

TEXAS HOME HEALTH · PAYER CONTRACTING · OCTOBER 2026

The Texas Home Health Payer Contracting Playbook

How to get in-network when every insurer says the network is closed. What is lawful, what you are owed, the seven doors that still open, a 90-day plan, and copy-ready letters.

7

doors to work in parallel

6

copy-ready letter templates

90

day plan with a tracker

By Arvind Sarin, founder, Copper Digital. For owners and administrators of Medicare-certified home health agencies in Dallas-Fort Worth and Houston. Facts, contacts and clocks checked October 7-8, 2026; confirm before you send. Templates are researcher syntheses: have Texas health-care counsel read anything before it goes out. Not legal advice.

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HOW TO USE IT

- 1 **Read sections 1 and 2** once, so you know what a payer can lawfully say and what it owes you.
- 2 **Work the seven doors in parallel** (section 3), using the payer maps in section 4 for the exact contact and payer ID.
- 3 **Fix your three numbers** and build the packet (sections 5 and 6) before you argue network need.
- 4 **Run the 90-day plan** (section 7) and copy the templates in section 8. Every bracket is a fact you fill in, never an estimate.

Why I wrote this

Two kinds of agencies keep telling me the same story. The first is a well-rated DFW agency with no commercial, Medicare Advantage or Medicaid managed-care contract at all, whose starts of care have collapsed as referrals moved to managed-care patients. Every payer it calls says: no open contracts unless you have a specialty. The second is a Houston-area agency that already holds a few MA and commercial contracts, is paid per visit at rates it wants to move, and is shut out of the plans its referral sources use most. Different problems, same wall. So I asked: when a payer says "closed," what is actually true, what is legally required of them, and what has worked in Texas?

01 The problem in one page

You call the plan's provider line. Weeks later a two-line email: "We are not accepting new applications for your provider type in your area." Sometimes it is softer: "We have enough agencies." Sometimes it comes from a vendor you have never heard of, and nobody can tell you whether the vendor or the plan decides.

Then the second conversation, which hurts more. A hospital case manager tells your marketer: "We like your nurses, but you only take five insurances." Her screen filters agencies by accepted insurance, and you are not on it.

Both conversations are structural, not personal. In the four core DFW counties, 607 Medicare-certified home health agencies are headquartered locally, and one Plano ZIP code (75074) sits inside 183 agencies' service areas ^[17]. The city of Houston alone has 260, with no new Houston certification in the CMS file since December 31, 2020 ^[17]. "Closed" is the default script.

607

Medicare-certified agencies headquartered in Dallas, Tarrant, Collin and Denton

517K

DFW Medicare Advantage lives, September 2026

59%

Medicare Advantage penetration across the Houston five-county area

Meanwhile the money has moved. In September 2026, about 517,000 Medicare beneficiaries in Dallas, Tarrant, Collin and Denton counties were in Medicare Advantage: Dallas 200,946 (55.0% penetration), Tarrant 183,650 (55.6%), Collin 70,484 (42.7%), Denton 62,078 (45.0%) ^[16]. Across Harris, Montgomery, Fort Bend, Brazoria and Galveston, MA penetration is 59.0%; Harris alone is 61.4% ^[16]. In Dallas, Tarrant and Harris counties an agency that bills only Traditional Medicare is competing for less than half the market; in Collin and Denton, for a shrinking majority.

You have no right to a contract. What you have is a right to a written reason, on state-regulated products a right to the application criteria, a legal way to be paid out of network on PPO products, vendor and referral-source

doors that do not depend on the plan's answer, and a 90-day plan to work all of them at once.

02 Why "closed" is lawful, and who really gates the network

"Our network is closed" is lawful in every product line you sell into. No Texas or federal law gives a Medicare-certified agency a right to a contract ^{[3][8][10][13]}. Accept that, and start working the mechanisms that do exist.

Medicare Advantage (federal rules only). Home health is not a measured facility type under the MA network-adequacy rule: 42 CFR 422.116(b)(2) lists 14 facility types and "home health" appears nowhere ^[1]. A plan may refuse providers "in excess of the number necessary to meet the needs of the plan's enrollees" (422.205(b)(1)) and owes you written notice of the reason (422.205(a)) ^[3]. What plans do owe is access: 422.112(a)(1)(i) requires a network "sufficient to provide adequate access to covered services" and names home health agencies; (a)(1)(iii) requires out-of-network care at in-network cost sharing when no in-network provider is available ^[2]. Since January 1, 2024, 422.112(b)(8)(i)(B) requires "a minimum 90-day transition period for any active course(s) of treatment" after enrollment, "even if the service is furnished by an out-of-network provider" ^[7]. Texas insurance law does not reach MA (42 U.S.C. 1395w-26(b)(3); 42 CFR 422.402).

Texas commercial HMO (TDI-regulated). An HMO must, on request, "make available and disclose to a physician or provider written application procedures and qualification requirements" (Ins. Code 843.302), must give written reasons (843.303(a)), may deny for "sufficient qualified physicians or providers" (843.303(b)), and must open a 20-day application window each year (843.305) ^[8]. Under 28 TAC 11.1402 the "Notice to Physicians and Providers" runs January 2-23 and the HMO must answer in writing within 90 days ^[9]. TDI enforces it: Order 2024-8760 (Superior HealthPlan, August 5, 2024) found 62 of 310 applications unanswered within 90 days as part of a \$240,000 penalty ^[9]. For an individual patient, Ins. Code 1271.055 and 28 TAC 11.1611(c) (amended effective March 30, 2025) require the HMO to process a network provider's non-network referral within five business days, approve a gap exception concurrently, and pay at the in-network benefit level ^[11].

Texas commercial PPO/EPO (TDI-regulated). Ins. Code 1301.051 gives a "fair, reasonable, and equivalent opportunity to apply" and written reasons; 1301.051(d) allows rejection for sufficient providers; 28 TAC 3.3706(b) requires "specific reason(s)" ^[10]. There is no decision clock, but there is an information right: under 1301.054(c), "On request, an insurer shall provide to any physician or health care provider information concerning the application process and qualification requirements," including "the use of economic profiling" (28 TAC 3.3706(a)(3)) ^[10]. Ask for it in writing, but do not claim the statute requires written form. For patients, 28 TAC 3.3707(j)-(k) require the insurer, within five business days, to approve a gap exception or recommend two "reasonably available" providers, and 1301.005(b) with 3.3708 require the preferred benefit level when none is ^[12]. Call your agency a "health care provider" (1301.001(1-a)), never an "institutional provider"; no bulletin, opinion or court has decided whether a home health agency is covered.

