



2023-2028 Texas State Health Plan

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**Statewide Health Coordinating
Council
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This report was prepared at the direction of the Statewide Health Coordinating Council. The opinions and recommendations expressed in this report are that of the Council and do not reflect the views of the Texas Health and Human Services Commission, Department of State Health Services, or Texas Health and Human Services System

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1. Executive Summary

By November 1 of even-numbered years, the Statewide Health Coordinating Council (SHCC) directs and approves the development of the Texas State Health Plan or its updates for submission to the Governor. This plan, following the legislatively determined purpose of the SHCC,^a seeks to ensure that the state of Texas implements appropriate health-planning activities and that health care services are provided in a cost-effective manner throughout the state.

This State Health Plan focuses on how different factors affect health equity in the state of Texas. The plan contains four sections that examine which groups are more likely to have poorer access to care. The sections look at the challenges faced by individuals residing in rural areas of the state, mental and behavioral health and the ability of the state's behavioral health care workforce to address these issues, and finally, the role that teleservices can play in addressing health disparities. Additionally, each section considers how COVID-19 has impacted health care in Texas.

Based on the evidence contained within each chapter, the SHCC makes policy recommendations consistent with goals of improving health care services in the state and ensuring those services are cost-effective for Texans. These recommendations include:

- Access to Care:
 - ▶ The state should support efforts to increase enrollment in Medicaid among those that are eligible.
 - ▶ The state should examine the varied causes that limit access to care for Texans.

- Rural Health:
 - ▶ The state should support new and innovative ways to bring health care providers to rural areas.
 - ▶ The state should support new and innovative methods of hospital financing.

^a See Texas Health and Safety Code [Chapter 104](#) and [Chapter 105](#).

- Mental Health and Behavioral Health Care Workforce:
 - ▶ The state should support efforts by schools to increase access to mental health services for students.
 - ▶ The state should continue to support the work of the Texas Child Mental Health Care Consortium.
 - ▶ The state should support efforts to increase the funding and stipends available to students of the mental health professions as they complete their education and training, as well as support the expansion of the Loan Repayment Program for Mental Health Professionals.

- Teleservices and Technology:
 - ▶ The state should support new and innovative ways to get teleservices to rural communities.
 - ▶ The state should encourage state, federal, and private health insurance organizations to promote their teleservice benefits.

2. Background

With an eye toward improving access and health care delivery systems throughout Texas, the 2023-2028 Texas State Health Plan provides guidance on how to achieve a high-quality, efficient health system that serves the needs of all Texans. Specifically, the plan identifies challenges in ensuring that a population as large and diverse as Texas' has access to the health care system, that health care services are provided in an efficient and orderly manner, and that an ample health care workforce exists to provide these services.

The plan is divided into four sections, each examining health challenges faced by Texas and its health care workforce and proposing solutions to these challenges. The first section focuses on issues related to differences in access to care for individuals across the state. The second section places focus on unique health care issues faced by those who live in rural Texas. The third section examines mental health and behavioral health issues as well as ways to bolster the health care workers in this field. The final section examines the impact of teleservices and technology on the health care field, as well as how teleservices and technology may aid in improving access to care.

3. Access to Care

This section discusses the health outcomes, health disparities, and demographic differences among the Texas population. Additionally, the unique challenges faced due to COVID-19 are discussed.

Defining Access to Care

Throughout much of Texas and the nation, access to health care is restricted by the availability of providers, resulting in federal designations of health professional shortage areas (HPSAs). This definition of access relies on the idea that those who need health care can access the system if there is an adequate supply of services, measured by the number of physicians, hospital beds, or some other metric.¹ Yet these geographic designations do not fully reflect the multifaceted concept of access to care. The Institute of Medicine has proposed the definition of access as “timely use of personal health care services to achieve the best possible outcomes”.² In addition to the availability of providers, this definition adds components of timeliness and quality, the latter in the form of positive outcomes. Another proposed definition of access is “fair access to consistently high quality, prompt and accessible services right across the country”,¹ introducing the important consideration of equity. This consideration is important given estimates that 30 percent of direct medical expenditures can be attributed to health disparities that create a sicker population and that these disparities are associated with barriers to accessing care.³

The successful performance of health care systems at local, state, and national levels is shown through the ability of individuals to access care when needed.⁴ Simplistically, access may be considered the ease with which consumers and communities are able to use appropriate services in proportion to their needs. Access can then be considered in economic or other terms, such as the time required to utilize health care services, travel distance to services, familiarity with the health system and providers, and other considerations.^{1,2,4} Researchers^{4,5} have proposed similar schema for categorizing potential barriers to access. Synthesized, they are as follows:

- **Affordability** – Affordability refers to the ability of the patient to pay the economic costs associated with health care. This may refer to directly

incurred costs or those associated with insurance coverage, including premiums, deductibles, etc.

- Availability – Availability refers to the level of fit between the patient’s health care needs and the ability of the system to fit these needs. For example, availability is a measure of the nearness and capacity of clinicians and clinical facilities.
- Acceptability – Acceptability refers to the ability of patients to interact with the health care system in light of social, cultural, linguistic, and other norms that may impede utilization.
- Appropriateness – Appropriateness refers to the extent to which the services available fit the needs of the client. On the one hand, appropriateness may refer to the patient’s level of comfort with the organization of the health system, such as procedures necessary to garner an appointment, available office hours, etc. On the other hand, this category may also include care meeting the patient’s expectations with respect to elements such as timeliness, the amount of time spent developing a diagnosis and treatment plan, and the technical and interpersonal quality of the services rendered.
- Approachability – Finally, approachability refers to the extent to which patients with health care needs are able to identify the appropriate services available, are aware of how to reach them, and recognize the potential impact on their health.

Of note, only one of the categories listed above is related to financial capacity of the individual to pay for health care. While financial barriers to access are important and associated with the presence of non-financial barriers, it is worthwhile to note that of those reporting barriers to care, 66.8 percent of U.S. adults reported non-financial barriers to care, a rate higher than those reporting financial barriers.⁴ Seventy one percent of Medicaid patients and 49 percent of Medicare patients reported non-financial barriers to accessing care.

With respect to availability, one of the main barriers to access that exists is a lack of specialists and subspecialists in low-income and rural areas. For example, one survey found that 91 percent of community health centers struggled to find adequate off-site subspecialty care for their uninsured patients.⁶

A major concern regarding acceptability is the extent to which patients are able to receive information and instructions in their preferred language. Often linguistically

based barriers can result in the delay or even denial of services, challenges with medication management, and the underutilization of preventive services.⁷ The National Committee for Quality Assurance and the Joint Commission on the Accreditation of Healthcare Organizations are beginning to recognize the role that language services play in the provision of quality health care. Clinical staff may need training on when to request a medical interpreter, as unqualified interpreters may lead to medical errors and poor patient understanding and adherence.

With respect to appropriateness, research² has noted that patients often experience a cumulative burden of barriers and are frequently in need of multiple avenues through which to access care. For example, offices seeking to increase appropriateness might work to reduce wait times for appointments, alter their office hours to reflect the needs of their clients, and offer advice by phone where appropriate: all key components of the patient-centered medical home. Research on community health centers, which often serve populations with low access, show greater patient satisfaction not only with hours of operation but with overall care.

Finally, approachability relies on the patient to recognize when they are in need of health services and to utilize these services, a term referred to as patient activation.⁸ Of note, different rural populations may require different strategies for ensuring patient activation, and rural populations are likely to require different strategies than metropolitan areas.^{4,8} Ultimately, access to healthcare is a complex idea that can be understood through all of the definitions provided.

Populations with Poor Access

In all, 18 percent of US adults experienced financial access barriers and 21 percent experienced non-financial barriers.⁵ Such barriers have been growing in the past decade, resulting in decreased likelihood of adults having a usual source of care, having recently seen a dentist, and having recently had a medical office visit.⁹ Generally, poor access is higher in lower-income, non-white, and young adult populations, in addition to individuals with at least one chronic disease.^{5,10} Some of these access challenges are related to affordability as racial and ethnic minorities often comprise a disproportionate percent of the uninsured, despite absolute and relative improvements in the rates of insurance coverage of Hispanics and African Americans.^{10,11} Indeed, reports show that access to care declined in all adult populations from 2000 to 2010 with the most dramatic declines present in uninsured populations.⁹ Thus, it comes as no surprise that being uninsured is associated with foregoing needed care because of cost, not having a usual source of care, not receiving recommended screening activities, high-risk adults not getting

checkups in the past two years, and patients with diabetes not receiving recommended diabetes care.¹²

According to the Institute of Medicine¹³, uninsured pregnant women receive fewer prenatal care services than insured pregnant women and are more likely to have poor birth outcomes, including low birthweight and prematurity. Following pregnancy, women need ongoing care for both physical and behavioral health needs, including treatment for chronic conditions such as diabetes and hypertension, as well as diagnosis and treatment for postpartum depression and substance use disorders. Women without health insurance often lack access to affordable contraceptives, including the most effective forms known as Long-Acting Reversible Contraceptives, which includes intrauterine devices and implants. Without access to contraceptives women are more likely to experience unintended pregnancies. Further, uninsured women with breast cancer are 30–50 percent more likely to die from cancer or cancer complications than insured women with breast cancer. Uninsured women are 60 percent more likely to receive a diagnosis of late-stage cervical cancer.¹³

Additionally, considerably more Hispanic and multiracial families reported needing an interpreter than white families.¹¹ These barriers may partially explain why lower proportions of Hispanics, African Americans, and multiracial children receive needed medical and dental care and why access to specialty care is worse for Hispanics and African Americans.

Texas Populations with Poor Access

Women and Men

Women and men in Texas have unique issues that affect access to health care services. When compared to men, women have similar rates of health insurance by type with 62.3 percent carrying private insurance, 17.3 percent with Medicaid/Children's Health Insurance Program (CHIP), and 16.8 percent uninsured.¹⁴ The percentages of men who are uninsured are similar, with 18.4 percent uninsured. Texas men are less likely to have a personal doctor when compared to women, with 28.9 percent of women and 37.6 percent of men reporting not having at least one personal doctor or health care provider.¹⁵ On the other hand, women have reported higher rates of not being able to access medical care due to costs, 17.2 percent compared to 13.0 percent of men.

When considering geographic distribution, men and women in border areas have higher rates of uninsuredness than those in non-border areas.¹⁶ While 24.5 percent

of both men and women in the state of Texas report not having health care coverage, 37.9 percent of those living in border areas report not having coverage. Furthermore, uninsuredness is higher for women than men in non-border areas, with 42.0 percent of women reporting that they do not have coverage, while 33.8 percent of men reported that they do not have coverage.

Low-Income and Less Educated Populations

Health care access for low-income Texans varies based on socioeconomic position. Over 44 percent of Texans at or below the federal poverty line (FPL) rely on Medicaid as their primary insurance, while 23.7 percent rely on private insurance.¹⁶ Almost 30 percent of Texans living at or below the FPL are uninsured. Use of Medicaid is less common as socioeconomic position rises, dropping to 27.2 percent for families whose income is at 200 percent of the FPL or below. Table 1 shows the percent of Texans who are uninsured and the percent of Texans that do not have a personal doctor separated by income.

Table 1. The percent of Texans that are uninsured and do not have a personal doctor by income level¹⁵

Annual Income	Percent Uninsured	Percent that do not have a Personal Doctor
<\$25,000	52%	45.7%
\$25,000-\$49,999	25.6%	34.5%
\$50,000-\$74,999	20.9%	24.2% ^b
\$75,000-\$99,999	16%	
\$100,000+	8.7%	

The percentage of Texans that are uninsured continues to drop as annual income increases and lower income Texans are more likely not to have a personal doctor.

Insurance coverage is more likely among higher educated groups.¹⁶ For example, among those aged 25+ years with less than a high school education, 38.8 percent

^b 24.2% of Texans with an annual income of \$50,000 or more do not have a personal doctor.

reported being uninsured. By comparison, 24.6 percent of high school graduates, 15.7 percent of those with some college, and 7.9 percent of college graduates reported being uninsured. Likewise, 22.1 percent of those without a high school degree reported having been unable to see a doctor when they needed to because of cost.¹⁵ For high school graduates, the percentage was 15.0 percent. For those with some college and college graduates, the percentages were 16.3 percent and 9.8 percent respectively.

