



Texas House of Representatives Committee on Public Health June 4, 2026

This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.





The committee met to hear invited and public testimony regarding the following interim charges, with length of public testimony subject to the discretion of the chair:

Monitoring and Implementation: Monitor the implementation and associated rulemaking of all legislation passed by the Committee and enacted by the 89th Legislature to ensure that legislative purposes are properly implemented, including the following:

- HB 18, relating to the establishment and administration of certain programs and services providing health care services to rural counties;
- HB 37, relating to perinatal bereavement care provided by certain hospitals, a perinatal bereavement care initiative, and a perinatal bereavement care hospital recognition program;
- HB 3000, relating to a grant program to provide financial assistance to qualified ambulance service providers in certain rural counties;
- SB 25, relating to health and nutrition standards to promote healthy living, including requirements for food labeling, primary and secondary education, higher education, and continuing education for certain health care professionals; authorizing a civil penalty.

Texas Rural Health Transformation Program: Study the implementation and impact of federal funding awarded to Texas under the Rural Health Transformation Program. Review the Texas Health and Human Services Commission's program applications, processes, and use of funds. Assess how the program may affect access to care, rural health care delivery, behavioral health and telehealth services, workforce stability, and provider sustainability. Identify opportunities to improve program oversight and maximize its long-term effectiveness.

Telehealth: Evaluate the use of telehealth and virtual care models in Texas, including their impact on access, cost, quality, and patient outcomes, and recommend opportunities to modernize health care technology.

Texas Health Care Workforce: Review the current and projected health care workforce shortage in Texas and make recommendations to reduce its impact on access to care and service delivery.



Agency Oversight: Pursuant to the broad oversight responsibilities granted to the Committee under Section 301.014, Government Code, and the House Rules of Procedure, monitor the agencies under the Committee's jurisdiction, including for fraud, waste, and abuse where applicable, including by receiving testimony from Texas Health and Human Services Office of Inspector General.

HB18, relating to the establishment and administration of certain programs and services providing health care services to rural counties;

Trey Wood, CFO of Health and Human Services (HHSC), provided an update on House Bill 18 (HB 18), which focuses on healthcare services in rural counties. The implementation of HB 18 is structured into three primary "buckets": Stabilization (grants and rate adjustments), Innovation (new service grants and telehealth), and Preparation for the Future (educational academies and consortia).

The definition of "rural" has been codified in statute through HB 18, defined as a county with a population of less than approximately 68,500, based on census data.

Grant Progress and Financial Stabilization. HHSC reported that \$22 million in financial stabilization grants were issued to nearly 80 hospitals in April 2024. Medicaid rates for rural hospitals were adjusted and implemented as of September 1, 2024, to better align with current operating costs. The application period for \$25 million in innovation grants closed recently, and HHSC is currently reviewing those applications.

Pediatric teleconnectivity grants opened for applications on the day prior to the hearing and will remain open through the end of the month.

About \$2 million of the \$3 million allocated for emergency hardship grants has been issued this year to hospitals facing unforeseen circumstances.

John Henderson TORCH. HB 18 also implemented an OBGYN add-on for rural hospitals that operate clinics, providing a rate increase for all services to help cover the infrastructure costs of maintaining 24-hour staffing. Rural hospitals receive a \$1,500 lump sum payment per Medicaid delivery in addition to standard reimbursement rates.



John Henderson noted that only about 60 of the 150 rural hospitals (40%) currently deliver babies, a significant decrease from 60% a generation ago.

Representative Collier raised concerns about maternal mortality and morbidity rates in rural areas; HHSC committed to providing specific data on how these rates compare to urban centers.

Representative Frank and John Henderson discussed the disparity between commercial insurance payments and government rates. Henderson cited a study showing rural hospitals are paid 44% less than urban hospitals for normal OB services and over 50% less for certain ER visits. The lack of "market leverage" for rural hospitals allows commercial payers to offer lower rates compared to consolidated urban systems.

Administrative staffing is a major hurdle as rural hospitals struggle to hire billing and coding staff because they often cannot compete with the higher wages offered by the oil and gas industry.

Representative Jones emphasized the need for "invisible" support staff, such as IT and billing professionals, who are essential for allowing doctors and nurses to function effectively.

HHSC Presentation Materials on HB18

HB 18 Key Provisions

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|--|-----------------------------------|--|
| 1 | Stabilization | <ul style="list-style-type: none">• Emergency Hardship Grants for Rural Hospitals• Financial Stabilization Grants for Rural Hospitals• Medicaid rates for Rural Hospitals aligned with Current Costs |
| <hr style="border-top: 1px dashed #ccc;"/> | | |
| 2 | Innovation | <ul style="list-style-type: none">• OB/GYN Medicaid Rate Add-on For Rural Hospitals• Innovation Grants• Pediatric Tele connectivity Grants for Rural Hospitals and Rural Health Clinics |
| <hr style="border-top: 1px dashed #ccc;"/> | | |
| 3 | Preparation for the Future | <ul style="list-style-type: none">• Rural Hospital Fiscal Officers Academy• Mental Health Consortium Hosted Telemedicine Program• Hospital Support Grants |

HB 18 Grant Programs Update

April 2026	Financial Stabilization Grant Up to \$22 million in FY 26
April 16 – May 28 2026	Innovation Grant Up to \$25 million in FY 26
May 18 – June 2026	Pediatric Tele-Connectivity Grant Up to \$10 million in FY 26
As needed	Emergency Hardship Grant Up to \$3 million in FY 26

Rural Hospital Officers Academy The four institutions of higher education contracted to administer the program, will provide:

- Professional development and continuing education at no cost to rural hospital leaders
- At least 100 hours of coursework and technical training

HB 37, relating to perinatal bereavement care provided by certain hospitals, a perinatal bereavement care initiative, and a perinatal bereavement care hospital recognition program

Dr. Amanda Hall, Deputy Commissioner for the Community Health Improvement Division at the Department of State Health Services (DSHS), provided an update on the implementation of House Bill 37, also known as Everly's Law. [Perinatal Bereavement Care Initiative | Texas DSHS](#). The bill establishes three primary components: a perinatal bereavement care service requirement for hospitals with maternal level of care designations, a DSHS initiative for bereavement care, and a hospital recognition program in collaboration with the Perinatal Advisory Committee.

DSHS is focusing on creating a consistent statewide standard of care to ensure families experiencing loss receive high-quality, respectful, and compassionate support.

Funding per the 2026-2027 General Appropriations Act is \$2.5 million per fiscal year to implement HB 37 (Article IX, Section 18.04)

Perinatal Bereavement Care Requirements

- Applies to all Maternal Level of Care (MLOC) hospitals.
- Hospitals will provide compassionate perinatal bereavement care counseling and ensure that any available bereavement devices are offered to support parents and families during the loss of their baby.
- Perinatal bereavement devices allow parents to hold their baby after death and say their final goodbyes.

Distribution of Perinatal Bereavement Devices. DSHS is actively distributing cooling devices, such as cuddle cots and caring cradles, to hospitals across the state. As of May 20, 106 devices have been distributed, with an additional 105 scheduled for distribution during the current month. Priority for these devices is given to hospitals that lack access to bereavement equipment, treat a high number of high-risk maternal patients, or have high delivery volumes.

These devices are essential for slowing the natural changes after death, granting families more time to sit with their baby, take photographs, and allow traveling family members to say goodbye.

Device Distribution

Maternal Level of Care	Total Number of hospitals	Total number of devices that have been distributed (as of 5/20/2026) *
Level I	56	30
Level II	82	49
Level III	45	16
Level IV	32	11
Total	215	106

*105 devices are scheduled to begin distribution in June 2026

- DSHS prioritizing hospitals that lack access to bereavement devices, treat a greater number of high-risk maternal patients, and deliver a greater number of babies.



Staff Training and Hospital Recognition DSHS partnered with the Texas EMS Trauma and Acute Care Foundation (TTAF) to develop training programs for hospital staff, including physicians, nurses, social workers, and chaplains. Training sessions were held in Austin, Houston, Dallas, Lubbock, and Corpus Christi, reaching 463 participants from 178 of the 215 maternal level of care hospitals in Texas.

The curriculum covers device maintenance, compassionate communication, mental health support for both families and staff, and practical bedside implementation like memory-making (handprints, footprints, and locks of hair).

A key feature of the training is a parent panel where bereaved mothers share their experiences to ground healthcare providers in the human impact of their care. Hospitals that attend training and have at least one bereavement device will receive certificates of recognition and be featured on the DSHS website.

Bedside Impact and Family Support. Catherine Quintana, a family support specialist from Parkland Health, emphasized that the bill has made bereavement care an essential part of patient care rather than an optional service. Parkland Health, which handles approximately 13,500 deliveries annually, has updated its documentation and processes to ensure every family experiencing loss is offered a cooling device. Ms. Quintana highlighted the importance of "time" for grieving parents, noting that cooling devices allow siblings and grandparents the opportunity to meet the baby and create tangible memories. The initiative has been particularly impactful for smaller rural hospitals that previously lacked the resources to purchase specialized equipment or provide bereavement-specific education.

Committee Inquiry and Future Considerations

Representative Shofner asked for data on how many of the 150 rural hospitals in the state hold a maternal level of care designation. The committee discussed the potential for telehealth to provide bereavement counseling in rural hospitals that lack dedicated staff.

Representative Shofner suggested involving local churches and faith-based organizations in future training phases to provide a source of trained volunteers for rural communities.



Representative Collier raised a concern regarding costs to families; Dr. Hall and Catherine Quintana clarified that bereavement services and the use of cooling devices should be provided free of charge to families.

HB 3000, relating to a grant program to provide financial assistance to qualified ambulance service providers in certain rural counties

Russell Gallahan, Comptroller's office testified on the implementation of House Bill 3000, which provides financial assistance to qualified rural ambulance service providers. The program's rules were adopted on March 18, 2026, establishing a standardized application process, deadlines for disbursement, and compliance reporting procedures. Qualified counties are permitted to use grant funds solely for the purchase of ambulances, including necessary accessories and modifications.

A key provision allows the Comptroller to disperse funds to counties before they place an order, acknowledging that many rural counties lack the upfront capital to initiate a purchase. Due to significant manufacturing backlogs in Texas, counties have up to five years from the date of receiving funds to take possession of the ambulance.

Mr. Gallahan recommended that counties deposit the grant money into interest-bearing accounts, noting that any interest earned can be used to buy additional equipment and supplies for the ambulances.

Application and Award Formula Details The application process was designed to be streamlined, taking approximately five minutes for a county judge to complete since the Comptroller's office already possesses most of the necessary county contact information.

Award amounts are tiered based on population: counties with 10,000 or fewer residents are eligible for \$500,000, while those with populations between 10,000 and 68,750 are eligible for \$350,000.

There are 202 eligible counties in Texas based on the decennial census and 172 counties applied for the grant in fiscal year 2026. As of June 1, 2026, the program has approved 154 counties for a total of \$65,450,000, with \$23,050,000 already disbursed to 53 counties. (In cases where multiple counties share the same service provider, a tie-



breaker formula is used with equal weight (33% each) given to per capita taxable property value, per capita income, and unemployment rates).

Carley French, Chief of EMS for the City of Seminole, highlighted the extreme lead times for ambulances, which currently range from 18 to 36 months. French pointed out a significant rise in costs: an ambulance that cost \$217,000 in 2020 rose to \$317,000 by 2023, and current quotes for basic models are between \$400,000 and \$450,000. A major concern raised was the ineligibility of ambulances ordered before grant approval. Ms. French argued that eligibility should be based on the date of expenditure rather than the initial order date to avoid penalizing services that planned ahead.

Brett Coghlan, President of the Texas Ambulance Association, testified that while a bare-bones frame is \$250,000, a fully deployed ambulance can cost between \$800,000 and \$1,000,000. Mr. Coghlan provided specific costs for critical equipment: heart monitors now cost approximately \$70,000, and power-loading stretcher systems are also around \$70,000.

Ms. French expressed concern over the "one grant per provider" rule, explaining that if one EMS provider serves multiple counties, only one of those counties may benefit, leaving others unable to replace aged equipment.

Representative Jones and Chief French discussed the potential need for legislative fixes to allow counties more flexibility, such as using funds for high-dollar equipment like cardiac monitors rather than just the vehicle itself.

Mr. Gallahan addressed the rumor of strict equipment restrictions, clarifying that the Comptroller's office intended to be flexible, allowing funds to cover everything from initial medical supplies (gauze) to high-end monitoring equipment. Regarding the request to pay for previously ordered ambulances, Mr. Gallahan noted the difficulty in incentivizing new capacity if the program merely funds existing orders, though the Chairman asked the office to take French's points into consideration.

Representative Frank noted that the program is justified by the fact that rural EMS often serves non-residents involved in traffic accidents on Texas roads, making it a benefit for all Texans.



