INDIAN HEALTH SERVICE RESPONSE TO COVID-19

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KEY TAKEAWAYS

- American Indians and Alaska Natives (AIAN) are at greater risk of developing serious complications from COVID-19 due to underlying socioeconomic factors and other disparities.
- To date, Congress has appropriated more than $2 billion to support the tribal response to the pandemic through recently enacted stimulus legislation.
- Funding for Indian Health Service providers is intended to support the prevention, preparation, and response to the outbreak in AIAN communities.

The COVID-19 pandemic has posed unprecedented challenges to communities across the nation. American Indian and Alaska Native (AIAN) populations have been hit particularly hard, as they are at high risk of complications from the virus due to underlying disparities in health, social, and economic factors.[i]

Within the Department of Health and Human Services (HHS), the Indian Health Service (IHS) is responsible for providing health services to AIAN people. IHS has collaborated with tribal leaders and state and local public health officials for a coordinated response to the outbreak.[ii]

Through COVID-19 stimulus legislation, Congress appropriated resources to support IHS' efforts to mitigate the outbreak, such as ensuring access to testing and treatment for AIAN patients and funding for tribal providers.

BACKGROUND ON THE INDIAN HEALTH SERVICE

The federal government has an obligation to provide health care services for AIAN populations, established through language in the U.S. Constitution and treaties with tribes. This obligation is further defined by case law and statute over the course of the relationship between the federal government and AIAN people.[iii]

The responsibility for these services falls to IHS, which provides a comprehensive federal health care delivery system for AIAN people.[iv] This health care delivery system comprises three parts, detailed in Figure 1. Eligibility for IHS services is largely limited to members and descendants of federally recognized AIAN individuals residing in the United States. IHS currently serves 574 federally recognized tribes in 37 states, amounting to 2.6 million AIAN people.

COVID-19 IMPACT AND IHS RESPONSE

Many AIAN people have underlying socioeconomic factors and other disparities that result in lower life expectancy and disproportionate incidence of chronic health conditions and serious disease.[v] These factors put this population at greater risk of developing serious illness or complications if they contract COVID-19. A recent analysis by the Kaiser Family Foundation puts that risk at 34 percent for nonelderly AIAN individuals—significantly higher than the estimated 21 percent for all nonelderly adults.[vi]

IHS works closely with tribal partners and state and local health officials to combat the COVID-19 pandemic. The agency has developed a coordinated approach to ensure access to testing, personal protective equipment, and other needed resources to mitigate the

Figure 1: Components of IHS Health Care Delivery System

Direct health care services

IHS directly provides health care services administered through 12 area offices and 170 service units managed by IHS and tribes.[vii]

Tribally operated health care services

IHS works closely with tribes and tribal organizations that control and manage certain health care services, which accounts for 60 percent of the agency appropriation.[viii]

Urban Indian health care services and resource centers

Through limited, competing contracts and grants with IHS, 41 Urban Indian Organizations provide health care and referral services for urban AIAN populations.[ix]

outbreak, and leverage telehealth to continue needed health care services during the outbreak. The agency also received priority distribution of rapid COVID-19 tests as part of the Trump administration's goal of extending the availability of testing in rural communities.[x]

FUNDING FOR IHS COVID-19 EFFORTS

Through recently enacted stimulus legislation, Congress has appropriated funding to support IHS activities related to the COVID-19 pandemic. To date, more than $2 billion in funding has been distributed to IHS and IHS providers.

The Coronavirus Preparedness and Response Supplemental Appropriations Act

The Coronavirus Preparedness and Response Supplemental Appropriations Act was the first stimulus package enacted to support the nation's response to the COVID-19 pandemic. The law appropriated $70 million to IHS to prevent, prepare, and respond to the pandemic in AIAN communities.[xi] Of that total, $30 million was allocated to support IHS federal health programs. The remaining $40 million was used to purchase personal protective equipment, provided at no cost to all IHS health programs.

The Families First Coronavirus Response Act

The Families First Coronavirus Response Act, the second stimulus package passed, provided several resources for IHS. First, the law appropriated $80 million to support COVID-19 mitigation by tribes, tribal organizations, and Urban Indian Organizations.[xii]

While IHS used part of the funding to supplement existing response efforts, $40 million was made available through grants to all eligible Title I and Title V tribes.[xiii] This law also appropriated $64 million to support IHS COVID-19 response activities, of which $3 million was targeted to Urban Indian Organizations.[xiv] The funding for Urban Indian Organizations was complemented by $8 million provided by the Centers for Disease Control and Prevention (CDC) through the National Council of Urban Indian Health. The remaining $61 million was allocated to IHS federal health programs and tribal health programs. IHS used existing methodology and mechanisms for program increases in hospital and health center funding to distribute the dollars.

The Coronavirus Aid, Relief, and Economic Security Act

The Coronavirus Aid, Relief, and Economic Security (CARES) Act appropriated a total $1.032 billion for IHS to support efforts related to the

COVID-19 pandemic. The legislation specified:

- a minimum of $450 million for distribution to programs directly operated by IHS, tribal health programs, and Urban Indian Organizations; and
- a maximum of $65 million for stabilizing and supporting electronic health records.

