

February 20, 2026

Dear Lieutenant Governor Patrick and Speaker Burrows,

To improve health and health care in Texas, the 84th Legislature created the Texas Health Improvement Network (THIN), a multi-institutional, cross-sector network of researchers, experts, and leaders in population health improvement. THIN has developed a set of interim charge recommendations for your consideration, summarized below. For all the below charges, we recommend including a rural focus.

1. Examine the current state of health literacy, digital literacy, and health education in Texas and evaluate their impact on health outcomes, health care costs, and access to care.
2. Identify ways to reduce the prevalence of obesity and improve health outcomes.
3. Assess the health landscape for Texas' seniors (including issues related to loneliness, as well as in-home and long-term care costs) and its impact on caregivers and explore policy strategies to promote healthy aging.
4. Report on strategies to incentivize providers, Medicaid managed care organizations, and community partners to coordinate, screen for, deliver, and evaluate interventions for non-medical drivers of health in Medicaid and CHIP.
5. Evaluate strategies to improve early childhood health and expand access to care, including increasing breastfeeding support, increasing vaccination rates, and enhancing early health education.
6. Explore next steps for leveraging patient monitoring and information technology to improve health and health care.
7. Identify strategies to support health-related workforce recruitment, retention, and training.
8. Evaluate state policy options to maximize the benefit of AI in health care delivery and population health management, while mitigating potential harm.
9. Assess methods to assure viability of rural hospitals and emergency services, including the implementation of the Rural Health Transformation Grant.
10. Identify the most effective value-based purchasing arrangements in Texas.

These suggested charges, which are described in greater detail in the following document, are intended to advance what we believe are key opportunities for improving the health and health care of Texans in a strategic and fiscally responsible manner.

Sincerely,



David Lakey, M.D.
THIN Executive Sponsor
Vice Chancellor for Health Affairs
& Chief Medical Officer
The University of Texas System



Lewis Foxhall, M.D.
THIN Chair
Vice President of Health Policy
UT MD Anderson Cancer Center

Texas Health Improvement 2026 Interim Charge Recommendations

1. Examine the current state of health literacy and health education in Texas and evaluate their impact on health outcomes, health care costs, and access to care.

Adult literacy gaps are widespread: statewide estimates indicate 19% of adults in Texas lack basic prose literacy skills, with low literacy concentrated among those living in poverty.¹ These trends directly affect Texans' ability to understand medical instructions, manage chronic conditions, and make informed-care decisions.² In 2024, Texas recorded decades-low reading performance, with about 43% of fourth-graders³ and approximately 39% of eighth-graders⁴ below the NAEP achievement level – which denotes partial mastery of the knowledge and skills that are fundamental for proficient work at a given grade, underscoring risks to future health-literacy capacity.

Limited health literacy is consistently linked in the literature to delayed diagnoses, poorer chronic disease management including decreased medication adherence, delayed uptake of preventive services, higher avoidable hospitalizations, and higher mortality. Additionally, limited health literacy is associated with greater emergency department utilization and readmission. The economic burden of low health literacy on the U.S. health system is substantial, with estimates ranging from \$106 to \$238 billion annually (≈7–17% of personal health care expenditures).⁵ Studies note higher medical costs among older adult Medicare beneficiaries with low health literacy.⁶

Digital access and skills are now essential and sit at the core of health navigation, including accessing patient portals, telehealth, and benefits enrollment. However, an estimated 2.8 million Texas households, representing about 7 million people, lack broadband.⁷ This lack of broadband disproportionately impacts rural areas but is only part of the problem. Approximately 1.4 million adult Texans report digital literacy as their main barrier to adopting broadband.⁸ These deficits limit access to telehealth and online care coordination. Lack of language access compounds these barriers. Roughly one-third of Texans speak a language other than English at home, which can impede comprehension of health information and navigation of coverage and services when materials and encounters are not culturally and linguistically aligned.