SB 25, relating to health and nutrition standards to promote healthy living, including requirements for food labeling, primary and secondary education, higher education, and continuing education for certain health care professionals; authorizing a civil penalty.

Dr. Manda Hall from the Department of State Health Services (DSHS) provided an update on the implementation of Senate Bill 25, which focuses on health and nutrition standards.

Senate Bill 25

Authored by Sen. Kolkhorst | Sponsor: Rep. Hull

- Food Product Labeling Rules: Adopted by DSHS with enforcement by the Attorney General
- Texas Nutrition Advisory Committee: Appointed by Governor and administratively supported by DSHS
- Education Requirements: Developed or adopted by applicable state agencies, the State Board of Education, and public and higher education entities

Food Product Labeling Rules . Rules adopted in the Texas Register on February 23, 2026 Rules Scope:

- Includes warning labeling requirements related to food containing artificial colors, additives, or certain banned chemicals
- Applies to product labels developed or copyrighted on or after January 1, 2027 Current Status (Subject to ongoing litigation (U.S. District Court – Western District of Texas – 6:25-cv-00566)).

The bill includes three main components: food product labeling requirements, education-related requirements, and the creation of the Texas Nutrition Advisory Committee (TNAC).

TNAC Duties

- Examine the impact of nutrition on human health and examine the connection between ultra-processed foods, including foods containing artificial color and food additives, and the prevalence of chronic diseases and other chronic health issues;
- Provide an independent review of scientific studies analyzing the effects of ultra-processed foods on human health;
- Provide education on the effects of ultra-processed foods on human health; and

•Develop and maintain dietary and nutritional guidelines based on the consensus of available scientific studies and information concerning diet and nutrition.

Annual Report – due September 1st:

- A summary of scientific studies regarding the impact of nutrition and ultra-processed foods on human health;
- Nutritional guidelines incorporating any new scientific findings; and
- Any other recommendations the advisory committee considers appropriate based on new scientific studies.

The TNAC is a seven-member committee appointed by the governor, featuring experts in metabolic health, functional medicine, and pediatric care, with representation from the Texas Department of Agriculture. Dr. Jacqueline Albin serves as the chair, and Dr. Anne Shippy serves as the vice chair of the TNAC. The committee is currently examining the link between nutrition and health, specifically focusing on the impact of ultra-processed foods on chronic disease. The Committee is required to submit its first annual report by September 1st, covering specific required topics and defining ultra-processed foods based on relevant scientific literature.

Texas Nutrition Advisory Committee (TNAC) Seven members appointed by the Governor, including at least:

- One expert in metabolic health, culinary medicine, lifestyle medicine, or integrative medicine;
- One licensed physician certified in functional medicine;
- One member representing the Texas Department of Agriculture;
- One member representing a rural community;
- One member representing an urban community; and
- One pediatrician specializing in metabolic health.

Physical Activity and Recess Regulations

Monica Martinez, Associate Commissioner for the Texas Education Agency (TEA), discussed the bill's impact on school districts regarding physical activity. Senate Bill 25 prohibits school districts from using recess or physical activity as a penalty for a student's academic performance or behavior. Texas Education Code requires students to engage in at least 30 minutes of moderate to vigorous physical activity daily, which can be part of Physical Education (PE) or separate recess.



Monica Martinez clarified that the prohibition on using activity as a penalty applies specifically to the time designated for the physical education curriculum. The TEA has provided briefing books and FAQs to districts to clarify how these provisions interact, especially when districts offer physical activity beyond the required curriculum.

Nutrition Curriculum and High School Course Development

The TEA is awaiting recommendations from the TNAC to help the State Board of Education (SBOE) update health education standards, known as the Texas Essential Knowledge and Skills (TEKS). Senate Bill 25 mandates the creation of a new one-half credit elective nutrition course for high schools, which must be offered starting in the 2027-2028 school year.

Education Requirements: Impact of TNAC Report/Guidelines Beginning with the 2027-2028 School Year: The State Board of Education will update essential knowledge and skills for health curriculum for grades K-8 and School districts and charter schools to update nutrition and wellness elective courses for high schools

Higher education institutions to expand nutrition education offerings and requirements, including for undergraduate medical and health care service-related majors and graduate medical education

By December 31, 2026 or January 1, 2027 the Texas Medical Board, Texas Board of Nursing, and the Texas Commission on Licensing and Regulation to update licensing and continuing education requirements.

To meet the implementation deadline, the TEA plans to convene a workgroup of educators and experts between September and November to draft course content. The SBOE is expected to hold a discussion and public hearing in November, with a goal of final adoption by April 2027. Ms. Martinez noted that while the course will be ready for the 2027-2028 school year, SBOE-approved instructional materials and textbooks likely won't be available until the 2028-2029 school year or later.

Addressing Nutritional Barriers and Oversight

Representative Collier questioned the oversight of these requirements, and Monica Martinez confirmed that the TEA does not have a specific FTE for monitoring and relies on anecdotal evidence or complaints.



The panel clarified that these new requirements apply to public school districts and open-enrollment charter schools, but not to private schools, even those accepting state dollars through voucher programs.

Representative Simmons raised concerns about the practical barriers to healthy eating in low-income districts, such as food deserts, lack of access to fresh produce, and the long shelf life of processed foods.

Dr. Manda Hall explained that the annual reports from the TNAC are intended to provide the legislature with data and guidelines to address these systemic health issues in future sessions.

Representative Simmons commented on the rising prevalence of colon cancer in younger populations and the need for cross-agency collaboration between DSHS and Health and Human Services to address geographic health disparities.

Telehealth: Evaluate the use of telehealth and virtual care models in Texas, including their impact on access, cost, quality, and patient outcomes, and recommend opportunities to modernize health care technology.

Valerie Mays, Chief Deputy for Medicaid and CHIP Services at the Health and Human Services Commission (HHSC), provided an overview of teleservices, which serves as an umbrella term for telemedicine, telehealth, and teledentistry. Telemedicine is provided by Texas-licensed physicians or their delegates, such as physician assistants and nurse practitioners, while telehealth involves other licensed professionals like counselors or social workers.

Teledentistry is currently available only for children in Texas Medicaid who are under 20 years of age.

A key regulatory requirement mentioned by Ms. Mays is that telemedicine must meet the same standard of care as in-person visits, including equivalent reimbursement rates and duration of care.



Ms. Mays explained that home telemonitoring is a method for remote health data transmission, such as using glucose monitors for type 2 diabetes patients to assist in clinical decision-making.

Teleservices in Medicaid Health care services provided by a licensed physician, or a health professional delegated by a physician, serving patients at a different location through telecommunications or information technology.

- The Professional: A licensed physician or physician’s delegated health professional
- The Method: Telecommunications or information technology
- The Setting: Remote delivery to patients at a different location

Implementation of Recent Legislation

House Bill 4 from the 87th Legislature established the framework for Medicaid to reimburse for telemedicine and telehealth while ensuring HIPAA compliance and allowing audio-only behavioral health services. Teledentistry was officially implemented in March 2025 following previous legislative direction.

Bill Implementation	
November 2023	House Bill (HB) 4, 87th Legislature, implemented allowing Medicaid reimbursement for telemedicine and telehealth
March 2025	HB 2056, 87th Legislature, implemented adding teledentistry as a Medicaid and CHIP service
2026 and beyond	HB 2727, 88th Legislature, and HB 1700, 89th Legislature, targeted final implementation dates

House Bill 2727 from the 88th Legislature expanded home telemonitoring providers to include Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as of September 2024. Although federal approval for the specific rates for FQHCs and RHCs is still pending, these entities are currently being paid, and the final rates will be retroactive to September.

HB 2727 Expands home telemonitoring providers

Add new provider types

- Federally Qualified Health Centers
- Rural Health Clinics

Assess high-risk pregnancy for home telemonitoring

- Clinically appropriate
- Cost-effective

Allows HHSC to assess additional conditions for home telemonitoring

HB 2727 Implementation Timeline

November 2023	Completed research of current telemonitoring policies
September 2024	Texas Medicaid Provider Procedure Manual updates effective, and state plan amendments submitted to the Centers for Medicare & Medicaid Services
February 2025	Texas Administrative Code rules effective
Pending	Rates SPA currently pending CMS approval

House Bill 1700 from the 89th Legislature established broad standards for patient consent, data sharing, and documentation across all state agencies, with Medicaid policy updates set to go live on July 1st.

HB 1700 (89th) Implementation Standardize record formats and retention requirements for teleservices

Adopt rules to standardize

- Patient consent
- Data collection
- Data sharing



Establish consent documentation requirements

Includes requirements for audio-only consent

HB 1700 Implementation Timeline	
Summer 2026	Texas Medicaid Provider Procedure Manual (TMPPM) updates implemented
Fall 2026	Two sets of Texas Administrative Code (TAC) regulatory rules effective
Pending	One set of TAC regulatory rules effective

HHSC is currently in "phase two" of implementing HB 2727, which involves researching the clinical appropriateness and cost-effectiveness of home telemonitoring for high-risk pregnancies. Specific conditions under review for telemonitoring include gestational hypertension, postpartum pre-eclampsia, and gestational diabetes.

The HHSC team is currently conducting federal and state research to determine if other states have found these telemonitoring services to be safe and cost-effective. The HHSC Regulatory Services Division is working on Texas Administrative Code rule changes to comply with HB 1700, with implementation expected in late 2026 or early 2027.

Chris Palazzola from the Texas Medical Board . The first thing to understand about the board's regulation of telemedicine in Texas is that a practitioner treating a patient who is physically located in the state through telemedicine, that practitioner must still hold a full and unrestricted Texas medical license. There is no separate licensure or registration pathway for individuals practicing telemedicine, and this is largely by design, given the requirement is that telemedicine providers meet the very same standard of care as in-person physician would for that patient. That includes establishing a valid practitioner-patient relationship and obtaining informed consent and maintaining full documentation. Texas law does allow practitioner-patient relationships to be established without an in-person visit. It can be formed through a



prior relationship, a call coverage arrangement, or through certain telemedicine technologies.

Providers must give appropriate follow-up instructions, coordinate with the patient's primary care provider when needed, and comply with all HIPAA privacy and security rules.

A foundational principle in Texas is that the practice of medicine occurs where the patient is located. That means out-of-state physicians generally need a Texas license to care for Texas patients, although there are some narrow exceptions for physician-to-physician consultations.,

Texas has made it easier for multi-state physicians to become licensed here by joining the Interstate Medical, Licensure Compact. Through that compact, TMB has issued roughly eight thousand licenses since twenty twenty-two.

During the COVID emergency, Texas did temporarily expand telemedicine flexibilities to allow for telephone-only consultations and to permit telephone refills for chronic pain medications. Ultimately, the board found the telephone refills for chronic pain medications as useful and safe, and so adopted rules in 2021 to allow that practice, indefinitely with some safeguards. .

Bryant Clayton, Director of Broadband Development Office (BDO) in the Comptroller of Public Accounts. [Texas Broadband Development Office](#). Mr. Clayton's comments today focused on the relationship between broadband availability and telehealth utilization, and how BDO-led statewide broadband initiatives are part of the larger efforts towards strengthening access to healthcare across the state.

In twenty twenty-one, the Texas Legislature created the BDO for the purpose of closing the digital divide and ensuring that every Texan has access to fast, reliable broadband, as well as the ability to leverage that access to improve their quality of life.

The BDO serves as the state's primary entity for broadband expansion, focusing on both access and adoption, particularly in underserved and unserved areas. The office administers state and federal funds, awarding grants to internet service providers, nonprofits, and communities for broadband infrastructure and digital adoption programs. To date, the BDO has made over two billion dollars in committed



investments to improve broadband access statewide. These investments will bring meaningful changes to communities.

With respect to telehealth, the positive relationship between broadband access and telehealth utilization is well-established. Expanding broadband access increases the availability of telehealth services, especially in rural and unserved areas. It reduces travel time and costs for routine care, strengthens patient management through remote monitoring, and improves access to specialty care that may not be available locally.

National research consistently shows that rural communities with reliable high-speed internet access experience higher telemedicine utilization. Conversely, areas with limited or inconsistent connectivity report lower levels of telehealth activity. The takeaway is straightforward. When broadband is limited or unreliable, telehealth remains underutilized, even when it could significantly improve access to services. This is particularly important in rural Texas, where long travel distances, limited provider availability, and persistent workforce shortages already strain the healthcare system.

Broadband investment therefore plays a central role in supporting stronger access to healthcare. It also underpins emerging models of care, such as remote patient monitoring and virtual behavioral health services, which depend on stable, high-quality connectivity.

Across the state, BDO initiatives are helping build the infrastructure that make these services possible. Improving connectivity for community institutions such as hospitals and libraries to strengthen their ability to support telehealth. Upgrades to healthcare facilities allow for reliable video consultations, timely review of electronic health records, and participation in telemedicine networks.