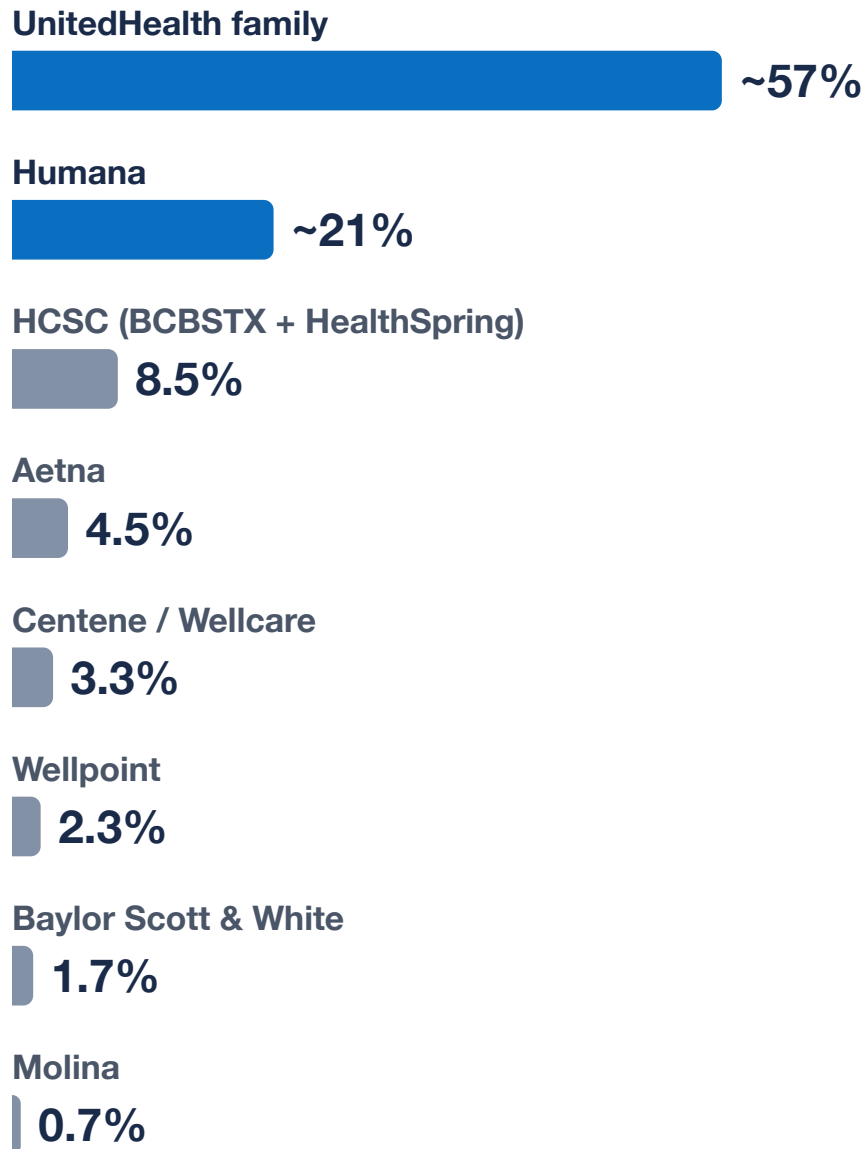
Texas Medicaid managed care. 42 CFR 438.12(a)(1) and the HHSC Uniform Managed Care Contract (Attachment B-1, 8.1.4.4) require written reasons, a missing-information notice within five business days and a credentialing decision within 90 days; 438.12(b)(1) says nothing requires contracting "beyond the number

necessary" ^[13]. There is no "any willing provider" status. Out-of-network care pays fee-for-service minus 5% under 1 TAC 353.4 ^[14].

Who really gates the network

In DFW, UnitedHealth-family contracts hold roughly 57% of MA lives and Humana about 21% (a researcher mapping of legal entities; KFF independently puts UHC at 55% of Dallas County) ^[16]. UHC's Texas MA volume is administered by WellMed for delegated plan packages: WellMed requires prior authorization for every home health code and publishes no ancillary contracting door. Humana's authorizations run through Humana Home Solutions "for some members," and it owns CenterWell in Plano. Both big carriers have a reason to say the network is full.

Who holds DFW Medicare Advantage lives



Share of 517,032 DFW MA enrollees by parent company. Parent shares are a researcher mapping of legal entities; KFF independently puts UnitedHealthcare at 55% of Dallas County MA (2024).

CMS September 2026 county files · KFF

Houston is more fragmented and more HMO-heavy. HealthSpring holds the largest single contract (13.6% of Harris MA); UnitedHealthcare entities about 27%; Aetna 11.4%; Humana 11.1%; KelseyCare Advantage 8.9% (the largest single plan); Centene 8.1%; Wellpoint 6.9%; Devoted 5.8% (researcher mapping; confirm against the CMS plan directory before quoting) ^[16]. Roughly four of five non-SNP Houston MA members are in HMO or HMO-POS products, where the capitated medical group (Kelsey-Seybold UM, WellMed, Astrana, Humana Home Solutions) is the practical gate; SNP and employer plans sit outside that ratio.

In DFW, only two vendors act as true delegated network contractors for home health today: tango (Wellcare Texas MA, since July 1, 2025) and Carelon Post Acute Solutions (Aetna MA; Wellpoint MA non-risk plans) ^{[28][29]}. EviCore also contracts agencies into Cigna's commercial network ^[27]. Houston adds two capitated gates:

Astrana holds delegated credentialing for Wellcare members assigned to its ASTHOU and ASTBEAU IPAs, and Kelsey-Seybold UM authorizes all KelseyCare Advantage home health ^{[29][30]}. Know which desk you are talking to before you write a word.

03 The seven doors, in priority order

I rank these by expected yield for an agency with few or no contracts. Work them in parallel, not in sequence.

1

DOOR 1

Diagnose the refusal before you answer it

What it is. Five different problems hide behind "closed." Only one needs a network-need case.

1. True sufficiency: the plan has enough agencies for this product and county.
2. Wrong decision-maker: a vendor portal or provider-services line that owns authorizations, not contracting.
3. Credentialing gap: accreditation or survey, liability limits, CAQH, Medicaid enrollment.
4. Economic mismatch: the rate offered does not cover your cost.
5. Existing contract loaded wrong: claims deny because the TIN, NPI, branch, product or effective date is wrong.

Example. A "WellMed" line on your remits is most plausibly a UHC contract loaded into WellMed's claims system (payer ID WELM2); confirm from the signed agreement, then repair the loading rather than reapply ^[23]. A "Carelton" letter in your files is a Medicare Advantage determination (Aetna MA or Wellpoint MA), never Aetna commercial, and does not mean a contract exists: if you are not in network with Aetna or Wellpoint, Carelon still needs the Agency Information Form and a credentialing invitation ^[28].

How to. For every decline, write down the product and county assessed, whether the plan or a delegate owns the decision, what credential is missing, the rate offered, and whether you already hold any agreement with this parent under any TIN.

Do not send a network-need packet to a credentialing deficiency, and do not treat registration in a vendor portal as a contract.

2

DOOR 2

Bill MA PPO members out of network at Original Medicare rates

What it is. A non-contracted agency treating an MA PPO member is paid what Original Medicare would pay (42 CFR 422.214(b); SSA 1866(a)(1)(O)), and a PPO "provides for reimbursement for all covered benefits regardless of whether the benefits are provided within the network" (422.4(a)(1)(v)(B)) "without prior authorization requirements" (Medicare Managed Care Manual Chapter 4, section 110.4) ^{[4][5]}.

Evidence it works. About 31% of DFW MA enrollees (159,772 of about 517,000 in the PPO file) are in PPOs, highest in Denton (40.8%) and Collin (37.6%) ^[16]. A Dallas 30-day period at case-mix 1.0 pays about \$1,983; Houston about \$1,997 (researcher computation from CMS inputs) ^[18]. Against a \$100-140 per-visit contract, that is a gross uplift of roughly 1.4x to 2.5x per period.

One 30-day period, three ways to be paid

Per-visit contract: 8 visits × \$100

\$800

Per-visit contract: 8 visits × \$140

\$1,120

Original Medicare amount: Dallas 30-day period

\$1,983

One 30-day period: what a per-visit contract pays versus the Original Medicare amount an MA PPO must pay a non-contracted agency. Gross, before member cost-share.

42 CFR 422.214(b) · CMS CY2026 rates · researcher computation

The three drags. Member cost-sharing can run to 50% coinsurance out of network (422.100(f)(6)(i)) ^[5]. "No PA" does not mean "no review": the plan may deny after the fact on Medicare criteria. And referral platforms filter out non-network agencies, so the volume has to come from referral sources you own.

