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Administrative burden as a social determinant affecting access to women's health care: a policy analysis of eligibility documentation and single-visit reimbursement requirements

Abstract

Texas ranks near the bottom of national assessments of women's health and reproductive care despite maintaining state-funded women's health programs. This analysis examines whether administrative factors, rather than absence of appropriation, contribute materially to that outcome. Using a structured document synthesis, we drew on peer-reviewed studies conducted within a safety-net clinic system, institutional program records, and publicly available state and federal data. Two mechanisms were identified by which current administrative design appears to reduce service delivery to eligible populations. First, eligibility documentation requirements are misaligned with the needs of the population the programs are intended to serve. Second, reimbursement oriented toward a single access visit is incompatible with clinical standards that Texas has codified in statute for certain conditions. Six recommendations are advanced, three of which require no financial commitment. Limitations include derivation from a single clinic system in one metropolitan county and the absence of perinatal, sexually transmitted infection, and contraceptive continuation outcome data.

Keywords: administrative burden, Medicaid eligibility, women's health, adolescent health, safety-net clinics, Healthy Texas Women, congenital syphilis, integrated behavioral health

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Administrative burden as a social determinant affecting access to women's health care

Texas occupies a persistent position near the bottom of national assessments of the status of women's health. The Commonwealth Fund's 2024 State Scorecard on Women's Health and Reproductive Care, which evaluates 32 measures of access, quality, and outcomes, ranked Texas second lowest among all states and the District of Columbia.[1] Texas also reports the fourth-highest congenital syphilis case rate in the nation, with cases increasing 148% between 2017 and 2022.[2]

These outcomes coexist with substantial state investment. Texas maintains Healthy Texas Women alongside a state Family Planning Program, together constituting the principal public financing mechanism for women's preventive health services for uninsured and underinsured low-income Texans.[3] Annually Texas spends approximately $9.82 to $12.36 per capita specifically dedicated to women's health. The population dependent on these programs is projected to grow following expiration of enhanced marketplace premium tax credits, modeling estimates up to 800,000 additional uninsured Texans and a state uninsured rate approaching 20%,[4] with Texas projected to record the largest absolute increase in uninsurance of any state.[5] Within metropolitan areas, it is speculated that some neighborhoods report uninsurance rates as high as 43%. The coexistence of appropriation and poor outcome invites a question analytically distinct from the question of funding adequacy: whether the administrative structure through which those funds are distributed itself constrains delivery.

A substantial literature bears on this question. Herd and Moynihan[6] characterize administrative burden as the aggregate of learning costs, compliance costs, and psychological costs that citizens incur when accessing public programs and demonstrate that such burdens function as policy instruments in their own right, with distributional consequences falling disproportionately on populations with the least capacity to absorb them. Where eligibility determination requires documentation generated by stable employment, stable housing, and stable family structure, the requirement operates as a screen on those attributes rather than on the eligibility criterion relevant to the target population.

Braveman and Gottlieb[7] situate this within the broader social determinants of health (SDOH) framework, arguing that the conditions producing health disparity are frequently upstream of the clinical encounter. Administrative burden represents a specific and modifiable instance: an upstream determinant located not in the patient's circumstances but in the design of the program intended to address them.

Purpose

This assessment addresses three questions. First, do current Texas eligibility documentation requirements measurably affect enrollment among applicants who meet substantive eligibility criteria? Second, is the prevailing reimbursement structure compatible with the clinical standards Texas has codified for the conditions the programs are intended to address? Third, what administrative and financing changes would align program design with program objectives?

Method

Design

This is a structured document synthesis and policy analysis. It is not a systematic review, and no formal quality-appraisal instrument was applied. The design was selected because the questions posed concern the interaction between administrative rules and service delivery, a relationship documented across heterogeneous source types - peer-reviewed empirical studies, statutory and regulatory text, agency guidance, surveillance data, and institutional operating records - that no single-format review could accommodate.

Setting

The clinic system examined comprises six sites in Houston, Harris County, Texas. Sites are located in inner-city and economically distressed neighborhoods characterized by adverse social determinants of health, with an additional site at the public county hospital. The system serves patients aged 13 to 26 across approximately 17,000 annual visits by approximately 9,000 unduplicated patients, without charge and without exclusion for inability to pay (Baylor College of Medicine Teen Health Clinics, 2026).