Children

Eleven percent of Texas children, 854,340 individuals, do not have health insurance.¹⁶ For those with health insurance coverage, 53.2 percent use private health insurance and 37.9 percent are enrolled in Medicaid/CHIP. Children that reside in households that earn 300 percent of the FPL or below have uninsured rates between 12 and 17 percent while those above 300 percent of the FPL have uninsured rates of 6 percent.¹⁵

Adult Populations

Texans between the ages of 19 to 44 are uninsured at rates that fall between 25.1 and 30.2 percent.¹⁶ For Texans that fall in the 45 to 54 year age group, only 20.6 percent reported having no health insurance coverage. For those 65 years of age or older, only 1.8 percent reported no health insurance coverage. Over half of younger Texans ages 18 to 29 do not have a personal doctor compared to 43.7 percent for those ages 30 to 44, 24.7 percent for those 45-64, and 9.1 percent for those ages 65+. Between 16.5 and 19.1 percent of Texans aged 18 to 64 reported that they were unable to see a physician due to costs. Only 5.3 percent of those aged 65+ were unable to see a physician due to costs.¹⁵

Minority Groups

Hispanics in the state of Texas have significantly higher rates of being uninsured when compared to other racial groups. The percentage of Hispanics that do not have health insurance coverage is 27.3, compared to 10.0 percent of whites, 15.0 percent of African Americans, and 11.4 percent from other racial backgrounds.¹⁶ White and African American Texans are more likely to have a personal doctor (75.6 percent of whites and 76.4 percent of African Americans), when compared to Hispanics at 52.9 percent. Percentages of Hispanics and African Americans that were unable to access a physician due to costs were similar, at 20.2 and 14.7 percent respectively, while only 11.3 percent of whites and 12.2 percent of multi-racial or other-raced individuals were unable to see a physician due to costs.¹⁵

Border Counties^c

Texans that reside near the Texas/Mexico border are less likely to have health insurance coverage when compared to the state as a whole, 37.9 percent compared to 24.5 percent.¹⁶ When considering only those aged 18-64 in non-border areas of the state, those who were uninsured was estimated to be 21.9 percent. In border areas, this percentage was almost doubled at 38.5 percent. The border region also has higher rates of Medicaid utilization when compared to the rest of Texas, 27.3 percent compared to 16.2 percent. Additionally, those living in border areas are less likely to have a personal health care provider, more likely to forgo needed medical treatment because of cost, and less likely to have had a routine checkup in the past year.¹⁵

COVID-19 and Access

Nationwide Access

Communities across the U.S. and specifically in Texas have been impacted by COVID-19, with communities being impacted in different ways.¹⁷ Due to the high demands of COVID-19 on medical staff, many individuals have reported experiencing reduced access.¹⁸ This issue was particularly severe in the earlier months of the pandemic. According to experimental survey research, in June and July of 2020, 38.7 percent of adults reported that they were unable to receive one or more types of care in the past two months due to the pandemic. This percentage dropped to 28.2 percent in August 2020. In May and June 2021, it had fallen further to 12.7 percent. According to the study, in each time period, women were more likely than men to report that the pandemic had caused them to be unable to receive one or more types of medical care.¹⁸ Furthermore, the onset of COVID-19 resulted in 5.4 million lost jobs in the U.S. and for many Americans the loss of a job also resulted in the loss of health insurance, reducing millions' access to health care.¹⁹

^c Border area is defined through the La Paz Agreement of 1986 and includes 32 Texas Border counties: Brewster, Brooks, Cameron, Crockett, Culberson, Dimmit, Duval, Edwards, El Paso, Frio, Hidalgo, Hudspeth, Jeff Davis, Jim Hogg, Kenedy, Kinney, La Salle, Maverick, McMullen, Pecos, Presidio, Real, Reeves, Starr, Sutton, Terrell, Uvalde, Val Verde, Webb, Willacy, Zapata, and Zavala.

Access in Texas

According to one study, an estimated 659,000 Texans lost health insurance as a consequence of job-loss due to COVID. Another study suggests the number of jobs lost may be even higher, indicating that as many as 1.6 million Texans lost their employer-sponsored health insurance due to job-loss during the COVID-19 pandemic.²⁰ Such losses during the pandemic are particularly concerning because when individuals are without health coverage they tend to delay seeking medical attention.¹⁹ This may have led to additional spread in the virus among those who did not know that they were infected.

Race & Ethnicity

Additional concerns around COVID-19 relate to differences in vaccination rates based on race. One major concern, particularly early in the vaccination distribution process, was ensuring that communities had equal access to the vaccine.²¹ As of 2022, in Texas, 53 percent of white individuals have received at least one dose of the vaccine, while only 46 percent of African-American individuals have been vaccinated. In contrast, 59 percent of Hispanic individuals have been vaccinated, and 73 percent of Asian individuals have been vaccinated in Texas.²² Nationally, 48 percent of white individuals, 32 percent of African-American individuals, 27 percent of Hispanic individuals, and 48 percent of Asian individuals have received at least one dose of the vaccine.²³ Texas exceeds vaccination rates among race/ethnicity categories compared to the nation as a whole.

Strategies for Improving Access

Three broad strategies are available to address the gaps in access to care identified above: improving rates of insurance coverage; increasing the availability of health care professionals, facilities, and services; and a reduction in social barriers to care. Ultimately, improving timely access to and quality of care will depend on collaboration among local clinicians, hospital leaders, insurance companies, policymakers, and community stakeholders.¹² Success in improving access to care relies on concurrent efforts to reduce financial and nonfinancial access barriers.⁵ Additionally, Texas has fewer physicians per capita than the national average, creating additional hurdles for those who need access to care.²⁴ Increasing the number of available physicians and other health care providers will improve access and lessen the burden on those health care professionals in the state. A fundamental aim of the redesign of primary care services is improving access to care. Patients who reported having a usual site of care and a provider at that site

are more likely to access that care, receive preventive services, and have improved health.² The following strategies seek to improve access by making health care more affordable, available, acceptable, appropriate, and approachable.

Covering More Texans

In order to improve the affordability of care and thus access in Texas, it should be a priority of this state to increase the number of Texans with insurance coverage and a usual source of care. This can be accomplished through greater public coverage of the poor and improved access to physicians and other providers within the public system. Projections²⁵ demonstrated that low-income Medicaid enrollees were significantly more likely to have a usual source of care and less likely to have unmet health care needs. Publicly covered adults are also more likely to report timely care and less likely to delay or go without needed medical care because of costs.

With respect to mothers and their children, increasing the percentage of covered mothers is likely to have a significant effect on access to health care, ability to pay medical bills, and mental health. Children are also expected to benefit, since their coverage and access to care have been shown to improve when their parents have coverage. Increasing the number of mothers with insurance may also improve outcomes for children in other ways, such as by reducing maternal depression, which can affect parenting abilities.

Medicaid, along with its companion CHIP, is a state/federal partnership that provides health care coverage to low-income children and their caretakers, pregnant women, people age 65+, and people with disabilities. Some states, though not Texas, have chosen to extend Medicaid coverage to childless, nondisabled, working age adults.

In Texas, the Medicaid and CHIP programs cover over four million people.²⁶ A large body of evidence suggests that these individuals are more likely to have a usual source of care, more likely to receive preventive health services, and less likely to have unmet or delayed needs for medical care than if they were uninsured.²⁵ Research has consistently indicated that people with Medicaid coverage fare much better than their uninsured counterparts on measures of access to care, utilization, and unmet needs. Evidence further shows that, compared to low-income uninsured children, children enrolled in Medicaid are significantly more likely to have a usual source of care and to receive well-child visits and immunizations, and significantly less likely to have unmet or delayed needs for medical care, dental care, and prescription drugs due to costs. Moreover, in some states that expanded Medicaid,

reports note that the expansion led to improvements in prenatal care use, in terms of either earlier or more adequate prenatal care.

The federal government currently subsidizes, via tax credit, marketplace health insurance premiums for households that earn from 100 percent to 400 percent of the FPL.¹³ Texas adults earning below the FPL, but who do not qualify for Medicaid or for federal subsidies to purchase care on the insurance exchange, fall into what is known as the “coverage gap.” Nationally, over two million poor uninsured adults fall into the coverage gap, a third of which reside in Texas. In total, there are 771,000 people that fall into the coverage gap in Texas, leaving them with no realistic options for affordable health insurance coverage.

Provider Participation in Medicaid

In order to improve access to care in Texas, it is important to address shortages in providers treating low-income individuals. Among the challenges providers face are the administrative burden of participation in Medicaid, the complexity of many patients’ needs, challenges in arranging mental health and specialty referrals, large patient panels associated with a general shortage of physicians, and lower reimbursement rates than other payers. National research has indicated that physicians may be optimistic about the ability of electronic health records and medical homes to mitigate challenges.²⁷

With respect to reimbursement, Texas is one of 22 states that pays 75 percent or less for Medicaid physician fees when compared to Medicare physician fees.⁵ There are 24 states that pay physician fees at 75 percent to 100 percent and three that pay greater than 100 percent for services under state-run Medicaid programs when compared to Medicare. Texas Medicaid pays approximately 65 percent compared to the federally funded Medicare program.³ Due to the gap in physician reimbursement between the two programs, physician participation has diminished. The number of Texas physicians willing to accept new Medicaid patients fell from 67 percent in 2000 to 31 percent in 2012⁴ and increased slightly to 34 percent in 2015.^{1,3} In order to guarantee strong provider networks for Texas low-income residents, Texas should strive to pursue a comprehensive approach to improving provider experience and increasing participation in Medicaid.

From 2013 to 2014, the federal government provided additional funding that allowed states to increase Medicaid payments to primary care physicians to match payments for the same services through Medicare.²⁸ These funds successfully sought to increase participation in Medicaid programs, especially primary care

services, effecting a five percent rise in physician participation in Medicaid during this time.^{1,3} However, the increase in payments was not made permanent in Texas.

Other Policy Considerations

Generally, the racial and ethnic profile of health care providers in Texas does not reflect that of the population at-large. In addition to cultural preferences pondered in the mental health section of this report, it has been shown that minority physicians are significantly more likely to care for minorities, the publicly insured, and uninsured patients.¹¹ Likewise, a more diverse workforce may help address the need for linguistic competency within the health provider workforce. In the interim though, the standardization of payment mechanisms for interpreter services and their inclusion in health plans may improve access for those who are not proficient in English.⁷

The expansion of teleservices, the appropriate utilization of physician assistants and advanced practice registered nurses, and stronger financial incentives for clinicians to practice in underserved areas may be useful for expanding access in geographically underserved areas.⁵

Policy Developments

The Delivery System Reform Incentive Payment (DSRIP) pool in the Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Demonstration (Waiver) began in 2012 and was set to conclude in September 2021.²⁹ The DSRIP program benefitted Texans and the Texas health care delivery system. Texas providers earned over \$15 billion in DSRIP funds from 2012 to January 2019, and it served 11.7 million people and provided 29.4 million encounters from October 1, 2013 to September 30, 2017. As the DSRIP pool came to a close, the state of Texas began working on new programs to support services in Texas. As part of the DSRIP transition plan, several programs that offer access to care, often for underserved communities, have been introduced. The Health and Human Services Commission (HHSC) submitted the following programs, which have been approved:

- Texas Incentives for Physician and Professional Service (TIPPS)³⁰: A value-based directed payment program for certain physician groups providing health care services to children and adults enrolled in the STAR, STAR+PLUS

and STAR Kids Medicaid programs.^d Eligible physician groups include health-related institutions, indirect medical education physician groups affiliated with hospitals, and other physician groups.