The remaining funds were left to the discretion of the IHS director for COVID-19 response activities, with at least $125 million transferred to IHS facilities. IHS announced April 3 it would immediately allocate $570 million to agency and tribal health programs, with $30 million targeted to urban Indian health programs. The agency used existing mechanisms to distribute the funding.

IHS provided tribal health and Urban Indian Organization leaders additional detail about the remaining dollars in an April 23 letter.[xvi] The letter was accompanied by an IHS funding announcement allocating:

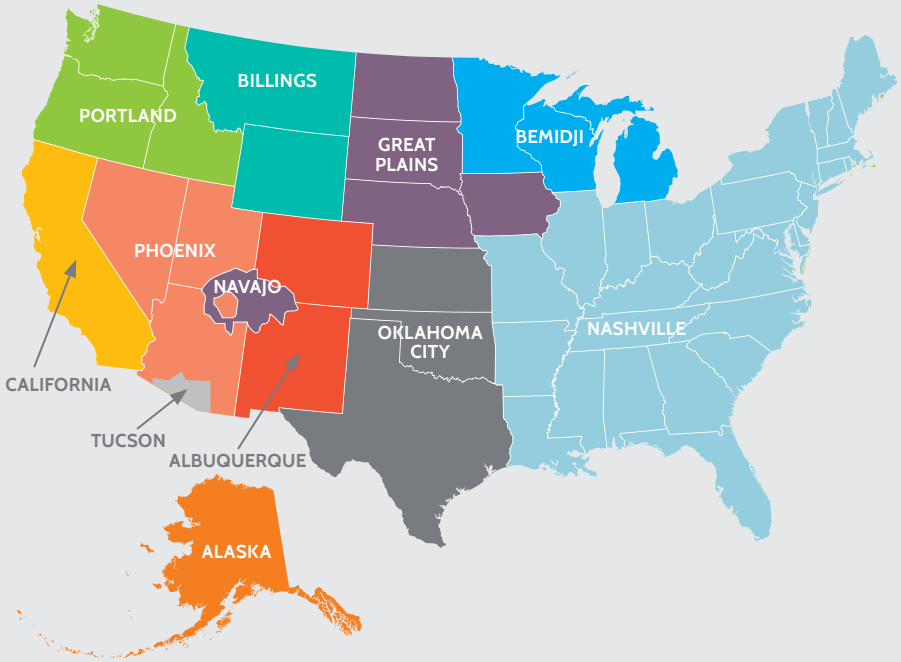
- $95 million to support telehealth expansion activities across all IHS health programs;
- $74 million for medical equipment needs;
- $26 million to support tribal epidemiology centers and national surveillance coordination activities;
- $10 million for sanitation and potable water needs; and
- $5 million to provide additional, no-cost test kits and materials to all agency health programs.[xvii]

Provider Relief Fund

Additionally, the CARES Act appropriated $100 billion for the Public Health and Social Services Emergency Fund, referred to as the Provider Relief Fund, to be used to aid hospitals and other providers incurring increased costs and lost revenue from responding to the pandemic. HHS on April 22 announced how it intended to allocate the relief fund among providers, which included IHS providers.[xviii]

On May 22, HHS distributed $500 million from the Provider Relief Fund to IHS providers. IHS hospitals received a $2.81 billion base payment with an additional 3 percent of total operating expenses. IHS, tribal clinics and programs, and urban programs received a base payment with an additional amount based on a calculation of a percentage of the service population multiplied by a per-user cost. HHS noted this allocation complements previous funds distributed to IHS facilities for COVID-19 response and for telehealth expansions.[xix]

Figure 2: IHS Service Areas



Rural Tribal COVID-19 Response Program

The Rural Tribal COVID-19 Response (RTCR) program, funded by the CARES Act and administered through the Health Resources and Services Administration (HRSA), allowed eligible federally recognized tribes and tribal organizations to apply for funding to support COVID-19 response activities in rural communities. On May 28, HHS—through HRSA—awarded $15 million to 52 tribes, tribal organizations, Urban Indian Health Organizations, and other providers that applied for the RTCR program. Tribes could request up to $300,000 and have flexibility in how to use the funds in responding to COVID-19 in their communities; for example, they could use the money to support workforce and build infrastructure.[xx]

Paycheck Protection Program And Health Care Enhancement Act

The Paycheck Protection Program and Health Care Enhancement Act, signed April 26, allocated an additional $75 billion for the Provider Relief Fund. Additionally, the law provides $25 billion to expand COVID-19 testing, with at least $750 million allocated to IHS for testing and related activities. As of this publication, it is unclear if HHS will allocate additional dollars from the Provider Relief Fund to IHS providers or how the agency will distribute testing-related funds.

Notes

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[ix] Ibid.

[x] *FAQs—Federal Response in Indian Country*. https://www.ihs.gov/coronavirus/faqs-federal-response-in-indian-country/. Accessed May 2020.

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