (contracts) and 23 Title V Tribes (compacts).[3] ISDEAA has provided Portland Area Tribes with the flexibility to tailor health care services to the meet the needs of their people and communities. My tribe, the Spokane Tribe, entered into a Title V compact with Indian Health Service in 2025.

Protect Direct Service Tribes from Harm. Many Tribal Nations continue to rely on federally-operated IHS facilities to provide health care to their people. The chronic vacancy rate of over thirty-five percent (35%) at facilities operated by the Indian Health Service has been exacerbated by recent Administrative Actions, including hiring freezes, reductions in in workforce, and layoffs which have further destabilized services to AI/AN people from Direct Service Tribes.

Tribal Consultation. Meaningful Tribal Consultation must occur with any changes to the IHS 638 contracting process. Each Tribe is unique with its own needs and considerations when IHS makes changes to processes.

IHS leadership indicated at a recent Tribal consultation that it anticipates that up to 70% of IHS annual appropriations will be managed by Tribes under ISDEAA agreements by the end of the calendar year 2026. Based on the change to the IHS system, I make the following recommendations to IHS 638 contracting.

---

[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).
[3] https://www.ihs.gov/portland/

1. Put Patients First. I recommend the IHS put patients first in all Agency and Area level decision-making when a Tribe is making the transition from Direct Service to Compacting or Contracting. Lapses in services are an impediment to patient care, and the IHS must ensure that Tribes have access to all patient records in the RPMS system, regardless of which electronic health record system they wish to transition to. IHS federally-operated facilities continue to use the RPMS system, a legacy system and problematic to use especially related to 42 CFR Part 2.

EHR systems are intended to improve patient care, coordination of care and efficiency, and reduce errors. Modern EHR systems also provide patients with access to their own records and communicate with their providers. The Indian Health Service, Tribes, and Urban Indian Organizations cannot continue to operate in an Electronic Health record system developed in 1985 – we need our federal partners to either fully fund our transition to a commercial-off-the-shelf system, or fully fund the modernization of RPMS.

Recently, when the Spokane Tribe of Indians transitioned from being an IHS federally-operated clinic to a 638 compact operated by Spokane, the transfer of RPMS patient records for newly assumed health care services was significantly delayed which impacted patient care. If IHS had modernized its EHR system, it would have allowed for a more efficient transfer of patient information/records.

2. ***Ensure Full Funding is Available.*** Tribal Nations who move from Direct Service to Contracting or Compacting must receive timely and adequate funding to hire and onboard providers. A delay or lack of funding can delay hiring and operations and create lapses in patient care. The Spokane Tribe experienced a delay in receipt of funding in making the transition from Direct Service to a compact which impacted both the delivery of patient care, and the timely transition of resources from the IHS to our Tribe.

Broadly, modernizing the 638 contracting process at IHS is impossible without full funding of IHS. IHS has been on the United States Government Accountability Office High Risk List since 2017 (GAO High Risk List).[5] With IHS funding at either 13% or 49% of its level of need, depending on who you ask, an aging infrastructure at IHS, a lack of vision for "addressing the root causes of IHS management weaknesses," and eight open recommendations on the GAO High Risk List - core issues must be addressed in any modernization effort.[4]

3. Ensure Adequate Staffing at Headquarters and Area Level. In the proposed IHS Alignment, the "Division of Intergovernmental and External Affairs", would be implementing and ensuring compliance with the ISDEAA through negotiation activities, the largest part of the IHS. To do this, IHS is recommending a new office be established, the "Office of Agency Negotiation." Any new Office of Agency Negotiation, or Office of Self-Governance, would require adequate staffing for all negotiations for Section 105(l) lease, Contract Support Costs, and Annual Funding Agreements in order for the negotiations to be completed in a timely manner. Recent Administrative changes,

---

[4] [4] National Indian Health Board. Advancing Health Equity Through the Federal Trust Responsibility: Full Mandatory Funding for the Indian Health Service and Strengthening Nation-to-Nation Relationships. May 2022. Page 1. Indian Health Service Operating Plan FY 2024. Accessed April 19, 2025.

including hiring freezes and RIFs, have impacted IHS agency wide. Any hiring restrictions must be lifted to ensure adequate hiring can occur.

4. Change Policy for Title I Contracts: Make policy changes to allow Tribes who contract services more flexibility to make changes to the program without IHS approval. Tribes who contract a program should have the authority to redesign, consolidate and re-allocate funds across other PFSAs that they have contracted without approval for each change.

Thank you again for the opportunity to testify. Self-determination is one of the bedrock principles of Tribal sovereignty and I look forward to working with this Subcommittee and the IHS as the authorities provided to Tribes in Public Law 93-638 continue to be modernized and improved upon.