Texas Women's Healthcare Coalition
PROMOTING ACCESS TO PREVENTIVE HEALTHCARE FOR ALL TEXAS WOMEN

November 13, 2025

Texas Health and Human Services Commission

Re: Comments on Healthy Texas Women 1115 Demonstration Waiver

On behalf of the Texas Women's Healthcare Coalition, thank you for the opportunity to provide feedback on the Healthy Texas Women 1115 demonstration. We would like to take this opportunity to reaffirm our **strong support for the program and to emphasize the vital role the Healthy Texas Women program plays in improving the lives of women across Texas.**

TWHC and its 75+ healthcare, faith, and community-based member organizations are dedicated to improving the health and well-being of Texas women, babies, and families by improving access to preventive healthcare, including annual exams, cancer screenings, and birth control. Access to these services throughout a woman's reproductive years – including health screenings and contraception – contributes to healthy, planned pregnancies as well as early detection and treatment of cancers and other chronic conditions.

We are submitting the following comments to highlight ongoing challenges impacting access to care and clinic operations across our provider network.

HTW Application: Implementation of 89th Session Budget Rider

The long-form MAGI application for the HTW program continues to be a major barrier to enrollment, delaying care for women who urgently need preventive services. Since its implementation in 2019, approval rates have dropped from approximately 50% to 30%, and procedural denials due to missing documentation have risen from about 13% to nearly 30%. This administrative burden disproportionately affects low-income and rural women who cannot readily provide full household tax documentation. The delays limit timely access to cancer screenings, STI testing and treatment, contraception, and chronic disease management.

The TWHC is in support of *rapid implementation of the HTW short form,* family planning-only application, as states like Mississippi and Alabama have done. This would ease administrative burdens on providers, accelerate enrollment, and improve access to preventive care in underserved communities.

Medicaid Enrollment and TMHP System Issues

Providers continue to face significant delays with Medicaid enrollment through the Texas Medicaid & Healthcare Partnership (TMHP) and its Provider Enrollment and Management System (PEMS). The system lacks transparency, clear timelines, and reliable communication channels. These problems affect not only individual providers but also new clinic sites and women's preventive mobile health units. HTW providers have waited up to nine months for enrollment or revalidation. Delays that prevent billing and reimbursement, creating severe financial strain on freestanding clinics that do not have the cash reserves of large hospital systems. Timely Medicaid payments are essential to sustain day-to-day operations and prevent service interruptions.

TMHP system inefficiencies compound these delays. The inability to track application progress or access timely assistance forces providers to spend extensive hours resubmitting documents and waiting weeks for responses. HTW providers spend a significant amount of time resubmitting documents and waiting for support. Even scheduling technical support can take

nearly a month, including five to seven business days simply to receive a callback to book an appointment. Disenrollment notices are sent only via email and often land in spam folders, leaving providers unaware of disenrollment until claims are denied, disrupting operations and delaying patient care. These inefficiencies disrupt clinic workflow and reduce time available for patient outreach and service delivery.

HTW Recertification

Healthy Texas Women (HTW) recertification has also become increasingly burdensome for established providers. Previously, providers could complete the HTW attestation separately, but now, providers must complete both attestation and Medicaid revalidation, if timelines overlap. This combined process is time-consuming and often requires site visits, and facility photographs, creating lengthy delays, sometimes up to ten months for final approval. During this period, providers are unable to bill or receive reimbursements, leading to significant cash-flow disruptions. These delays can jeopardize clinic stability, potentially leading to staff reductions or even clinic closures.

HTW Transition to Managed Care

The 1115 Waiver approval will also transition the delivery of HTW services from fee-for-service (FFS) to a managed care model. We look forward to working with HHS and MCOs to deliver essential health services to women in Texas. We offer additional considerations to provide continuity of services during this transition.

Credentialing Across Managed Care Organizations

The administrative burden extends beyond PEMS. Providers must credential with numerous managed care organizations within the service delivery area (SDA), as well as several outside of the SDA. Each Managed Care Organization (MCO) imposes separate credentialing requirements with distinct documentation, timelines, and review processes. MCO credentialing processes can lead to delays in onboarding of new providers and clinic sites, disproportionately affecting rural and underserved areas where provider shortages are already critical. The lack of standardized credentialing hinders provider capacity to meet community needs and undermines continuity of care.

Develop Process to Reimburse Medicaid Enrolled HTW Providers for Covered Services Rendered to Eligible Patients Prior to MCO Credentialing Effective Date

In many instances, providers experience gaps in reimbursement between the date they are enrolled with Medicaid and when they are credentialed with a managed care organization. For example, a provider may submit a Medicaid enrollment application in May 2025 but does not receive final approval until September 2025. The Medicaid enrollment effective date is backdated to May 2025. The provider can receive reimbursement for services delivered to patients with FFS since May 2025. However, the provider cannot start the credentialing process with most Medicaid MCOs until it receives final approval from TMHP. If the provider submits a credentialing application in September 2025, the MCO can take 30 days or longer to review and approve and additional time to edit claims systems for new providers. As a result, it is possible the provider will not be able to bill for any services delivered prior to the effective credentialing date. It is possible the provider would not get reimbursed for services delivered to MCO patients between May – September 2025. Rather than turn patients away who need family planning services, the provider will eat the cost of providing services during the credentialing timeframe. We urge HHS to develop a process to help ease the financial burden on providers and allow continuity of care regardless of the delivery model.