How to. Request a pre-service organization determination under 422.566(c)(1)(ii); the plan must decide within 7 calendar days for PA-subject services and 14 otherwise (422.568(b)(1)), 72 hours if a physician requests expedited review (422.570); once approved, 422.138(c) bars a later medical-necessity denial absent fraud or error ^[6]. Bill exactly as Medicare (UB-04/837I, HIPPS code, TOB 32x); route WellMed-delegated packages to WELM2 ^[23]. Collect the member share under a written pre-SOC disclosure. For a patient already on service when MA enrollment takes effect, cite 422.112(b)(8)(i)(B) in the first claim's cover note ^[7]. Houston, being HMO-heavy, gives this door less room.

Do not run a long-stay recertification book through this door; it is for short post-hospital episodes. Never balance bill an MA member.

3 **DOOR 3** **The delegated-vendor doors that take applications on their own**

What it is. Some vendors contract home health networks independently of the plan's "closed" answer.

Evidence it works. tango's join form says "tango is continually looking for partnerships with skilled home health providers" ^[29], and trade press reports 60-90 day onboarding at rates "as close to Medicare as possible" ^[42]. Carelon publishes explicit criteria: CMS star rating of at least 1.5, accreditation or survey within three years, \$1M/\$3M liability ^[28].

How to.

- tango (Wellcare Texas MA, payer ID 26748): join form at tangocare.com; contractmanagement@tangocare.com; 1-888-224-1409 ^[29].
- Carelon (Aetna MA, 34010; Wellpoint MA, 34009): the Smartsheet "Agency Information Form" only loads you for authorizations; credentialing is by invitation to credentialing@carelon.com; 833-585-6262; a closure notice stays on file six months ^[28]. Aetna commercial needs Aetna's own Type 2 facility request (60 days; one-year bar).
- EviCore (Cigna commercial): ECRM portal at ecrm.evernorth.com, "Contracting" request; Credentialing@eviCore.com ^[27].
- Houston only: Kelsey-Seybold takes a Letter of Interest at affiliateproviders@kelsey-seybold.com (company overview, services, locations, geographic coverage, specialty services, staff roster) ^[30]; for Astrana ASTHOU/ASTBEAU members, ask PR.Houston@SuperiorHealthplan.com in writing which entity contracts and pays home health ^[29].

Do not assume a Carelon credential reaches Aetna commercial lives, and do not pay a consultant who cannot name the payers, products and executed agreements they have delivered.

4 **DOOR 4** **The referral-source assets you already hold or can claim**

What it is. Hospital discharge lists, ACO preferred lists and referral platforms do not run through a payer's network-need decision.

Evidence it works. 42 CFR 482.43(d)(1) says the hospital's list must include Medicare-participating HHAs that serve the area "as defined by the HHA," and that "HHAs must request to be listed by the hospital as available"; (d)(2) says the hospital "must not specify or otherwise limit the qualified providers" ^[15]. Southwestern Health Resources earned \$42.6 million in ACO REACH shared savings in PY2024, and its preferred organizational list already includes independent DFW agencies; check whether you are on it ^[32].

How to. Send Template E with a ZIP or county service-area definition to the discharge-planning director of every hospital you serve: in DFW, Texas Health, UT Southwestern, Methodist, Medical City (HCA) and Baylor Scott & White; in Houston, Houston Methodist, Memorial Hermann, HCA Houston, St. Luke's/CommonSpirit, Harris Health and UTMB ^[15]. In DFW, confirm the SWHR Preferred Provider agreement before year-end 2026 and secure carry-over into SWHR's LEAD participation from January 1, 2027 (David Mastin, David.Mastin@southwesternhealth.org, 214-389-7272). File for Methodist's MAP2 list (about 50 agencies, refreshed each February and August) before the February 2027 refresh (Shannon Huggins, MethodistACO@mhd.com, (214) 947-6575) ^[32]. In Houston, Houston Methodist's ACO runs its post-acute network on Bamboo Health "Pings"; subscribe, then approach the ACO's post-acute team (Medical Director-Post-Acute Kathryn Agarwal, MD; ACO contact Julia Andrieni, MD, 346-356-1553, jdandrieni@houstonmethodist.org) rather than hospital case managers, and request EpicCare Link access (helpdesk 832-667-5600; confirm HHA eligibility), the cheapest route to discharge summaries. Register on WellSky CarePort and Aidin; in Houston, ask each case-management office which platform it uses, since no Houston system is publicly confirmed on CarePort.

Do not offer anything of value to a referral source for a letter or a listing, and have counsel review any per-admit marketer commission against the anti-kickback safe harbors (my inference, not a legal finding).

5

DOOR 5

Apply everywhere, in writing, to force written reasons and start clocks

What it is. Every product type carries a duty to say why in writing, a written application starts whatever clock exists, and a dated willing-to-contract letter has value in TDI waiver proceedings.

Evidence it works. The 90-day HMO clock is enforced: TDI's Superior order is the proof ^[9]. Where carriers must document refusals, "no network need" is the stated reason 51% of the time (Nevada, CY2021): context, not leverage ^[38]. UHC publishes a reassessment form (March 10, 2026) for providers told that applications are not being accepted; UHC does not state it applies to home health, but file it when the closure email arrives ^[22]. Highmark's Special Consideration standard, outside Texas, is the only published closed-network exception found; write to its sentence: exceptions are "approved only in limited circumstances when a provider can demonstrate a unique service, specialized expertise, or other distinct value that addresses an identified network need not currently met by participating providers" ^[37].

How to. File Template A to every payer and delegate in Section 4. On a decline, send Template B, then Template G with the evidence packet, rather than resubmitting. If an HMO is silent at day 91, call TDI's Help Line (800-252-3439) and file a complaint citing 843.305(c) and 11.1402(c). For MA, a CMS provider complaint is a nudge, not a lever: CMS has never sanctioned a plan for network inadequacy.

Watch the calendar. January 2-23, 2027 is when every Texas commercial HMO must publish its "Notice to Physicians and Providers"; request the 11.1402(d) filings from TDI at MCQA@tdi.texas.gov. Expect Cigna's next Texas open-enrollment window between December 2026 and February 2027; confirm with NTXOKContracting@Cigna.com (DFW) or 9SouthTXC@Cigna.com (Houston) ^[27].

Do not threaten a regulatory complaint you cannot support to bargain for a rate, and do not resubmit an unchanged application.

6

DOOR 6

Medicaid and D-SNP alignment, as a lever, not a revenue line

What it is. Texas full duals now flow into integrated D-SNPs that pair one parent's Medicare plan with that parent's STAR+PLUS plan: in Dallas County, Molina and Superior today and UnitedHealthcare from January 1, 2027; in Harris County, Molina and UnitedHealthcare today and Community Health Choice expected from January 1, 2027 ^[31]. UHC says providers "must be in both the UnitedHealthcare Medicare Advantage and UnitedHealthcare Community Plan of Texas networks" to serve them.

Evidence it works. This is alignment, not Medicaid skilled-visit money. Texas Medicaid fee-for-service pays \$98.92 per RN/LVN visit (frozen since January 1, 2018) and \$46.09 per aide visit ^[20]. One statewide CVO (Verisys) serves every Texas MCO, so one credentialing file serves all of them.

How to. Enroll with TMHP/PEMS, onboard HHAeXchange for EVV, then file simultaneous letters of interest to every STAR+PLUS MCO in your service area (DFW: Molina, Superior, UHC Community Plan; Houston: Community Health Choice, Molina, UHC Community Plan) ^{[30][31]}. If you already hold a STAR+PLUS LTSS or personal-assistance agreement under any affiliated entity, file a product addition, not a new LOI. If you are in UHC Dual Complete, confirm the agreement includes Community Plan code 7R.

Do not model Medicaid skilled visits as revenue: for adults it covers acute conditions expected to resolve within 60 days and requires prior authorization for every visit.