Improvements to community anchor institutions also create secure and connected access points for individuals who may lack high-quality internet access at home. Broader BDO-funded programs, such as expanding last-mile service, enhancing middle-mile infrastructure, and supporting broadband adoption, are creating the foundation for universal connectivity. While these efforts benefit multiple sectors of the Texas economy, they have particularly significant implications for healthcare by ensuring that telehealth can function reliably statewide. While broadband is not the only factor influencing telehealth use, in many ways, broadband infrastructure has become a form of healthcare infrastructure. Continued investment in physical networks and digital



adoption will strengthen that foundation and support greater access to care for all Texans across diverse communities

Questions and Answers from the Panel

Representative Frank questioned the logic of paying the same rate for virtual visits as in-person visits, suggesting that virtual visits should be more cost-effective due to lower facility costs. Ms. Mays clarified that equivalent reimbursement is a requirement found in state statute and rules for Texas Medicaid. Victoria Grady, Deputy CFO, explained that Texas Medicaid is generally not a cost-based reimbursement system but uses a fee schedule based on the value of the service and standards of care. Ms. Grady stated that if the state used a cost-based system and it would likely pay significantly more for all services than it currently does under the efficiency-focused fee schedule.

Representative Collier supported payment parity, arguing that virtual visits require the same high-level skill set and provide essential access to specialists for rural patients.

Representative Schofield expressed concern that cost-effective telemedicine might lead to "dumping" in-person care in rural areas, effectively forcing patients to use virtual services. Ms. Mays explained that 97% of Medicaid members are served by Managed Care Organizations (MCOs) which must adhere to strict network adequacy standards. The state monitors choice, time, and distance standards for various provider types in metro, micro, and rural categories. Ms. Mays emphasized that telehealth services do not count toward meeting these time and distance standards, ensuring that physical access to providers is maintained.

In response to inquiries by the Committee, Mr. Palazola discussed the approximately 8,000 physicians licensed through the interstate compact pathway, noting that while they may reside out of state, they must maintain a US mailing address. Regarding international doctors, Mr. Palazola stated that the Medical Board relies on accrediting bodies like ACGME and ECFMG to verify the adequacy of foreign medical schools and training programs.

Most foreign-trained applicants are required to complete an accredited training program within the United States before applying for Texas licensure. Licenses must be renewed every two years, at which point doctors must answer questions regarding criminal convictions, impairments, and lawful presence in the United States.



Representative Cunningham inquired about the tracking of doctors who "ghost" the system or fail to renew, and Mr. Palazola noted that while they track non-renewals, they do not always know the specific reasons, such as retirement.

Representative Shofner raised concerns about cybersecurity and whether vendors are able to share or protect patient information adequately. Ms. Mays stated that telemedicine platforms must meet the same HIPAA and privacy data standards as in-person visits, and providers are responsible for securing patient data.

Representative Simmons and Bryant discussed broadband access gaps in urban and rural areas that hinder telemedicine utilization. It was noted that there are currently programs in place to connect locations that do not meet the minimum required broadband speeds.

Leslie Ferrell, Administrative Director of Virtual Care for Harris Health, discussed the "safety net" services provided to 5 million patients across 1,778 square miles in Harris County. Transportation remains a massive barrier for patients accessing clinics in central urban areas, Ben Taub (Level 1 trauma center), and a Level 3 trauma center currently being rebuilt as Level 1.

Harris Health completed 200,000 virtual encounters in the last 12 months, including synchronous video visits, specialty consults for hospital-at-home patients, and correctional health services at the Harris County Sheriff's Office Jail. The system utilizes e-visits (patient-initiated) and e-consults (provider-to-provider); of the 14,000 annual e-consults, only 20% required a follow-up in-person visit.

An emergency telemedicine program was launched in late 2020 via an "Ask My Nurse" line has achieved a 78% avoidance rate for in-person ER visits for low-acuity cases. Ms. Ferrell advocated for legislative support for broadband access in "digital deserts" and reimbursement for remote patient monitoring, even when data is patient-entered rather than automatically transmitted.

Dr. Thomas Kim, an internist and psychiatrist representing the Texas Medical Association (TMA).



I recall speaking to this committee on this topic in twenty seventeen. It was then that Texas constructed a framework built on the idea that telehealth care is health care. The passage of SB 1107 was soon followed by the COVID-19 pandemic. That pandemic created a period of extraordinary, accelerated telehealth development. We've learned a lot from this experience and realized numerous benefits in addition to identifying areas needing deeper consideration. I intend to speak to the interim charges, but I wish to share some thoughts on the current state of telehealth. These insights are not mine alone and include perspectives from many colleagues. I also speak not just for myself or those principally engaged in telehealth. I speak for over sixty thousand Texas Medical Association physicians and med students and thirty-one million Texans who stand to benefit from a care system that meaningfully includes telehealth.

While telehealth care is health care, it's not a replacement for conventional care. The pandemic lifted regulatory restrictions, and new use cases emerged across every specialty. And as I testified to the Ways and Means Subcommittee in twenty twenty-one, fraud and abuse concerns did not materialize despite high utilization. This was followed by a sharp reduction in utilization, suggesting that those involved had grown more skilled in determining when and how telehealth was of some benefit.

In terms of the post-pandemic regulations, we've seen a series of extensions which allows for continued telehealth activity, specifically with Medicare, but has the unintended chilling effect of long-term uncertainty. What this tells me is that telehealth is no longer one thing, and its application is nuanced and varied. Telehealth is perhaps best understood as a skill to be mastered rather than a product or service.

Turning to the interim charges, access to care remains one of our most significant challenges. I imagine you agree that improving access to needed services is good. It is through this agreement that exceptions were made for health professional shortage areas that often overlap with rural communities. But whether you're two hundred miles or two blocks from your physician, people experience complications impacting access to care.

I routinely care for people from their home or in their car during lunch without losing a day's pay or facing some other access barrier. So, given the impact on access and evidence of telehealth maturing, I ask, how can Texas be mindful of waiver extension uncertainty, leading individuals and institutions alike to actually discontinue offering telehealth, leaving access challenges to persist?



Healthcare costs are complicated. It is also an issue beyond the scope of telehealth, but telehealth can positively impact costs. Improved and timely access creates opportunities to maintain wellness rather than react to illness. Cost concerns around increased utilization have also not been demonstrated. But one concerning area involving cost is payment, with some advocating for reduced telehealth payment relative to conventional care. Candidly, I do not understand the logic of different payment rates other than to predict further reduction in telehealth availability for obvious reasons should that happen.

Quality is an even more complicated question. The Agency for Healthcare Research and Quality identifies three domains: structural, processes, and outcomes. Structurally, telehealth offers significant value, including workforce distribution and potentially retention. I, for one, have supported the same juvenile detention center in Louisiana for over twenty years. Another measure would include infrastructure to expand and maintain affordable broadband access.

I was privileged to serve on the Governor's Broadband Council that led to the formation of the Broadband Office and the subsequent award of over three billion dollars of federal BEAD funds. And where structural measures set the framework for quality care, process measures reveal improved clinical practice. So, whether you're screening for heart disease, diabetic retinopathy, or depression, telehealth contributes to better care, overcoming distance, time constraints, financial pressures, stigma, and more.

Process also involves digital health information and the promise of interoperability. Being the right person at the right time with the right information is key to better health care.

And thirdly, outcomes. A separate committee charge, sure, but they're intimately related to the other quality measures as well as access, cost, and more. One of the most challenging topics to demonstrate, certainly. I often cite the difficulty of proving a negative. So, when I schedule an urgent telehealth encounter due to suicidality, I leverage my therapeutic relationship, and I can give care with timely efficiency. And in avoiding an emergency department visit or hospitalization or worse, this remains speculative until a large enough dataset demonstrates a positive outcome trend. Fortunately, that dataset continues to grow, and I remain hopeful that the results will confirm my personal experience.



The final forward-looking charge is the most interesting. I believe the role of government is not to innovate, but instead to create an environment that encourages progress while maintaining guardrails of safety. The evolving complexity of telehealth will require a delicate balance between what we can and what we should do. Fortunately, the framing from twenty seventeen continues to hold up in twenty twenty-six. Agreeing that telehealth care is health care allows us to build on the existing regulatory framework where the focus is on the therapeutic relationship rather than constructing endless exceptions to accommodate an ever-changing field. In summary, telehealth payment parity, further investment in affordable, accessible infrastructure, and continued work on information interoperability are three high-impact areas to support a healthier Texas.

Questions and Answers

During questioning from Representative Simmons, Ms. Ferrell explained that telehealth provides "micro touch points" between annual visits, allowing for medication management and checking blood pressure without requiring patients to take four hours off work. Dr. Kim shared an anecdote about providing continuous care to a youth from a pre-adjudication center to a prison facility, highlighting how telehealth maintains the therapeutic relationship across different locations.

Ms. Ferrell argued that virtual care can lead to cost avoidance because providers use critical thinking and "investigative skills" (like looking into a patient's refrigerator or observing home fall risks) rather than reflexively ordering every test and image as is common in defensive ER environments.

In response to questioning, Dr. Kim noted that while the "sick care" system makes tracking specific savings difficult, keeping people well through frequent check-ins is inherently cheaper than reactive hospitalizations.

Representative Schofield raised concerns about the "degradation of healthcare" caused by private equity buying practices and the loss of the "Dr. Marcus Welby" style personal relationship. Dr. Kim agreed that private money is "severely wounding" healthcare delivery and described a potential "medical apocalypse" where companies focus on selling pills via subscription rather than building therapeutic relationships.



Regarding AI, Dr. Kim and Representative Jones discussed the risks of AI chatbots, mentioning a lawsuit involving a young man who committed suicide after interacting with a chatbot (character.ai). Dr. Kim distinguished between AI being "nice" (polite/predictive) versus a human doctor being "kind" (doing what is right for the patient, even if it involves difficult conversations about medication). Dr. Kim stated he does not fear AI taking his job because it lacks intention, but he advocates for transparency, suggesting doctors should ask patients if they are using AI chatbots just as they ask about firearms in the home.

Representative Frank highlighted that the current healthcare system is a "sick care system" that provides zero financial incentives for wellness behaviors. Dr. Kim listed what he considers the "five most powerful medicines": sleep, water, food, weight training, and social fitness.

Both the panel and the committee members agreed that the lack of insurance discounts for these healthy behaviors is a significant systemic problem that needs addressing.

Dr. Kim concluded by noting that while he can find professional joy helping patients navigate their health within a "sick care" system, the broader market incentives remain misaligned with preventive wellness.

Dr. Kelly Rone, Chief Medical Officer for Avail eCare, ([Avel eCare Telemedicine Experts](#)) presented the company's model of clinician-to-clinician telehealth, which focuses on partnering with hospitals and EMS teams rather than direct-to-consumer care. Dr. Rone characterized telehealth as a vital clinical infrastructure designed to address workforce shortages, clinician burnout, and uneven access to care across Texas. This model allows board-certified emergency physicians to support bedside teams in real-time, reducing the dependence on expensive travel physicians and on-call coverage for overworked rural staff.

Representative Jones questioned Dr. Rone about the company's origins, and she explained that Avail eCare spun off from a South Dakota health system in 2022 and now operates in 20 states.

Dr. Rone noted that the cost for a rural hospital to contract for these emergency services is approximately the cost of one nurse per year. Hospitals utilizing the



teleemergency model have reported annual savings of approximately \$1.8 million by reducing the need for locum tenens staffing. Dr. Rone shared that over 80% of partner organizations see improvements in physician recruitment and retention when virtual clinical support is available.

Specific case studies included a rollover accident involving two pediatric trauma patients where virtual support allowed a local physician assistant to manage stabilization and arrange air transport while remaining at the bedside. Behavioral health services through this model have reduced emergency department length of stay by roughly 2.5 hours per patient.

Virtual hospitalist programs have generated nearly \$1 million in additional annual revenue for some organizations by reducing unnecessary patient transfers and keeping care local. Dr. Rone also highlighted virtual pharmacy services, including a San Antonio-based hub that provides 24/7 medication safety support to facilities with limited overnight staffing.

Texas Universities and Telehealth Engagement

Dr. Sarah Mallard Wakefield from Texas Tech University Health Science Center described the massive geographical challenges of providing care in West Texas, where some counties have populations well under 10,000. Dr. Wakefield stated that telehealth is essential for complex cases, such as postpartum depression and that utilizing virtual visits reduced no-show rates by allowing mothers to receive care from home without the burden of travel.

The Texas Child Health Access Through Telemedicine (TCHAT) program was mentioned as a successful hub-and-spoke model providing academic-level care to students across various communities.

The Extensions for Community Health Outcomes (ECHO) model was discussed as a way to push specialist knowledge in areas like dementia and cancer to frontline rural clinicians, helping them decide when a patient can safely stay in their community.

Dr. Carly McCord, Executive Director of the Texas A&M Health Telehealth Institute, emphasized a strategy involving clinical care, research, and education.



