



COVID-19 and the Indian Health Service

April 14, 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](#). IHS has seen [nearly 1,000 positive tests](#) as of early April for coronavirus. This Insight discusses the coronavirus and IHS.

IHS Is a Three-Tiered System with Resource Constraints

IHS provides health care to eligible American Indians/Alaska Natives. It does this 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 in the Indian Self-Determination and Education Assistance Act (ISDEAA, 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 across the system and by facility. UIOs offer outpatient services, while the IHS and the ITs may provide both outpatient and inpatient care, with [IHS operating half of the system's 46 hospitals](#). 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). Generally, PRC requires prior approval except in cases of emergency. [PRC funds are limited](#), as such, not all PRC claims are authorized. UIOs do not have [access to PRC funds](#). To be authorized, claims must meet [medical priority levels](#), individuals [must not be eligible for another source of coverage](#) (e.g., Medicaid or private health insurance), and individuals must live in certain geographic areas. IHS has stated that treatment of COVID-19 is considered to be [medical priority one \(i.e., an emergent or urgent care service\)](#).

IHS and COVID-19

As noted, IHS facilities have reported cases of COVID-19; the [ability to test for coronavirus](#) and to treat active cases varies throughout its system. For example, some tribes have reported [shortages of tests](#), the [materials needed to administer testing](#), and the [personal protective equipment needed by health providers](#).

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Tribes are also concerned about workforce shortages and their ability to isolate patients if positive cases present to their facility. 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.

IHS, like other types of health facilities, have 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. Tribes, like other providers, may receive additional flexibilities as a result of the March 13, 2020, presidential declaration of a disaster, and I/T/Us 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

Funding to augment the I/T/U system has been included in the three laws enacted in response to COVID-19.

Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, 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 reported awarding—\$80 million, or \$40 million more than what was required to be provided—to supplement grants that CDC awards for tribal public health activities (Tribal Public Health Capacity Building and Quality Improvement Grants). In addition, though IHS was not eligible for these initial funds, 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 second coronavirus related package—the Families First Coronavirus Response Act—included funds to 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. It provided \$64 million for this purpose to be allocated at the discretion of the IHS director. 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 (CARES Act) included funding for IHS and set asides in a number of health programs for IT/TOs and UIOs. 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 under ISDEAA 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.
- 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.

Author Information

Elayne J. Heisler
Specialist in Health Services

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