7

DOOR 7

Side doors with no network-need decision at all

- VA Community Care Network (Region 4) and TRICARE West, both through TriWest: one Provider Contract Request at joinournetwork.triwest.com. Skilled "bundled" care pays through Medicare PDGM ^[34].

- Texas workers' compensation: the non-network maximum for a licensed HHA is 125% of the Medicaid schedule under 28 TAC 134.215, about \$123.65 per skilled-nursing visit and \$57.61 per aide visit (computed from the TMHP schedule) ^[20]. Adjusters and nurse case managers are the referral source.
- Group and retiree MA PPOs pay any Medicare-approved provider at Medicare's allowable schedule without a contract. The City of Houston's retiree Humana Group MA PPO letter: "You may receive reimbursement for treating these members even if you are not contracted with Humana as long as you are a Medicare-approved healthcare provider" ^[33]. TRS-Care (UHC Group PPO) works the same way. The same letter says prior authorizations are "strongly preferred," so request a pre-service determination anyway, and expect the same Medicare-criteria review as any out-of-network PPO claim ^[33].

Do not treat VA aide hours as a stable line: VA North Texas approvals of more than 20 hours a week fell from 37% to 11% in a year ^[41].

Doors 3, 4 and 5 all need the three numbers in Section 5 and the packet in Section 6. Without them the request has no evidence behind it.

04 The payer maps

Route by the payer ID and delegate name on the member's card, not by the plan name. Contacts were verified on October 7-8, 2026.

How long each payer takes to decide

Devoted



30-60 days

Aetna



60 days

one-year bar after denial

tango



60-90 days

BCBSTX



up to 90 days

CAQH within 45

Texas HMO



90 days

28 TAC 11.1402(c)

Medicaid MCO



90 days

42 CFR 438.12

Most payers publish no decision clock. Most payers publish none; where one exists, write the due date on your tracker the day you file.

Payer manuals and TDI rules, checked October 7-8, 2026

DFW payer map

Payer (approx. DFW MA lives)	Who gates home health	How to apply	Published clock
UnitedHealthcare / AARP (~294,000)	WellMed for delegated PBPs (PA required; payer ID WELM2); UHC for non-delegated PBPs (no HH PA since April 1, 2025)	Onboard Pro, then the "Home health and hospice service questionnaire" via Provider Portal chat; answer a "market closed" email with the March 10, 2026 reassessment form [21] [22]	None published

Payer (approx. DFW MA lives)	Who gates home health	How to apply	Published clock
Humana (~107,000)	Humana Home Solutions (800-572-4317) "for some members"; OneHome coordinates Texas referrals, contracting role unresolved	NTXNM@humana.com, subject "Join Humana's medical network"; application to credentialinginquiries@humana.com; status 1-800-626-2741 [24]	Not published
HealthSpring (HCSC; ~32,600)	In-house PA since January 1, 2026 (60-day bundles; plan of care within 7 days; payer ID 52192)	Provider Data Intake form; CAQH + Verisys; 800-230-6138 [25]	None; recredentialing 36 months
Aetna MA (~23,000)	Carelon (payer ID 34010; 833-585-6262); reaches no Aetna commercial or ASO lives	Carelon Smartsheet form; credentialing by invitation to credentialing@carelon.com; Aetna commercial via Type 2 facility request [28]	Aetna 60 days, one-year bar; Carelon closure notice six months
Wellcare / Wellcare By Allwell (~17,000)	tango (payer ID 26748) since July 1, 2025	tango join form; contractmanagement@tangocare.com; 1-888-224-1409 [29]	60-90 day onboarding (trade press)
Wellpoint MA / D-SNP (~12,000)	Carelon (payer ID 34009); no DFW STAR+PLUS	LOI + W-9 to TXCredentialing@wellpoint.com [30]	5-business-day incomplete notice; 90-day decision
BSW SeniorCare Advantage (~8,600)	BSWHP; home health is an AccentCare joint venture	New facility contract form; Aperture CVO; Provider Services 844-633-5325 [43]	"Allow 30-45 days"; exiting Texas Medicaid (August 31, 2026) and the individual market (2027)
BCBSTX (commercial PPO/HMO, HealthSelect, TRS-ActiveCare, STAR/CHIP; exits MA for 2027)	BCBSTX (payer ID 66006); commercial is the target	Provider Onboarding Form; April 2026 Ancillary/Facility Specialty Checklist; AncillaryContracting_SW@bcbstx.com; Houston: Provider_Relations_houston@bcbstx.com [26]	"Up to 90 days"; CAQH within 45 days; "in no way guarantees acceptance"
Cigna commercial	EviCore manages HH network and contracting; Cigna decides clinically; TDI fined Cigna \$100,000 on March 3, 2026	EviCore ECRM portal; Credentialing@eviCore.com; backup window NTXOKContracting@Cigna.com (DFW) or 9SouthTXC@Cigna.com (Houston), subject "Open Enrollment 2026" [27]	90 days (open-enrollment route)
Medicaid MCOs (DFW)	MCO UM; EVV via HHAEExchange; one statewide CVO (Verisys)	Molina (855) 322-4080; Superior SHP.NetworkDevelopment@SuperiorHealthPlan.com; UHC Community Plan uhc_cp_prov_relations@uhc.com; Parkland PCHP.ContractingDepartment@phhs.org [13] [31]	90 days from a complete application

Houston payer map

BCBSTX and Cigna commercial routes are as in DFW (Houston contacts in that table).

Payer (Harris MA lives, Sept 2026)	Who gates home health	How to apply	Published clock
HealthSpring (H4513, 54,551; 13.6%; largest single contract)	In-house PA; plan of care within 7 days; 60-day bundles; NOMNC two days before authorization end	Provider Data Intake; PA 1-800-453-4464 / 800-511-6932; service 800-230-6138 ^[25]	None; recredentialing 36 months
UnitedHealthcare (~27%; H4514 HMO/HMO-POS 45,524; H2001 Sierra PPO 32,283)	WellMed for delegated PBPs including H4514-014 (14-day PA lead per the November 1, 2026 PAL); Houston-specific WellMed HH PA unverified ^[23]	As DFW; confirm which PBPs are in network and whether the agreement includes Community Plan 7R	None
KelseyCare Advantage (H0332; 36,240; 8.9%; largest single plan; Optum-owned)	Kelsey-Seybold UM authorizes all HH (713-442-5339); capitated, physician-owned; panel cap unknown	Letter of Interest to affiliateproviders@kelsey-seybold.com; kelseycredentialing@kelsey-seybold.com; Provider Relations 713-442-9528 ^[30]	None; recredentialing 36 months
Aetna / CVS (~11.4%)	Carelon (Portal.mynexuscare.com; 1-833-585-6262)	As DFW ^[28]	As DFW
Humana (~11.1%)	Humana Home Solutions; OneHome; CenterWell in-house	HumanaHoustonPD@humana.com, subject "Join Humana's medical network"; 1-800-626-2741 ^[24]	Not published
Centene: Wellcare of Texas (17,096) + SelectCare/TexanPlus (16,206); ~8.1%	tango for skilled HH; for members assigned to Astrana IPAs ASTHOU/ASTBEAU, all authorization and referral requests go to Astrana; tango-vs-Astrana payment unresolved	tango join form (the only published door); Astrana 346-275-2280; Wellcare Houston PR.Houston@SuperiorHealthplan.com ^[29]	tango 60-90 days
Wellpoint (H8849, 28,047; 6.9%; largest Harris D-SNP carrier)	Carelon (34009); 30-day auth periods	TXCredentialing@wellpoint.com; HHSC contact Jennifer Bausch 713-346-7287 ^{[30][31]}	5 business days / 90 days
Devoted (23,579; 5.8%; 5-star)	Devoted direct (no vendor); 1-877-762-3515	Join page: "If you do not hear from us, you do not need to contact Devoted Health" ^[30]	30-60 days
Molina (STAR+PLUS 7S; integrated D-SNP since January 1, 2026)	Molina UM	(855) 322-4080; Contract Request Form; Denise Arvia, Denise.arvia@molinahealthcare.com; product addition if a STAR+PLUS LTSS agreement exists ^{[30][31]}	Not published
Community Health Choice (STAR+PLUS since September 1, 2024; DualCare Aligned D-SNP ~1,003 enrollees; Marketplace; expected integrated D-SNP January 1, 2027)	CHC UM	Existing providers: Facility/Ancillary Profile form to CHC.Contracting@CommunityHealthChoice.org; new LOIs via Salesforce portal; Wanda Henry 713-576-0893 ^{[30][31]}	Up to 90 days
US Family Health Plan (CHRISTUS)	Fixed post-acute panel; re-apply only with a documented gap	chp.networkdevelopment@christushealth.org	45-60 + 45-60 days

