House Committee on Public Health
Written Testimony of Adrian Billings, MD, PhD
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Testifying on behalf of:
Texas Medical Association
Texas Academy of Family Physicians

On behalf of the Texas Medical Association and the Texas Academy of Family Physicians, thank you for the opportunity to testify. I am Adrian Billings, MD, PhD, a family medicine and community physician serving Alpine, Marfa, and Presidio. My goal today is to give you a firsthand perspective of the significant challenges that rural patients face accessing health care. Additionally, I will provide pragmatic recommendations to strengthen Texas' rural health care – a system on which *all* Texans depend.

While definitions of "rural" vary depending on the state or federal program and/or agency, a good reference point is to think of counties with 50,000 or fewer residents. In Texas, this definition applies to 186 of Texas's 254 counties (73%), home to nearly 3 million people.

According to a recent analysis by The Perryman Group, over the past two decades, both people and jobs have become more concentrated in urban areas – no surprise to anyone living in metropolitan places. Between 2001 and 2021, urban Texas grew nearly 45% compared to 10% for rural communities. From 2020 to 2021, the population of 67 rural counties declined, a trend that without doubt will continue.

Nevertheless, rural communities remain vital to the state's economy. They support jobs in a variety of important sectors, including energy, agriculture, ranching, and tourism, all of which help make life in urban and rural areas possible. Furthermore, many major transit corridors traverse rural counties, with people and goods regularly passing through them as they journey to urban areas or points beyond. Thus, whether living and working in rural Texas, vacationing, or just passing through, people get sick, have car accidents, or deliver babies. That means access to high-quality, safe, and effective rural health care is important to all Texans, as well as the millions of non-Texans who visit each year.

Unfortunately, providing such care is getting harder and harder to do.

When I spoke to the committee last October, I informed you of the ongoing need to divert labor and delivery services from my community hospital to other facilities in the region, often hundreds of miles away, due to severe nursing shortages. Unfortunately, that diversion continues. On any given Thursday through Monday morning, the dedicated labor and delivery unit cannot be fully staffed with labor and delivery nurses. The maternity unit closes at other times, too, such as over holidays, or when the nursing staff are unable to work due to illness or family emergencies.

Pregnant women must plan, if possible, to deliver far from home. However, as you know, babies often arrive on their own schedule. If labor begins over the weekend, then women must deliver in the emergency department (ED).

As excellent as the emergency physicians and nurses are, routinely delivering babies in the emergency department is not the standard of care because the ED lacks resources and skills of a labor and delivery workforce. Without such knowledge and resources, emergency room staff may not have the ability to detect a problem and intervene before it becomes potentially life threatening or even tragic.

Let me give you another example of a rural health care resource limitation. On a drive from my clinic in Presidio to Alpine several months ago, I witnessed a small plane crash. I called 911 and turned my truck

around to help at the crash site. To my relief, I saw the lone Presidio EMS unit drive by, appearing to respond. However, the EMS vehicle passed me on its way to another emergency in Alpine, leaving me and a deputy sheriff to respond instead. We found two passengers, both critically injured. Thankfully, air ambulances were able to Life-Flight the injured patients to trauma facilities in El Paso.

While I don't know if the passengers survived, had the air ambulances from elsewhere not been able to respond, these visitors would have had little or no chance of surviving. Yet, rural EMS operates on a shoestring, struggling to cover a vast region, often with volunteers. If I or my loved ones had a car accident in a rural county, you'd want rural EMS capable of providing timely and life-saving prehospital emergency care.

The above stories are raw and recent, highlighting some of the more extreme examples of the health care challenges rural residents, physicians, health care professionals, and travelers face.

However, between delivering babies and treating traumatic injuries, our rural system must also be able to treat everything else in between. Children need preventive health care. Ranchers need broken bones set. Some of the most serious job-related accidents are agriculturally related. Moms with postpartum depression need mental health treatment. Clerks, construction workers, and retirees need treatment for heart disease or diabetes and acute conditions, such as stroke.