Data Sources

Sources were drawn from three tiers, distinguished by evidentiary weight.

Tier 1: Peer-reviewed empirical studies

Several peer-reviewed studies conducted within the clinic system supplied participant-level findings. Abacan et al.[3] analyzed 521 Healthy Texas Women applications submitted between 2020 and 2022 by patients confirmed eligible, supplemented by patient and staff interviews. Smith, Van Horn, et al.[8] using a social determent approach reported enrollment, retention, certification, and employment outcomes for an allied health workforce program. Findings suggest that non-medical factors had financial ramifications that impacted medical and employment outcomes. An additional study of integrated behavioral health documented eligibility considerations that impacted screening, conducted February through December 2024, participation adherence, positivity, referral, and connection data.[9]

Tier 2: Institutional program records

Operating expense data, service volume, site inventory, service-line description, and funding-source composition were drawn from the clinic system's Community Report 2026 (Baylor College of Medicine Teen Health Clinics, 2026). These data are self-reported and unaudited.

Tier 3: Public government and policy data

In order to ascertain statewide implications, Texas ranking data were obtained from the Commonwealth Fund.[1] Syphilis surveillance data were obtained from the Texas Department of State Health Services via the Texas Medical Association,[10] from the Houston Health Department (n.d.),[11] and from America's Health Rankings.[12] Statutory prenatal screening requirements were obtained from Texas Health and Safety Code[13] § 81.090 and associated agency provider guidance.[14] Coverage projections were obtained from Dague and Ukert[4] and the Urban Institute.[5] Federal funding opportunity parameters were obtained from the Office of Population Affairs.[15]

Search and retrieval

Institutional documents were supplied directly by the clinic system. Public sources were retrieved through targeted searches of agency websites, peer-reviewed literature, and policy research organizations between July and August 2026, using terms including Texas women's health ranking, syphilis screening requirement, Healthy Texas Women eligibility, and Title X funding opportunity. Retrieval was purposive rather than exhaustive: the objective was to locate authoritative documentation for specific empirical claims arising from the Tier 1 and Tier 2 material, not to survey a literature.

Analytic approach

Claims were extracted from each source and classified as reported, derived, or unsupported. Reported claims appear in a source as stated. Derived claims were calculated from reported figures and are identified as such throughout; these comprise cost per visit, cost per unduplicated patient, expense category shares, and the projected annual count of patients identified with depressive symptoms. Unsupported claims were excluded.

Statutory clinical requirements were then compared against reimbursement structure to identify points of misalignment. This comparison constitutes the analytic core of the paper and is, by construction, a documentary rather than statistical exercise.

Findings

Eligibility documentation is associated with reduced enrollment among eligible applicants

In March 2021, the Healthy Texas Women application expanded from two pages to thirteen in order to satisfy a Centers for Medicare and Medicaid Services requirement under the Section 1115 waiver that applicants be screened stepwise for all available Medicaid programs. Abacan et al.[3] analyzed applications submitted before and after this change by patients whose substantive eligibility had been confirmed.

During the study period, approval declined from 56% (175 of 312) under the two-page instrument to 36% (75 of 209) under the thirteen-page instrument, a 20-percentage-point difference among applicants meeting identical eligibility criteria.[3] The stated purpose of the change - stepwise screening into other Medicaid programs -was not realized: fewer than 3% of applicants completing the expanded instrument were approved for any other Medicaid program.[3]

Applications averaged 6.39 incomplete fields and 0.80 errors (Abacan et al., 2024). Absence of a Social Security number was significantly associated with denial ($p = .0002$), although provision of a Social Security number is not stated as an eligibility criterion in program materials (Abacan et al., 2024). Unemployment was associated with approval, consistent with the operation of the income threshold. Notably, the number of times an applicant applied was significantly associated with reduced likelihood of approval, indicating that the instrument does not become more navigable through repetition (Table 1).[3]

Approval was significantly affected by the absence of one or more required entries. Enrolling providers also cannot ascertain why an eligible applicant was denied,[3] because clinic access to the denial rationale requires the applicant's physical presence. Applicants frequently do not return and rarely reapply.