- Comprehensive Hospital Increased Reimbursement Programs³¹: A directed payment program for hospitals providing health care services to adults and children enrolled in STAR and STAR+PLUS. Eligible hospitals include children's hospitals, rural hospitals, mental health hospitals, state-owned hospitals, and urban hospitals.
- Directed Payment Program for Behavioral Health Services³²: A directed payment program for community mental health centers to promote and improve access to behavioral health services, care coordination, and successful care transitions. It also incentivizes continuation of care for STAR, STAR+PLUS, and STAR Kids members using the Certified Community Behavioral Health Clinic model of care.
- Rural Access to Primary and Preventive Services³³: A directed payment program for rural health clinics that provide primary and preventative care services to STAR, STAR+PLUS, and STAR Kids members.

Policy Recommendations for the Legislature, the Governor, and Executive Branch Agencies

Encourage the use of health care teams that include different types of health care providers.

In 2021, 34 of the 254 counties in Texas had no primary care physicians and 31 counties had no direct patient care physicians.²⁴ Using teams that include different types of health care providers can facilitate the provision of care for those without physicians nearby. Using teams also promotes more efficient care in addressing the health care needs of patients and provides physicians with the opportunity to focus on the more serious and complex needs of patients. This shift would help to redistribute responsibilities and allow physicians to utilize their time working with those patients who need their expertise. This would allow physicians to more efficiently allocate their time, which is critical due to the shortage of physicians in the state.

^d STAR, STAR+PLUS, and STAR Kids are Texas Medicaid and CHIP Programs. More information about the individual programs can be found at <https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members>.

Conduct a study examining which factors decrease physician participation in Medicaid programs.

Improving our understanding regarding why more physicians do not participate in Medicaid is an important first step in increasing access. Many factors may influence physicians' decision to not participate in Medicaid programs, such as the process of becoming a Medicaid provider, patient participation, reimbursement rates, etc. Understanding the hurdles preventing physicians from participating will allow for more targeted approaches in improving physician participation in Medicaid which would improve access for many Texans.

Support the furthering of health literacy and utilization of preventative services for those on Medicaid.

According to the CDC, health literacy is "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others."³⁴ Furthering health literacy would aid in improving health outcomes.³⁵ Research has shown that patients who are better informed make better choices for their health, ultimately improving health outcomes. Health literacy is also key for effective preventative medicine.³⁶ Health literacy helps prevent health problems, protect individuals' health, helps people better manage health problems when they arise, and improves individuals' ability to identify health problems early, which is often key to treatment.³⁷ Additionally, preventative medicine improves health outcomes, and increasing the utilization of such services would improve the health of Texans.³⁸ During the 87th Legislature, Regular Session, the House Select Committee on Health Care Reform was created. The committee's duties are to "examine the potential impact of delayed care on the state's health care delivery system, health care costs, and patient health outcomes, as well as best practices for getting patients with foregone or delayed health interventions back into the health care system. The study should consider patient delays in obtaining preventative and primary health services..." Together, improving health literacy and utilization of preventative services for those on Medicaid could improve the health of Texans across the state.

Support efforts to increase enrollment in Medicaid among those that are eligible.

During the 87th Legislature, Regular Session, the House Select Committee on Health Care Reform was created. The committee is charged with studying ways to improve

outreach to families with children who are eligible for, but are not enrolled in, Medicaid or CHIP. This targets increasing enrollment of children who are eligible, but there should also be similar efforts to increase outreach for all those who are eligible for Medicaid but not enrolled in the program.

Continue to support programs like TIPPS, which provides increased Medicaid payments to certain physician groups providing health care services to persons enrolled in STAR, STAR+PLUS, and STAR Kids.

On March 25th, 2022 the TIPPS program was approved by the Centers for Medicare and Medicaid Services.³² This program is for delivery system and provider payment initiatives under Medicaid managed care plan contracts. Three classes of providers are eligible to participate: (1) health-related institution physician groups, (2) physician groups affiliated with hospitals that receive indirect medical education funding, and (3) other physician groups.

TIPPS funds are paid through three components of the managed care capitation rates:

- Component 1 is equal to 65 percent of the total program value and provides a uniform dollar increase paid monthly. Only health-related institutions and indirect medical education physician groups are eligible for Component 1.
- Component 2 is equal to 25 percent of the total program value and provides a uniform rate increase paid semi-annually. Only health-related institutions and indirect medical education physician groups are eligible for Component 2.
- Component 3 is equal to 10 percent of the total program value and provides a uniform rate increase for applicable outpatient services and is paid at the time of claim adjudication. All participating physician groups are eligible for Component 3.

Increased Medicaid payments compensate providers and may encourage greater participation in the programs, which would increase the capacity to provide care to those on Medicaid.

Support the development of quality thresholds that must be met by those providers participating in TIPPS.

The TIPPS program has the following quality goals:

- Promote optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities, and the health care system to address root causes of poor health.
- Promote effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs.

Subsequently, TIPPS providers must provide qualitative and numeric data, which will be used to monitor provider-level progress toward state quality objectives. While these quality measures must be reported, there are no minimums that currently must be met so there should be a shift to developing standards that would assess whether care is meeting or exceeding the quality goals that have been developed.

Examine the varied causes that limit access to care for Texans.

While affordability plays a role in access to care, it is only one factor to consider when examining barriers to health care. Lawmakers should further examine other factors that limit access to care. This includes the level of fit between patients' health care needs and the ability of the system to fit these needs, which includes the nearness and capacity of clinicians and clinical facilities.⁵ Another factor that should be examined is the ability of patients to interact with the health care system in light of social, cultural, linguistic, and other norms that may impede utilization. These factors are particularly important due to the large Hispanic population in the state. Texas had a higher percentage of individuals five years of age and over who spoke a language other than English at home (35.5 percent) compared to the nation (21.5 percent) from 2014 to 2018.³⁹ Texas has the second highest percentage of individuals who spoke a language other than English at home (behind California). The most common language other than English spoken at home in Texas was Spanish (29.5 percent), followed by Asian and Pacific Islander languages (2.9 percent) and other Indo-European languages (2.2 percent).

Additionally, the extent to which the services available fit the needs of the patient should also be examined.⁵ This may include the patient's level of comfort with the organization of the health system. It may also include care meeting the patient's expectations with respect to elements such as timeliness, the amount of time spent developing a diagnosis and treatment plan, and the technical and interpersonal quality of the services rendered. Finally, the extent to which people with health care needs are able to identify the appropriate services available, are aware of how to

reach them, and recognize the potential impact on their health should be included when examining access to care.

4. Rural Health

This section discusses the health outcomes, health disparities, and demographic differences in rural areas throughout the state of Texas. Additionally, the unique challenges faced by hospitals and health practices are discussed.

Health Outcomes in Rural Areas

Nationally, residents in rural areas have a life expectancy 1 to 5 years less than residents in urban areas.⁴⁰ Those in rural areas are more likely to smoke, less likely to exercise, and have less nutritional diets than those in suburban areas.⁴¹ These factors contribute to higher mortality rates and higher rates of chronic diseases in rural areas. Approximately 43 percent of deaths in rural areas can be attributed to modifiable risk factors such as smoking, excessive drinking, and obesity, compared to about 37 percent in urban areas.⁴² Rural residents are more likely to have hypertension, diabetes, arthritis, and high cholesterol than urban residents. Rural children are more likely to be obese than urban children.⁴³ Rural areas also have higher age-adjusted mortality for heart disease, cancer, chronic respiratory disease, and stroke.⁴⁴ In 2019, the age-adjusted mortality was 834.0 per 100,000 population in rural communities and 693.4 in urban communities.⁴⁵ Rural residents were also more likely to die due to unintentional injury, drug poisoning, and suicide than urban residents.

Rural health in Texas faces both similar and unique challenges compared to rural health nationally.⁴⁶ The rural populations of Texas are incredibly diverse; for example, the Texas-Mexico border area is predominantly Hispanic (88.4 percent) compared with the rest of the state (35.5 percent).⁴⁷ There are colonias, which are “residential area[s] lacking some basic infrastructure like a drinking water supply, sewage treatment, paved roads, adequate drainage, etc.”⁴⁸ Adult residents of colonias report worse physical health compared to adults nationally and Hispanic adults as a whole.⁴⁹

COVID-19

The first pandemic surge in Spring 2020 resulted in higher incidence and mortality in urban areas. During the second surge in Summer 2020, the rates in rural areas surpassed those in urban areas. Since then, incidence and mortality rates have remained higher in rural than urban areas.⁵⁰ Rural areas felt a greater impact from COVID-19 due to poor health literacy and health care infrastructure, as well as

having higher proportions of elderly and people with comorbidities.⁵¹ Rural areas have higher incidences of underlying medical conditions that increase the risk of severe illness from COVID-19, such as obesity, diabetes, hypertension, and smoking.⁵² Rural areas also tend to have lower COVID-19 vaccination rates.⁵³ Residents of rural areas are more likely to distrust vaccines than those of urban areas.⁵⁴

Emergency Medical Services

Emergency medical services (EMS) face challenges in rural Texas.⁵⁵ As requirements for EMS personnel increase and access to training in rural Texas decreases, this exacerbates staffing issues in rural Texas. Rural EMS providers tend to be staffed less than urban EMS. EMS agencies are often staffed by volunteers or a mix of volunteers and paid staff. One study found that those agencies staffed by volunteers are often less trained and would benefit from additional training for their positions.⁵⁶ Additionally, a study found that rural EMS are more likely to lose staff to burnout than urban EMS. The closure of rural hospitals also puts strain on EMS by increasing drive times to facilities.⁵⁷ The Texas Department of Transportation Safety Division through the Texas A&M Engineering Extension Service provides funding for Texas Rural/Frontier EMS training; however, funds are limited.⁵⁵ Senate Bill 8 of the 87th Legislative Session, 3rd Special Session, allocated funding for EMS education programs.⁵⁸ This included \$21 million that goes towards scholarships for EMS students with special consideration for those in rural parts of Texas.⁵⁹

Teleservices

The current COVID-19 pandemic has resulted in the rapid expansion of telehealth and telemedicine services. The Centers for Medicare and Medicaid Services has expanded the number of services eligible for telehealth.⁶⁰ Additionally, emergency rules were issued expanding telehealth and telemedicine.⁶¹ A report identified telemedicine as a way for rural residents to access subspecialist services and for expanding services offered by nurse practitioners and physician assistants.⁶² Broadband access is a barrier to receiving telehealth and telemedicine in rural areas of Texas.⁵⁵ There are over 2 million households in Texas without high-speed internet access.⁶³ Fiber infrastructure and broadband access have been identified as a key concern among rural residents.⁵⁵

Older Adults in Rural Areas

Nationally, the rural population is older than the urban population.⁶⁴ In 2015, the median age was 51 years in rural areas and 45 in urban areas. Rural communities

also had a higher proportion of people aged 65 and older in 2016, as this age group comprised 18.4 percent of the population in rural areas compared to 14.5 percent in urban areas. According to the Texas Demographic Center, rural counties experienced the greatest increases in median age from 2010 to 2018.⁶⁵ For instance, 18 percent of rural counties saw an age increase of two to four years, and 16 percent saw an increase of more than four years. Metropolitan counties saw an age increase of two to four years in 13 percent of counties and more than four years in only 2 percent of counties. Older adults are at higher risk of chronic disease, and many manage two or more chronic conditions.⁶⁶ Older adults often require more complex health care that may be more difficult to receive in rural areas.

Challenges for Low-Income and Uninsured Populations in Rural Areas

In 2018, Texas had the highest number of uninsured people in any state.⁶⁷ Rural households also report a lower median income than urban households.⁶⁴ In 2016, the median income was \$46,000 for rural households and \$62,000 for urban households. Moreover, the poverty rate was 16.9 percent in rural areas and 13.6 percent in urban areas. In 2013, the food insecurity rate was 15.8 percent in rural communities and 14.5 percent in urban communities. Low-income communities have limited access to fresh foods and environments that are conducive to physical activity.⁶⁸ Income and poverty have been established as being associated with poor health and increased mortality.