¹ [Literacy Facts - Literacy Texas](#)

² [Health Literacy Fact Sheets - Center for Health Care Strategies](#)

³ [The Nation's Report Card: 2024 Reading Snapshot Report for Texas Grade 4](#)

⁴ [The Nation's Report Card: 2024 Reading Snapshot Report for Texas Grade 8](#)

⁵ J. Vernon, A. Trujillo, S. Rosenbaum, B. DeBuono Low health literacy: Implications for National Health Policy Health Policy Management Faculty Publications. (2007)

⁶ Tipirneni R, Roberts ET, Levy HG, et al. Health Care Utilization and Costs for Older Adults Aging Into Medicare After the Affordable Care Act. *JAMA Health Forum*. 2025;6(1):e245025. doi:10.1001/jamahealthforum.2024.5025

⁷ [U.S. Census Bureau QuickFacts: United States](#); [Comptroller Glenn Hegar Releases Texas Broadband Plan](#)

⁸ [connectednation.org/blog/lack-of-digital-literacy-prevents-1.4-million-texans-from-adopting-broadband](#)

2. Identify ways to reduce the prevalence of obesity and improve health outcomes.

Texas faces a persistently worsening obesity crisis with broad implications for population health, health care spending, education, workforce productivity, and military readiness. One third of adult Texans and one fifth of Texas children ages 10-17 have obesity.⁹

The latest data show that adult obesity prevalence in Texas is 35.6%, above national benchmarks¹⁰ and contributing to substantial chronic disease risk and downstream costs. Among children, 15.9% of Texas children ages 2–4 (WIC participants) and 15.8% of youth ages 6–17 have obesity; additional Texas specific research also reports that about 1 in 4 school age children have obesity.¹¹ The economic impact is extensive. Overweight and obesity cost Texas an estimated \$39.8 billion in 2022 (≈1.7% of state GDP), including \$928.6 million in higher state Medicaid costs and \$6.6 billion in additional federal Medicare/Medicaid spending; Texas employers incurred \$4.9 billion in health care costs linked to obesity and overweight.¹² Military readiness is also affected.

Texas has a foundation of programs to build upon. The Texas Department of State Health Services Obesity Prevention Program (OPP) collaborates statewide on policy, systems, and environmental approaches to reduce obesity. In schools, the Coordinated Approach to Child Health (CATCH), originating from NIH supported research and now widely implemented, has demonstrated improvements in student nutrition and physical activity and is a key tool for reducing childhood obesity at scale.

Given the measurable health, fiscal, workforce, and readiness impacts, the Legislature should identify and study:

- the statewide availability and reach of prevention, treatment, and long-term management options for children and adults (including rural access);
- cost-effective, locally based initiatives to promote nutrition, physical activity, health promotion, and education as well as primary care initiatives to prevent, diagnose, and manage individuals with overweight and obesity, mitigating the chronic disease burden;
- access to nutritious foods and safe places for physical activity as key metrics tied to cancer, diabetes, and heart disease risk; and
- coverage pathways for evidence-based treatments not yet included in Medicaid, CHIP or the state-employee plan, applying a cost-neutral or cost-positive lens for the state (e.g., intensive behavioral and lifestyle interventions, nutrition counseling, multidisciplinary obesity care, and evaluating access to FDA-approved anti-obesity medications).

3. Assess the health landscape for Texas’ seniors (including issues related to loneliness, as well as in-home and long-term care costs) and its impact on caregivers and explore policy strategies to promote healthy aging.