Dr. McCord has overseen the training of more than 250 psychology doctoral students in telehealth, many of whom have chosen to remain in Texas to practice. Over the last 18 months, Texas A&M telehealth services saved patients an estimated 1.7 million miles of travel, which translates to over \$1 million in savings and 35,000 travel hours. Clinical data from the institute indicates that audio-only and video counseling are equally effective, and over 90% of surveyed patients felt their telehealth care was as good as in-person visits. Dr. McCord argued that for telehealth to grow confidently, organizations need stability, flexibility, and payment parity, noting that current instability in some service lines creates a lack of growth.

Curtis Donaldson (Texas A&M) highlighted that the Rural Medicine Program is now active in 72 counties following support from the 88th Legislature. Dr. Donaldson identified broadband gaps as a critical barrier, noting that patients often lose service just twelve miles west of Llano.

Digital literacy and generational preferences remain challenges. Dr. Donaldson shared an anecdote about his father-in-law in Fredonia who insists on shaking a provider's hand before discussing his health. Trust is a major factor in adoption; local entities like Frontera Health Care act as "trust brokers" to help rural residents feel comfortable with new medical technologies.

Collaborative Models Texas A&M and Texas Tech are collaborating on an access-to-care model using "BUILD" container clinics, which are shipping containers converted into medical facilities by students. A container clinic is currently operational in Fort Davis (Jeff Davis County), located centrally near the county courthouse and EMS station. These clinics pair an on-site nurse with telehealth connectivity; primary care is delivered by Texas Tech Health Science Center, while tele-behavioral health is supported by the Texas A&M Telehealth Institute.

Dr. Donaldson emphasized that no single entity could solve healthcare access alone and that platforms must be designed around the community rather than asking the community to adapt to the technology.

Cole Johnson (Texas Tech) noted that their service region covers 130,000 square miles and that 40 Texas counties still have no primary care physician as of 2025. While Texas Tech graduates over a quarter of the state's healthcare professionals annually, Johnson argued that telehealth is an immediate necessity to backfill gaps when local providers



like Dr. James Lukey retire. Dr. Johnson stressed the importance of data interoperability so that rural patients seen by specialists at larger systems do not have to repeat their medical history to every provider.

The university is transitioning its "Frontiers in Telemedicine" training lab into a digital space to train the next generation of clinicians on telehealth competencies developed by the AAMC.

Questions and Answers

Representative Frank argued that the current insurance-driven "sick pay" model "sucks the life out of doctors" and discourages general practitioners from staying in rural areas where the patient volume is lower. Representative Frank proposed studying the "Direct Primary Care" (DPC) model, which utilizes smaller patient panels of 400 to 800 people compared to the 1,500 to 2,500 required by traditional models.

One panelist, a psychiatrist, noted that a DPC model would be "music to every doctor's ears" because it would eliminate the constant need for prior authorizations and administrative hurdles.

The committee discussed the need to change the underlying financial model of rural medicine to prevent the system from collapsing when a single independent doctor leaves a small town.

Dr. Shawn Savitz, representing UTHealth Houston, testified that the institution has over 20 years of experience in telemedicine and currently provides more than 100,000 patient visits annually. The telehealth services cover approximately 180 Texas counties, utilizing a network that includes seven schools and several nationally recognized programs to reduce barriers to care regardless of geography. Dr. Savitz emphasized that telehealth is an essential component for connecting specialists to community hospitals, emergency departments, and clinics across the state.

Stroke Telemedicine and AI Innovations

Stroke is the third leading cause of death in Texas, with approximately 70,000 new cases annually; Dr. Savitz highlighted that "time is brain," as delayed treatment results in the loss of millions of brain cells. UTHealth developed one of the nation's first stroke telemedicine networks, using telerobots and AI to help emergency clinicians quickly evaluate patients, review imaging, and determine eligibility for clot-busting medications.



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New research at the institution is leveraging AI to allow specialists to remotely view imaging from less advanced devices, further reducing costs and family burdens. Looking forward, Dr. Savitz said he envisions using AI and standard laptop or mobile cameras to monitor patient movements at home to assist in recovery, though he stressed that a human provider must remain in the loop.

The institution is expanding into telerehabilitation to provide physical, occupational, and speech therapy via video, which has proven feasible and effective for stroke survivors.

In the realm of behavioral health, UTHealth operates the largest academic psychiatric hospital complex in the nation, including the Dunn Behavioral Science Center and the Harris County Psychiatric Center. Under the direction of Umair Imani, the telepsychiatry program utilizes 10 full-time equivalent psychiatrists and five psychologists to serve six state institutions, managing about 4,000 patient encounters annually.

Dr. Savitz urged the committee to maintain stable telehealth reimbursement, expand broadband access, and improve data interoperability. There is a significant focus on workforce development. UTHealth is creating specialized training modules for residents, fellows, and therapists to learn the specific parameters of delivering care via video.

Representative Simmons and Dr. Savitz discussed the ongoing curriculum development supported by the Lone Star Stroke Consortium to ensure providers are effectively trained for remote evaluations.

Dr. Schofield inquired about the "clinician to clinician" model and the status of mobile stroke units (ambulances equipped for stroke care). Dr. Savitz confirmed that telemedicine is a vital component of mobile stroke units and noted that Houston led the nation in their application. He expressed high optimism for the future of stroke treatment in Texas, noting that treating patients within the first hour of symptoms significantly reduces long-term disability and helps return citizens to the workforce.

Nora Cox Texas eHealth Alliance [Texas e-Health Alliance](#) provided a historical overview of telemedicine legislation in Texas, tracing it back to 1997. She highlighted key bills like HB 2386, which established Medicaid payment parity, and HB 2017, which addressed concerns about patients being forced into virtual care. Ms. Cox emphasized



that the committee has been central to major policy shifts, including direct-to-consumer telemedicine (SB 1107) and COVID-era flexibilities (HB 4). Looking ahead, she identified federal barriers like the Ryan Haight Act regarding controlled substance prescribing as a major hurdle. She also cautioned the committee to be deliberate regarding payment parity mandates, advising that they must include exceptions for value-based purchasing to avoid locking the state into a fee-for-service model.

Lauren Ingram, representing Access Telecare, [Acute Care Telemedicine](#) | [Access TeleCare](#) shared her experience as a nurse practitioner in rural East Texas, illustrating how acute inpatient specialty telemedicine has transformed local care. Previously, patients with complex conditions like strokes were almost always transferred to metropolitan hospitals, causing financial and emotional strain on families. Ingram described how her local hospital launched the first virtual critical care program in Texas, which has since grown to include neurology, cardiology, and infectious disease services. This model allows rural hospitals to retain higher-acuity patients, strengthens local bedside teams, and ensures that a patient's ZIP code does not dictate the quality of their specialty care.

Mercer May of Teladoc Health ([24/7 Care, Sign In & Register with Teladoc Health](#)) highlighted Texas's leadership in adopting technology-neutral definitions for telemedicine, which allows providers to use their clinical judgment to choose the best modality for a patient. He shared that over 8.4 million Texans have access to Teladoc services, with an average savings of \$472 per visit. May advocated for Texas to join additional interstate licensure compacts, specifically the counseling and dietitian compacts, to address significant workforce shortages. He cited data showing that 13.4 million Texans live in mental health professional shortage areas and encouraged the committee to look at Florida's telehealth-specific registration model as a potential gold standard for licensure flexibility.

Carrie O'Rourke from OnMed ([Clinic-in-a-Box](#) | [OnMed](#)) introduced the "Care Station" model—clinic-grade, satellite-enabled, self-sterilizing telehealth units placed in high-traffic community areas like Fiesta Mart grocery stores, libraries, and pharmacies. These stations feature a full suite of diagnostic tools, including stethoscopes and thermal scans, allowing for a more comprehensive exam than a standard video call. Ms. O'Rourke noted that 60% of their patients would have otherwise used the ER or urgent care. She requested that the committee consider policies that allow these hybrid



models to qualify for billing with both public and private payers and suggested a mechanism to track emergency room diversion metrics and patient satisfaction.

The committee engaged in a detailed discussion with Ms. O'Rourke regarding the practicalities of OnMed Care Stations. Members inquired about the cost and business model, which O'Rourke clarified is a subscription-based service costing \$30,000 per month, typically paid for by hospital systems or health plans like UnitedHealthcare and Molina. She explained that the stations are designed for accessibility, featuring live intake specialists to assist with literacy barriers and bilingual clinicians. Representative Jones and Representative Shoffner questioned the referral process, with Ms. O'Rourke explaining that while the goal is to refer patients back to their established medical homes or in-network providers, the stations serve as a critical entry point for the uninsured and those in broadband deserts to access care through rural health clinics etc.

Public Comment

Laura Detman Telemed2U ([Home - TeleMed2U Specialty care for everyone, it's About Time!](#)) testified regarding the specialty care crisis in Texas, noting that patients wait an average of 31 days to see a specialist, with 20% waiting one to three months. She highlighted that fewer than one in ten physicians practice in rural Texas, making access a significant challenge for the state. Telemed2U focuses on longitudinal relationships in specialties like endocrinology, cardiology, and neurology, serving about half of the Texas Health plans across commercial, Medicare, and Medicaid segments. Ms. Dettman shared a personal anecdote where she was told it would take 14 months to see a rheumatologist within a major health system, illustrating the need for faster virtual care options. She expressed support for the Rural Health Transformation program, specifically initiative number three regarding telehealth and AI.

John Scott, Texas Society of Anesthesiologists. ([Texas Society of Anesthesiologists](#)) raised concerns about telehealth companies prescribing ketamine on a "subscription" basis and mailing it directly to homes. He explained that ketamine is a Schedule III drug that is strictly monitored in hospitals via the Pyxis system, where every milligram must be accounted for or wasted properly.

The Pyxis system is an automated, decentralized medication dispensing cabinet used in hospitals, long-term care facilities, and other healthcare settings to manage



medication storage, tracking, and distribution efficiently and securely. It combines sophisticated hardware and integrated software to ensure that the right medication is delivered to the right patient at the right time, reducing the risk of human error.

Dr. Scott reported that a TSA member was able to order 30 doses of 60-milligram ketamine online in a 17-minute appointment without providing medical documentation from a primary care physician. He warned that misuse of ketamine can lead to respiratory depression, heart attacks, and dissociative episodes, noting there is no reversal agent available if a patient overdoses at home. While acknowledging the benefits of ketamine for veterans with PTSD and treatment-resistant depression, he argued that administration should only occur in monitored clinics with healthcare professionals present.

Dr. Scott informed the committee that ten other states have already outlawed the mailing of ketamine and recommended that Texas pass similar legislation.

Representative Jones and Representative Frank questioned the legality of current "subscriptions," with Dr. Scott clarifying that while it is a controlled substance, Texas does not yet have a specific law prohibiting it from being mailed.

Representative Shofner asked about the use of telehealth in anesthesiology; Dr. Scott noted that while anesthesiologists must be physically present for procedures, their pain management colleagues may use it for follow-ups.

Dr. Scott cited national data from 2019 to 2023 showing ketamine was present in 912 deaths and a direct contributor in 440 deaths, emphasizing that these figures are on the rise.

Committee members expressed concerns regarding the purity of mail-order ketamine and whether it might be manufactured in non-sterile environments or mixed with dangerous additives.



Texas Rural Health Transformation Program: Study the implementation and impact of federal funding awarded to Texas under the Rural Health Transformation Program. Review the Texas Health and Human Services Commission’s program applications, processes, and use of funds. Assess how the program may affect access to care, rural health care delivery, behavioral health and telehealth services, workforce stability, and provider sustainability. Identify opportunities to improve program oversight and maximize its long-term effectiveness.

HHSC Trey Wood. [house-public-health-committee-rts-june-2026.pdf](#)

Trey Wood, Chief Financial and Operations Officer for the Health and Human Services Commission (HHSC), provided an update on the Rural Texas Strong program, also known as the Rural Health Transformation Program (RHTP). The program is part of a federal initiative providing \$50 billion over five years; Texas received the largest allotment of any state at approximately \$1.4 billion.

The Rural Health Transformation Program (RHTP) will provide approved states \$50 billion in federal funds over the next five years. The Centers for Medicare & Medicaid Services (CMS) required states to apply through a competitive process. Texas’ application included six initiatives collectively known as the Rural Texas Strong program. These initiatives focus on locally driven, sustainable health care efforts.

Engagement Opportunities

- The HHSC Rural Health Transformation Program website ([Rural Health Transformation Program | Provider Finance Department](#)) provides program resources and is updated with new procurement opportunities
- New email: RuralTexasStrong@HHS.Texas.gov
- Stakeholders, applicants and vendors are encouraged to subscribe to the new Rural Texas Strong GovDelivery ([GovDelivery](#)) to receive notifications and announcements on procurement opportunities.



Texas submitted its application in November and received the award in December. A revised budget was submitted in January to account for an extra \$400 million beyond the initially assumed \$1 billion. Final approval was granted in April, and Request for Proposals (RFPs) were launched within 14 days of that approval.