In summation, people that live in rural areas tend to have poorer health outcomes when compared to their urban counterparts. These issues are highlighted by the lower incomes and lower insurance rates in rural areas. These issues make rural health access complex and highlight why the issues surrounding facilities and providers, as discussed below, are particularly important.

Hospital and Nursing Facility Closures

Access to quality health services was identified as the top priority in rural health over the last decade.⁴⁶ Types of access that were identified as the most concerning include emergency services, primary care, and insurance. Since 2010, 26 rural hospitals have closed in Texas.⁶⁹ Hospital closures in rural areas negatively impact access to care and potentially health outcomes as well.⁷⁰ Hospital closures lead to loss of access to emergency care, making emergency medical transport even more important. For patients that rely on hospitals for specialty care or referrals, they

lose that access as well. In particular, communities often lose access to obstetric care, mental health care, and diagnostic testing when hospitals close. Communities that lose hospitals have a difficult time recruiting employers and industries to the area.

Hospital closures can lead to increases in the amount of time patients must travel to obtain care.⁷¹ Longer travel times can lead to negative health outcomes, especially for conditions like traumatic injuries and stroke.

There was a significant amount of nursing home closures between June 2015 and June 2019.⁷² Research shows there were 555 nursing home closures nationwide during these years, including 65 in Texas. Moreover, 40 percent of the nursing home closures in Texas were in rural areas.

In 2018, Texas had the highest number of uninsured people in any state, and Texas has not expanded Medicaid through the Affordable Care Act (ACA).^{67,73} People of color are more likely to be low-income and uninsured, so Medicaid expansion affects them more significantly.⁷⁵ Additionally, the ACA expansion of Medicaid has been found to be associated with reduced probabilities of hospital closures.⁷⁶ In states that expanded Medicaid, rural hospitals increased revenue that likely reduced the number of closures.

Providers

Data from the Texas Department of State Health Services (DSHS) indicate that non-metropolitan counties had 36.7 percent fewer primary care physicians per capita than metropolitan counties in 2021.²⁴ Non-metropolitan counties had 56.6 percent fewer direct patient care physicians per capita than metropolitan counties. In the same year, there were 34 counties in Texas with no primary care physicians and 31 counties with no direct patient care physicians.

Some reasons why health care clinics close include physician retirement or because they, like hospitals, are not financially solvent. Clinic closures in rural Texas can lead to longer drives to access care and delaying care due to the distance.⁷⁷ An example was highlighted in a news article that described the impact of the closure of the clinic in Cottle County that resulted in one resident having to drive 30 minutes to Childress County, the next closest clinic. Residents in rural areas must make hard choices about whether or not to move to obtain better access to care, especially as they age.

Older Providers

As illustrated by data from DSHS, direct patient care physicians in rural Texas areas tend to be older.²⁴ In 2021, the median age of direct patient care physicians was 49 years in metropolitan counties and 56 years in non-metropolitan counties.

As physicians in rural areas age and retire, they may leave practices that have to close because there are no physicians in the area to continue the practice.⁷⁸ When the nurse practitioner who ran the only health clinic in Memphis, Texas retired, the clinic closed. Now residents must drive approximately 140 miles to receive care.

Obstetric Services

According to DSHS data, non-metropolitan counties had 63.4 percent fewer obstetricians and gynecologists per capita than metropolitan counties in 2021.²⁴ Projections show that the shortage of obstetricians and gynecologists is projected to continue through 2032 in seven of the eight public health regions in Texas.⁷⁹

Nationally, the number of hospitals providing obstetric care in rural areas has decreased over the last 20 years.⁸⁰ This can lead to increased travel time for women in rural areas. A study that examined factors associated with rural obstetric unit closures found that common risk factors included: low number of births, private hospital ownership, low number of family physicians in county, and lower income county.

As obstetric units close, women must drive farther distances to give birth.⁸⁰ This may be dangerous for women with high-risk pregnancies or complications. Obstetric unit closures in rural counties that are not adjacent to urban counties are associated with higher rates of preterm births.⁸¹

Policy Recommendations for the Legislature, the Governor, and Executive Branch Agencies

Support new and innovative methods of hospital financing.

Hospital financing is a significant factor in whether a hospital stays in a rural area. By encouraging innovative financing, Texas can create novel solutions to strengthen rural hospitals. In the report from Texas A&M University, facility conversion is identified as a solution for hospitals.⁶² Another model, the Pennsylvania Rural Health Model, transitions rural hospitals from fee-for-service to global budget

payments.⁸² The Texas A&M University Rural and Community Health Institute provides technical assistance to rural hospitals in such areas as finance challenges, grant writing, and community engagement.⁸³

By evaluating services, hospitals can best adjust their services to meet the needs of the community. Additionally, facilities can formalize relationships with other facilities to provide other services. Sharing resources such as key personnel, health information technology, and board membership can help to optimize limited fiscal resources and improve continuity of care.⁸⁴

Monitor the impact of the coronavirus pandemic on the number of uninsured people in Texas.

Prior to the coronavirus pandemic, Texas had the highest number of uninsured people of any state. More than 4.9 million people in Texas, or about 17.3 percent of the state's population, were uninsured in 2020.⁸⁵ An estimated 659,000 adults in Texas lost coverage due to job loss during the pandemic.⁸⁶ As this is a rapidly changing situation, leaders must continue to track and determine the impact of the pandemic on the number of uninsured people in the state.

Monitor the impact of the coronavirus pandemic on the shortage and maldistribution of health care providers.

A survey conducted by the American Association of Critical Care Nurses found that 92 percent of respondents felt that the pandemic had "depleted nurses at their hospitals and, as a result, their careers will be shorter than they intended."⁸⁷ Many physicians are also experiencing burnout due to the pandemic.⁸⁸ Nationally, employment in the health care field is down by 306,000, or 1.9 percent, since February 2020.⁸⁹ This could exacerbate the existing workforce maldistribution in the state and shortage in rural areas. Notably, the number of Texas counties designated as primary care shortages areas jumped from 129 in 2019 to 228 in 2021.⁹⁰

During the pandemic, many nurses left their jobs to become traveling nurses due to higher earning potential. The nursing shortage has driven up the price of traveling nurses, making employing them much more costly to hospitals that are experiencing staffing shortages.⁹¹ To adequately provide for the medical needs of all Texans, the state must correct its chronic shortage and maldistribution of health care providers.

Support expanding the state’s loan repayment programs to include more health professions.

The Texas Higher Education Coordinating Board has loan repayment programs for physicians, nurses, and mental health professionals who practice in underserved areas.⁹² Two of these are the State Physician Education Loan Repayment and Rural Resident Physician Grant programs. Research by the Association of American Medical Colleges shows that physicians tend to stay and practice medicine in the area where they trained.⁹³ The 2016 National Health Service Corps Participant Satisfaction Survey found that 88 percent of participating clinicians who received loan repayment assistance in exchange for working in underserved areas stayed in that area for up to one year after their obligation, and 43 percent intended to stay for five or more years.⁹⁴ Expanding the loan repayment programs to include more health professions could increase the number of people practicing other health professions in underserved areas and incentivize people to enter a health profession. These programs should also be advertised to expand their reach.

Support new and innovative ways to bring health care providers to rural areas.

Rural Americans live an average of 10.5 miles from the nearest hospital, compared to 4.4 miles for those in urban areas.⁹⁵ By supporting alternative methods of bringing health care providers into rural areas, more patients in underserved areas could receive care. Programs like Care Van, a collaboration between the Caring Foundation of Texas and other institutions including the Texas Tech University Health Sciences Center, brings health care providers to communities, including rural communities, at no cost to those who qualify.⁹⁶

The availability of teleservices must also expand to ensure greater access to health care services. There are currently numerous barriers to the practice of telehealth and telemedicine. House Bill 5, 87th Legislature, Regular Session, 2021, established a Broadband Development office to improve access to broadband services in rural areas.⁹⁷ A Texas A&M University report identified telemedicine as a way for rural residents to access subspecialist services and for expanding services offered by nurse practitioners and physician assistants.⁶²

Ensure that high school students are educated about the health care system and careers in health care.

Health care workers from rural areas are more likely to practice in rural areas. Therefore, high school students in rural areas should be encouraged to enter the

health care field.⁹⁸ They can be provided with education about how the health care system works, what careers are available to them in health care, what kind of preparation is necessary for these careers, and how to apply to training and educational programs. The Health Professions Recruitment and Exposure at the University of Texas Southwestern Medical Center accomplishes these goals by “expos[ing] high school students to medicine and science through a variety of workshops and hands-on activities.”⁹⁹

High schoolers can also begin their path toward professional licensure. Seven vocational nursing programs in Texas offer options for high school students to take nursing courses and become licensed shortly after high school graduation.¹⁰⁰ Supporting programs for high school students could increase prospective entrants into health care fields experiencing workforce shortages.

5. Mental Health and Behavioral Health Workforce

This section covers the growing need for U.S. and Texas mental health services for distinct demographic categories. In addition, it discusses and displays the shortages of the behavioral health workforce and the challenges faced for recruitment and retention.

Background

Nationally, almost half of adults (46.4 percent) will experience a diagnosable mental disorder in their lifetime.¹⁰¹ On an annual basis, over one in four adults (26.2 percent) in the U.S. experience mental illness and about one in 17 (5.8 percent) experience a serious mental illness.¹⁰² Half of diagnosable mental disorders begin by the age of 14 and three-fourths begin by the age of 24.¹⁰¹ Moreover, an estimated 14 to 20 percent of young people annually have mental, emotional, and behavioral disorders.¹⁰³

According to the 2020 National Survey on Drug Use and Health, 52.9 million adults aged 18+ (21.0 percent) experienced mental illness and 14.2 million adults (5.6 percent) experienced serious mental illness in the past year.¹⁰⁴ Among children and adolescents aged 12 to 17, 4.1 million (17.0 percent) experienced a major depressive episode and 2.9 million (12.0 percent) experienced a major depressive episode with severe impairment in the past year.

The 2020 survey results also indicate that only 46.2 percent of adults who experienced mental illness and 64.5 percent of adults who experienced serious mental illness in the U.S. received inpatient or outpatient mental health services or took prescription medication for a mental health condition in the past year. Furthermore, an unmet need for mental health services in the past year was perceived by 30.5 percent of adults who experienced mental illness and 49.7 percent of adults who experienced serious mental illness. Among children and adolescents aged 12 to 17 who experienced a major depressive episode, just 41.6 percent received treatment for depression in the past year.

Additionally, the 2020 survey results indicate that the COVID-19 pandemic negatively affected mental health. From October to December 2020, the majority of adults (73.0 percent) and the majority of children and adolescents aged 12 to 17

(69.1 percent) in the U.S. perceived that the COVID-19 pandemic had a negative effect on their mental health. For adults as well as children and adolescents aged 12 to 17, 18.3 percent perceived that their mental health was negatively affected “quite a bit or a lot” because of the COVID-19 pandemic. Another 54.7 percent of adults and 50.8 percent of children and adolescents perceived that their mental health was negatively affected “a little or some” because of the COVID-19 pandemic.

A national study conducted by the Center for Studying Health System Change found that 66.8 percent of primary care physicians were unable to refer their patients to high-quality outpatient mental health services.¹⁰⁵ This percentage of unavailability is much higher than the percentages reported by primary care physicians for other common referrals, including high-quality specialist referrals (33.8 percent), high-quality imaging services (29.8 percent), and nonemergency hospital admissions (16.8 percent). Primary care physicians reported that the unavailability of high-quality outpatient mental health services was due to lack of or inadequate health insurance coverage, a shortage of providers, and health plan barriers.

Despite the established need for mental health services, a mental health workforce shortage is evident nationwide. According to the Health Resources and Services Administration (HRSA), over 148.2 million people in the U.S. live in the 6,222 HPSA’s for mental health.¹⁰⁶ Areas designated by HRSA as HPSA’s for mental health may be based on the ratio of population to psychiatrist, the ratio of population to core mental health provider (includes psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists), or both of these ratios.

