HOUSE COMMITTEE ON
NATURAL RESOURCES
CHAIRMAN BRUCE WESTERMAN

To:	Subcommittee on Indian and Insular Affairs Republican Members
From:	Subcommittee on Indian and Insular Affairs Staff: Ken Degenfelder (Ken.Degenfelder@mail.house.gov) and Hannah Hulehan (Hannah.Hulehan@mail.house.gov); x6-9725
Date:	Monday, December 8, 2025
Subject:	Oversight hearing titled *"Modernizing the Implementation of 638 Contracting at the Indian Health Service"*

The Subcommittee on Indian and Insular Affairs will hold an oversight hearing titled "*Modernizing the Implementation of 638 Contracting at the Indian Health Service*" on **Thursday, December 11, 2025, at 10:00 a.m. in room 1324 Longworth House Office Building**.

Member offices are requested to notify Haig Kadian (Haig.Kadian@mail.house.gov) by 4:30 p.m. on Wednesday, December 10, if their Member intends to participate in the hearing.

I. KEY MESSAGES

- With tribes administering most of the Indian Health Service (IHS) budget, effective federal support for 638 contracting, which allows for greater tribal self-governance in health care, is crucial.
- For many tribes, the most significant barriers to 638 implementation are delays: slow contract amendments, uncertain review processes, and backlogs in 105(l) leases. Since IHS does not publish standardized data on processing times, staffing gaps, or pending approvals, measuring progress remains a core oversight issue.
- As more tribes pursue 638 contracts and assume management of health programs, the need for clarity, timely responses, and consistent processes increases. Successful self-governance depends on an IHS structure that can support tribes efficiently across all the agency's Office Areas.
- IHS is pursuing a substantial agency realignment aimed at improving consistency, strengthening technical support, and reducing variation across Office Areas. A well-designed structure has the potential to streamline processes, clarify roles, and better support tribes as they continue expanding self-governance. But stakeholder concerns reveal that Congressional oversight remains necessary to ensure that the realignment proceeds as intended.

II. WITNESSES

Panel I (Administration Witnesses):

- **Mr. Benjamin Smith,** Deputy Director, Indian Health Service, U.S. Department of Health and Humans Services, Rockville, Maryland

Panel II (Outside Experts):

- **The Honorable Chuck Hoskin Jr.,** Principal Chief, Cherokee Nation, Tahlequah, Oklahoma
- **The Honorable Victoria Kitcheyan,** Council Member, Winnebago Tribe of Nebraska, Winnebago, Nebraska
- **The Honorable Greg Abrahamson,** Chairman, Spokane Tribe of Indians, Wellpinit, Washington
- **Mr. Jay Spaan,** Executive Director, Self-Governance Communication & Education Tribal Consortium, Tulsa, Oklahoma *(Minority witness)*

III. BACKGROUND

Overview

In 1975, Congress enacted the Indian Self-Determination and Education Assistance Act (ISDEAA).[1] The law established a new model for delivering federal services to tribes by allowing federally recognized Indian tribes to take over federal programs, including health programs, from the agencies that had historically run them.[2] ISDEAA allows for this transfer through several agreement options, including "638 contracts" (named after the statute's public law number, P.L. 93-638) under Title I and self-governance compacts under Titles III, IV, and V.[3]

Tribal self-governance in health care has dramatically expanded over the past five decades. Today, the Indian Health Service (IHS) is party to 246 Title I contracts with 206 tribes and tribal organizations, as well as to 112 Title V self-governance compacts, the latter of which cover more than two-thirds of all federally recognized tribes.[4] Through these agreements, roughly 62 percent of IHS's budget is administered by tribes.[5] The remaining 38 percent of IHS funds largely support federally-operated IHS facilities and services.[6]

This expansion reflects ISDEAA's success in enabling tribes to design and operate health services that best fit their communities' needs. The shift towards self-governance also means that

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[1] P.L. 93-638.
[2] Mariel J. Murray, et al., "Tribal Self-Determination Authorities: Overview and Issues for Congress," Congressional Research Service, January 10, 2025, https://crs.gov/Reports/R48256.
[3] *Id.*
[4] *Id.*
[5] "Tribal Leader and Urban Indian Organization Leader," November 13, 2025, https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2025_Letters/DTLL_DUIOLL_11132025.pdf.
[6] *Id.*

IHS's role has been increasingly transformed from that of a health services provider to that of a partner to, and funder of, tribal health programs.

