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Oversight Hearing
"Modernizing the Implementation of 638 Contracting at the Indian Health Service."

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Good morning, Chairman Hurd, Ranking Member Leger Fernandez, and Members of this Subcommittee. I am Benjamin Smith, Deputy Director at the Indian Health Service (IHS). Thank you for the opportunity to provide testimony on the topic, "Modernizing the Implementation of 638 Contracting at the Indian Health Service," in the Department of Health and Human Services (Department).

IHS is an agency within the Department of Health and Human Services (HHS), and our mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/ANs) to the highest level. This mission is carried out in partnership with AI/AN Tribal communities through a network of over 600 Federal and Tribal health facilities and 41 Urban Indian Organizations (UIOs) that are located across 37 states and provide health care services to approximately 2.8 million AI/AN people annually.

The IHS was established to carry out the responsibilities, authorities, and functions of the United States, as provided in federal statutes and treaties, to provide health care services to Indians and Indian tribes. IHS is the 18th largest health care system in the United States, which consists of 12 Area offices that oversee 170 Service Units proving care at the local level. Health services are provided through facilities managed by the IHS, by tribes and tribal organizations under authorities of the Indian Self-Determination and Education Assistance Act, and through contracts and grants awarded to urban Indian organizations authorized by the Indian Health Care Improvement Act.

Background Indian Self Determination and Education Assistance Act

Fifty years ago, the Indian Self-Determination and Education Assistance Act marked a monumental turning point in federal Indian policy, empowering Tribal Nations to reclaim authority over essential services and decision-making that directly affect their people.

The Indian Self-Determination and Education Assistance Act (ISDEAA; P.L. 93-638, 25 U.S.C. §§5301 et seq.) emphasized tribal self-determination and self-governance "in planning, conduct,

and administration" of certain federal programs. Passed by Congress in 1975, Title I of ISDEAA authorized the Departments of the Interior (DOI) and HHS to contract with tribes to assume planning and administering certain federal services and programs with federal funding, referred to as 638 contracts or self-determination contracts. In 2000, the Title V IHS Tribal Self-Governance Program (P.L. 106-260, 25 U.S.C. §§ 5381 et seq.) was created and permanently authorized compacts for some IHS programs.

Both Title I and Title V of the ISDEAA authorized the Secretary of the Department Health and Human Services (Secretary) to contract or compact with tribes, upon a tribe's request. For Title I of the ISDEAA, federally recognized tribes or tribal organization contract with the IHS to plan, conduct, and administer one or more individual programs, functions, services, or activities (PFSAs) or portions thereof, that the IHS would otherwise provide for Indians because of their status as Indians. For Title V of ISDEAA, federally recognized tribes or tribal organizations compact with the IHS to assume full funding and control over programs, services, functions, or activities (PSFAs) or portions thereof, that IHS would otherwise provide for Indians because of their status as Indians. Some of the Title I provisions include:

- the option to enter into contracts for a period of up to three years, unless the Secretary and the tribe agree to a longer term, with the terms of the contract renegotiable annually to account for changed circumstances and cost increases (25 U.S.C. §5324), and
- the opportunity to consolidate two or more self-determination contracts into a single contract (25 U.S.C. §5321).

Title V established the Tribal Self-Governance Program within the Office of the Director in IHS (25 U.S.C. § 5382). Among other things, Title V:

- allows a participating tribe to negotiate funding agreements (annual or multiyear) with IHS for PSFAs to be assumed by the tribe (25 U.S.C. § 5385) and
- permits tribes to redesign or consolidate federal programs and to reallocate funds within selected programs (25 U.S.C. § 5386(e)).

A key difference between self-determination contracts and self-governance compacts is the amount of tribal flexibility. Under Title I, IHS must approve any substantial changes to a contract. Under Title V, a tribe may redesign or consolidate PSFAs, and reallocate funding, under a compact without IHS's approval as long as the redesign does not have the effect of denying eligibility. Thus, although PSFAs may be redesigned under contracts and compacts, tribes with a contract must receive prior approval to do so.

The IHS Tribal Self-Governance Program strengthens the government-to-government relationship between the United States and Indian Tribes by enabling each Indian tribe to choose the extent of its participation in self-governance, and by transferring full control and funding of certain IHS PSFAs, or portions thereof, to Tribal governments.

Under Title V of ISDEAA, tribes have the discretion to plan, conduct, redesign, and administer PSFAs, or portions thereof, that they have assumed. As a result, significant variations exist among tribally administered health programs. These benefits can include:

- Creation of a comprehensive approach to health services;
- Increased community engagement;
- Program design driven by the needs and priorities of each Tribal community;
- Improvement in communication and coordination between Tribal programs, resulting in the reduction of service duplication and improved efficiency;
- The ability to leverage self-governance funding, maximize resources, and provide more comprehensive community-wide services; and
- Development of innovative health programs and services.