⁹ Obesity Prevention Program, [Obesity Prevention Priority Strategies](#), Texas Health and Human Services 2023

¹⁰ [The State of Obesity: Better Policies for a Healthier America 2025](#) Trust for America’s Health

¹¹ [Fast Facts: Obesity Among Children in WIC | Obesity | CDC](#)

¹² [Global Data Report Highlights Staggering Economic Costs for Texas of \\$39.8 Billion Due to Obesity](#)

In 2025, an average of 11,400 baby boomers are turning 65 every day. This period is known as "Peak 65," where more than 4.1 million Americans¹³ annually will reach this milestone through 2027, marking a significant increase from the previous, long-standing average of 10,000 per day. By 2030, all baby boomers will be at least 65 years old. This represents a major demographic shift, with older adults expected to represent over 20% of the population by 2050.¹⁴ The health care delivery system is already suffering from a provider shortage, and to meet the needs of this population, Texas must develop innovations in service delivery in addition to growing the provider pipeline. Mental health care is the most frequently billed service for telemedicine and telehealth, and new strategies leveraging everything from artificial intelligence to home care robots have the potential to be part of the solution for patients and their caregivers. Texas should also consider using digital tools to assist in providing caregiver support.

Additionally, legislative leadership and agency policymakers should review the data and consider recommendations from the latest Aging Texas Well report, which addresses many of these issues.¹⁵

4. Report on strategies to incentivize providers, Medicaid managed care organizations, and community partners to coordinate, screen for, deliver, and evaluate interventions for non-medical drivers of health in Medicaid and CHIP.

Much of what is required for a person to stay healthy resides outside the traditional health care system. Improving health and controlling health care costs require addressing non-medical drivers of health (NMDOH), also known as upstream drivers, such as patients' access to safe housing, healthy foods, and transportation to seek care. These factors have a greater influence on health than medical care alone. As a result, providers, Medicaid managed care, and community-based organizations are exploring new ways to work together to screen for, deliver, and evaluate interventions that address NMDOH. However, clearer strategies are needed to incentivize and sustain these partnerships within Medicaid and CHIP, including in rural areas.

Recent legislative activity demonstrates growing interest in policies that address NMDOH. In the 88th session, House Bill 1575 authorized the state Medicaid agency to develop a uniform NMDOH screening tool and pay for case management services and new provider types that address NMDOH. In the 89th session, House Bill 26 used the Medicaid In Lieu of Service provision to authorize a pilot program covering medically tailored meals for women with high-risk pregnancies due to diet-related conditions. The Texas Health and Human Services Commission (HHSC) is implementing programs authorized in HB 1575 and HB 26 through managed care contracting and oversight. These efforts are synergistic with the agency's foundational work on the Medicaid and CHIP Non-Medical Drivers of Health (NMDOH) Action Plan. To fully realize the value of these investments and to better position Texas to apply similar

¹³ [The U.S. Has Reached the Peak 65® It's Time to Apply Retirement Readiness Lessons from the Boomer Experience](#), PR Newswire Jan. 28, 2025

¹⁴ [By 2030, All Baby Boomers Will Be Age 65 or Older](#), U.S. Census Bureau

¹⁵ <https://www.hhs.texas.gov/sites/default/files/documents/aging-texas-well-strategic-plan-2024-25.pdf>

approaches to other health priorities, a focused study is needed to identify strategies to incentivize NMDOH partnerships within Medicaid and CHIP, including in rural areas.

5. Evaluate strategies to improve early childhood health and expand access to care. Including increasing breastfeeding support, increasing vaccination rate, and enhancing early health education.

Early childhood is a crucial developmental period when foundations affecting future health, learning, and success are built. Between birth and age three, children’s brains are developing at an extremely rapid pace.¹⁶ Supporting families during this time can improve health outcomes and protect them from disease and infection. Breastfeeding and vaccinations both help protect against illness and disease, strengthening immune systems.¹⁷ Providing families with early health education can ensure babies get all the necessary care timely.

Review the available resources provided by state agencies like HHSC and DSHS on early health education, including breastfeeding support. Assess how available resources are promoted to ensure parents can access them when needed. Examine available programs to ensure resources meet the need across the state, including rural areas.