The Trump administration has signaled strong support for increasing efficiency in, and local control of, the provision of public services. Expanded tribal self-governance is central to achieving those objectives. In 2020, President Trump signed the PROGRESS Act,[7] a major update to ISDEAA that streamlined and strengthened self-governance authorities. The PROGRESS Act created a more consistent statutory framework between the Department of the Interior's and IHS's self-governance programs and added provisions to improve administrative efficiency, for example, standardizing rules, clarifying reporting requirements, and offering technical assistance to tribes managing federal programs.[8] This was a positive step in reinforcing tribal self-determination. It aimed to reduce red tape and make it easier for tribes to assume responsibility for health programs.

Despite these improvements, significant challenges remain within IHS, as more tribes seek to implement 638 contracts. These difficulties can weaken tribes' ability to smoothly take over programs and threaten the sustainability of both tribal and federal health services.

Furthermore, as tribal management of health programs has expanded, IHS's role has shifted toward negotiating contracts, administering funding agreements, and overseeing a smaller, but still substantial, federally-operated health system. This modern role requires IHS to execute hundreds of complex agreements each year and to ensure equitable and lawful implementation across its decentralized structure.

IHS carries out these responsibilities through twelve regional Area Offices across the U.S.[9] These Area Offices are the primary points of contact for tribes and are the front-line administrators of 638 contracts. Area Offices negotiate contracts and compacts, process amendments, disburse funding via Annual Funding Agreements (AFAs), and provide technical assistance and monitoring. IHS Headquarters in Rockville, Maryland, sets national policy direction and provides legal, financial, and administrative support.

IHS "Strategic Realignment" Initiative and Tribal Consultation

The growth of 638 contracting has transformed IHS from primarily a direct service provider into a hybrid organization responsible for both operating federal facilities and supporting tribal health systems.

In response, in the summer of 2025, IHS announced a proposed "Strategic Realignment."[10] This agency-wide realignment is intended to modernize IHS's internal structure and improve its

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[7] P.L. 116-180.
[8] "PROGRESS Act Amendments to Titles I and IV of the ISDEAA," Hobbs, Straus, Dean & Walker, LLP, October 22, 2020, https://www.tribalselfgov.org/wp-content/uploads/2020/10/02-10-22-20-PROGRESS-Act-Title-I-and-Title-IV-Amendment-Final.pdf.
[9] "IHS Offices," Indian Health Services, https://www.ihs.gov/ihsoffices/.
[10] "Dear Tribal Leader and Urban Indian Organization Leader", Indian Health Service, June 13, 2025, https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2025_Letters/DTLL_DUIOLL_06132025.pdf.

support for tribal self-determination. According to a letter to tribal leaders, the reorganization's goal is to create a "more accountable, efficient, and responsive IHS that maximizes resources and improves outcomes while simultaneously strengthening intergovernmental relationships."[11] IHS further described the realignment as a movement toward a "patient-centered, self-determination-driven, operationally efficient, and fiscally sustainable health care system."[12] In short, IHS leadership recognizes that, with most care now managed by tribes, the agency must adapt its structure to a "modern mission" focused on policy, oversight, and partnership rather than top-down management.