Citation: Smith PB, Ivey TR, FACOG, et al. Administrative burden as a social determinant affecting access to women's health care: a policy analysis of eligibility documentation and single-visit reimbursement requirements. *MOJ Women's Health.* 2026;14(1):46–50. DOI: 10.15406/mojwh.2026.14.00336

Table 1 Most frequently incomplete fields on the expanded healthy texas women application

Field	Applications incomplete	Documentary prerequisite
Change in employment in past year	140	Continuous employment record
Pre-tax contributions	92	Payroll documentation
Other income source	82	Formal income reporting
Employer telephone number	68	Current formal employment
Employer name and address	57	Current formal employment
Loss of employer health insurance	54	Prior insured employment
Child traveling with migrant farm worker	52	Not applicable to most urban applicants
Social Security number	32	Documented status

Note. Data from Abacan et al.[2] The documentary prerequisite column represents the authors' classification and is not a reported variable.

Reimbursement structure conflicts with codified clinical standards

The second finding concerns the temporal structure of financing. Reimbursement oriented toward a single access encounter is incompatible with clinical standards Texas has established in statute, and it does not accommodate same-day treatment of diagnosed infection.

The clearest instance concerns treatment for syphilis dependent of the reason for visit. Texas Health and Safety Code § 81.090 requires that a physician or other person attending a pregnant patient obtain a specimen for syphilis testing at three separate points: the first prenatal examination, an examination in the third trimester no earlier than the 28th week of gestation, and admission for delivery (Tex. Health & Safety Code Ann. § 81.090; Texas Department of State Health Services, n.d.). In family planning services, non-pregnant patients are required to return for a subsequent visit because treatment on the day of diagnosis is not reimbursable.

Integrated behavioral health achieves high referral-to-connection rates

The capacity to make good contraceptive decisions can be impacted by compromised mental health. Between February and December 2024, clinic medical staff administered the Patient Health Questionnaire–9 (PHQ-9) and the Generalized Anxiety Disorder–7 (GAD-7) during routine visits under an institutional review board–approved protocol. Of 833 charts reviewed, 801 (96%) included a PHQ-9 and 800 (96%) a GAD-7. Screening identified 145 patients (18%) above the depression threshold and 118 (15%) above the anxiety threshold. Screened patients were 48.79% African American, 38.64% Hispanic, and 9.63% Caucasian or multiracial, and predominantly female (Table 2).[9]

Table 2 *Behavioral health screening, referral, and connection outcomes*

Stage	PHQ-9 (depression)	GAD-7 (anxiety)
Charts reviewed	833	833
Screened	801 (96%)	800 (96%)
Above clinical threshold	145 (18%)	118 (15%)
Declined referral	54 (37%)	38 (32%)
Referred (in house)	81 of 91 (89%) [AQ9]	70 of 80 (88%) [AQ9]
Connected to care	73 of 81 (90%) [AQ9]	65 of 70 (93%)

Referral-to-connection rates of 90% and 93% warrant emphasis. Referral from a medical encounter to an external behavioral health provider commonly fails to result in a completed visit; the co-location of a licensed clinician within the same facility appears to be the operative mechanism to improve this. Applying the 18% positivity rate to the annual unduplicated patient population yields a derived estimate of approximately 1,600 patients per year identified with clinically significant depressive symptoms at encounters scheduled for other purposes.

Cost structure

Reported annual operating expenses total $9,015,224 (Baylor College of Medicine Teen Health Clinics, 2026). Salaries constitute 76.6%, medical supplies including pharmaceuticals 11.6%, laboratory 5.3%, indirect costs 4.0%, and miscellaneous 2.6%. Derived from reported service volume, this yields approximately $530 per visit and approximately $1,002 per unduplicated patient annually. Program records indicate that state funding provides the majority of clinic operating support, with private philanthropy partially subsidizing contraceptive supply, immunization, and laboratory costs. A full-time behavioral health clinician is costed at approximately $100,000 per site annually, placing the behavioral health recommendation at approximately $600,000- $650,000 across the six-site network.

Discussion

Two mechanisms emerge by which Texas administrative design constrains delivery of services Texas finances. The first operates at entry: documentation requirements calibrated to a population with stable employment and housing screen out applicants whose eligibility arises from the absence of those conditions. The second operates during care: financing structured around a single encounter cannot complete clinical pathways the state has defined as multi-encounter.

Both are properly characterized as design defects rather than policy disagreements. The eligibility expansion was adopted to achieve stepwise Medicaid screening; it produced enrollment in other programs for fewer than 3% of applicants while reducing approval by 20 percentage points among the eligible).[3] The prenatal screening statute (Tex. Health & Safety Code Ann. § 81.090) and the

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reimbursement structure were established through separate processes and appear not to have been reconciled. Neither finding requires attributing intent, and nor requires the state to revise its objectives in order to correct.