The Six Key Initiatives

- Initiative 1: Make Rural Texas Healthy Again. This focuses on rural hospitals, wellness centers, and partnerships with grocery stores for fresh food. One part for public hospitals closed recently, and another for public/private hospitals closed on the day of the meeting.
- Initiative 2: Rural Texas Patients in the Driver's Seat. This aims to enhance patient portals, virtual visits, and the use of wearable tech like smartwatches, glucose monitors, and in-home dialysis equipment.
- Initiative 3: Lone Star Advanced AI and Telehealth. This initiative seeks to bridge service gaps for specialty providers and use AI for note-taking and improving the accuracy of billing codes to reduce claim rejections.
- Initiative 4: Next Generation of the Small Town Doctor and Team. This includes career paths for high school students, scholarships, relocation bonuses, and new residency programs, as well as support for backend staff.
- Initiative 5: Unified Care Infrastructure and Rural Cyber Protection. This focuses on hardware upgrades to protect against ransomware and viruses, potentially reducing the high costs hospitals pay for ransomware insurance.
- Initiative 6: Infrastructure Capital Investments. This covers facility renovations and equipment, such as MRI machines and EMS trucks, to keep services local and ensure long-term financial sustainability.

Rural Texas Strong Project		
Initiative	Funding Amount In Application	Updated 5/27/2026
Make Rural Texas Healthy Again: Part 1.1, Direct Awards	\$217,859,529	\$280,000,000
Make Rural Texas Healthy Again: Part 1.2, Competitive	N/A	\$153,524,850
Rural Texas Patients in the Driver's Seat	\$150,000,000	No Change
Lone Star Advanced AI and Telehealth	\$150,000,000	No Change
The Next Generation of the Small Town Doctor and Team	\$200,000,000	\$330,052,380
Unified Care Infrastructure and Rural Cyber Protection	\$100,000,000	No Change
Infrastructure and Capital Investments for Rural Texas	\$150,000,000	\$192,936,677

Capacity Building and Technical Support

Melissa Lackey from Texas A&M Health Science Center discussed the TexRep program, which provides free resources and support to rural hospitals and clinics using legislative funding.

THE TEXAS A&M RURAL TEXAS STRONG HUB

- Inform:** Serve as a centralized hub that equips Texas A&M System members with a clear understanding of Rural Texas Strong program initiatives. In addition to self-directed resources, RCHI will offer RTS webinars and RTS presentations to Texas AM System members upon request.

- **Communicate:** Disseminate RTS updates and opportunities to participate. Provide a public database that displays Texas A&M expertise and interest in RTS initiatives and a listing of Texas A&M System member RTS collaborations with rural stakeholders.
- **Connect:** Link rural health care entities with Texas A&M System members and resources. Offer guidance to system members on how their expertise can best support rural health care projects.

RCHI's extensive and ongoing experience partnering with nearly 150 rural hospitals and clinics statewide provides the foundation for our role as the Rural Texas Strong (RTS) Hub. Though funding will generally not be available to institutions of higher learning, it is anticipated that rural health care facilities and rural health-focused organizations will seek expertise in the design and implementation of RTS projects. In addition to maintaining the RTS Hub, the RCHI team can offer feedback on RTS conceptual proposals to work with rural health partners and facilitate initial meetings with rural health organizations.

TexRep works with approximately 130 hospitals and clinics to help with financial viability, workforce expansion, and proposal development for Rural Texas Strong grants. A major focus is placed on coding and billing training, as accurate front-end data collection is critical for hospital reimbursement. Support is also provided for community health needs assessments and financial sustainability planning to ensure projects can survive after the grant period ends.

Challenges and Stakeholder Feedback

John Henderson, CEO of TORCH, testified that while Texas received the most money, it actually received the least amount per rural resident compared to other states. There is a high level of participation in Texas, with 97% of eligible rural hospitals applying for Initiative 1.

Stakeholders expressed concerns about "vendor overload" and the complexity of the application process, noting that some small hospitals do not have dedicated grant writers.

Technical issues with the submission portal led to some applicants missing the 10:30 AM deadline, prompting a request for the state to show grace for those who had



technical difficulties. There is a concern regarding the cost-reimbursement structure in the first two years and how smaller facilities will bridge funding gaps before performance-based pay begins.

Mr. Wood emphasized that the state is looking for projects with a clear sustainability path to avoid a "financial cliff" when the five-year grant period ends. To gather input for the program, HHSC conducted a written comment period and held a "roadshow" with listening sessions in Rio Grande City, Stanton, Lufkin, Childress, and Giddings. He stated that local leaders requested flexibility, stating that solutions in Austin may not work for every unique rural community. Due to state procurement laws, HHSC was limited in the feedback it could accept once the RFP process began to ensure a fair competitive process.

Committee members were reminded by the Chair that they have legislative privilege to contact HHSC for more detailed briefings if they receive complaints or questions from constituents about the procurement process.

Jana Eubank, CEO of the Texas Association of Community Health Centers (TACHC), represented 80 federally qualified health centers (FQHCs) that serve nearly two million Texans at 700 clinic sites. FQHCs are not-for-profit organizations governed by consumer-based boards where 51% of members must be patients, ensuring care is community-driven. These centers provide integrated primary care, dental, behavioral health, pharmacy, and vision services, and are legally required to see patients regardless of their ability to pay or insurance status.

In rural Texas, 40 health centers operate 150 clinics across 84 counties, serving approximately 260,000 rural residents. Ms. Eubank expressed gratitude that HHSC and Congress included FQHCs as prioritized providers in the Rural Health Transformation Fund.

Ms. Eubank noted that FQHCs were ineligible for Initiative One (Make Rural Texas Healthy Again) because awards were limited to rural hospital districts with operating hospitals, which she called a missed opportunity. She recommended that HHSC allow FQHCs to apply for future Initiative One dollars to better leverage existing infrastructure in counties without hospitals.



For Initiative Four (Workforce), she suggested a regional approach to funding to allow providers to leverage resources across multiple counties rather than being restricted to one.

Ms. Eubank proposed expanding behavioral health activities under Initiative Four to include master's-level training and placement, rather than just physician residencies.

She recommended that the legislature pass a sustainability strategy allowing behavioral health associates to be reimbursed by Medicaid while completing supervised clinical hours.

Regarding Initiative Six (Capital Infrastructure), she noted there are only 75 awards for 202 eligible counties and suggested funding regional mobile units to reach remote patients would make better and broader use of the funding

Finally, she advocated for refunding the FQHC Incubator program as a successful tool for expanding the rural healthcare footprint.

Paula Graumann, a pharmacist from Hallettsville owning three rural pharmacies and a family practice clinic, argued that Texas pharmacists are "caged" by excessive regulation. Although pharmacists now graduate with a Doctor of Pharmacy degree after six to eight years of education, Graumann stated they are often unable to practice at the top of their license.

She highlighted a "payer gap" where she cannot bill insurance for clinical services like diabetes education unless a nurse practitioner or physician assistant is in the room. Ms. Graumann pointed out that Texas has over 800 pages of state regulations for pharmacists (more than California) and this discourages innovation and recruitment.

She noted that 29 other states allow "test and treat" for conditions like flu and strep, whereas Texas pharmacists must send patients to a clinic for a prescription even after a positive test. She cited a Cicero Institute score of three out of ten for Texas regarding pharmacy scope of practice, suggesting the state is leaving money and care opportunities on the table. [Cisero Institute 2025-Policy-Strategies-for-Full-Practice-Authority-8-20-2025.pdf](#)



Questions and Answers

Representative Frank questioned Ms. Eubank on why FQHCs were excluded from certain funds in the "One Big Beautiful Bill." She clarified that FQHCs were not considered "eligible entities" for specific rounds of funding, which were restricted to rural hospital districts and community hospitals.

Representative Frank expressed concern that FQHCs were excluded despite being prioritized in federal legislation and having a presence in areas without hospitals. He speculated that HHSC might have limited the pool to move the money quickly but stated he would follow up with the agency to ensure FQHCs are included in future funding cycles.

Ms. Eubank emphasized that FQHCs are primary care focused and should be eligible for initiatives targeting chronic disease management and prevention.

Texas Health Care Workforce: Review the current and projected health care workforce shortage in Texas and make recommendations to reduce its impact on access to care and service delivery.

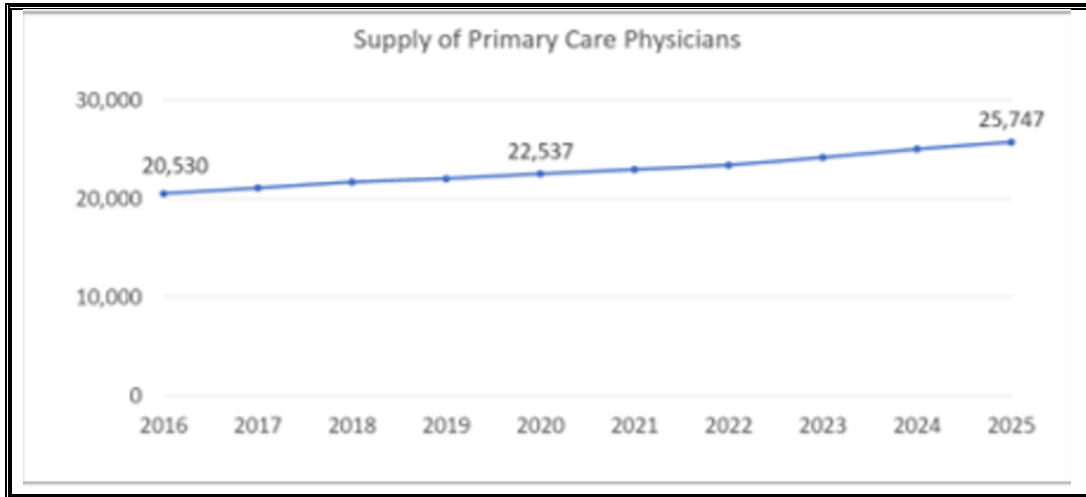
[Department of State Health Services Workforce Presentation](#)

[Materials](#) Dr. Manda Hall from the Department of State Health Services (DSHS) presented the current landscape of the Texas healthcare workforce, highlighting that while licensing is progressing, demand is projected to far outpace supply by 2036.

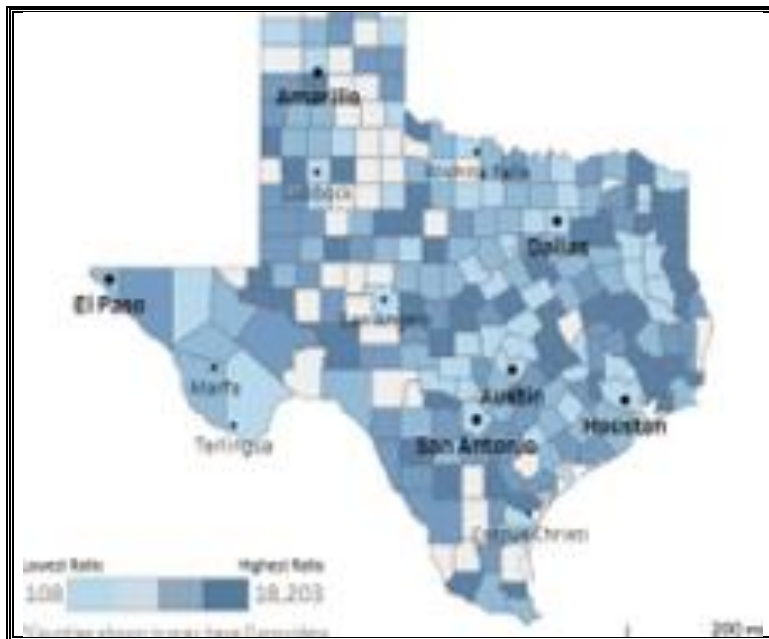
DSHS publishes state-level projections for physicians, psychiatrists, nurses, and dentists. This approach is also used by the Health Resources and Services Administration and other state-level workforce entities. DSHS last released current physician supply and demand projections in 2024 then released corresponding graduate medical education data in 2026. DSHS plans to update physician supply and demand projections in 2028.