Statistically, rural Texans are older, sicker, and poorer, meaning not only do they often have more complex medical needs than their urban counterparts – such as multiple chronic conditions – but they also need community resources to help them live fully and healthily – such as help obtaining healthy foods or transportation to medical appointments. Yet these resources also are few and far between in rural areas. A patient's rural ZIP code can and does represent a risk factor to their health.

Too many rural residents, like urban ones, also lack health insurance. According to the United States Census Bureau, an estimated 19% of Texans are uninsured, though this number is higher among working-age parents and adults, who almost always lack access to public coverage options, such as Medicaid. Without health insurance, patients delay or postpone care, potentially harming not only their health but the financial stability of their families.

High numbers of uninsured also contribute to soaring uncompensated care costs for rural physicians, clinics, and hospitals, a key factor in rural hospital and practice closures. For young physicians completing their residency training with extensive medical debt, it is difficult to recruit them to practice in Big Bend or other rural communities knowing so many of their patients will be unable to pay for their care.

For the last several legislative sessions, lawmakers have invested resources to stabilize the rural health system, including new dollars to support rural hospitals – funding our organizations strongly support. Lawmakers also proactively enacted legislation to expand use of telemedicine, even before the COVID-19 pandemic necessitated its swift adoption. **However, Texas has not implemented a cohesive, enduring, long-term rural health enhancement plan to address the myriad needs of the rural health care system** – workforce, infrastructure, emergency medical care, and population health.

More than 30 years ago, state lawmakers approved omnibus legislation, known as the Rural Health Care Rescue Act, dedicated to this goal. Within the legislation were provisions creating many of the initiatives we now know work, such as dedicated rural medical school and residency training tracks to foster the next generation of rural physicians, as well as loan repayment programs and resources to modernize limited and aging rural health care infrastructure.

In 2023, lawmakers should consider a similar approach – omnibus legislation or a package of bills with the single aim of strengthening rural health care access and outcomes. Elements of the package would include tried-and-true programs, such as renewed or enhanced funding for the physician loan repayment program, rural training tracks, nursing education and training – in addition to efforts to promote and sustain innovative rural health care delivery models.

I have practiced family medicine for 16 years in the Big Bend. Through that experience, I have seen rural health initiatives come and go, even those with proven results. What has changed is the acute shortage of health care workers is now chronic. The COVID-19 pandemic exacerbated an already difficult situation, which will not get better without new approaches.

That is why I believe Texas must implement a collaborative, coordinated, comprehensive approach that will help the state achieve genuine improvements, versus just Band-Aiding problems from session to session. Additionally, it is critical for the state to foster research and innovation in new approaches to addressing long-standing, tenacious rural health problems, such as workforce shortages.

Our organizations do not pretend to have all the answers. Many rural clinics, hospitals, academic health centers, and mental health professionals are constantly testing practical, innovative ways to improve care within rural communities. However, without a dedicated center or mechanism to share those best practices and foster new ones, many rural communities lose out.

In the coming weeks, our organizations will be collaborating with rural hospitals, academic health centers, community clinics, nurses, and others, to assess a potential model for this approach in addition to formulating a more robust package of potential reforms. In the meantime, we encourage the committee to strongly support investing in proven initiatives to accomplish our shared goals to sustain a vibrant, effective, and efficient rural health care system:

- **Redouble Texas' efforts to make comprehensive, affordable health insurance available to all.** Decades of research show the lack of health care coverage not only poses serious health consequences but also contributes to higher health care costs and curtailed job growth. High rates of uninsurance also mean higher uncompensated care costs for rural physicians and hospitals, which already operate on razor-thin margins.

- **Promote adoption of value-based payment initiatives to improve health outcomes and access for rural Medicaid enrollees, including initiatives focused on improving rural maternal and mental health services.** Successfully participating in value-based care requires access to useable data, staff training, robust care coordination, and investments in population health services, all of which can be challenging for rural physicians and hospitals to undertake without assistance.

