Congressional Research Service
Informing the legislative debate since 1914

INSIGHT

COVID-19 and the Indian Health Service

Elayne J. Heisler
Specialist in Health Services

Updated May 1, 2020

The Indian Health Service (IHS) within the Department of Health and Human Services (HHS) is the lead federal agency charged with improving the health of American Indians and Alaska Natives. In FY2019, IHS provided health care to approximately 2.6 million eligible American Indians/Alaska Natives. Its total FY2020 annual appropriation was $6.2 billion. As of April 30, IHS has seen more than 3,000 positive tests for coronavirus among its service population. In particular, the Navajo Nation has experienced one of the largest outbreaks nationally.

IHS Is a Three-Tiered System with Resource Constraints

IHS provides health care either directly or through facilities and programs operated by Indian tribes (ITs) or tribal organizations (TOs) through self-determination contracts and self-governance compacts authorized under P.L. 93-638. IHS also provides services to urban Indians through grants or contracts to Urban Indian Organizations (UIOs). The system is referred to as the I/T/U system, and services available vary. UIOs offer outpatient services, while the IHS and the ITs may provide both outpatient and inpatient care. IHS does not offer a standard benefit package, nor is it required to cover certain services that its beneficiaries may receive at facilities outside of IHS. When services are not available at an IHS facility, facilities may authorize payment through the Purchased Referred Care Program (PRC). PRC funds are limited, and as such, not all PRC claims are authorized; however, IHS has stated that COVID-19 care meets its medical priority for payment. UIOs do not have access to PRC funds.

IHS and COVID-19

As noted, I/T/Us have reported cases of COVID-19; the ability to test for coronavirus and to treat active cases varies throughout its system. Initially, tribes reported some testing challenges, such as shortages of tests, the materials needed to administer testing, and the personal protective equipment (PPE) needed by health providers. IHS has since received rapid testing, but these were distributed to some, not all IHS sites.

Congressional Research Service
7-....
www.crs.gov
IN11333

Despite improvements, IHS faces challenges in delivering COVID-19 care. Specifically, provider vacancies have been a long-standing IHS challenge, which may be exacerbated if providers are exposed or sickened by coronavirus. In addition, some IHS personnel are members of the Commissioned Corps who have been deployed outside of the IHS system to respond to the disaster, which could increase existing shortages. Beyond staffing challenges, some IHS facilities do not have the capabilities to provide all the services that COVID-19 patients need and have sent patients to outside facilities for care.

IHS, like other types of health facilities, has been restricting nonemergency visits to lessen virus transmission and to reserve capacity for the most needed cases. However, in doing so, facilities have reported lost revenue, which may challenge their ability to maintain services throughout the emergency and beyond. IHS, like other providers, has increased its use of telehealth and may also be able to receive reimbursements for telehealth visits provided to IHS-Medicare enrolled beneficiaries who may receive services in their homes. The ability to use telehealth may be limited in some areas because of limited internet connectivity.

COVID-19 Response Funding Available to I/T/U System

Discretionary funding to augment the I/T/U system has been included in the four laws enacted in response to COVID-19. In addition, HHS has chosen to allocate additional funds provided by those laws to the I/T/U system.

Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123), required that not less than $40 million of the amount provided to the Centers for Disease Control and Prevention (CDC) for public health activities (e.g., surveillance) be allocated to ITs/TOs/UIOs—this funding was not available to IHS-operated facilities. Though tribes reported a number of delays with accessing these funds, CDC awarded $80 million—or $40 million more than what was required to be provided—to supplement existing CDC grants for tribal public health activities (Tribal Public Health Capacity Building and Quality Improvement Grants). In addition, HHS transferred an additional $70 million from the amount that was appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) to IHS to support direct services at IHS facilities and acquire PPE.

The Families First Coronavirus Response Act (P.L. 116-127) included $64 million for IHS to also be distributed to ITs/TOs/and UIOs for COVID-19 testing and related health services, and specified that eligible Indians would be able to receive these services without cost-sharing regardless of whether the service was authorized under PRC. IHS noted that IT/TOs and UIOs may use funds to pay for COVID-19 testing and treatment.

The third coronavirus related package, the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136, CARES Act), included funding for IHS and set asides in a number of health programs for IT/TOs and UIOs and Indian health providers. The act also provides support to the Bureau of Indian Affairs and tribal governments; that support is not discussed in this Insight. For the I/T/U system, the law included the following:

- $1.032 billion for IHS to prevent, prepare for, and respond to coronavirus. It requires that not less than $450 million be transferred to ITs/TOs and reserved some of this funding for electronic health records and the catastrophic health emergency fund (which pays for high-cost cases), and permits up to $125 million to be transferred to the Indian Health Facilities account, if needed. IHS announced its plan to allocate these funds on April 24.
- A transfer of not less than $15 million from the funds provided to the Substance Abuse and Mental Health Services Administration to support behavioral health treatment at ITs/TOs or UIOs or organizations that provide behavioral health services to tribes.

- A transfer of not less than $15 million from the PHSSEF that was transferred to the Health Resources and Services Administration to support telehealth for ITs/TOs or UIOs or health service providers to tribes.
- A transfer of not less than $125 million from CDC for public health activities (e.g., surveillance, laboratory capacity, and infection control) undertaken by ITs/TOs/UIOs or health service providers to tribes.
- CARES also created a Provider Relief Fund to provide payments to health providers who have lost revenue during the pandemic. I/T/U facilities are eligible to apply for these funds and HHS provided $400 million to IHS from this fund.
- The Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139, PPPHCE Act), the fourth law enacted in response to COVID-19, included not less than $750 million to be allocated to ITs/TOs or UIOs or health service providers to tribes.