DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

August 20, 2025

Dear Tribal Leader:

I am writing to you to reaffirm the commitment of the Indian Health Service (IHS) to strengthening the Purchased/Referred Care (PRC) program and to share important program-related updates and progress.

Unobligated Balances: In Calendar Year (CY) 2023, the IHS established strategic spending plans for PRC balances and set carryover amount targets of 15 percent or less of the PRC program's recurring base budget. By the end of Fiscal Year (FY) 2024, the IHS achieved a 31 percent reduction in unobligated PRC balances from $378 million in FY 2023 to $259 million in FY 2024. In FY 2025, monitoring PRC strategic spend plans continues to be an Agency priority. Service Units continue to execute their PRC spend plans to maximize authorizations for patient care. The projected end-of-year carryover for FY 2025 is between $150 and $200 million, or approximately 18 percent carryover of appropriations.

Medical Priorities: In CY 2024, the IHS fully implemented new medical priorities for PRC and coordinated multiple training sessions across the Agency and with Tribal programs to educate and implement the new medical priorities. Ninety-eight percent of Federal facilities currently pay medical priority levels 1 and 2 (essential and necessary) referrals and cover some, if not all, medical priority level 3 (justifiable/elective) referrals. The new medical priorities allow for more preventative care; additional medical, dental, and vision services; and durable medical equipment that were not previously covered by PRC.

Authorization and Payment: The IHS has continuously worked with the Fiscal Intermediary (FI) to reduce the number of pending claims and improve the purchase order payment process. This involved revising reports and software functionality to reduce and resolve pending claims. As a result, pending claims decreased by 50 percent from December 2023 to January 2025. Ninety-eight percent of all "clean" claims are processed and paid in 30 days or less. The FI processed 405,796 claims in FY 2024.

Catastrophic Health Emergency Fund (CHEF): The purpose of the CHEF) is to meet the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses who are within the responsibility of the IHS. New regulations became effective on October 29, 2024, and lowered the reimbursement threshold amount from $25,000 to $19,000 for FY 2024, allowing more cases to be eligible for reimbursement and expanding access to health care in Indian Country. The threshold amount is adjusted each year based on the medical care expenditure category of the Consumer Price Index. In FY 2025, the IHS approved just over $30 million in CHEF reimbursements to Federal and Tribal facilities. The IHS has developed improved tools and tracking mechanisms to further expedite the approval process for these high-dollar cases.

No Patient Liability Language: The IHS revised referral language to include the Indian Health Care Improvement Act's No Patient Liability language to trigger patient protections, and the same language was added to FI and vendor correspondence. The IHS is building on past actions, including working to improve the payment process through our FI, advocating at the local level for patients with unfair billing or collection issues, and working with the Department of Health and Human Services' Office of the General Counsel to draft letters to cease to debt collectors.

Purchased/Referred Care Delivery Area (PRCDA) Redesignations: The Indian Health Care Improvement Act, 25 U.S.C. § 1678a(a) directs the IHS to designate the States of North Dakota and South Dakota as PRCDAs for the purpose of providing PRC services to members of Indian Tribes in those states. However, § 1678a(b) prohibits the designation from decreasing health care services to Indians residing on any reservation, or in any county that has a common boundary with any reservation, in the States of North Dakota and South Dakota. Similarly, 25 U.S.C. § 1678(a) directs the IHS to designate the State of Arizona as a PRCDA for the purpose of providing PRC services to members of Indian Tribes in that state, but § 1678(b) prohibits this designation from decreasing health care services to Indians residing on reservations in Arizona.

By letter dated June 23, 2025, I provided Tribal Leaders in the States of North Dakota and South Dakota with an update on the feasibility study to create state-wide PRCDAs in North Dakota and South Dakota. On February 21, 2025, the IHS awarded a contract to Tribalhealth Alliance to perform the study. The study is anticipated to be complete at the end of October 2025, and I will continue Tribal Consultation to review the impact of the state-wide redesignation prior to making a final decision.

Similarly, by letter dated June 23, 2025, I provided an updated to the Tribal Leaders in the State of Arizona on the feasibility study that was previously conducted and on the need to continue Tribal Consultation to review the impact of the state-wide redesignation prior to making a final decision.

The highlights listed above represent just a few of the many ongoing efforts to strengthen and improve the IHS PRC Program. I look forward to hearing your comments and feedback regarding the PRC program via the Tribal Consultations mentioned above. If you have questions, please contact CDR Tracy Sanchez, Acting Director, Office of Resource Access and Partnerships, IHS, by telephone at (301) 443-3216 or by email at tracy.sanchez@ihs.gov.

Sincerely,

Phillip B. Smith -S

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P. Benjamin Smith, M.B.A., M.A.
Acting Director