The timing window: AEP runs October 15 to December 7, 2026. Memorial Hermann (about 11,600 members) and CHRISTUS MA end December 31, 2026 ^[44], BCBSTX stops offering MA, Harris drops from 69 MA plans to 57 ^[46], and UHC and Humana sent 2027 non-renewal notices dated October 2, 2026, with Texas counties not yet

named ^[46]. Requests landed in October-December 2026 ride the member re-shuffle into plans that must re-prove 2027 adequacy.

05 The three numbers to fix before you apply

Carelon's marketing lists the six factors it selects on: CMS stars, outcomes, utilization, length of stay, readmissions, cost. Plans weigh the hospitalization rate more than any other single item and treat Care Compare as unbiased data.

1. **Acute-care hospitalization / potentially preventable hospitalization.** Find your rate on Care Compare and compare it with your HHVBP cohort threshold (12.01% in the DFW cohort we checked) ^[17]. If it reads "Worse Than National Rate," fix it or explain it in one sentence before a payer finds it.
2. **Discharge to community.** A "Worse Than National Rate" here is common among agencies we reviewed. Pair it with a written discharge-planning improvement note.
3. **HHCAHPS volume and top-box.** A small agency can sit at fewer than 40 completed surveys with a suppressed star. Get above 40 completed surveys so the star publishes. The mirror image is a strength: a 4-star record on 100+ surveys is the lead for any MA plan whose own Star Ratings depend on member experience.

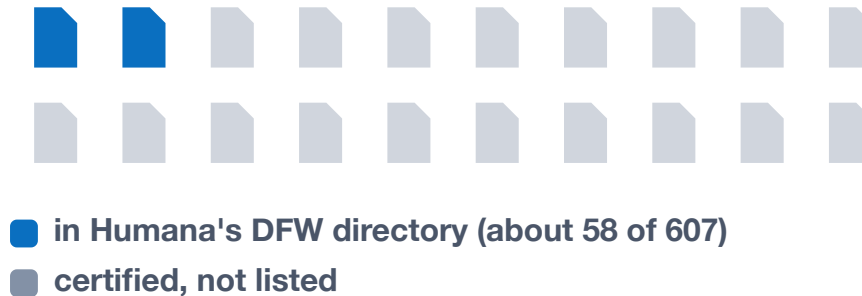
Leading with "4.5 stars" would strike a DFW payer as naive: dozens of DFW agencies are rated 4.5 or 5. Lead with what the payer screens on, and explain the weak number in one sentence.

Also fix before filing: accreditation or a CMS/state survey within three years; liability of \$500,000/\$1,000,000 (BCBSTX) and ideally \$1M/\$3M (Carelon); a current CAQH and Verisys file; separate practice-location records if affiliated entities share a suite (CMS cited Texas co-location as a fraud marker in the May 2026 moratorium notice ^[40]); and marketer pay restructured away from per-admit commissions before you sign a per-visit contract.

06 The packet checklist

Format: a two-page decision brief (where care is unavailable, how often, what you can deliver now, what agreement you are asking for), an evidence appendix, and a separate credentialing packet.

How many DFW agencies one payer lists



Roughly one in ten certified DFW agencies appears in Humana's public directory. That is your evidence that "we have enough agencies" is contestable.

Humana FHIR directory, queried October 7, 2026, name-matched to the CMS file

- ☐ **County directory analysis from the payer's own directory.** Humana's public FHIR directory matches roughly 58 distinct DFW home health locations (Dallas 41, Tarrant 13, Collin 8, Denton 1), about 10% of the 607 certified agencies, including 1-2 star agencies; Cigna's commercial directory matches about 49 ^[39]. Name-matching undercounts, but "we have enough quality agencies in Collin and Denton" is contestable with the payer's own data. No Houston pull has been made.
- ☐ **Gap exceptions and single-case agreements the plan has granted you,** as counts by period and county. Each is the payer's own admission of in-network unavailability.
- ☐ **Referral-source letters.** Hospital case management, physician groups and ACO contacts stating in writing how many of the plan's members they could not place with you because you are out of network. The most persuasive exhibit in the packet.
- ☐ **A 90-day refused-referral log per plan.** Fields: referral ID, payer/product, ordered service, territory, required start date, agencies contacted, responses, eventual placement. Count unique eligible referrals; exclude incomplete orders, patient preference and your own staffing refusals.
- ☐ **Care Compare and HHVBP page,** HHCAHPS once n is above 40, and one paragraph explaining any weak measure.
- ☐ **Deliverable capacity by discipline and county** after current census.
- ☐ **For TDI-regulated PPOs only:** a note that you will file the packet as evidence at any network waiver hearing (NetworkWaivers@tdi.texas.gov, SERFF number in the subject line).

Privacy rule: patient-level logs stay in the clinical system; removing names is not de-identification. Have a privacy professional review every aggregate exhibit.

07 The 90-day plan and the tracker

Run the doors in parallel. Here is the cadence I use.

- Day 0.** Confirm legal name, TIN, NPI and CCN for the applicant entity. Pull every signed agreement and rate exhibit you already hold, including LTSS agreements under affiliated entities. Compute cost per visit by discipline. Start the refused-referral log. Submit Template A to every payer and delegate on your map, and Template E to every hospital you serve.
- Day 7.** Confirm receipt and reference number for every submission. Register on CarePort and Aidin (Houston: Bamboo Pings).
- Day 30.** First status checks. File Carelon, tango, Wellpoint, TriWest and BCBSTX commercial onboarding with a dated 1301.054(c) letter. In Houston, add Devoted (1-877-762-3515) and send the Kelsey-Seybold Letter of Interest. File Medicaid LOIs or product additions with every STAR+PLUS MCO.
- Day 45.** BCBSTX CAQH attestation check (it must finalize within 45 days or the case restarts). Meeting requests to ACO post-acute leads with the Care Compare page.
- Day 60.** Aetna decision due. With cost per visit and the first out-of-network PPO claims in hand, open rate conversations with any plan you already hold: county-level directory counts, a case-rate option, a quality-linked escalator, inclusion in 2027 integrated D-SNP and group products, and a dated review. Do not terminate anything before replacement volume is real.
- Day 75.** Send Template B to every decline received so far, with the pilot terms attached. Where the payer has a reconsideration form (UHC), file it with the packet.
- Day 90.** Escalate: intake contact, then regional ancillary or post-acute network owner, then the payer's post-acute operations sponsor. Deliver the evidence packet and ask for the stated trigger for the next review. Re-approach quarterly on your own calendar, never with the same packet: each time add a new data point (a fresh refused-referral count, a gap exception the plan granted, a Care Compare refresh). No payer publishes a quarterly panel review; do not claim one.