Stakeholders who have participated in the consultation process report that the realignment proposal remains at a high level. During the first consultation session, in early 2025, IHS did not provide a draft plan or a clear description of how responsibilities, offices, and functions would be restructured. According to stakeholders, it was difficult to offer meaningful input without knowing what the agency had in mind.[13]

IHS acknowledged this shortcoming and committed to a second round of consultation. That second phase is now underway. In a November 13, 2025, Dear Tribal Leader Letter, IHS announced new consultation sessions in December 2025 and January 2026. IHS also stated it had "additional details to share regarding the proposed realignment structure."[14] Stakeholders note that updated materials have not yet been circulated for review.[15] Tribes seek clarity on the final plan and its implementation schedule. At the same time, IHS continues to emphasize that the intent is to "clarify roles, reduce administrative burden," and enable both field and headquarters leaders to focus on core mandates.[16]

Current Challenges in 638 Implementation Across IHS Areas

The challenges tribes experience when pursuing or administering 638 contracts fall into several interrelated areas: (1) variation across Area Offices; (2) slow and inconsistent administrative processes; (3) the scale of §105(l) lease backlogs; (4) major enterprise modernization demands, including electronic health records (EHR); and (5) funding inaccessibility. Each challenge area is described in greater detail below.

I. Inconsistency and Variation Across Area Offices

Because so much of 638 implementation occurs at the Area level, tribal experiences vary significantly by region.[17] Some Area Offices have developed strong collaborative relationships

[11] *Id.*
[12] *Id.*
[13] Conversation between IIA Staff and Self-Governance Communication & Education Tribal Consortium (SGCETC), December 1, 2025.
[14] Dear Tribal Leader and Urban Indian Organization Leader", June 13, 2025.
[15] Conversation between IIA staff and Self-Governance Communication & Education Tribal Consortium (SGCETC), December 1, 2025.
[16] "Dear Tribal Leader and Urban Indian Organization Leader", Indian Health Service, June 13, 2025, https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2025_Letters/DTLL_DUIOLL_06132025.pdf.
[17] "INDIAN HEALTH SERVICE – Many Federal Facilitates are in Fair or Poor Condition and Better Data Are Needed on Medical Equipment," U.S. Government Accountability Office, November 2023, https://www.gao.gov/assets/870/863620.pdf.

with tribes. Others have faced criticism for slow processes or a lack of support. These disparities have practical consequences. For tribes considering assumptions of health programs, inconsistent Area Office performance can introduce significant operational uncertainty.[18] As demands on IHS's administrative functions increase, uneven performance across Area Offices may further vary tribal access to self-determination opportunities.

These gaps persist partly because IHS does not publish standardized performance metrics, such as average approval timelines, staffing vacancies, or pending contract actions. This information could help identify underlying issues. Without consistent data, neither tribes nor Congress can fully evaluate IHS or Area Office performance.

This concern has been echoed by the U.S. Government Accountability Office (GAO). Since 2017, GAO has placed IHS on the High-Risk List for "Improving Federal Management of Programs that Serve Tribes."[19] In its 2025 update, GAO acknowledged some progress by IHS but found that the agency still has not met four of the five criteria for removal from the High-Risk List. Specifically, GAO noted shortfalls in capacity, action planning, monitoring, and demonstrated progress.[20]

Unlike the Bureau of Indian Affairs (BIA), which updated its self-governance regulations in 2024 and issues detailed policy chapters in the Indian Affairs Manual, IHS maintains 638 policies that are viewed as outdated or unevenly applied. Tribes have urged IHS to create a comprehensive 638 implementation manual or handbook, analogous to BIA's, to instruct IHS employees (and inform tribes) on the standards and processes for negotiating and managing ISDEAA agreements. Such guidance could help eliminate the knowledge gaps between Area Offices.

II. Slow Processes and Administrative Bottlenecks

Even when tribes have strong partnerships with their Area Offices, administrative delays still occur when establishing or amending contracts and compacts.[21] Although ISDEAA imposes a 90-day deadline for approving or declining proposals, many of the steps needed before reaching those formal decisions, budget reviews, legal analyses, indirect cost rate alignment, IPA processing, and Memorandum of Agreement (MOA) negotiation have no internal deadlines and can drag on for months.