- If based on the ratio of population to psychiatrist, geographic designations must have a ratio of 30,000 to 1. In areas with high needs,^e geographic designations or population designations must have a ratio of 20,000 to 1.
- If based on the ratio of population to core mental health provider, geographic designations must have a ratio of 9,000 to 1. In areas with high needs, geographic designations or population designations must have a ratio of 6,000 to 1.

^e High needs areas are those that meet specific qualifications on population to provider ratios, percent of population below the FPL, and/or distance to health care. More information can be found at [Scoring Shortage Designations | Bureau of Health Workforce \(hrsa.gov\)](https://www.hrsa.gov/scoring-shortage-designations).

- If based on the ratios of both population to psychiatrist and population to core mental health provider, geographic designations must have a population to psychiatrist ratio of 20,000 to 1 and a population to core mental health provider ratio of 6,000 to 1. In areas with high needs, geographic designations or population designations must have a population to psychiatrist ratio of 15,000 to 1 and a population to core mental health provider ratio of 4,500 to 1.

Most HPSA's for mental health are designated based on the ratio of population to psychiatrist. Estimates show that an additional 7,420 mental health providers would be needed to remove the existing health professional shortage area designations for mental health in the U.S.

Demand for mental health services is projected to increase nationwide due to the aging population.¹⁰⁷ The number of older adults with mental and behavioral health problems is projected to increase by 11 million from 1970 to 2030. Moreover, the aging of the national population requires behavioral health service providers with special knowledge and skills.¹⁰⁸

HRSA issued national-level supply and demand projections for several behavioral health occupations from 2016 to 2030 that incorporate estimates of unmet need for behavioral health services. These projections are based on the unlikely assumption that there are no changes in the levels of behavioral health care service provision or utilization from 2017 to 2030. Based on these projections, there will be an estimated shortage of 34,940 addiction counselors,¹⁰⁹ 21,150 adult psychiatrists, 14,300 clinical, counseling, and school psychologists, and 40,140 mental health counselors nationwide in 2030. These projections also indicate that there will be an estimated surplus of 3,720 child and adolescent psychiatrists, 1,650 marriage and family therapists, 2,440 psychiatric nurse practitioners, 1,500 school counselors, and 200,280 social workers nationwide in 2030.

Workforce-based explanations for an inadequate supply of mental health and addiction providers at-large generally focus on insufficient numbers of providers, high turnover, low compensation, a lack of diversity, and limited competency in evidence-based treatments.¹⁰⁸ Describing the mental health workforce shortage quantitatively can be problematic, as relevant data have not been universally collected and there is no agreed-upon definition of adequate supply.¹¹⁰ However, efforts to describe the mental health workforce shortage should consider both the population's need for mental health services and the number of providers available to deliver these services.

Texas' Need for Mental Health Services

As noted above, one part of describing a workforce shortage involves demonstrating the needs of the population for mental health services. A standard definition of mental health need is not available at the state or national level.

Children

No reliable statewide survey data on mental health needs exist for children younger than high school age. However, data from HHSC indicate that 44,031 children who were 13 years of age or younger received mental health services from local mental health authorities in Texas during state fiscal year 2017.¹¹¹ The top five diagnostic groups were attention deficit disorder (53 percent), adjustments/other non-psychotic (9 percent), disruptive behavior disorder (8 percent), affective disorders - other (8 percent), and affective disorders - major depression (6 percent).

Adolescents

According to the 2019 Texas Youth Risk Behavior Survey, 38.3 percent of Texas high school students reported feeling so sad or hopeless almost every day for at least two weeks in the past year that they stopped doing some usual activities.¹¹² Similar results were reported by age and grade level where high school students 18 years of age and older (46.1 percent) were significantly more likely to report feeling so sad or hopeless almost every day for at least two weeks in the past year that they stopped doing some usual activities than those 15 years of age and younger (34.7 percent). Twelfth graders (43.2 percent) were significantly more likely to report such than ninth graders (32.7 percent). Females (48.6 percent) were significantly more likely to report these feelings than males (28.3 percent). No significant differences were reported by race/ethnicity.

The 2019 survey results also indicate that 18.9 percent of Texas high school students reported seriously considering a suicide attempt in the past year. Females (25.3 percent) were significantly more likely to report seriously considering a suicide attempt in the past year than males (12.6 percent), and those in the "Other" races/ethnicities category (25.5 percent) were significantly more likely to report such than Hispanics (16.7 percent). No significant differences were reported by age or grade level. In addition, 15.0 percent of Texas high school students reported making a plan in the past year for how they would attempt suicide. While there were no major differences reported by age, grade level, or race/ethnicity, females (19.4 percent) were significantly more likely to report making a plan in the past year for how they would attempt suicide than males (10.6 percent). Results

further indicate that 10.0 percent of Texas high school students reported attempting suicide at least once in the past year and 3.4 percent reported requiring medical treatment after doing so. No major differences were reported by age, gender, grade level, or race/ethnicity.

The percentage of Texas high school students who reported feeling sad or hopeless, seriously considering a suicide attempt, making a suicide plan, attempting suicide, and requiring medical treatment following a suicide attempt increased significantly from 2009 to 2019. No significant differences were found between Texas high school students and high school students nationwide in the likelihood of reporting feeling sad or hopeless, seriously considering a suicide attempt, making a suicide plan, attempting suicide, or requiring medical treatment following a suicide attempt in 2019.

Adults

The 2020 results from the Texas Behavioral Risk Factor Surveillance System¹⁵ indicate increases in all categories displayed here as compared to the 2018 results.¹¹¹ Just over 23 percent of Texas adults reported having poor mental health for five or more days in the past 30 days. Adults between 18 and 29 years (33.8 percent) were significantly more likely to report having poor mental health for five or more days than those between the ages of 45 and 64 (21.1 percent) and adults who are 65+ years (13.7 percent). Moreover, adults between 30 and 44 years (21.3 percent) and adults between 45 and 64 years were significantly more likely to report having poor mental health for five or more days than those 65+ years (10.3 percent). Results by gender indicate that females (27.9 percent) were significantly more likely to report having poor mental health for five or more days than males (18.4 percent). No significant differences were reported by race/ethnicity. Additionally, 13.2 percent of Texas adults reported having poor mental health for 14 or more days in the past 30 days. No significant differences were reported by age, gender, or race/ethnicity.

The 2020 survey results also indicate that 17.7 percent of Texas adults reported ever being told by a doctor, nurse, or other health professional that they had a depressive disorder, including depression, major depression, dysthymia, or minor depression. Females (22.5 percent) were significantly more likely to report ever being told by a doctor, nurse, or other health professional that they had a depressive disorder than males (12.7 percent), and whites (21.2 percent) were significantly more likely to report such than Hispanics (14.8 percent). No significant differences were reported by age.

Texas' Mental Health Workforce

In addition to patient need, a shortage of providers determines the insufficiency of the mental health workforce. The supply of providers can be conceptualized as being composed of two broad determinants. The first is the entire number of providers qualified to serve in mental health, and the second is the number of those providers committed to providing patient care and the percentage of their productive time committed to doing so.¹¹³

DSHS uses the population to psychiatrist ratio that is at least 30,000 to 1 or, in areas with high needs, 20,000 to 1 to apply for HPSA's for mental health through HRSA. As of June 2020, 236 of the 254 counties (92.9 percent) in Texas were wholly or partially designated as a HPSA for mental health.¹¹⁴ Moreover, as of September 2019, 173 counties (68.1 percent) in Texas had no psychiatrists.

The state's mental health workforce shortage is expected to worsen, as the workforce is aging and many providers are nearing retirement age. At the same time, educational institutions in the state and the nation are not producing enough new graduates to meet projected demand. Given the nationwide mental health workforce shortage, it is unlikely that Texas can meet its staffing needs by recruiting providers from other states.¹¹⁵

DSHS issued a report in 2020 projecting the supply and demand for all physicians and 35 physician specialties in Texas from 2018 through 2032.¹¹⁶ Statewide results from this report indicate that there will be an estimated shortage of 1,043 full-time equivalent psychiatrists by 2032.

In addition to a shortage of providers, other sociodemographic factors contribute to the state's inadequate mental health workforce. For example, mental health providers are not distributed evenly across the state, resulting in differential access to care by region, especially in rural areas and along the border. Further, the mental health provider workforce does not reflect the state's growing racial/ethnic diversity, resulting in the continued need for culturally competent mental health care.

Mental Health Workforce by Profession Among Racial/Ethnic Categories, Texas, 2019

The racial/ethnic distribution of Texas' mental health workforce differed greatly from that of the Texas population in 2021. The composition of Texas' population

was estimated to be 40.5 percent white, 40.0 percent Hispanic/Latino, 12.0 percent African American, and 7.5 percent from other races/ethnicities. Yet, whites were overrepresented in the majority of mental health professions when compared to the Texas population. However, over 60 percent of community health workers or promotores were Hispanic or Latino and 22 percent were African American, which were larger proportions than within any other profession. Whites were overrepresented in psychiatry by 13 percentage points and people in the “Other” category by 22 percentage points.

Overview of Mental Health Workforce by Profession

The tables below are based on licensure data that¹¹⁷ DSHS receives annually from the respective state licensing board for the following professions: clinical nurse specialists, community health workers or promotores, licensed baccalaureate social workers, licensed chemical dependency counselors, licensed clinical social workers, licensed master social workers, licensed professional counselors, licensed psychological associates, licensed psychologists, licensed specialists in school psychology, marriage and family therapists, nurse practitioners, provisionally licensed psychologists, and psychiatrists.

Counts include only providers who were licensed with their Texas board and actively working in their profession. Clinical nurse specialists and nurse practitioners include only those who indicated they were employed in the field of nursing and had a specialty in psychiatric/mental health. Psychiatrists include only those who indicated they provided direct patient care. Analyses include all providers for whom the respective data were available.

Table 2. Number of Providers and Population to Provider Ratio of Mental Health Workforce by Profession, Texas, 2021

Profession	Number of Providers	Population to Provider Ratio
Clinical Nurse Specialists ^f	152	192,061.0
Community Health Workers or Promotores	4,515	6,681.9
Licensed Baccalaureate Social Workers	3,623	8,327.1
Licensed Chemical Dependency Counselors	5,999	5,029.0
Licensed Clinical Social Workers	9,262	3,257.3
Licensed Master Social Workers	11,310	2,667.5
Licensed Professional Counselors	23,043	1,309.2
Licensed Psychological Associates	813	37,108.2
Licensed Psychologists	4,955	6,088.6
Licensed Specialists in School Psychology	3,748	8,049.3
Marriage and Family Therapists	2,955	10,209.5
Nurse Practitioners ^f	1,002	29,135.0
Psychiatrists	2,438	12,374.5

Using 2021 population projections from the Texas Demographic Center and the total number of providers in Texas, licensed professional counselors had the lowest

^f Nursing professions data for nurse practitioners and clinical nurse specialists were only available for years 2016-2019. Figures for these professions are from 2014.

population to provider ratio statewide in 2021, followed by licensed master social workers and licensed clinical social workers.

Table 3. Percentage of Providers and Population to Provider Ratio of Mental Health Workforce by Profession for Most and Least Populous Counties, Texas, 2021

Profession	Percentage of Providers - Five Most Populous Counties	Population to Provider Ratio - Five Most Populous Counties	Percentage of Providers - 249 Least Populous Counties	Population to Provider Ratio - 249 Least Populous Counties
Clinical Nurse Specialists ^f	61.8%	138,427	38.2%	278,984.9
Community Health Workers or Promotores	50.4%	5,916.8	49.6%	6,019.9
Licensed Baccalaureate Social Workers	29.6%	12,567.6	70.4%	6,545.1
Licensed Chemical Dependency Counselors	43.6%	5,146.1	56.4%	4,938.3
Licensed Clinical Social Workers	58.6%	2,482.9	41.4%	4,352.6
Licensed Master Social Workers	54.7%	2,177.5	45.3%	3,259.1
Licensed Professional Counselors	45.6%	1,283.5	54.4%	1,330.8

Profession	Percentage of Providers - Five Most Populous Counties	Population to Provider Ratio - Five Most Populous Counties	Percentage of Providers - 249 Least Populous Counties	Population to Provider Ratio - 249 Least Populous Counties
Licensed Psychological Associates	50.6%	32,779.8	49.4%	41,533.4
Licensed Psychologists	63.2%	4,300.2	36.8%	9,163.8
Licensed Specialists in School Psychology	48.6%	7,390.3	51.4%	8,673.5
Marriage and Family Therapists	54.3%	8,394.1	45.7%	12,794.2
Nurse Practitioners ^f	56%	23,194.5	44%	36,691.9
Psychiatrists	61.7%	8,963.7	38.3%	17,857.2

Texas’ mental health workforce is not evenly distributed throughout the state. In 2021, the state’s five most populous counties (Harris, Dallas, Tarrant, Bexar, and Travis) had roughly 44.6 percent of the population. The majority (9 out of 13) of mental health professions had over half of their workforce in these five counties.