Tracker columns (one row per payer and product): Payer | Product line | Delegate | Intake route | Submitted | Published clock | Decision due | Status | Written reason requested (date, statute) | Reason received | Decision-maker confirmed (plan or delegate) | Re-request date or stated trigger | Rate offered vs cost per visit | Contribution margin | Full-cost margin | OON member volume last 90 days | Owner | Next action.

Dated items for the wall: November 1, 2026, WellMed PAL with the 14-day home health PA lead time ^[23]. November 13, 2026, first six-month decision point on the HHA enrollment moratorium (effective May 13, 2026) ^{[40][45]}. Late November 2026, TDI decision on Docket 2868 (the home health row on PPO adequacy forms); the Section 6 waiver note is usable only until it is adopted or withdrawn ^[12]. December 8, 2026-February 28, 2027, non-renewal SEP; January 1-March 31, 2027, MA OEP ^[46]. Before year-end 2026 (DFW), SWHR ACO REACH

confirmation and LEAD carry-over. Before January 1, 2027 (Houston), CHC, Molina and UHC Community Plan filed. January 2-23, 2027, HMO notice windows. Before February 2027, Methodist MAP2 application.

08 Templates, short form

Researcher syntheses; counsel reads them before you send them. Never fill a bracket with an estimate presented as fact. Template D (the evidence packet) is the checklist in Section 6; Template F (the tracker) is the column list in Section 7.

The eight templates. A Letter of interest · B Closed-panel response · C Gap exception / single-case agreement · D Evidence packet (the Section 6 checklist) · E Hospital discharge-list request · F Tracker (the Section 7 columns) · G Reconsideration after a decline · H Pilot term sheet

TEMPLATE A Letter of interest

Yellow = fill in · Blue = keep the one that applies

" [Agency legal name] (DBA [name]) requests participation in the [payer] home health network for [product lines] in the [Dallas-Fort Worth / Houston] service area." Then identifiers (Type 2 NPI, TIN, CCN and certification date, Texas HCSSA license and service area, Medicaid TPI, CAQH/DataSpring ID, Verisys status, accreditation or last survey date); services actually staffed; capacity as incremental starts per week by discipline; Care Compare measures with one sentence on any weak one; network need (refused referrals, the payer's own directory count, gap exceptions served); and terms (standard agreement, no exclusivity, open to a case rate). If you own several CCNs, apply as one lead entity and disclose the affiliates exactly as filed on the CMS-855A.

Closers by product. HMO: "Under Tex. Ins. Code 843.302, please also provide your written application procedures and qualification requirements and the dates of your 843.305 annual application period." PPO/EPO: "Under Tex. Ins. Code 1301.054(c) and 28 TAC 3.3706(a)(3), please provide information concerning the application process and qualification requirements for participation as a preferred provider, including any economic profiling used; we would appreciate receiving it in writing." MA: "Please confirm whether network decisions for home health are made by [payer] or by [delegate]."

TEMPLATE B Closed-panel response, by product type

Yellow = fill in · Blue = keep the one that applies

"We understand your home health network for [products] is currently closed in [counties]. We ask four things.

1. Written reasons and the decision-maker. [PPO: Tex. Ins. Code 1301.051(b)-(c) and 28 TAC 3.3706(b).] [HMO: 843.303(a) and 843.305(c); a written answer is due within 90 days under 28 TAC 11.1402(c).] [MA: 42 CFR 422.205(a) and Medicare Managed Care Manual Chapter 6 §60.1.] [Medicaid: 42 CFR 438.12(a)(1) and UMCC Attachment B-1 §8.1.4.4.] In each case, the service area and provider category assessed and whether [payer] or [delegate] owns this decision.
2. The record: we hold no exclusivity, responded to every contact, and will contract at your standard fee schedule.
3. A narrower agreement limited to [county/discipline/cohort] for [90-180 days].
4. The earliest resubmission date and what changed facts would trigger an earlier review."

TEMPLATE C Gap exception / single-case agreement request

Yellow = fill in · Blue = keep the one that applies

Open with the member, the discharge, the disciplines and HCPCS codes, and the in-network agencies contacted with dates and responses. Then the product-specific sentence:

- Texas PPO/EPO: "Under 28 TAC 3.3707(j) please, within five business days, approve a network gap exception or recommend two reasonably available in-network providers (3.3707(k)); under Ins. Code 1301.005(b) and 28 TAC 3.3708 payment is due at the preferred benefit level."
- Texas commercial HMO: "This referral is requested by [network provider] under Ins. Code 1271.055; under 28 TAC 11.1611(c) please process it within five business days, approve a network gap exception concurrently, and confirm the in-network benefit level."
- MA PPO: "We request a pre-service organization determination under 42 CFR 422.566(c)(1)(ii); payment is at the Original Medicare amount under 422.214(b)." MA HMO: "We request out-of-network authorization under 42 CFR 422.112(a)(1)(iii) at in-network cost-sharing."
- MA, member enrolled after start of care: "The member's course of treatment with our agency began [date], before the [date] effective date of enrollment; under 42 CFR 422.112(b)(8)(i)(B) the plan may not disrupt or require reauthorization of it for at least 90 days."
- Medicaid MCO: "We request an out-of-network authorization or single-case agreement under 1 TAC 353.4 and UMCC §8.2.1.2 at the FFS rate less 5%."

Always add: "This request concerns this member only and is separate from any network participation request."

TEMPLATE E Hospital discharge-list request

Yellow = fill in · Blue = keep the one that applies

"[Agency], a Medicare-participating home health agency (CCN [number]), requests to be included on your discharge-planning list of available home health agencies. Our geographic service area, as defined by the agency, is [counties/ZIP list]. Under 42 CFR 482.43(d)(1) and CMS State Operations Manual Appendix A, Tag A-0813, the list must include Medicare-participating HHAs that have requested to be listed and that serve the patient's area, and patients must be informed of their freedom to choose among participating providers (Tag A-0814). Please confirm inclusion in writing."

TEMPLATE G Reconsideration after a network-capacity decline

Yellow = fill in · Blue = keep the one that applies

"We received a network-capacity decline on [date/reference] for [legal entity, branch and product]. Please confirm the specific service area and provider category assessed, the current qualification criteria, and whether [payer or delegate] owns this network decision. We request review of a targeted agreement for [territory and skilled service]." Attach the evidence packet (Section 6) and the one-page pilot term sheet (Template H). Close: "If the panel remains closed, please identify the reconsideration trigger or next application window."

TEMPLATE H Pilot term sheet

Yellow = fill in · Blue = keep the one that applies

One page, headline terms only. Scope: product, counties, cohort, starts per week by discipline, 90-180 days. Payment: per visit by discipline or a per-30-day case rate benchmarked to [x] % of the county PDGM amount; upside-only quality component; no downside risk. Authorization and claims process. Clocks: referral response within [x] hours; SOC within 24-48 hours. Monthly reporting. Governance. Continuation criteria. No exclusivity. No guaranteed volume. Counsel review against 42 CFR 1001.952 before it is sent.

09 The economics: what contracts pay, break-even, red flags, when to walk away

What Medicare pays (the yardstick). CY2026: national standardized 30-day period \$2,038.22; per-visit LUPA amounts SN \$176.96, PT \$193.42, aide \$80.12 ^[18]. Wage-adjusted, a Dallas 30-day period at case-mix 1.0 pays about \$1,983 and Houston about \$1,997; a SN LUPA visit is about \$172 in Dallas and \$173 in Houston (researcher computations from CMS inputs) ^[18]. MedPAC's yardstick is about \$237 average Medicare payment per in-person visit and 8.5 visits per full period ^[19].