6. Explore next steps for leveraging patient monitoring and information technology to improve health and health care.

Texas has seen steady integration of telemedicine, telehealth, and remote patient-monitoring technologies, but gaps remain, particularly in rural areas. A Texas Medical Association survey reports that three out of four Texas physicians use telemedicine, and about 75 percent use it for roughly one in ten patient visits.¹⁸ In Medicaid, telehealth visits declined from 1.6 million in FY 2022 to slightly more than 1.1 million in FY 2023, and behavioral health diagnoses were the most common telehealth services in both years.¹⁹ Remote monitoring continues to grow, with home-telemonitoring use increasing to nearly 4 percent from FY 2022 to FY 2023 and expenditures rising from 26.2 million dollars to 31.2 million dollars. Access remains uneven, as the number of telemonitoring providers in rural Texas fell from 56 to 54, and about 80 percent of counties lacking telemonitoring providers are rural.²⁰

Texas has not yet built a seamless data infrastructure that shares data among health providers to help better coordinate care, improve outcomes and contain costs. We recommend assessing the availability of health information exchanges and their variability across communities, to develop a statewide strategy that leverages existing Health Information Exchange and aligns with both the CMS Health Tech Ecosystem and the Trusted Exchange Framework and Common Agreement that was part of the 21st Century Cures Act. Many rural providers are still burdened with paperwork and fax machines, with patients still filling in paper forms at their provider's

¹⁶ <https://www.zerotothree.org/why-0-3/>

¹⁷ <https://www.cdc.gov/breastfeeding/features/breastfeeding-benefits.html>

¹⁸ [Telemedicine Continues to Connect Patients with Their Physicians](#), Texas Medical Association June 12, 2024

¹⁹ [2024 Teleservices in Texas Medicaid Report](#), Texas Health and Human Services

²⁰ [2024 Teleservices in Texas Medicaid Report](#), Texas Health and Human Services

office so that their data can be manually entered into the provider's Electronic Health Record. Although some of these issues are addressed as part of the Texas application for the Rural Health Transformation Program, not all providers will be able to participate and benefit from RHTP.

In 2023, the Texas Legislature passed HB 2727 (Price/Perry), which modernized the remote patient monitoring (RPM) benefit for Texas Medicaid by removing outdated patient criteria, adding a requirement for each patient to have a plan of care, expanding the services covered by Medicaid to include RPM for high-risk pregnancies, and giving HHSC the authority to add additional services to the RPM benefit without having to see additional legislation. Even though HHSC has this new authority, they are not required to adopt any new services for coverage, and in the meantime the technology for RPM is evolving rapidly. Texas should consider developing a way for providers to have these services fast-tracked, so they are able to deploy them more rapidly.

Additionally, digital health tools have the potential to connect patients with health data, providers, and care management to improve health outcomes. The legislature should:

- Identify challenges for patient monitoring programs in medically underserved rural areas.
- Evaluate local community driven initiatives to improve adoption, utilization, and health outcomes using digital tools.
- Evaluate potential cost savings to health care systems from increasing access to digital health tools to underinsured and uninsured adults with chronic disease.
- Identify effectiveness of these tools for disease management using outcome data?
- Identify the specific health models for using and dispersing these technologies to provide the best patient outcomes?
- Explore workforce training and needs for these models, including how to connect them with rural areas.
- Explore interoperability of these technology options and the state role in standardizing requirements/standards.

7. Identify strategies to support health-related workforce recruitment, retention, and training.

The vast majority of Texas counties are health professional shortage areas, and this crisis has only worsened. This is especially true for mental health professionals, where 80% of Texas counties are designated by the Health Services and Resources Administration (HRSA) as Mental Health Professional Shortage areas. Chronic staffing shortages, high turnover rates, increased burnout, both an aging workforce as well as an aging patient population, and significant challenges in recruitment are just a few factors that have led to decreased health care access and quality of care in rural Texas.