Out of Network Services

Under the 1115 Waiver, Medicaid managed care members have the right to choose any participating Medicaid provider regardless of whether the provider is in or out of network. The MCO is required to pay no less than the FFS amount for services in-network and follow the HHS administrative rules for OON.

> *The MCO must provide, at minimum, the full scope of Covered Services available under Texas Medicaid program for family planning services. The MCO must reimburse family planning agencies no less than the Medicaid FFS amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies, and must reimburse OON family planning providers in accordance with HHSC's administrative rules. The MCO must not require a PA for family planning services whether rendered by a Network or OON provider. (2.6.53.2.1 STAR Family Planning Specific Requirements)*

> *The MCO must reimburse family planning agencies no less than the Medicaid FFS amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies and must reimburse OON family planning providers in accordance with HHSC Administrative Rules. The MCO must not require a PA for family planning services whether rendered by a Network or OON provider. (2.6.53.2.2 HTW Family Planning Specific Requirements)*

The MCO cannot require prior authorization for family planning services whether rendered in or out of network. The contract language is not aligned with the OON rules in 1 TAC 353.4 which do not require the MCO to provide OON reimbursement for non-emergency services unless certain criteria are met. We request clear exemption from the administrative rules to confirm that family planning services are provided and reimbursed to Medicaid providers.

> *(2) Other authorized services. The MCO must allow referral of its member(s) to an out-of-network provider, must timely issue the proper authorization for such referral, and must timely reimburse the out-of-network provider for authorized services provided if the criteria in this paragraph are met. If all of the following criteria are not met, an out-of-network provider is not entitled to Medicaid reimbursement for non-emergency services:*
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> *(A) Medicaid covered services are medically necessary and these services are not available through an in-network provider;*
> *(B) a participating provider currently providing authorized services to the member requests authorization for such services to be provided to the member by an out-of-network provider; and*
> *(C) the authorized services are provided within the time period specified in the MCO's authorization. If the services are not provided within the required time period, a new request for referral from the requesting provider must be submitted to the MCO prior to the provision of services.*

In addition, any OON services are set to be reimbursed at the FFS rate minus 5% based on the administrative rules. We request HHS clarify that any Medicaid enrolled provider must be reimbursed at 100% of the FFS rate for family planning service regardless if the provider is OON.

> *(2) Emergency and authorized services performed by out-of-network providers.*
> *(A) Except as provided in § 353.913 of this chapter (relating to Managed Care Organization Requirements Concerning Out-of-Network Outpatient Pharmacy Services) or subsection (j)(2) of*

this section, the MCO must reimburse an out-of-network, in-area service provider the Medicaid FFS rate in effect on the date of service less five percent, unless the parties agree to a different reimbursement amount.
(B) Except as provided in § 353.913 of this chapter, an MCO must reimburse an out-of-network, out-of-area service provider at 100 percent of the Medicaid FFS rate in effect on the date of service,

unless the parties agree to a different reimbursement amount, until the MCO arranges for the timely transfer of the member, as determined by the member's attending physician, to a provider in the MCO's network.

Out of network provisions are important to HTW as young women may apply for the program in one county (e.g. where their parents live) but may be attending a higher education institution in another county and service delivery area, resulting in higher out of network utilization.

To support and strengthen the HTW provider network and ensure timely access to care, we respectfully request that HHSC prioritize the following actions:

1. Rapidly implement the HTW short-form application for individuals requesting only HTW coverage to expedite the enrollment process.
2. Enhance PEMS system functionality and provider support by fully funding and staffing the SB 1266-mandated support team with authority to resolve issues promptly and transparently.
3. Require MCOs to adhere to standardized timelines for completing credentialing and resolving claims, with enforcement mechanisms for noncompliance.
4. Update HTW attestation policies by simplifying procedures for established HTW providers to minimize administrative barriers and improve program efficiency.

SB 1266, passed during the 89th Texas Regular Legislative Session, addresses many of these inefficiencies directly. The TWHC and our provider network are eager to participate in PEMS workgroups to help resolve these issues. We are optimistic that this collaboration will reduce administrative burdens, ensure timely technical support, and allow deficiencies to be corrected within 30 days before disenrollment.

If you have any questions or if we can provide further information, feel free to contact Desiree Ingram at: dingram@healthyfutures-tx.org

Respectfully submitted,

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