[Texas Health Data - Workforce Supply & Demand Projections](#)

Primary Care Physician Supply Trends 2016-2025

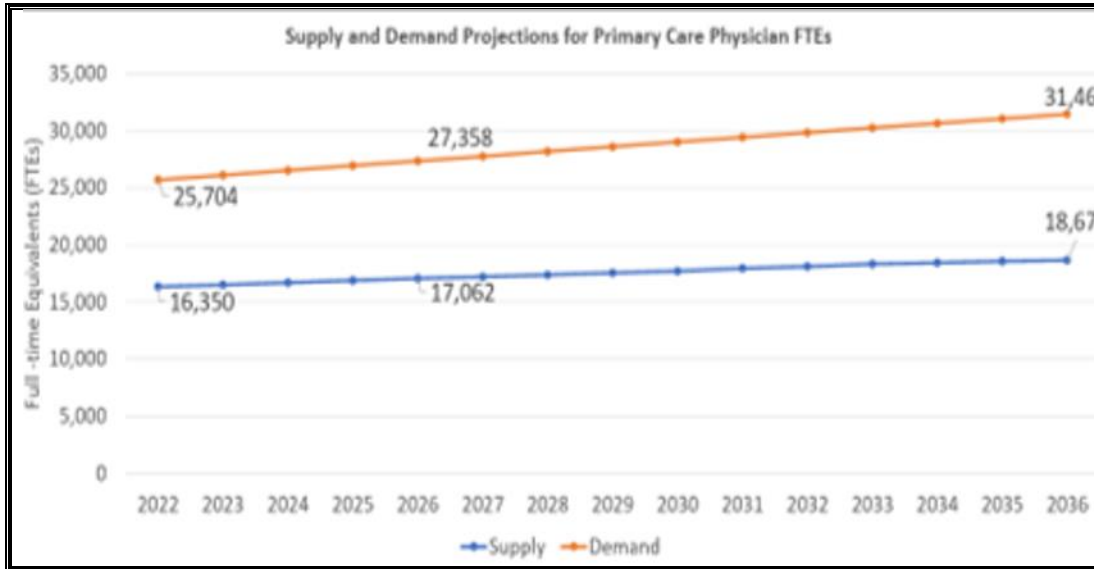


Ratio of Population to Primary Care Physicians by County, 2025

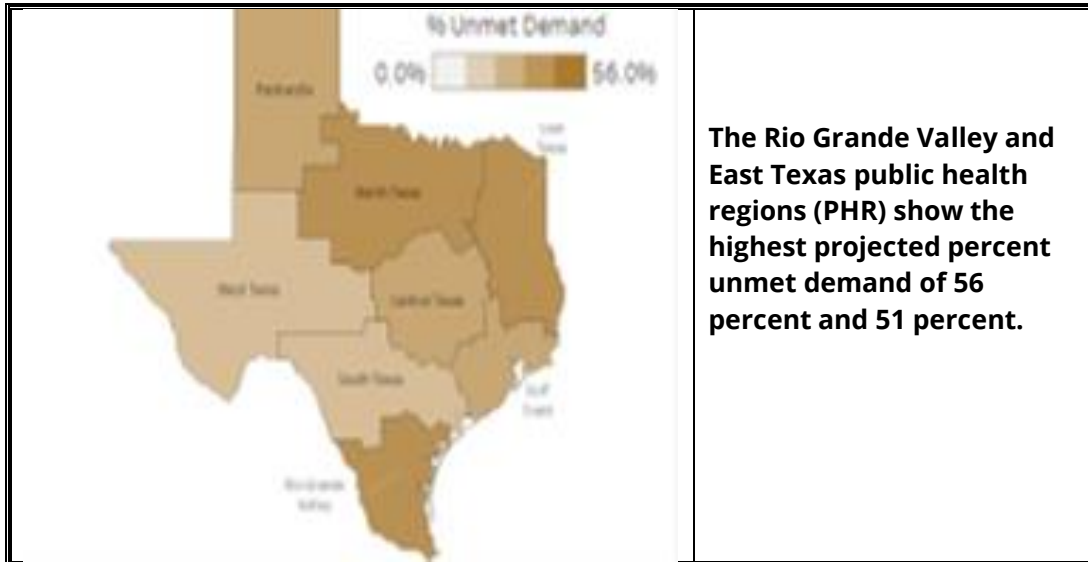


The DSHS model focuses on full-time equivalents (FTEs) rather than headcounts, revealing that 40 Texas counties currently have no primary care physicians, an increase from 32 in 2020.

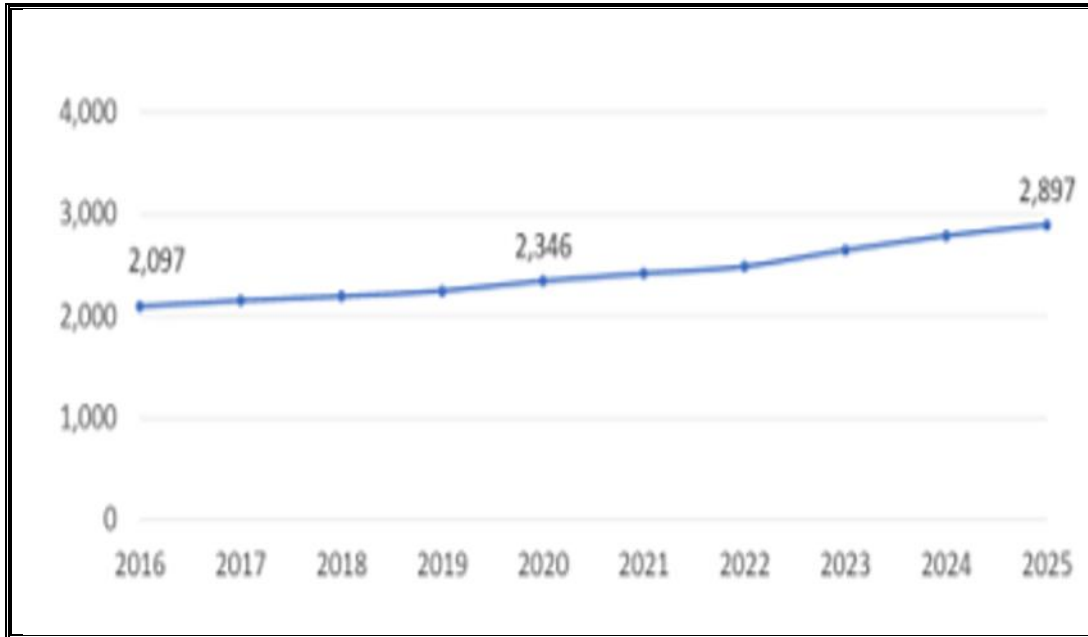
Projections for Primary Care Physician FTEs



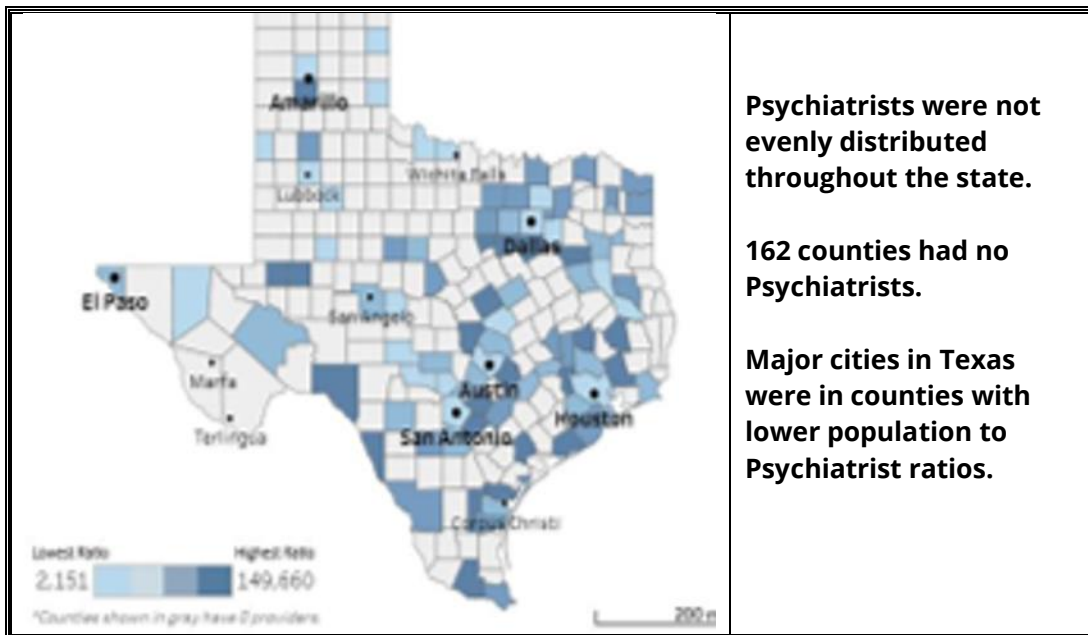
Unmet demand for primary care is expected to rise from 36% in 2022 to 41% by 2036, with the Rio Grande Valley and East Texas facing the highest shortages.

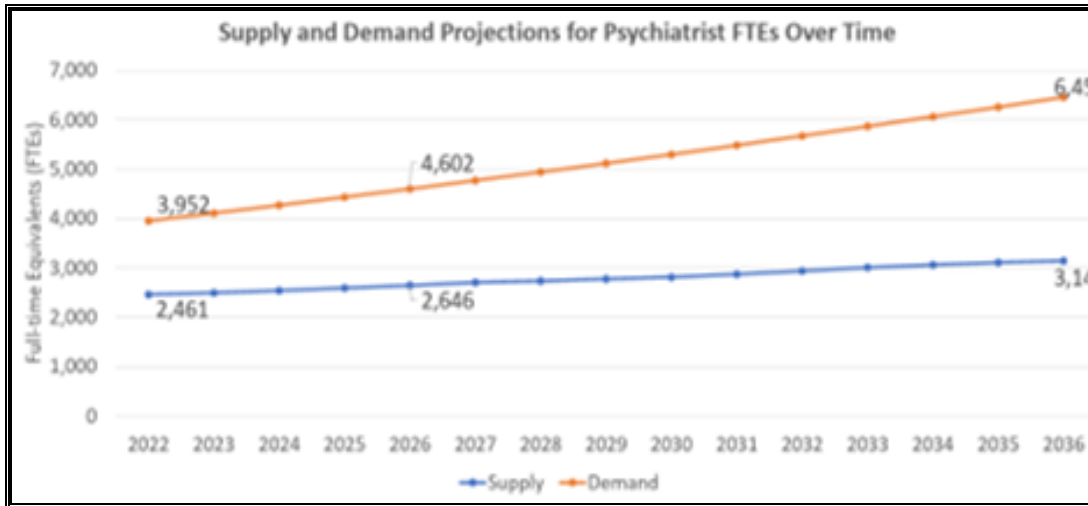


Psychiatrist Supply Trends, 2016-2025

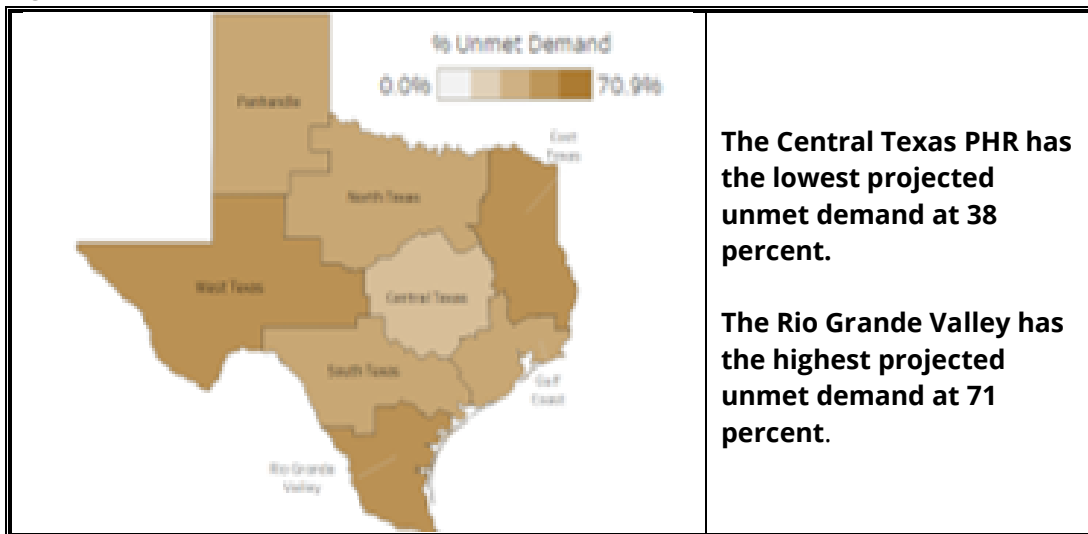


Ratio of Population to Psychiatrists by County, 2025





Percent unmet demand for Psychiatry in 2036 Darker colors in the map represent a higher unmet demand Source: Texas Health Data