What contracts pay. Texas operators quote MA per-visit offers of \$70-140 against direct costs of about \$97 per visit ^[35]. Agency owners we spoke with report roughly \$100 from one plan and \$140 from another (self-reported; unverified). Offers of \$95-140 equal 40-59% of MedPAC's \$237 FFS yield. Against Medicaid's \$98.92 and

workers' comp's \$123.65 ^[20], \$100 a visit is below Medicaid-plus-25% and about 58% of the Houston Medicare SN LUPA amount; \$140 is about 81%.

Break-even logic. Set the floor from your own cost, not from benchmarks. Compute direct cost per visit (clinician pay, supplies, mileage, documentation and QA, amortized intake and marketing), then fully loaded cost. Run two lines for every offer: contribution margin on incremental visits while you have idle capacity, and full-cost margin once the capacity is used. Model realization (start with an assumed 95%, then replace it with your own collections history) and working capital.

A worked example with illustrative inputs (replace with your P&L): variable cost of roughly \$63-68 per visit and fully loaded cost of roughly \$93 to \$109. A \$100 contract is near break-even on full absorption but carries roughly a one-third contribution margin on incremental visits while nurses sit idle; \$140 yields roughly +22% to +34% fully loaded. Filling idle capacity raises blended margin, provided any per-admit commission is restructured first. One warning: a large census built on very few starts implies stays measured in years; a managed-care book re-bases you to a 28-day post-acute profile. Price for that.

Red flags in an offer.

- A "percentage of Medicare" rate that does not specify the base year, grouping, wage index, LUPA and outlier treatment, and the update mechanism.
- Authorization that does not guarantee payment; open-ended recoupment; electronic-claims fees; short timely-filing terms (Astrana-delegated Wellcare claims carry 60 days).
- Per-visit payment where you asked for episodic: in one national operator's data, per-visit MA stays had 12% higher adjusted odds of inpatient transfer than episodic (OR 1.12; single-company observational data; support for clinical flexibility, never causation).

When to walk away. "No contract is better than a bad contract." Healing Hands Healthcare in North Central Texas computes \$97 direct cost per visit against an MA offer of \$70 and declines ^[35]. The one documented national-payer walk-away is Enhabit: it gave UnitedHealth Group termination notice in August 2024 and signed a new multi-year per-visit agreement effective January 1, 2025 on terms it called "agreeable" but did not disclose ^[36]; it went private in May 2026, so current status cannot be verified. It is a large-operator renegotiation, not a small agency forcing entry; what transfers is the sequence: nine months of talks, a credible termination with replacement volume, and a parallel pipeline of regional contracts.

If you already hold contracts, target the weak line, not the strong one. A \$140 visit is already above the Texas norm and the workers' comp MAR; that conversation is about scope (Community Plan, the 2027 integrated D-SNP, group PPO products) and a case-rate option, not a raise. The \$100 line is the one to move: a floor above \$123.65 for SN, with a case rate at 90-100% of the Houston PDGM amount as the alternative. Parity with Medicare is not a realistic target, in the words of one Texas operator the trade press quotes ^[35]. The aim of the first call is a named owner and a dated review.

10 Five mistakes the record shows

1. **Citing Texas law to a Medicare Advantage plan.** Chapters 843, 1271 and 1301, Texas prompt-pay, TDI network adequacy: all preempted for MA. Cite 42 CFR 422.205(a) for the written reason and stop.
2. **Arguing network adequacy.** Every DFW and Houston PPO reports home health "Adequate" to TDI, and CMS has no time-and-distance standard for home health. The gap-exception rights are the lever.
3. **Leading with the star rating.** Dozens of DFW agencies have 4.5 or 5 stars. Payers screen on hospitalization, discharge to community and survey volume. Lead with those, and explain the weak one before they find it.
4. **Treating a vendor portal or a single-case agreement as a contract.** Registration in Carelon's or tango's system loads you for authorizations; contracting is a separate decision. One approved SCA does not make you "in network."
5. **Taking a logo at a loss.** Compute cost per visit first. Insist on the base year and grouping behind any "percentage of Medicare." If the number does not clear your floor, ask for a narrower pilot or walk.

11 What we could not verify

- **No independently verified small Texas home health agency case** documents all three steps: a closed-panel rejection, the intervention that reversed it, and an executed full-network contract. Consultant case studies and forum anecdotes are unverified.
- **No documented case of an HHA winning an MA contract solely on a specialty** was found. Specialty programs are credible in a packet; they are not a key.
- **No Texas payer publishes a closed-network exception form.** Highmark's is outside Texas; UHC's reassessment form is not stated to apply to home health.
- **OneHome's contracting role for Humana in Texas and tango versus Astrana** for Wellcare ASTHOU/ASTBEAU members are both unresolved; get each in writing before changing a workflow.
- **Houston-specific WellMed home health prior authorization** is unverified; the July 2026 WellMed PAL URL returned 404.
- **Harris County parent-company shares** are a researcher mapping of contract names; confirm against the CMS plan directory before you publish them.
- **The "Houston Methodist leaving MA for 2027" premise** has no official or press source. Confirm with Houston Methodist Managed Care (877-493-3228) before repeating it.
- **Self-reported rates** (\$100 and \$140 per visit; an owner's "\$95 BCBS" figure) are owner-reported; BCBSTX fee schedules sit behind a contracted-provider wall. **Cost-per-visit figures in Section 9** are an illustrative worked example, not audited numbers.

- **Whether CMS will extend the HHA enrollment moratorium** on November 13, 2026 is unknown. One law-firm partner called extension "somewhat likely"; the 2013 moratoria lasted 5.5 years.

12 Sources

1. 42 CFR 422.116, Network adequacy. <https://www.law.cornell.edu/cfr/text/42/422.116>
2. 42 CFR 422.112, Access to services. <https://www.law.cornell.edu/cfr/text/42/422.112>
3. 42 CFR 422.205, Provider antidiscrimination. <https://www.law.cornell.edu/cfr/text/42/422.205>
4. Medicare Managed Care Manual, Chapter 4 (Rev. 121), section 110.4. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>
5. 42 CFR 422.214; 422.4; 422.100. <https://www.law.cornell.edu/cfr/text/42/422.214>
6. 42 CFR 422.566; 422.568; 422.138. <https://www.law.cornell.edu/cfr/text/42/422.566>
7. CMS-4201-F, CY2024 MA final rule, 88 FR 22120 (April 12, 2023). <https://www.govinfo.gov/content/pkg/FR-2023-04-12/pdf/2023-07115.pdf>
8. Tex. Ins. Code 843.302, 843.303, 843.304, 843.305. https://texas.public.law/statutes/tex._ins._code_section_843.305
9. 28 TAC 11.1402; TDI Order 2024-8760 (Superior HealthPlan, August 5, 2024). <https://www.tdi.texas.gov/commissioner/disciplinary-orders/documents/20248760.pdf>
10. Tex. Ins. Code 1301.051, 1301.054, 1301.001; 28 TAC 3.3706. https://texas.public.law/statutes/tex._ins._code_section_1301.054
11. Tex. Ins. Code 1271.055; 28 TAC 11.1611 (effective March 30, 2025). <https://www.law.cornell.edu/regulations/texas/28-Tex-Admin-Code-SS-11-1611>
12. TDI Order 2024-8601 adopting 28 TAC 3.3704, 3.3707, 3.3708; TDI proposed amendments to 3.3704 and 3.3707 (filed May 15, 2026; Docket 2868). <https://www.tdi.texas.gov/rules/2023/documents/20248601.pdf> ; <https://www.tdi.texas.gov/rules/2026/documents/33704prop.pdf>
13. 42 CFR 438.12; HHSC Uniform Managed Care Contract, Attachment B-1. <https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf>
14. 1 TAC 353.4. <https://www.law.cornell.edu/regulations/texas/1-Tex-Admin-Code-SS-353-4>
15. 42 CFR 482.43, Discharge planning. <https://www.law.cornell.edu/cfr/text/42/482.43>
16. CMS, MA State/County Penetration and Enrollment files (September 2026). <https://www.cms.gov/files/zip/ma-state-county-penetration-september-2026.zip>
17. CMS Provider Data Catalog, Home Health Care Agencies (refresh May 27, 2026) and Expanded HHBP Model Agency Data. <https://data.cms.gov/provider-data/api/1/datastore/query/6jpm-sxkc/0>
18. CMS Transmittal R13488CP, CR 14304, CY2026 Home Health PPS rate update. <https://www.cms.gov/files/document/r13488cp.pdf>
19. MedPAC, March 2025 Report to the Congress, Chapter 7 (home health). https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch7_MedPAC_Report_To_Congress_SEC.pdf
20. TMHP Medicaid Fee Schedule, Home Health Agency; TDI Workers' Compensation Rules, 28 TAC 134.215. <https://www.tdi.texas.gov/wc/rules/documents/wcrules.pdf>