These bottlenecks reflect broader structural issues identified by GAO: insufficient staff capacity, poorly defined internal processes, and gaps in monitoring. The lack of a standardized process map for contract actions means tribes often receive different answers depending on the Area or the individual reviewer. A modern 638 system would incorporate internal timelines, templates,

[18] Conversation between IIA Staff and Spokane Tribe of Indians, December 2, 2025.
[19] "Improving Federal Administration of Programs that Serve the American Indian Population," U.S. Government Accountability Office, December 12, 2017, https://www.gao.gov/blog/2017/12/12/improving-federal-administration-of-programs-that-serve-the-american-indian-population.
[20] "High-Risk Series: Heightened Attention Could Save Billions More and Improve Government Efficiency and Effectiveness," U.S. Government Accountability Office, February 25, 2025, https://www.gao.gov/products/gao-25-107743.
[21] Conversations between IIA Staff and Utah Navajo Health System and Spokane Tribe of Indians, December 2, 2025.

and clearer delegations of authority to reduce unnecessary legal escalation and repetitive documentation.

GAO cited the need for IHS to draft a longer-term work plan, improve monitoring, and show measurable improvements to shed the high-risk designation.[22] IHS has initiated efforts to address internal weaknesses. It developed a 2023 Agency Work Plan to implement recommendations from GAO and the U.S. Department of Health and Human Services (HHS) Inspector General, aiming to create a "targeted approach to monitoring progress [and] hold staff accountable for continued action."[23] As part of this, IHS convened a Director's Policy Advisory Council to track reform recommendations and ensure they result in concrete changes.[24] These are positive steps, but it remains unclear whether they have specifically translated into improved 638 contract outcomes.

III. Backlogs of Section 105(l) Leases

Section 105(l) leases have created one of the largest administrative workloads associated with 638 contracting. Tribes that use their own facilities to operate federal programs are entitled to a lease reimbursing reasonable facility costs. Demand for these agreements has increased rapidly, with IHS reporting 901 leases executed from 2012 to mid-2024 and a backlog of 1,351 pending leases in Fiscal Year (FY) 2025.[25]

In 2024, IHS moved 105(l) oversight from the Alaska Area to a centralized team within the Office of Direct Service and Contracting Tribes.[26] Although this change was intended to improve consistency, tribes report that detailed guidance and predictable timelines remain unavailable.

IV. Electronic Health Record (EHR) Modernization and Implications for 638 Tribes

Health information technology modernization has become a key structural challenge for 638 implementation. IHS and tribal health programs currently operate on the Resource and Patient Management System (RPMS), a legacy electronic health record and practice management platform that is more than 40 years old and that IHS leadership has described as outdated and unsustainable going forward.[27]

In 2019, HHS issued a report evaluating strategic options for modernizing the IHS electronic health record system. This report emphasized the need to address system deficiencies that affect

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[22] "High-Risk Series: Heightened Attention Could Save Billions More and Improve Government Efficiency and Effectiveness," U.S. Government Accountability Office, February 25, 2025, https://www.gao.gov/products/gao-25-107743.
[23] "IHS Fact Sheet IHS Oversight and Accountability," Indian Health Service, March 2023, https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/IHSOversightandAccountability.pdf.
[24] *Id.*
[25] *Fiscal Year 2025 Congressional Justification*, U.S. Department of Health and Human Services, Indian Health Service, p. 146–147.
[26] *Id.*
[27] Jayla Whitfield, "Indian Health Service to Debut EHR in 2025 Amid New Modernization Plan," GovCIO Media & Research, December 21, 2023, https://govciomedia.com/indian-health-service-to-debut-ehr-in-2025-amid-new-modernization-plan/.

tribal health programs and highlighted tribal concerns about data ownership, interoperability, and multiple reporting requirements.[28]