Use of ISDEAA Contracts and Compacts: Because participation in ISDEAA agreements is voluntary, tribes have options in determining how they receive IHS authorized services. For example, a tribe could choose to:

- receive services directly from IHS, sometimes referred to as a direct service tribe;
- enter into a contract with IHS to administer individual programs and services that IHS otherwise would provide directly to the tribe (i.e., a self-determination contract);
- enter into a compact on a government-to-government basis with IHS to assume control over programs that IHS otherwise would provide directly to the tribe (i.e., a self-governance compact); or
- combine the above options to receive services.

Many, but not all, tribes enter into contracts or compacts under ISDEAA. In FY2024, under Title I, there were 232 Tribes and Tribal Organizations operating 247 contracts and annual funding agreements. Under Title V, IHS was party to 114 compacts and 141 funding agreements. Approximately $3.0 billion of the IHS budget was transferred to Tribes and Tribal organizations through these contracts and compacts. Sixty-eight percent of federally recognized tribes participate in Title V under IHS.

The ISDEAA is key legislation with successful outcomes, allowing tribes to self-determine and self-govern health, education, and social services in ways that reflect their values, priorities, and cultures, rather than relying on distant federal agencies. At the heart of ISDEAA are Public Law 93-638 contracts and self-governance compacts. These tools enable tribes to assume control over the operation of federal programs, including IHS hospitals, clinics, and health programs.

ISDEAA Modernization and Successes and Opportunities at the IHS

As we focus on the title of this oversight hearing, "Modernizing the Implementation of 638 Contracting at the IHS," it is important to note that the P.L. 93-638 itself is modernizing through the differences between Title I and Title V explained previously. While not all tribes enter into contracts or compacts, the tribes that do, have choice. Tribes can choose the amount of tribal

flexibility under Title V, versus under Title I. Under Title I, IHS must approve any substantial changes to a contract. Under Title V, a tribe may redesign or consolidate PSFAs, and reallocate funding, under a compact without IHS's approval as long as the redesign does not have the effect of denying eligibility. Additionally, the increase in Tribes choosing to contract or compact since P.L. 93-638 inception is another example of modernizing the implementation of the 638 contracting. We have come from a time when IHS was the direct provider of health care and health care programs in Indian Country. Now, approximately 62% of the IHS budget is now managed by tribes through ISDEAA contracts or compacts. These self-governance arrangements have not only expanded service access but also improved patient satisfaction and Tribal oversight. Thus, Tribes and Tribal organizations are developing their own strategic health plans, improving clinic efficiency, and maximizing third-party revenue through Medicaid, Medicare, and private insurance billing.

Some successes of the ISDEAA include the following. A tribe in Washington State developed a state-of-the-art family health clinic integrating primary care, dental, behavioral health, and an opioid treatment program. A Tribe in Oregon established a Wellness Center, offering integrated, culturally grounded medical, dental, and behavioral health services. Additionally, tribes in Arizona and Oklahoma operate some of the largest and most comprehensive Tribal health systems in the U.S., encompassing hospitals, specialty care, and wellness initiatives. Their innovation in technology integration, workforce development, and policy advocacy has made them a national model for Tribal health governance.

The landscape is changing continuously as more tribes enter Title I and V contracts and compacts. In FY 2025, six tribes and tribal organizations entered the IHS Tribal Self-Governance Program.

Becerra v. San Carlos Apache Tribe was a landmark Supreme Court case decided on June 6, 2024. This case was consolidated with a similar dispute by the Northern Arapaho Tribe. The Supreme Court held that IHS must reimburse tribes for administrative costs associated with providing health care services, including those funded by third-party revenue like Medicare and Medicaid and private insurance. This has resulted in increased requests for technical assistance and letters of intent to assume PFSAs from the IHS.

Access to Quality Health Care Services through Modernization and Improved Infrastructure

Modern health care also depends on modern health information systems. The IHS's current Electronic Health Record (EHR) system is more than 40 years old and has been identified by the Government Accountability Office as one of the top ten critical Federal legacy systems in need of modernization. The FY 2026 Budget provides $191 million to advance the deployment of a new, interoperable EHR platform. This investment will contribute to improved clinical outcomes, patient safety, disease management, care coordination, opioid tracking, and public health reporting. The system will also support billing for over $1 billion in third-party reimbursements annually and will be interoperable with the Department of Veterans Affairs, Department of Defense, tribal and urban Indian health programs, academic affiliates, and

community partners, many of whom use different health information technology platforms.

The Indian health system also faces substantial physical infrastructure challenges – IHS hospitals are approximately 42 years old on average, which is over three times the average age of hospitals in the United States. Infrastructure deficiencies limit the health care services that can be provided. The FY 2026 Health Care Facilities Construction Budget maintains funding flat with the prior year at $183 million to maintain support for priority projects, including continued construction of the Alamo Health Center in New Mexico and Phoenix Indian Medical Center in Arizona. The remaining projects on the 1993 Health Care Facilities Construction Priority List total approximately $6.2 billion as of April 2024.

In conclusion, the IHS values the ongoing partnership with tribes, and Tribal Organizations to provide health care in our Tribal communities, on and off tribal lands. We will continue to work together to enhance programs, support Tribal communities further, and create avenues for Tribal self-determination. Thank you for your commitment and dedication to improving health care for American Indians and Alaska Natives. I will be happy to answer any questions the Committee may have.