21. UnitedHealthcare, Home health and hospice service questionnaire (PCA-3-25-02225). <https://www.uhcprovider.com/content/dam/provider/docs/public/jon/join-our-network-hhh.pdf>
22. UnitedHealthcare, Network reassessment request (March 10, 2026). <https://www.uhcprovider.com/content/dam/provider/docs/public/jon/join-our-network-reassessment.pdf>
23. WellMed Prior Authorization Requirements effective November 1, 2026; UHC 2026 MA Quick Reference Guide, WELM2. <https://www.wellmedhealthcare.com/wp-content/uploads/2026/09/WellMed-PAL-November-2026.pdf>
24. Humana, MA Prior Authorization List effective January 1, 2027; Join Humana's medical network. <https://provider.humana.com/join-humana-network>
25. HealthSpring, In-Network Provider Manual, Medicare Advantage (October 2026). <https://www.healthspring.com/static/docs/providers/healthspring-manual-2026-participating-providers.pdf>
26. Blue Cross and Blue Shield of Texas, Provider Onboarding Process. <https://www.bcbstx.com/provider/network/network/provider-onboarding-process>
27. EviCore, Home Health Agency Network Standards; Cigna, Credentialing (Texas open-enrollment notice). <https://static.cigna.com/assets/chcp/resourceLibrary/medicalResourcesList/medicalDoingBusinessWithCigna/medicalDBwCCredentialRecredential.html>
28. Aetna, Join the Aetna network; Carelon Post Acute Solutions, Aetna provider resources and Credentialing Packet HHA 2026. <https://providers.carelonmedicalbenefitsmanagement.com/postacute/provider-materials/aetna-provider-resources/>
29. tango, Join our network; Wellcare of Texas, Delegation to Astrana Health. <https://tangocare.com/providers/join-our-network/> ; <https://www.wellcare.com/en/texas/providers/bulletins/astrana-health>
30. Wellpoint Texas, Join our network; Community Health Choice, Become a Community Provider; Devoted Health, Join us; Kelsey-Seybold Clinic, Affiliate Provider. <https://www.wellpoint.com/tx/provider/state-federal/join-our-network> ; <https://www.kelsey-seybold.com/affiliate-provider>
31. HHSC, Options for Medicare and Medicaid Dual Coverage; HHSC, MCO Provider Relations Contacts (revised January 2026). <https://www.hhs.texas.gov/sites/default/files/documents/mco-provider-relations-contacts.pdf>
32. ACO REACH Preferred Facility and Organizational Providers list (Texas Health; February 22, 2026); Methodist MAP2 ACO Home Health Agencies list (August 2026). <https://texashealth.bynder.com/m/61a3870f93f6ea4c/original/ACO-REACH-Facility-and-Organizations.pdf>
33. City of Houston, Humana Group Medicare Advantage PPO provider letter (January 1, 2026). https://www.houstontx.gov/hr/hrfiles/benefits/medical/humana_provider_letter.pdf
34. TriWest, CCN Provider Handbook; Provider Contract Request. <https://joinournetwork.triwest.com/>
35. Home Health Care News, "No Contract Is Better Than A Bad One": Home Health Providers Share Their MA Strategies (March 2023). <https://homehealthcarenews.com/2023/03/no-contract-is-better-than-a-bad-one-home-health-providers-share-their-ma-strategies/>
36. Enhabit, Inc., Form 10-Q (Q2 2024) and Form 8-K (December 5, 2024); Home Health Care News (August 7, 2024). <https://www.sec.gov/Archives/edgar/data/1803737/000180373724000203/ehab-20241205.htm>
37. Highmark, Organizational Credentialing (Special Consideration Questionnaire). <https://providers.highmark.com/provider-network/credentialing/organizational.html>

38. Nevada Division of Insurance, Annual Report on Provider Denials, CY2021 (March 4, 2022). [https://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/News_and_Notices/Provider Denial Report Memorandum CY2021 Final \(Exec\).pdf](https://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/News_and_Notices/Provider%20Denial%20Report%20Memorandum%20CY2021%20Final%20(Exec).pdf)
39. Humana Provider Directory FHIR API, Texas (queried October 7, 2026; name-matched to the CMS file). <https://fhir.humana.com/api/Organization?address-state=TX>
40. FR Doc 2026-09717, Announcement of Nationwide Temporary Moratoria on Enrollment of Home Health Agencies, 91 FR 27954 (May 15, 2026) (moratorium; Texas co-location cited as a fraud marker). <https://www.govinfo.gov/content/pkg/FR-2026-05-15/html/2026-09717.htm>
41. CBS News Texas, North Texas veterans face cuts to VA-funded in-home care (August 1, 2025); Rep. Gonzalez letter to VA (February 5, 2026). <https://www.cbsnews.com/texas/news/disabled-veterans-home-health-care-va/>
42. Home Health Care News, Independence Blue Cross Taps tango to Scale Value-Based Medicare Advantage Home Health Network (January 6, 2026). <https://homehealthcarenews.com/2026/01/independence-blue-cross-taps-tango-to-scale-value-based-medicare-advantage-home-health-network/>
43. Baylor Scott & White Health Plan, Join; New facility contract form; Process for Joining BSWHP. <https://www.bswhealthplan.com/form/new-provider>
44. The Money Overview, Memorial Hermann is closing its Medicare Advantage plan on December 31 (October 7, 2026); Becker's, 10 payers exiting Medicare Advantage in 2027. <https://themoneyoverview.com/memorial-hermann-closing-medicare-advantage-plan-december-31-special-enrollment-february-28-2027/>
45. Home Care Roadmap, Home health and hospice enrollment moratorium decision (October 2, 2026); National Alliance for Care at Home, letter to CMS on the moratoria (September 4, 2026). <https://homecareroadmap.com/news/2026/10/home-health-hospice-enrollment-moratorium-decision>
46. Newsweek, List of insurers tightening their Medicare Advantage networks next year (October 5, 2026); Becker's Payer, Humana to exit Medicare Advantage plans covering 600,000 members in 2027; MedicareAdvantage.com, Harris County, TX 2027 plans; UnitedHealthcare, 2027 MA Service Area Reductions Provider FAQ. <https://www.beckerspayer.com/payer/medicare-advantage/humana-to-exit-medicare-advantage-plans-covering-600000-members-in-2027/> ; <https://www.medicareadvantage.com/plans-by-state/texas/harris>

If you want the tracker, templates and payer maps as working files, or help building the refused-referral log from your own data, that is the work Copper Digital does with Texas agencies. Reach me at arvind@copperdigital.com or 469-742-1095, or book 15 minutes at <https://cal.com/arvindsarin>.