Table 4. Growth Trends of Mental Health Workforce by Profession, Texas, 2016-2021

Profession	Average Annual Growth Rate - Number of Providers	Average Annual Growth Rate - Population to Provider Ratio
Clinical Nurse Specialists ^f	(5%) ^g	(7.1%)
Community Health Workers or Promotores	3.2%	(1.4%)
Licensed Baccalaureate Social Workers	(6.3%)	8.9%
Licensed Chemical Dependency ^h Counselors	Not available	Not available
Licensed Clinical Social Workers	4.7%	(2.9%)
Licensed Master Social Workers	2.8%	(1.0%)
Licensed Professional Counselors	4.9%	(3%)
Licensed Psychological Associates	(1.9%)	3.7%
Licensed Psychologists	2.4%	(0.7%)

^g Parentheses in this table indicate a decrease.

^h Data to calculate annual growth rates of licensed chemical dependency counselors between 2016 and 2021 were unavailable. However, available data show that the number of active licensed chemical dependency counselors in Texas has increased 17.8 percent since 2014. Available data also show that, relative to population growth, the size of the licensed chemical dependency counselor workforce has improved by 8.8 percent over the past five years.

Profession	Average Annual Growth Rate - Number of Providers	Average Annual Growth Rate - Population to Provider Ratio
Licensed Specialists in School Psychology	3.1%	(1.4%)
Marriage and Family Therapists	1.7%	(0.05%)
Nurse Practitioners ^f	21.6%	16.0%
Psychiatrists	2.9%	(1.2%)

Among the 13 mental health professions for whom annual growth rates between 2016 and 2021 were available, nine professions had an increase in the average annual growth rate for the number of providers in Texas. When considering population growth, only three of these 13 mental health professions had an improvement in the size of the workforce over these five years.

Table 5. Number of Counties with No Providers of Mental Health Workforce by Profession, Texas, 2016-2021

Profession	2016	2021
Clinical Nurse Specialists ^f	208	218
Community Health Workers or Promotores	131	112
Licensed Baccalaureate Social Workers	52	63
Licensed Chemical Dependency Counselors	82	78
Licensed Clinical Social Workers	114	91
Licensed Master Social Workers	79	74
Licensed Professional Counselors	46	37
Licensed Psychological Associates	153	168
Licensed Psychologists	143	147
Licensed Specialists in School Psychology	166	105
Marriage and Family Therapists	132	112
Nurse Practitioners ^f	206	185
Psychiatrists	173	168

Many counties in Texas do not have any providers for at least one mental health profession. The number of counties in the state with no providers increased for four mental health professions between 2016 and 2021, while the number of counties in the state with no providers decreased for nine mental health professions.

Table 6. Percentage of Mental Health Workforce by Profession Eligible for Retirement in 10 Years, Texas, 2021

Profession	56-65 Years	Over 65 Years	Totalⁱ
Clinical Nurse Specialists^f	32.9%	59.9%	92.8%
Community Health Workers or Promotores	10.8%	4.9%	15.7%
Licensed Baccalaureate Social Workers	25.9%	11.6%	37.5%
Licensed Chemical Dependency Counselors	27.3%	18.9%	46.2%
Licensed Clinical Social Workers	16.9%	16.4%	33.3%
Licensed Master Social Workers	10.3%	5.9%	16.2%
Licensed Professional Counselors	17.2%	16.4%	33.6%
Licensed Psychological Associates	24.1%	24.4%	48.5%
Licensed Psychologists	17.2%	25.6%	42.8%
Licensed Specialists in School Psychology	10.9%	11.6%	22.5%
Marriage and Family Therapists	18.6%	29.5%	48.1%
Nurse Practitioners^f	14.5%	5.7%	20.2%
Psychiatrists	21.6%	24.4%	46%

ⁱ Calculations in the total column are based on unrounded numbers.

Policy Recommendations for the Legislature, the Governor, and Executive Branch Agencies

Support efforts by school districts to increase access to mental health services for students.

Increasing the number of counselors and psychologists employed by school districts in the state is one way that school districts may increase access to mental health services for students. Generally, the recommended student to provider ratio differs based on the profession. For example:

- The American School Counselor Association recommends a student to school counselor ratio of 250 to 1.¹¹⁸
- The National Association of School Psychologists recommends a student to school psychologist ratio between 500 to 1 and 700 to 1.¹¹⁹

According to the Texas Education Agency, there were 13,864 full-time equivalent counselors and 2,089 full-time equivalent licensed specialists in school psychology or psychologists employed by school districts in Texas during the 2020-2021 school year.¹²⁰ Based on the statewide enrollment of 5,371,586 students, there was a student to counselor ratio of 387.4 to 1 and a student to licensed specialist in school psychology or psychologist ratio of 2,570.4 to 1 for the 2020-2021 school year.¹²¹

As the statewide ratios for counselors and licensed specialists in school psychology or psychologists employed by school districts exceed the ratio recommended by the respective professional association listed above, it is important that school districts consider increasing the number of counselors and psychologists that they employ. Moreover, additional providers employed by school districts would better ensure that students have access to mental health services in the school setting.

Another way that school districts in the state may increase access to mental health services for students is to partner with community mental health centers. Currently, school districts are not required to provide mental health services to students or to partner with community mental health centers in providing such services. As not all school districts have prioritized providing mental health services, many students throughout the state may not have access to mental health services in the school setting.

Due to the challenge of providing mental health services and the limited resources of many school districts, particularly in rural areas, it is important that school districts not be burdened with creating their own infrastructure for providing mental health services. In addition, solutions should be developed that leverage existing services. As community mental health centers already have the staff, training, and experience necessary to help students, partnering with them would allow school districts to take advantage of existing services in a cost-effective manner. Furthermore, it may not be necessary for every school district to have a full-time mental health provider. Partnering with community mental health centers would allow school districts, especially those that do not provide mental health services, to increase access to cost-effective mental health services for students.

Post-secondary students face their own challenges on campus. A 2021 study reported that suicide is the third leading cause of death in students and that up to 44 percent of college students reported having symptoms of depression and anxiety.¹²² Additionally, of those who have been diagnosed with a mental health disorder, most (75 percent) have their first episode by age 24. Texas A&M University conducted a study in 2020 of the effects of COVID-19 on college students' mental health.¹²³ They found that 71 percent of undergraduate students reported experiencing increased stress and anxiety due to the COVID-19 pandemic. Of those students, 91 percent were concerned about the health of their loved ones and themselves, 89 percent experienced difficulty concentrating, 86 percent reported disruptions to sleeping patterns, 86 percent reported decreased social interactions due to physical distancing, and 82 percent reported increased concerns on academic performance. Nationally and statewide, college and university students are facing complex mental health issues.

Continue outreach efforts to de-stigmatize behavioral health, and for resources for mental health providers for students.

According to the 2019 Texas Youth Risk Behavioral Survey results, 10 percent of Texas high school students attempted suicide, and 38.3 percent felt sad or hopeless for two weeks in a row within the year leading up to the survey.¹²⁴ The lack of outreach, resources, and efforts to normalize mental health in schools has led to the isolation of students struggling with mental health issues. In addition to the recommendation above, schools should create curriculum on mental health topics and incorporate this knowledge into classes, campaigns, and assemblies that invite

experts on relevant mental health topics. The de-stigmatization of mental health challenges will decrease the barriers to improving mental health for students.

Continue to support the work of the Texas Child Mental Health Care Consortium (TCMHCC).

Senate Bill 11, 86th Legislature, Regular Session, 2019, established the TCMHCC.¹²⁵ Members of the consortium include 13 health-related institutions of higher education, HHSC, the Texas Higher Education Coordinating Board, and three nonprofit organizations that focus on mental health care.¹²⁶ These nonprofit organizations currently include the Meadows Mental Health Policy Institute, the Hogg Foundation for Mental Health, and the Texas Council of Community Health Centers.¹²⁷ The consortium is governed by an executive committee.¹²⁸

The purpose of the consortium is to:

- Leverage the expertise and capacity of the 13 health-related institutions of higher education to address urgent mental health challenges and improve the mental health care system in the state in relation to children and adolescents; and
- Enhance the state's ability to address the mental health care needs of children and adolescents through collaboration of the 13 health-related institutions of higher education.¹²⁹

The consortium is tasked with the following initiatives:

- Establish a network of comprehensive child psychiatry access centers; and
- Establish or expand telemedicine or telehealth programs to identify and assess behavioral health needs and provide access to mental health care services.

In addition, the executive committee is authorized to provide funding to any of the 13 health-related institutions of higher education for the purpose of expanding the state's child mental health workforce.¹³⁰ Such funding may be provided to expand the child psychiatry workforce and/or to add a child and adolescent psychiatry fellowship.

The 2022-23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021, increased the TCMHCC funding, which allocated \$19.5 million in funds for the TCMHCC to support the Child Psychiatry Access Network and the Texas Child Health Access Through Telemedicine initiatives.¹³¹

As the initiatives of the TCMHCC have the ability to improve access to mental health services for children and adolescents throughout the state, it is imperative that the work of the consortium continue to be supported. Such support will better ensure that the state is able to address the mental health care needs of children and adolescents.

Continue to support the work of the Statewide Behavioral Health Coordinating Council.

The 2016-17 General Appropriations Act, House Bill 1, 84th Legislature, Regular Session, 2015 (Article IX, Section 10.04), established the Statewide Behavioral Health Coordinating Council.¹³² Members of the council include representatives of state agencies and institutions of higher education that receive state funding to provide behavioral health services. The purpose of the council is to ensure a strategic statewide approach to behavioral health services.¹³³ The council is primarily charged with the following duties:

- Develop and monitor the implementation of a five-year statewide behavioral health strategic plan;
- Develop a biennial coordinated statewide behavioral health expenditure proposal; and
- Annually publish an updated inventory of behavioral health programs and services that are funded by the state that includes a description of how those programs and services further the purpose of the statewide behavioral health strategic plan.

House Bill 4074, 87th Legislature, Regular Session, 2021, called for the assembling of a subcommittee on suicide prevention and the inclusion of a suicide prevention plan in the Statewide Behavioral Health Strategic Plan.¹³⁴

In the *Texas Statewide Behavioral Health Strategic Plan, Fiscal Years 2017-2021*, the behavioral health workforce shortage was identified as one of the gaps in the state's behavioral health system.¹³⁵ As the Statewide Behavioral Health Coordinating Council is addressing the state's mental health workforce shortage, it is imperative that the work of the council continue to be supported. Such support will allow the council to further develop strategies that may improve access to the state's behavioral health system.

Support efforts to increase the funding and stipends available to students of the mental health professions as they complete their education and training.

Completing the education and training required to become a mental health provider is a timely and expensive process. To lessen the financial burden faced by students of the mental health professions, consideration should be given to expanding the funding and stipends available to them as they complete their education and training. By expanding such funding and stipends, more individuals may be incentivized to select a mental health profession, likely leading to an increase in the state's mental health workforce.

Support the expansion of the Loan Repayment Program for Mental Health Professionals.