  To help rural physicians, community clinics, and hospitals adapt to a new payment system that pays practices for improving health versus solely for the service, Texas should establish a Medicaid accountable care grant initiative. Grant funding could be prioritized to rural hospitals and physician practices of 20 or fewer that agree to participate in or enhance existing value-based payment arrangements. Grants could be used to support physician and staff training, acquisition of data and decision support tools, patient-centered medical home certification, establishment of continuous quality improvement protocols, and other services or tools as determined by the Texas Health and Human Services Commission that will accelerate physician participation in value-based payment initiatives.

- **Replenish funding for the state Physician Education Loan Repayment Program (PELRP) to encourage physicians to practice in rural areas.** PELRP provides loan repayment assistance to physicians practicing in Health Professional Shortage Areas (HPSAs). The loan repayment amounts are based on the expectation that participating physicians will provide at least four years of service, earning up to $180,000. Since 2009, more than 2,300 physicians have participated in this widely successful program. Unfortunately, funding for the program was reduced in the 2022-23 biennium, and the program has been unable to accept new applicants.

  Texas should establish a one-time endowment to strengthen and expand PELRP. An endowment amount of $30 million with an annual interest growth rate of 3% would produce approximately

$900,000 a year that would fund, on average, 20 slots annually. Rural communities face serious challenges in competing with urban centers to recruit physicians. This program is one of the few incentives rural communities can offer, and it is highly valued.

- **Fund the Professional Nursing Shortage Reduction Program (PNSRP) to increase rural nurse recruitment/retention**. The program provides grants to nursing education programs at state public and private institutions of higher education to increase the number of initial licensure nurses through investments in enrolling, retaining, and graduating nurses. The Texas Legislature could increase PNSRP funding and prioritize growth in initial licensure students by dedicating additional funds for scholarships, tuition discounts, and/or loan repayment programs for initial licensure nurses who practice in Texas, and by creating high school-to-college nursing apprenticeships and career pathway programs. These new funds could be weighted to prioritize rural recruitment and placement.

- **Allocate $20 million to boost the Family Medicine Residency Program (FMRP), established in 1977.** Forty-five years later, it remains just as critical as ever. Family medicine is the largest medical specialty represented in rural medicine. Indeed, according to the Agency for Healthcare Quality and Research, family physicians are more likely to practice in rural areas and to distribute themselves proportionally among the U.S. population. Yet, because their residency programs are typically in a community setting versus a hospital, they receive less federal funding for specialties that train in teaching hospitals.

  FMRP provides grants to Texas' 37 nationally accredited family medicine residency programs, located in every region of the state. The program is designed to increase the number of physicians selecting family medicine as their medical specialty and to encourage those physicians to establish their practices in rural and underserved communities in Texas. Over the past decade, state budget cuts have severely impaired this critical training and a major pipeline for rural physicians.

- **Increase physician supply by sustaining Texas' investments in graduate medical education.** To preserve the physician residency positions created through the state Graduate Medical Education Expansion Grant Program in the 2024-25 state budget, more dollars will be needed to ensure Texas medical school graduates seeking to remain in Texas for residency training will have a place to train.

  With the recent openings of new medical schools, it is critically important that residency positions be created in synch with that growth. Without it, Texas will not be able to meet the state's target ratio of 1.1 to 1 – that is 1.1 first-year residency positions per Texas medical school graduate. Action is needed to prevent the loss of homegrown Texas physicians to other states for residency training.

- **Activate the state Rural Training Track grant program,** established by the legislature in 2019 (House Bill 1065), by allocating $1 million to fund the creation of rural training tracks in the state.

- **Support telemedicine payment parity to ensure rural physicians who want to offer the service to their patients can do so**.

I appreciate the opportunity to testify before you today, and I thank you for making rural health care a priority in Texas! I would be glad to answer any questions you may have.