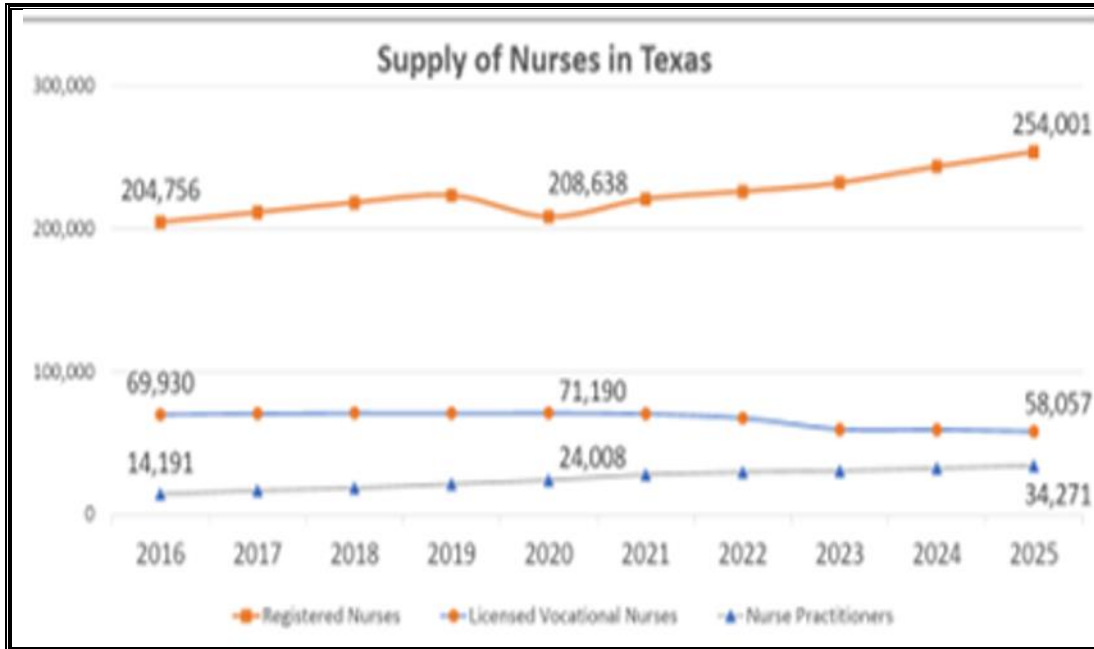
Graduate Medical Education Report

Specialty Slots to be added each year, from 2027-2033	Baseline:	GME-based Increase, Scenario 1:	Demand-based Increase, Scenario 2:	Supply-based Increase, Scenario 3:
	AY 2024-2025 THECB approved GME positions	Increase baseline approved GME positions by 10% each year	Increase baseline GME positions each year for supply to meet demand by 2036	Increase projected 2036 supply by 10%
General Internal Medicine	1,911	192	253	19
Geriatrics	35	4	28	1
Pediatrics	719	72	166	18
Psychiatry	613	62	221	21

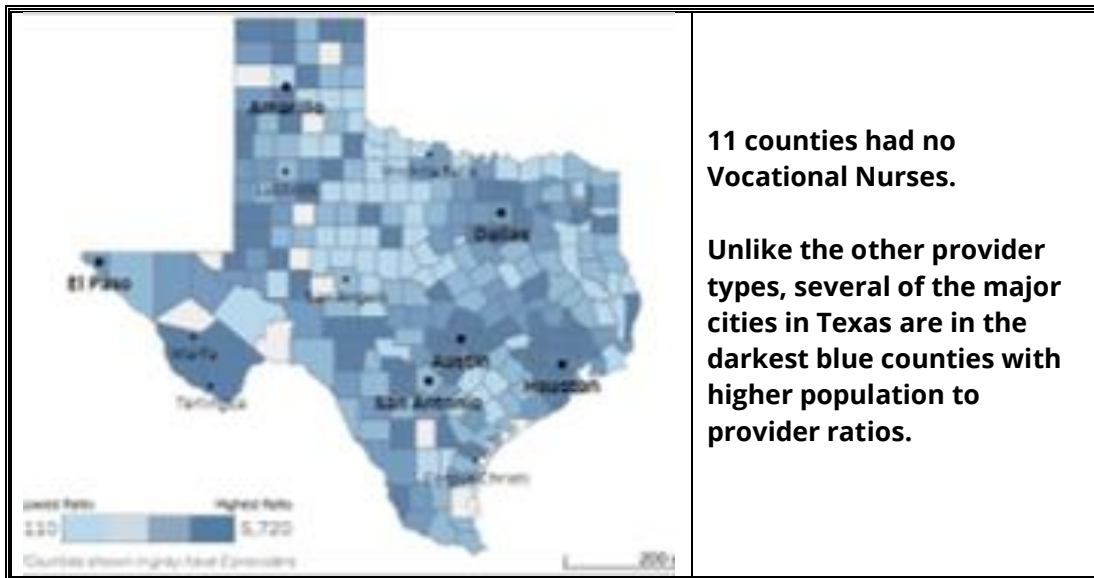
Dr. Hall outlined three scenarios for increasing Graduate Medical Education (GME) slots to address these gaps, noting that the most aggressive approach would require adding 253 positions annually.

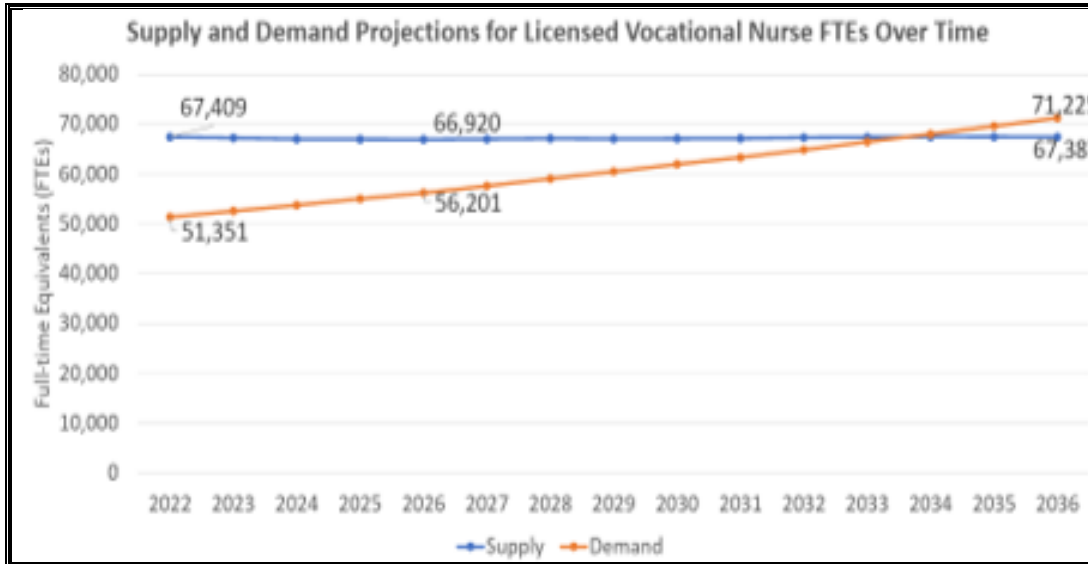
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Nursing Workforce Trends and Education Challenges **Kristen Benton, Executive Director of the Texas Board of Nursing**, reported that Texas has over 346,000 practicing nurses, the third highest in the country.

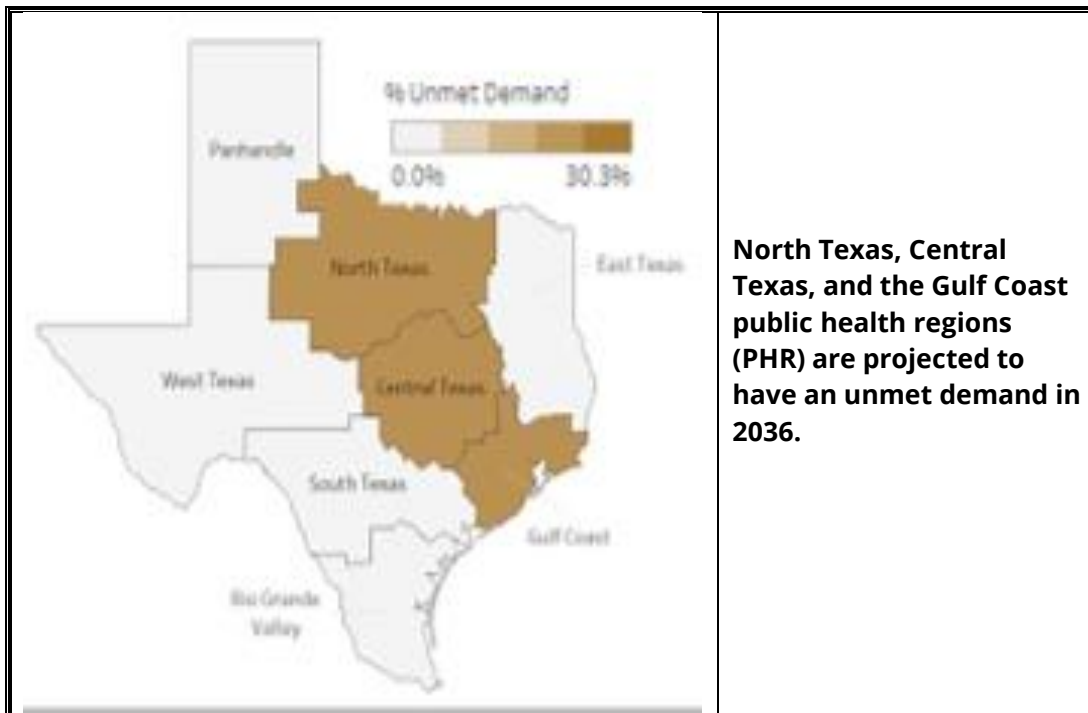


While the number of registered nurses (RNs) has increased by 24% over the last decade and nurse practitioners have more than doubled, licensed vocational nurses (LVNs) have seen a decline since 2019.

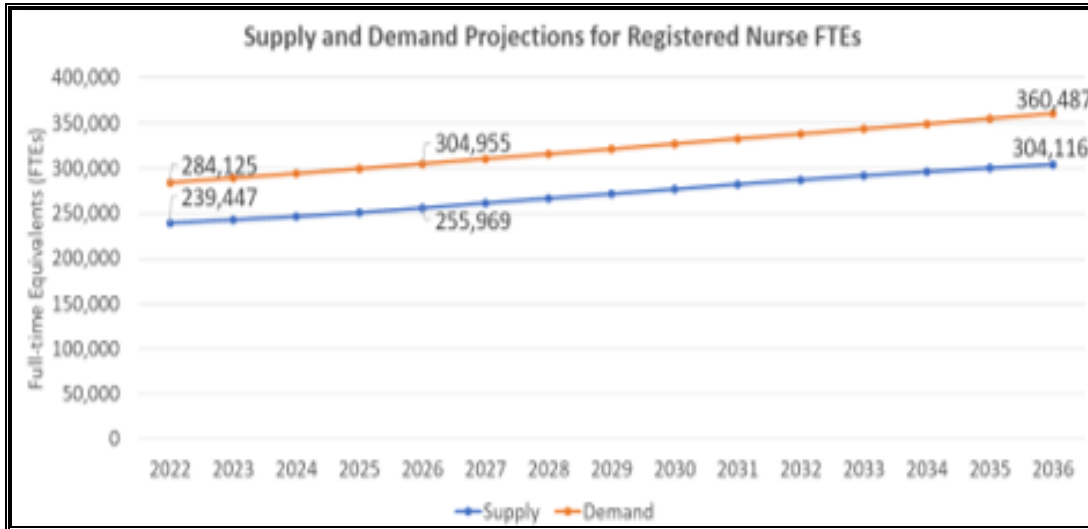




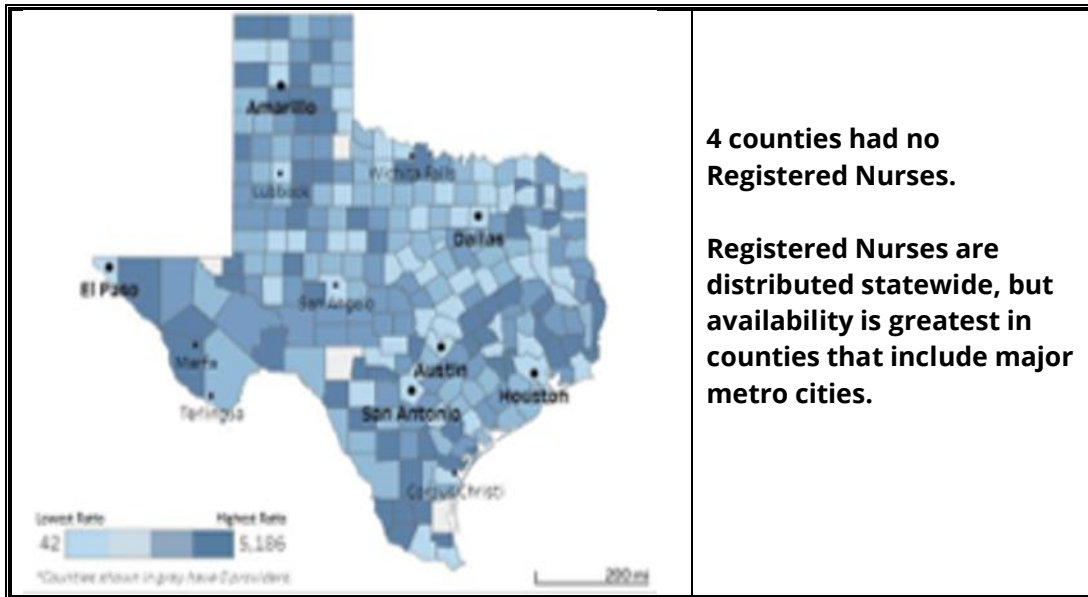
Percent unmet demand for Vocational Nurse FTEs in 2036