To recruit individuals to the state's mental health workforce and to retain the existing mental health workforce, it is important to expand practice incentives for mental health providers. One practice incentive that could be expanded is the Loan Repayment Program for Mental Health Professionals that is administered by the Texas Higher Education Coordinating Board.¹³⁶ The eligibility criteria for this program could be expanded to include additional practice specialties, practice areas, and/or types of recipients that receive care. For example:

- The practice specialties of mental health providers could be expanded to include licensed psychological associates, licensed specialists in school psychology, provisionally licensed psychologists, licensed baccalaureate social workers, licensed master social workers, and/or community health workers or promotores.¹³⁷
- The practice location of mental health providers could be expanded to include areas not designated by HRSA as HPSA's for mental health.¹³⁸
- The types of recipients that receive care from mental health providers could be expanded to include individuals who receive mental health services but are not:
 - ▶ Enrolled in Medicaid;
 - ▶ Enrolled in CHIP;
 - ▶ Committed to a secure correctional facility operated by or under contract with the Texas Juvenile Justice Department; and/or
 - ▶ Confined in a secure correctional facility operated by or under contract with any division of the Texas Department of Criminal Justice.

The funding for the Loan Repayment Program for Mental Health Professionals could also be expanded. Doing so could improve the efficacy of the program, as new program participants may be able to enroll in the program sooner and the overall number of mental health providers participating in the program may increase.

By expanding the eligibility criteria and/or funding for the Loan Repayment Program for Mental Health Professionals, the ability to recruit and retain mental health providers would be strengthened. Moreover, given that the state's mental health workforce is aging and many providers are nearing retirement age, it is imperative that measures are taken to encourage and incentivize individuals to enter a mental health profession.

Support expanding the reciprocity of licenses for behavioral health providers between states.

The process of obtaining a license in a new state can be difficult for licensed mental health providers who are transitioning from one state to another. This process can require a considerable amount of time to complete and be cumbersome to navigate due to states having different requirements. To ease the process for licensed mental health providers seeking to relocate to Texas and become licensed by the state, it is important to expand the reciprocity standards between states. Doing so may lead to an increase in the state's mental health workforce and, thus, greater access to mental health services in the state.

Support the increase of reimbursement rates for behavioral health providers.

The current payment system is a key barrier that affects the recruitment and retention of mental health providers in the state. As the current payment system fails to adequately reimburse mental health providers, many providers are not able to sustain providing mental health services and/or expand their capacity of doing so. To lessen this barrier, consideration should be given to increasing reimbursement rates for mental health providers. By increasing such rates, the state would strengthen its ability to recruit and retain mental health providers, as well as better ensure access to mental health services throughout the state.

Increase the amount of education on suicide prevention for students within health care fields.

Often times, health care providers and first responders are the personnel that patients first see before they see a psychiatrist, psychologist, social worker, counselor, or other behavioral health provider. Providing more education on suicide prevention, depression, and anxiety for primary care providers, nurses, and first responders would allow for more detection of these conditions and for patients to receive the care needed. Additional options could include questions between patient and provider at annual physicals or routine appointments and additional intake

forms prior to an appointment to detect issues before they increase in severity for the patient. HRSA has allocated federal funding toward colleges and universities that educate the medical health care workforce to more holistically educate them on the diverse needs of each patient.¹³⁹ The continuation and expansion of these types of resources would allow the Texas health care workforce to detect and treat mental health issues before they become exacerbated.

Monitor the effects of the COVID-19 pandemic on behavioral health in Texas.

Texans' mental and behavioral health faced tremendous challenges around access to care before the COVID-19 pandemic. Overall, Texans had a greater percentage of people who faced symptoms of anxiety disorder or depressive disorder (34.5 percent) than nationally (31.5 percent).¹⁴⁰ Younger age groups had more symptoms of anxiety and depression, 48.4 percent of the 18-29 age category reporting anxiety and depression symptoms, while 17.8 percent of people over 80 reporting symptoms. Nationally, 14.5 percent (40.3 million) of people aged 12 and over faced substance abuse disorder in 2020.¹⁰⁴ HHSC estimates that 11.3 million Texans are living with substance use disorder.¹⁴¹ There is a general gap in data surrounding Texans facing substance use disorder during the COVID-19 pandemic. During 2020, Texas fell below national rates of drug overdose deaths per 100,000 people at 14.3 versus 28.3, respectively.¹⁴² Expanding the processes, methods, and technology for data collection would improve our insights into Texans' mental and behavioral health trends. It is imperative that this work obtains support, as statistics often contribute to how compelling research is communicated to institutions and legislative entities, and more mental and behavioral health services would be able to reach Texans.

Having access to data during different stages of the COVID-19 pandemic has granted Texas mental and behavioral health care institutions the ability to adapt to needs within their communities. During the onset of the COVID-19 pandemic, HHSC launched a mental health support line in an effort to help Texans gain access to mental health services.¹⁴³ The COVID-19 Mental Health Support Line (833-986-1919) has provided information on the ongoing COVID-19 pandemic, direct access to local mental and behavioral health authorities, statewide testing and vaccine information, and referrals to resources through 2-1-1 (essential services provided through United Way). In 2022, HHSC launched a \$23.3 million substance use prevention awareness campaign with the goal of reducing drug use among Texas youth and families. Without data on the continuing effects of the COVID-19 pandemic on the mental and behavioral health of Texans, services like these would

not exist. The data, accuracy, methods, procedures, and reports could better serve health care institutions and Texans with investment for further examination.

Continue to support the investment in recruitment and retention of the mental and behavioral health care workforce.

The mental and behavioral health care workforce shortage has persisted in Texas since before the COVID-19 pandemic. The Statewide Behavioral Health Coordinating Council's December 2020 report states that workforce shortage has been a decades-long issue.¹⁴⁴ The plan details the short, mid, and long-term action items surrounding the retention and recruitment of behavioral health care providers. The Statewide Behavioral Health Coordinating Council formed a subcommittee in 2019 to develop a plan for increasing and improving the workforce in Texas to better serve people with mental and substance use issues.

Texas faces behavioral workforce shortages in a variety of professions within the field. When speaking about psychiatrists specifically, demand will continue to outpace supply by almost two percentage points from the years 2017-2030.¹¹⁶ HRSA reports that Texas contains 476 mental HPSA's in the state, meaning those areas contain a higher ratio than 30,000 to one health professional per region.¹⁴⁵ With the unknown, emerging, and persistent mental and behavioral health issues Texans are facing, the mental and behavioral health care workforce should be expanded and supported to the fullest extent.

Allocate funds toward the implementation of the 988 Suicide Prevention Lifeline.

In February 2021, HHSC received a \$180,000 grant from Vibrant Emotional Health to support the new 988 Suicide Prevention Lifeline.¹⁴⁶ The lifeline will make it easier for people in crisis to reach someone within their local community for mental health support and resources. In July 2022, the 988 Suicide Prevention Lifeline replaced the National Suicide Prevention Lifeline, formerly known as 1-800-273-8255(TALK). The grant funds will help existent call centers within Texas prepare for infrastructure needs, additional callers, purchase headsets, phones, and computers, train and educate staff, and collect data. Increasing the funding of this endeavor will support launch efforts and continuation.

6. Teleservices and Technology

This section discusses the definition, use, and benefits of teleservices in Texas. Additionally, it includes how teleservices have been expanded due to the COVID-19 pandemic and how teleservices will continue to be used and changed post-pandemic.

Defining Teleservices

Federal Medicaid defines telemedicine as an alternative to traditional care in which a patient and provider meet in real time, using both audio and video equipment, at separate sites.¹⁴⁷ According to the Texas Occupations Code, telemedicine is required to fulfill the same standard of care that would be applied in an in-person setting.¹⁴⁸

Telemedicine and telehealth are often used as interchangeable terms. Telemedicine is defined as “the remote delivery of health care services and clinical information using telecommunications technology” while telehealth is “used to describe diagnosis and management, education, and other fields of health care.”^{149,150} The term “teleservices” will be used to include both “telemedicine” and “telehealth” for the remainder of this section. For information and data relating specifically to “telemedicine” or “telehealth,” those terms will be applied.

Use of Teleservices in Texas

H.B. 2386, 75th Legislature, Regular Session, 1997 allowed medical providers to be reimbursed for telemedicine services.¹⁵¹ In 2016, the e-Health Advisory Committee was established to advise HHSC on “the development, use, and long-range plans for telemedicine, telehealth, and home telemonitoring services.”¹⁵² The most common users of these teleservices are those diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD), followed by schizophrenia, schizoaffective disorder, and bipolar disorder.¹⁵¹

Texas Medicaid users were included among those for whom teleservices were available. While this has been the case for over 20 years, it is only recently that the service has begun to see wider spread adoption. From 2012 to 2018, there has been a 119 percent increase in use of teleservices compared to a 338 percent in overall use of providers offering teleservices. From fiscal year 2018 to 2019, the

utilization of telemedicine services increased by 19 percent, telehealth services increased by 37 percent, and telemonitoring services increased by 23 percent.¹⁵¹

COVID-19 and the Expansion of Teleservices

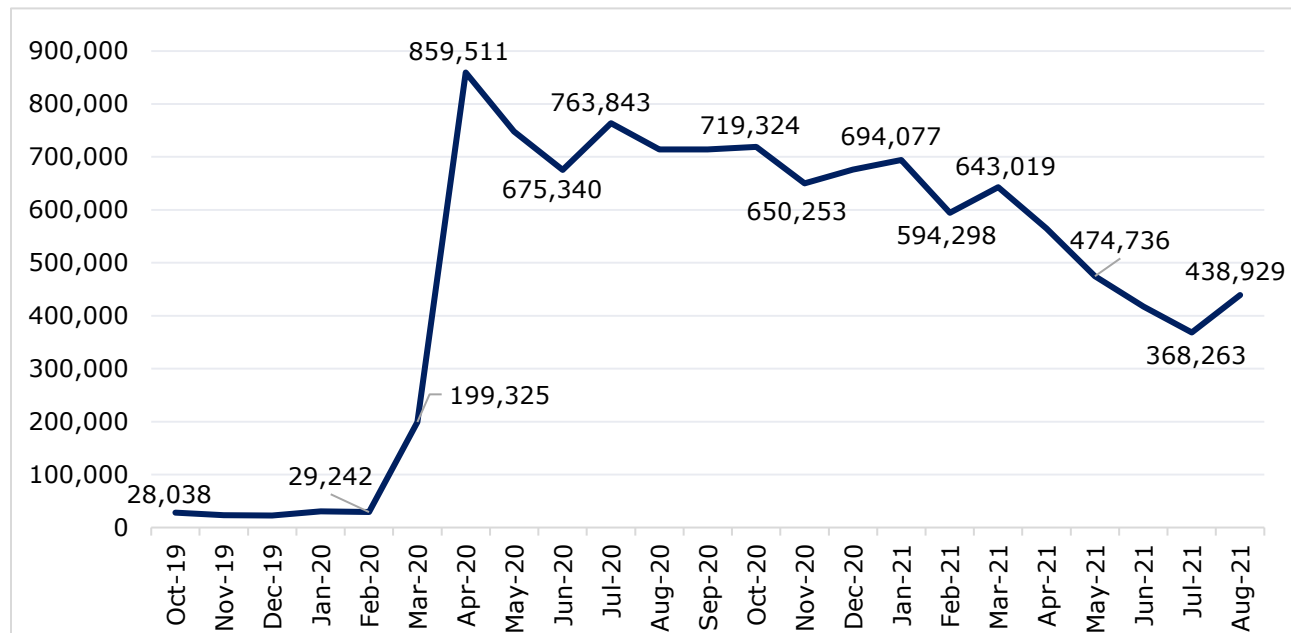
On January 31, 2020, a national Public Health Emergency was declared due to the 2019 novel Coronavirus.¹⁵³ On March 17, 2020, Governor Greg Abbott announced an emergency rule to “allow telemedicine visits for patients with state-regulated plans to be paid the same as in-office visits for insurance purposes.”¹⁵⁴ On September 25, 2020, this rule was extended through the end of 2020 and expanded to include other major health insurers in Texas, ensuring that Texans could continue utilizing telehealth during the pandemic.¹⁵⁵

In 2021, several bills passed and became effective that supported reimbursement to providers for teleservices. These include, H.B. 4, 87th Legislature, Regular Session, 2021: reimbursement for health programs using telecommunications;¹⁵⁶ S.B. 228, 87th Legislature, Regular Session, 2021: relating to the reimbursement of “claims by certain health benefit plan issuers for telemedicine services and telehealth services;”¹⁵⁷ and S.B. 434, 87th Legislature, Regular Session, 2021: pertaining to the delivery of “certain health, mental health, and educational services in this state” through telecommunication or information technology.¹⁵⁸ Other bills relating to teleservices were also introduced as a result of the pandemic, such as S.B. 488, 87th Legislature, Regular Session, 2021 addressing teledentistry services.¹⁵⁹

Due to the need and the opportunity to take advantage of teleservices, the number of teleservices increased drastically after the COVID-19 pandemic began. There was a 2,840 percent increase in teleservices provided to Texas Medicaid clients in the first few months of 2020.¹⁶⁰

The data in Figure 1 below includes the number of teleservices provided across all Medicaid and CHIP programs in Texas. In February of 2020, right before the COVID-19 virus was detected in Texas, the number of monthly teleservices was less than 30,000 statewide. A Public Health Disaster Declaration was issued in Texas in March of 2020 and subsequently the number of monthly teleservices drastically increased to over 850,000 in April 2020. While teleservices have decreased from this peak in April 2020, they remain high.