Texas needs to rapidly identify and implement solutions that will build and broaden the number of individuals entering health care fields, increase retention of its current workforce, and

increase recruitment from outside Texas, especially to improve health care access in rural communities. This may include better support of rural training tracks in health care, bolstered funding for rural hospitals, strengthening rural network adequacy, expanding telemedicine and telehealth access, and increasing fee payments in both Medicare and Medicaid. Areas of focus should include both the primary and behavioral health workforce including the full spectrum of providers such as physicians, nurses, medical assistants, nursing aids, social workers, counselors, qualified mental health professionals, peer support specialists, and recovery coaches. Furthermore, Texas should evaluate ways to maximize the efficiency of Texas' health care workforce including enabling team-based health care, leveraging telehealth, and promoting integrated physical and behavioral health care.

8. Evaluate state policy options to maximize the benefit of AI in health care delivery and population health management, while mitigating potential harm.

New AI tools are revolutionizing health care. Texas should explore the latest implications and applications, including how best to leverage machine learning to elevate patient care and increase efficiencies to mitigate workforce shortages.

While the appropriate roles for both federal and state regulation of AI are the subject of much debate and discussion, health care still has inherent ethical obligations to make sure that AI tools are used appropriately without harming patients. There should also be policy distinctions drawn between tools that support population health broadly and are not engaging with individual patients, as opposed to AI tools that may be interacting with a patient directly. Distinctions should also be made between AI tools that may be supplementing decision-making versus independently making the decision. Educational tools should be developed to ensure that patients and providers understand these new technologies, including how they may be impacting their care delivery. The role of state health professional licensing boards should also be evaluated so they can give appropriate guidance to their regulated professionals.

Additional areas to explore include:

- where clinical processes and AI can align to improve patient experience and outcomes.
- possible efficiencies for clinicians and patients using AI, such as increased use of dictation by physicians, which can lead to greater interaction with patients.
- the use of AI for earlier identification of high-risk patients for early interventions.
- medical liability of using and of not using AI.

9. Assess methods to assure viability of rural hospitals and emergency services, including the implementation of the Rural Health Transformation Grant.

Evaluate long-term strategies to ensure the viability of rural hospitals and emergency care access across Texas. Texas is one of the largest and most geographically diverse states in the nation, and its rural communities face persistent barriers to sustaining local health care access.

Despite serving as critical access points for nearly 4.7 million rural Texans²¹, rural hospitals continue to shoulder significant financial pressures, with 26 closures since 2010 and 76 additional facilities now at risk of closure, including 12 facing immediate threat.²² These closures can result in the loss of approximately 170 local jobs and \$22 million in payroll per community, creating cascading economic, workforce, and health care access impacts.

Majority of the counties in Texas are designated as rural (177 out of 254) with virtually all rural counties designated as health provider shortage areas.^{23,24} Currently only 43% of the rural hospitals in Texas offer obstetrical services, leaving large regions of the state as OB deserts and forcing many women to travel long distances for labor and delivery care.²⁵ Financial strain remains a defining challenge: more than half of rural hospitals operate with negative margins, four in ten hold fewer than 20 days cash on hand, and 15% are heavily leveraged, with debt exceeding 50% of total capitalization. These systemic vulnerabilities erode local service capacity and increase the risk of additional closures.²⁶

In response, the Texas Legislature has taken steps to stabilize rural access, including through HB 18 (89th Legislature), which established the Rural Hospital Officers Academy to strengthen rural hospital leadership and management capacity. In parallel, the state secured a historic \$1.4 billion federal investment through the Rural Health Transformation (RHT) Program, known in Texas as Rural Texas Strong, which will distribute \$281 million per year over five years to enhance rural infrastructure, workforce recruitment, technology, emergency services, and cybersecurity. These aligned initiatives create an unprecedented opportunity to assess and modernize rural health care delivery models statewide.