The behavioral health and cost findings function as existence proof rather than as independent argument. They establish that integrated mental health care of this type is achievable at documented cost within existing Texas infrastructure: a 96% screening adherence rate demonstrates protocol feasibility, a 90–93% connection rate demonstrates that co-located follow-up converts identification into care (Smith, Abacan, et al., in press), and a $530 all-in visit cost establishes the price at which the clinical encounter is delivered.

Limitations

Several limitations bear on interpretation. First, all Tier 1 and Tier 2 data derive from one clinic system serving a specific age group in one metropolitan county. The eligibility findings concern a statewide instrument and are likely generalizable to other providers; the operational and cost findings reflect a mature program with five decades of accumulated infrastructure and should not be assumed replicable at the reported cost elsewhere. Second, the authors are affiliated with the program analyzed and authored several of the primary studies cited. Findings favorable to the program should be weighed accordingly.

Third, operating expenses, volume, and indirect-rate figures are self-reported and were not independently verified.

Fourth, perinatal outcomes, sexually transmitted infection treatment completion, contraceptive continuation, and behavioral health symptom change were not measured. The purpose of this assessment was to evaluate misalignment between eligibility criteria and successful eligibility determination, and between same-day and follow-up treatment reimbursement rules. The analysis therefore rests on documented misalignment between clinical needs and financing structure This is the principal evidentiary limitation of the analysis.

Fifth, Texas Medicaid unit costs for the adverse events these recommendations would avert were not obtained, precluding formal cost-effectiveness analysis. Claims of fiscal return are therefore directional rather than quantified.

Recommendations

1. **Simplify the eligibility instrument.** Reinstate the two-page application, or, where federal concurrence under the Section 1115 waiver precludes reinstatement, remove or consolidate the employment and income-detail sections that account for the majority of incomplete submissions (Table 1). The empirical basis is a 20-percentage-point approval decline against a stated objective realized for fewer than 3% of applicants.[3]
2. **Permit income self-attestation with retrospective verification.** For applicants applying for Healthy Texas Women, a Medicaid-like program, for patients below a defined threshold, accept attested income at application and verify against existing state data systems thereafter, rather than requiring applicant-produced documentation (cf. Herd & Moynihan, 2018).
3. **Require provider-accessible denial rationale.** Furnish coded denial reasons to enrolling providers without requiring applicant presence, enabling correction of remediable deficiencies.3
4. **Finance a defined care episode rather than a single encounter.** Establish bundled or periodic payment covering initiation and continuation together: prenatal through postpartum, sexually transmitted infection diagnosis through test-of-cure, and contraceptive initiation through continuation (Table 3).
5. **Recognize integrated behavioral health as reimbursable.** Include standardized screening and same-site brief treatment by a licensed clinician within the covered benefit for patients aged 13 to 26, at an estimated $100,000 per site annually.[9]
6. **Establish a flexible services allowance.** Permit a defined proportion of each contract to be applied at provider discretion to contraceptive supply, immunization, laboratory, and transportation costs presently financed by philanthropy.

Table 3 Alignment between clinical standard and single-visit reimbursement, by service line

Service line	Clinical standard	Encounters funded
Prenatal and perinatal care	Serial visits across three trimesters; statutory screening at three points	First visit
Postpartum care	Follow-up for hypertension, hemorrhage, infection, and postpartum depression	None
Sexually transmitted infection	Treatment, partner services, and test-of-cure or three-month retest	Diagnosis
Contraception	Initiation, resupply, side-effect management, method switching	Initiation
Behavioral health	Screening followed by a course of treatment	Screening

Note. Clinical standards are drawn from Tex. Health & Safety Code Ann. § 81.090 and prevailing clinical guidelines.

Conclusion

Texas finances women's preventive health services and records among the nation's poorest women's health outcomes. This analysis locates part of the discrepancy in administrative design rather than appropriation level: an eligibility instrument that screens on documentary capacity rather than eligibility, and a financing structure that funds the initiation of clinical pathways the state requires to be completed. The corrections proposed are largely administrative, and is achievable at documented cost already exists within Texas.

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None.

Conflicts of interest

The author declares that there are no conflicts of interest.

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