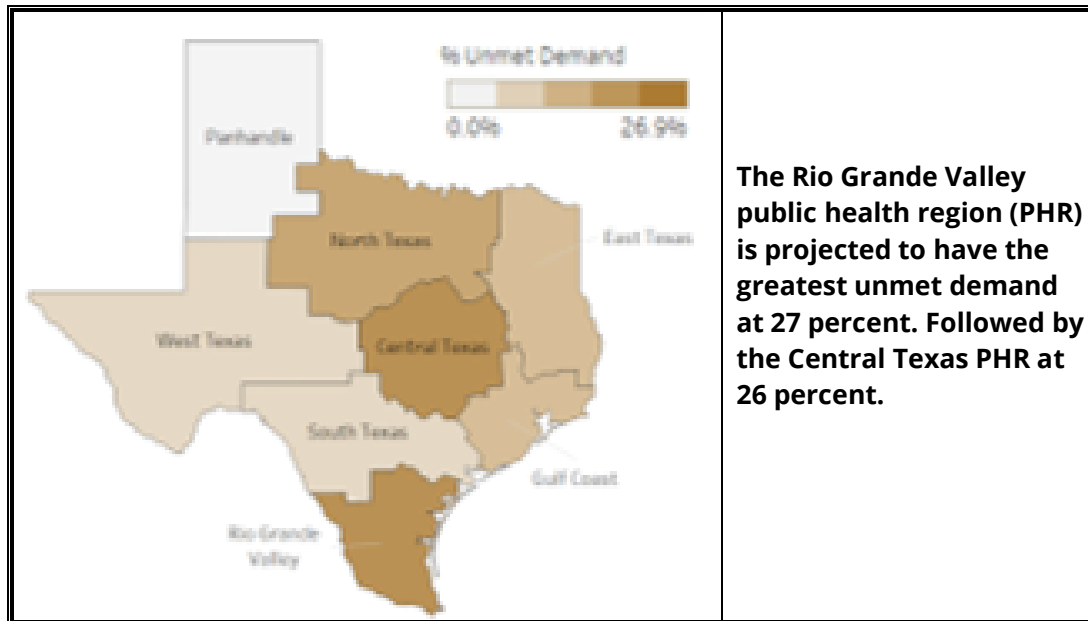
Projections for Registered Nurse FTEs



Ratio of Population to Registered Nurse by County, 2025



Percent unmet demand for Registered Nurse FTEs in 2036. Darker colors in the map represent a higher unmet demand



The Rio Grande Valley public health region (PHR) is projected to have the greatest unmet demand at 27 percent. Followed by the Central Texas PHR at 26 percent.

Despite a 45% increase in RN graduates since 2016, a significant number of qualified applicants are turned away from nursing programs. The primary barriers identified are a lack of clinical space and a shortage of qualified faculty. Innovative solutions discussed included the Shared Nurse Academic Practice Partner Initiative (SNAPPi), which allows bedside nurses to serve as faculty without needing a second job.

Economic Impact and Labor Market Growth

Mariana Vega from the Texas Workforce Commission (TWC) emphasized that healthcare is the fastest-growing sector in Texas, representing 13.8% of total employment and adding 1.1 million jobs over 30 years. Demand is currently exceeding supply across 42 healthcare occupations, with significant gaps for physical therapists (24,000 workers) and RNs (16,000 workers).

Mary York, also from the TWC, detailed the strategic approach to building a talent pipeline, including the use of state-funded Skills Development Funds and federal grants. Since 2021, the state has invested nearly \$10 million to train over 10,000 workers. TWC is also promoting "earn-while-you-learn" apprenticeship models and has awarded over



\$33 million for cutting-edge equipment in high school career and technical education programs.

Higher Education and GME Funding

Commissioner Whin Rosser of the Texas Higher Education Coordinating Board (THECB) discussed the board's role in approving programs and administering \$304 million in GME appropriations for the current biennium. This funding represents a 30% increase from the previous period. Texas maintains a 1.14 to 1 ratio of residency positions to medical school graduates, exceeding its target. Representative Schofield and other members questioned the effectiveness of these investments, requesting more granular data on where residents ultimately choose to practice. Commissioner Rosser committed to utilizing tri-agency data to track graduates for up to ten years to determine how many remain in Texas and in which regions.

Challenges in Rural and Frontier Medicine

Dr. Adrian Billings provided a perspective on the acute healthcare crisis in rural and frontier Texas. He argued that the best predictor of a physician practicing rurally is being from a rural area and having rural exposure during training. He highlighted academic disadvantages for rural students, such as lack of AP or IB courses, which makes them less competitive for medical school. Dr. Billings advocated for the Rural Admissions Medical Program (RAMP) to provide mentorship and pathways similar to the existing JAMP program. He noted that a rural zip code is currently a risk factor for one's life due to declining access to essential services, including obstetrical care.

Questions and Answers

A question was raised about the average cost of nursing education and requested detailed information on student loans, specifically whether they are private, government-backed, or part of FAFSA. The Texas Higher Education Coordinating Board (THECB) agreed to following up with data regarding the cost of attendance and current loan debt levels for students in Texas higher education. The follow-up will also include specifics on grant programs and the loan repayment program intended for nurses to help mitigate accumulated debt.



Representative Simmons raised concerns about how social and political factors in Texas might influence a provider's choice to practice in the state, specifically mentioning the potential legal risks for OBGYNs.

Representative Jones inquired whether the current political climate is being factored into recruitment and retention strategies for rural areas, noting that some physicians express fear of losing their licenses or facing criminal charges.

The Chair noted that while the questions were valid, the current panel might not be the appropriate group to provide the specific data or answers regarding political impacts on recruitment.

It was emphasized that the strategy for retention involves prioritizing Texas applicants for medical schools and residency programs, as those with local roots are more likely to stay in the state.

Discussion focused on the importance of creating graduate medical education (GME) programs in rural communities, as data suggests residents often stay within 75 miles of where they trained.

Dr. Billings identified several existing rural residency programs in locations such as Alpine, Fort Stockton, Pecos, Sweetwater, Lufkin, and Sulfur Springs. The THECB manages the Rural Resident Physician Grant Program, which received a \$3 million appropriation for the 2025-2027 period. This program has already made six awards to various health-related institutions and hospitals to support rural training tracks.

Representative Frank inquired about the Coordinating Board's authority to limit or discontinue degree programs that show a low return on investment or a lack of job opportunities for graduates. Commissioner Rosser explained that while the THECB does not have direct statutory power to close programs, they produce an annual "low-producing program report" based on graduation numbers. This report is shared with university governing boards, presidents, and legislative leadership, though the final decision to close a program remains with the individual university's governing board. The THECB also promotes the "My Texas Future" ([My Texas Future: Adult & K12 Learner Resources for Schools & Careers](#)) tool to help students align their career interests with credentials that have strong wage data.



Ashley King from Workforce Solutions Capital Area highlighted that the primary barrier to expanding healthcare programs is not a lack of student interest, but a shortage of clinical placements. To address this, the Central Texas Healthcare Partnership is expanding clinical rotations into evening, weekend, and potentially overnight shifts to maximize hospital capacity. The Board of Nursing currently allows up to 50% of clinical hours to be completed via simulation, which helps reduce the pressure on physical hospital placements. These efforts have led to the addition of six new nursing programs in the Austin region over the last five years, doubling the number of nursing graduates. Additionally, over 300 medical assistants have been certified through an "earn and learn" apprenticeship model supported by the Texas Workforce Commission.

Juliette Stepich of the Gulf Coast Workforce Board reported a projected need for 10,000 allied healthcare workers over the next decade and another 10,000 in life sciences within five years. The Gulf Coast region is utilizing a "regional operating system" to connect K-12 students to healthcare careers through internships at institutions like the Texas Medical Center and HCA.

Barb Clapp, CEO of Dwyer Workforce Development, emphasized that Certified Nursing Assistants (CNAs) are the backbone of the industry but noted that Texas has lost nearly 25% of its CNA workforce over the last decade. Dwyer Workforce Development provides holistic support, including case management for life barriers like childcare and transportation, and has served 6,500 Texas scholars since 2022. Ms. Clapp recommended that the legislature invest in stackable credentials and outcomes-based programs that measure success by employment and career advancement rather than just enrollment.

It was noted that burnout is a primary challenge for hospitals offering clinical opportunities, as staff must serve as both caregivers and educators. A mentality shift was encouraged where hospitals view clinical placements as long-term job interviews for future coworkers, and students evaluate if a unit or hospital system is the right fit for their career.

Liability was dismissed as a major barrier to offering placements due to existing insurance policies and extensive student compliance requirements.



Solution strategies discussed include using a centralized placement system to shift students between facilities like North Austin Medical Center and Round Rock Medical Center based on space.

There is the potential of utilizing overnight clinical shifts, which are currently under-utilized and reflect the reality of new graduate nursing schedules. Increasing the use of high-fidelity mannequins in simulation labs accounts for up to 50% of required clinical hours, reducing the burden on hospital placements.

K-12 Educational Outreach and Career Development Ms. King explained that outreach efforts are focused primarily on middle school students to influence endorsement selections during their eighth-grade year. The program provides teachers with occupation packets for 12 different roles, including lesson plans, salary information, and hands-on activities. Nursing academies are held for high school students, allowing them to visit various nursing programs in Austin to experience simulation labs and learn about prerequisites.

Representative Jones questioned if the lack of paid clinical placements was a barrier, noting that clinical hours currently function as unpaid internships where credit is the primary "payment."

Grace Adkins from Texas 2036 testified on the success of House Bill 8, which transitioned community college funding to a 95% outcomes-based model. Since the implementation of the new funding model, health professional credentials awarded by Texas community colleges have increased by 18.3% in two years.

Stella Logan, representing Texas Nurse Practitioners (TNP), recommended investing in clinical training for nurse practitioners, noting the cost is approximately \$2,000 per semester compared to much higher physician residency costs. TNP suggested removing regulatory barriers, specifically the requirement for nurse practitioners to maintain physician contracts for their entire careers.

Representative Shofner and the Chair discussed the transformative effect of outcomes-based funding on the Texas healthcare workforce pipeline.

Noah Jones of Leading Age Texas warned of a "silver tsunami," with a projected shortfall of 56,370 registered nurses by 2036 as the population over 65 increases.



Direct resident care RNs in long-term care facilities faced a median turnover rate of 50.9% in 2024, which was actually an improvement from 66.7% in 2022.

Recommendations to improve retention include ensuring adequate compensation, providing health insurance, and implementing loan repayment programs specifically targeted at long-term care in rural areas.

Casey Fortson, a volunteer for Texans for Vaccine Choice, argued that vaccine mandates and coercive employment policies have driven qualified professionals out of the healthcare field and discouraged students from entering.

Agency Oversight: Pursuant to the broad oversight responsibilities granted to the Committee under Section 301.014, Government Code, and the House Rules of Procedure, monitor the agencies under the Committee's jurisdiction, including for fraud, waste, and abuse where applicable, including by receiving testimony from Texas Health and Human Services Office of Inspector General

Inspector General Raymond Winter (*As a side note: The Office responsible for transparency and accountability would not provide the public with a copy of their testimony*). Inspector General Winter reported that the Office of Inspector General (OIG) safeguards approximately \$53 billion in annual health and human services spending. National studies suggest that approximately 10% of healthcare expenditures, or \$5.3 billion in Texas, are lost annually to fraud, waste, and abuse. In fiscal year 2025, the OIG recovered \$465 million and excluded 364 bad actors from the system, returning \$4.21 to the state for every dollar invested in the agency.

A specific criminal case was highlighted where a mother was sentenced to 17 years in federal prison for diverting Medicaid funds intended for her disabled son's care, leading to his neglect and death.

The OIG identified "upcoding" and illegal kickbacks as common provider misconduct, such as a Dallas dental provider settling for \$4 million after using marketing agents to funnel kickbacks to clients.

Regarding the SNAP program, Winter noted a surge in benefits theft via skimming devices and recommended transitioning from magnetic strips to chips on EBT cards.



Representative Pierson questioned the OIG regarding the distinction between civil administrative settlements and criminal prosecutions. The OIG clarified that while most dollar losses come from sophisticated provider schemes, the volume of investigations is higher on the client side, with 19,000 client cases compared to 2,000 provider cases last year.

In Closing The Chair announced that a second interim hearing will likely be scheduled for late July to allow more time for certain interim charges to develop. The committee will coordinate with members to check calendars and schedules before finalizing the date for the next hearing.

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