To continue the conversation, we recommend that Texas explore innovative ideas that are being supported by HB 18 and the Rural Health Transformation Grant. These can include, but are not limited to initiatives that support:

- Improving the infrastructure needed to support that community and hospital in the long term.
- Exploring alternative clinical models in rural areas, including the viability of regional partnerships for increased sharing of administrative and financial resources across multiple hospitals.
- Explore other alternatives to emergency services such as outpatient clinics, and the financial viability of these alternative models for emergency services.

²¹ [https://www.census.gov/newsroom/press-releases/2022/urban-rural-populations.html#:~:text=Vermont%20was%20the%20most%20rural%2C%20with%2064.9%25,populations%20are%20Texas%20\(4%2C744%2C808\)%20North%20Carolina%20\(3%2C474%2C661\)](https://www.census.gov/newsroom/press-releases/2022/urban-rural-populations.html#:~:text=Vermont%20was%20the%20most%20rural%2C%20with%2064.9%25,populations%20are%20Texas%20(4%2C744%2C808)%20North%20Carolina%20(3%2C474%2C661))

²² <https://www.torchnet.org/advocacy--rural-hospital-closure.html>

²³ <https://texasagriculture.gov/portals/0/forms/er/rural-metro%20counties.pdf>

²⁴ Rural Texas Strong: Supporting Health and Wellness:

<https://pfd.hhs.texas.gov/sites/default/files/documents/hospital-svcs/rural-txstrong-prjct-narr.pdf>

²⁵ <https://www.hhs.texas.gov/sites/default/files/documents/rural-hospital-services-strat-plan-nov-2024.pdf>

²⁶ [https://pfd.hhs.texas.gov/sites/default/files/documents/hospital-svcs/analysis-tx-rural-hosp-financial-solvency.pdf#:~:text=Liquidity%20analysis%20of%20cash%20position%20provides%20a,than%2020%20days\)%20which%20may%20indicate%20vulnerability](https://pfd.hhs.texas.gov/sites/default/files/documents/hospital-svcs/analysis-tx-rural-hosp-financial-solvency.pdf#:~:text=Liquidity%20analysis%20of%20cash%20position%20provides%20a,than%2020%20days)%20which%20may%20indicate%20vulnerability)

- Analyzing how supporting outpatient clinics and primary health access can alleviate reliance on emergency services in rural settings, including financial viability.

10. Identify most effective value-based purchasing arrangements in Texas.

Across the US and in Texas, for over ten years there has been a coordinated effort to move from fee-for-service payment for health care (which incentivizes more care) to value-based purchasing arrangements that incentivize cost effective care and better patient outcomes. At the national level, the Health Care Payment Learning & Action Network (HCP-LAN) and Centers for Medicare Medicaid Services (CMS) Innovation Center lead this work. In Texas, the HHSC has established managed care requirements for value-based contracting in Medicaid and the Children's Health Insurance Program (CHIP). Despite these efforts, health care costs continue to grow and quality results from value-based care initiatives have been mixed. Texas needs to explore the following:

- Value-based purchasing (VBP) models for both adults and children and identify models that have demonstrated effectiveness in meeting the triple aim of health care (improving care clinical outcomes, patient satisfaction, and reducing costs).
- VBP range of options such as shared savings, bundled payments, pay-for-performance, and capitation and challenges, especially in rural areas, including up front infrastructure costs, barriers to data sharing, the use and impact of VBP arrangements in small populations. It is important to recognize the need for actuarial assessment to address the adverse impact associated with high-cost cases on small populations. Additionally, to consider variables in ramping up VBP, and models for collective participation in VBP.
- Cost effectiveness, and health outcomes of current value-based purchasing in the public and private insurance markets.
- Ways to impact participation barriers (e.g., access to specialty referrals, support for non-clinical drivers of health and rural constraints, such as workforce, hospital closures/financial instability, broadband, travel distance for care)