Figure 1: Number of Teleservices per Month Under Medicaid and CHIP¹⁶¹



Benefits of Teleservices

The benefits of teleservices are widespread. For clients of Texas Medicaid who are blind or have a disability, utilizing teleservices led to less use of inpatient, outpatient, and emergency department services. Overall, the use of teleservices for these clients cost \$502 less per client per month than using in-person services. It was also found that overall medical spending for this population increased, suggesting that teleservices are fulfilling previously unmet needs.¹⁵¹

Rural areas in Texas also benefit greatly from teleservices. Rural communities often use teleservices to “augment limited provider resources” caused by losing and having difficulties recruiting health providers.¹⁶⁰ Teleservices also decrease the number of no-show patients because factors like childcare, transportation, and parking are less of an issue.¹⁶⁰ Health providers, through teleservices, are also able to “assess a patient’s living environment” which can be indicative of certain health outcomes.¹⁶⁰

A study on medically complex children (children with one or more chronic conditions that require continuous medical attention) showed that clinical outcomes favored those using teleservices by 66 to 98 percent, reducing hospital and pediatric intensive care unit admissions. Teleservices also reduced total health system costs by 91 percent per child, per year.¹⁶²

Access to Teleservices

In order to partake in offered teleservices, individuals must have access to broadband or highspeed internet, access to technologies that can function as audio and visual tools, and the knowledge to work these technologies.^{160,163} Those without access to these three elements are often the socioeconomically disadvantaged and those living in rural areas.

Access in Rural Counties

The success of teleservices is dependent on the patient's access to teleservices and on the provider's ability to deliver teleservices. In December 2020, 96 percent of households in Texas had the option to connect to broadband internet, leaving 316,700 households without that ability.¹⁶⁰ Of those remaining households, 89 percent were considered rural.¹⁶⁰ Without widespread access to broadband, rural households, specifically those who are socioeconomically disadvantaged, risk being "left further behind with the increased implementation of telehealth," due to their lack of access to necessary technologies.¹⁶³ H.B. 5, 87th Legislature, Regular Session, 2021 created "the Broadband Development Office which will award grants and loans and provide other incentives in the interest of expanding access to broadband in underserved areas," enabling rural areas to gain much needed access to telemedicine.¹⁶⁴

House Bill 76, 87th Legislature, 3rd Special Session was introduced on September 16, 2021, related to a pilot project to provide emergency telemedicine services and telehealth services in rural areas. The bill ultimately did not pass but the proposed program would connect emergency providers in rural areas to a call center that would help determine where the patient needs to go and help the emergency providers treat them, prehospital, in the field.^{165,166} Even with these kinds of programs being developed in rural areas, the majority of teleservice providers "continue to be located in large Metropolitan Statistical Areas, such as Dallas-Fort Worth-Arlington, San Antonio, and Houston-The Woodlands-Sugar Land."¹⁵¹

Providers' Ability to Deliver Teleservices

Another limitation of teleservices is the ability for a provider to offer those services under existing legislation or regulation. In March of 2020, the Texas Medical Association released a document outlining the rules and regulations on the technology, billing, and policies surrounding telemedicine due to the COVID-19 pandemic.¹⁶⁷

If a patient travels or moves out of state, they cannot continue seeing their provider, even through teleservices, if their provider is not licensed in the state of their physical location. The Interstate Medical Licensure Compact (IMLC) allows doctors to become licensed in multiple states and is one way a provider can continue giving care to patients who have moved out of their original state.¹⁶⁸ The IMLC was launched even before the start of the COVID-19 pandemic, but many states do not participate.¹⁶⁹ Texas is still in the process of implementing the IMLC for physicians.¹⁶⁸

Before the pandemic, Health Insurance Portability and Accountability Act (HIPAA) privacy standards disallowed providers from utilizing more user-friendly platforms to conduct teleservices. After emergency protocols were put into place during COVID-19, HIPAA compliance was relaxed and many providers began using platforms like Skype and FaceTime. As pandemic legislation expires, providers must use more HIPAA-compliant platforms that are often less accessible to patients, making it more difficult for these providers to deliver teleservices.¹⁶⁹

Teleservices Post-COVID-19

Two years after the Public Health Emergency was declared, states are beginning to retighten their rules on teleservices.¹⁶⁹ However, the COVID-19 pandemic forced many physicians, who had previously never provided teleservices, to begin shifting their practice to become more teleservice focused. Because of this, “nearly 11,000 additional providers served Medicaid beneficiaries using teleservices, with about 5,000 of this group providing a teleservice to a rural resident.”¹⁶⁰ This increased the number of physicians experienced in teleservices and increased health care services in rural areas. Throughout 2022, HHSC will evaluate the feasibility of continuing certain teleservices that were available under Medicaid and CHIP during the Public Health Emergency.¹⁷⁰

Legislation was introduced to continue the expansion of teleservices. S.B. 434, 87th Legislature, Regular Session, 2021 as discussed in the “Expansion of Telemedicine” section above requires the executive commissioner to adopt certain rules, “including rules governing when the delivery of service coordination benefits using telecommunications or information technology is appropriate.”¹⁵⁸ In Section 403.153 of Senate Bill 434, under “Use of Telecommunication Technology,” license holders will be able to “provide a service solely through the use of an interactive audiovisual communication system, whether real-time or two-way, including a smartphone.” The bill did not pass, but looking towards future sessions, it is possible that legislation affecting telehealth services will continue to be filed.

Ultimately, whether teleservices will continue to be provided and used will depend on Medicare and private insurance companies continuing to cover them. If Congress does not extend Medicare’s teleservices coverage, Medicare could begin excluding teleservices to clients and taking away reimbursement that has helped thousands of Texans throughout the public health emergency.¹⁶⁰ HHSC’s stakeholders have “expressed interest in making COVID-19 telemedicine, telehealth, and telephonic flexibilities permanent benefits of Texas Medicaid.”¹⁵¹

Policy Recommendations for the Legislature, the Governor, and Executive Branch Agencies

Continue to expand the Statewide Health Information Exchange and incentivize its use among third party teleservices agencies.

Many Texans choose third party teleservices agencies when seeking care. Health Information Exchange programs are utilized by health care providers and enable better health care coordination, better quality of care, and can also keep health care costs down.¹⁷¹ The Health Information Technology for Economic and Clinical Health Act was enacted in 2009 to incentivize the promotion of health information technology and exchange.¹⁷² The Texas Health Information Exchange Implementation Advanced Planning Document defines the funding opportunities for eligible health professionals who adopt health information exchange systems.¹⁷³ These funding mechanisms are supported by Centers for Medicare and Medicaid Services and may not always reach third party teleservice providers. By connecting third party teleservice providers with patients’ primary care physicians through Health Information Exchange programs, the state is ensuring that patients are receiving quality, safe, and effective care as well as improving public health reporting and monitoring.¹⁷¹

Encourage state, federal, and private health insurance organizations to promote their teleservice benefits.

Teleservices provide an array of benefits for patients, including the elimination of transportation costs and scheduling flexibility.¹⁶⁷ Benefits also extend to providers and organizations who can provide more cost-effective care¹⁶⁹ to a larger population, specifically in rural areas.¹⁶⁶ Many state, federal, and private health insurance organizations have policies regarding teleservices, including the reimbursement and steps for utilization. Insurance consumers would benefit from learning and understanding the services they already have access to.

Support new and innovative ways to get teleservices to rural communities.

Getting teleservices to rural communities is essential in ensuring that these communities have access to health care. With 4 percent, or more than 300,000 households, unable to access broadband internet across Texas,¹⁶⁰ rural communities need options for teleservices that don't require this broadband access. One example is organizations that have provided direct-to-consumer care using telemedicine kiosks placed in pharmacies in rural areas. These kiosk systems have been observed to increase health care access without requiring an internet connection at home.¹⁷⁴ Community Health Workers could also be considered to help bridge the gap in knowledge needed to access teleservices, especially for the elderly population.

Investigate the training requirements for teleservice providers to determine if adequate training is being conducted at health institutions.

As the number of teleservices provided each month remains high, more than ten times the number of teleservices provided to Medicaid and CHIP recipients in February 2020,¹⁶¹ the need for health care providers to be able to deliver these services is also high. Especially at the beginning of the COVID-19 pandemic, physicians and other health care providers began providing care through teleservices, often for the first time. Providers should be trained to deliver teleservices through their practice to ensure that quality of care is being met.

7. List of Acronyms

Acronym	Full Name
ACA	Affordable Care Act
CHIP	Children’s Health Insurance Program
COVID-19	Coronavirus Disease 2019
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
EMS	Emergency Medical Services
FPL	Federal Poverty Level
HHSC	Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
HPSA	Health Professional Shortage Area
HRSA	Health Resource Services Administration
IMLC	Interstate Medical Licensure Compact
STAR	State of Texas Access Reform
STAR+PLUS	State of Texas Access Reform Plus
TCMHCC	Texas Child Mental Health Care Consortium

Acronym	Full Name
TIPPS	Texas Incentives for Physician and Professional Service

Appendix A. Statewide Health Coordinating Council Roster

Gubernatorial Appointees	Role
Elizabeth Protas, P.T., Ph.D. Chair, League City	Public Member
Kimberly Haynes, D.M.D, C.A.G.S., F.I.D.I.A. Leander	Health Care Professional
Emily Hunt, D.N.P Houston	Hospital Representative
Carol Boswell, Ed.D., R.N., C.N.E., A.N.E.F., F.A.A.N. Andrews	University Representative
Bharath Thankavel, M.D. Dallas	HMO Representative
Chelsea Elliott Austin	Public Member
Cheryl Sparks, Ed.D. Big Spring	Community College Representative
Melinda Rodriguez, P.T., D.P.T. San Antonio	Health Care Professional
Tamara Rhodes, M.S. Amarillo	Nurse Representative
D. Bailey Wynne, M.H.A., R.Ph., C.H.E.S. Dallas	Public Member
Doris Jackson, D.H.A. Pearland	University Representative
Ken Holland Huntsville	Public Member
Yasser Zeid, M.D. Tyler	Health Care Professional
State Agency Members	Representing
Jimmy Blanton, M.P.Aff. Austin	Texas Health and Human Services Commission
Courtney Harvey, Ph.D. Austin	Texas Health and Human Services Commission

Aelia Akhtar
Austin

Elizabeth Mayer, M.P.Aff.
Austin

Texas Department of State Health
Services

Texas Higher Education Coordinating
Board

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