Building on that work, IHS selected General Dynamics Information Technology (GDIT) in late 2023 to implement a new enterprise electronic health record system using Oracle-Cerner technology under an indefinite-delivery, indefinite-quantity contract.[29] IHS has stated that the new enterprise health IT system is intended to be built "together with tribal and urban partners," to support consistent, high-quality care with integrated data across the Indian health system.[30] IHS has also indicated that RPMS will continue to be supported until all interested facilities can transition and that legacy data will remain accessible.[31]

V. Funding Inaccessibility

Another facet of modernizing 638 implementation is ensuring that new programs and funding streams are available for tribes to manage, instead of being administered only from Washington, D.C. Tribal leaders often note that while ISDEAA allows them to assume management of virtually any health program, in practice IHS sometimes channels new initiatives through grants or other mechanisms that are less accessible to tribes under self-determination contracts.

For example, in FY 2024, IHS administered over $59 million in various behavioral health programs aimed at issues like substance abuse prevention, suicide prevention, domestic violence, and treatment for youth.[32] However, this funding was distributed via competitive grants. This meant that tribes had to apply for limited tranches of funding, and not everyone who needed it could get it.

From a tribal self-governance perspective, the Biden administration's approach was at odds with the intent of ISDEAA. Rather than having tribes compete and adhere to federal grant program rules, tribal advocates argue the funding should be allocated by formula or incorporated into 638 compacts, allowing every interested tribe to receive support and design programs to fit their communities. In other words, modernizing 638 means folding agency funds into the self-determination framework.

Conclusion

Looking forward, as the Trump administration considers broader modernization of the IHS, several priorities stand out. First, the agency's continued failure to meet GAO's criteria for

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[28] "Strategic Options for the Modernization of the Indian Health Service Health Information Technology Final Report, October 2019 https://www.hhs.gov/sites/default/files/ihs-hit-final-report-C-102019.pdf.

[29] Jayla Whitfield, "Indian Health Service to Debut EHR in 2025 Amid New Modernization Plan," GovCIO Media & Research, December 21, 2023, https://govciomedia.com/indian-health-service-to-debut-ehr-in-2025-amid-new-modernization-plan/.

[30] *Id.*

[31] "IHS Health Information Technology Summit Addresses Modernization Initiative's Funding, Staffing, and Rollout," National Indian Health Board, December 13, 2023, https://legacy.nihb.org/the-washington-report/IHS-Health-Information-Technology-Summit-Addresses-Modernization-Initiatives-Funding-Staffing-Rollout.php.

[32] "NCUIH Recommends Noncompetitive Funding Model and Support for Whole Family Substance Abuse Treatment in IHS Behavioral Health Initiatives," National Council of Urban Indian Health, August 26, 2024, https://ncuih.org/2024/08/26/ncuih-recommends-noncompetitive-funding-model-and-support-for-whole-family-substance-abuse-treatment-in-ihs-behavioral-health-initiatives/?print=pdf.

removal from the High-Risk List remains a disservice to both direct- and indirect-service tribes. Without measurable progress on capacity, monitoring, and internal accountability, tribes will continue to shoulder the consequences of systemic inefficiencies that they do not control.

Second, IHS must bring consistency and predictability to its guidance on self-governance of health programs. IHS should look to replicate BIA's approach, especially regarding the latter's uniform, standardized, and up-to-date handbook.

Third, Tribal Nations deserve better than a forty-year-old electronic health record system. Thankfully, the Trump administration is finalizing a new interoperable system to modernize health records and enhance health care for tribal citizens.

Finally, funding intended for tribal health must reach tribes in a form that aligns with self-determination.

As Congress continues its oversight, maintaining an open, transparent line of communication with IHS will be essential. Modern self-governance succeeds only when the federal partner is capable, accountable, and responsive. Tribes have waited long enough for IHS to meet that standard.