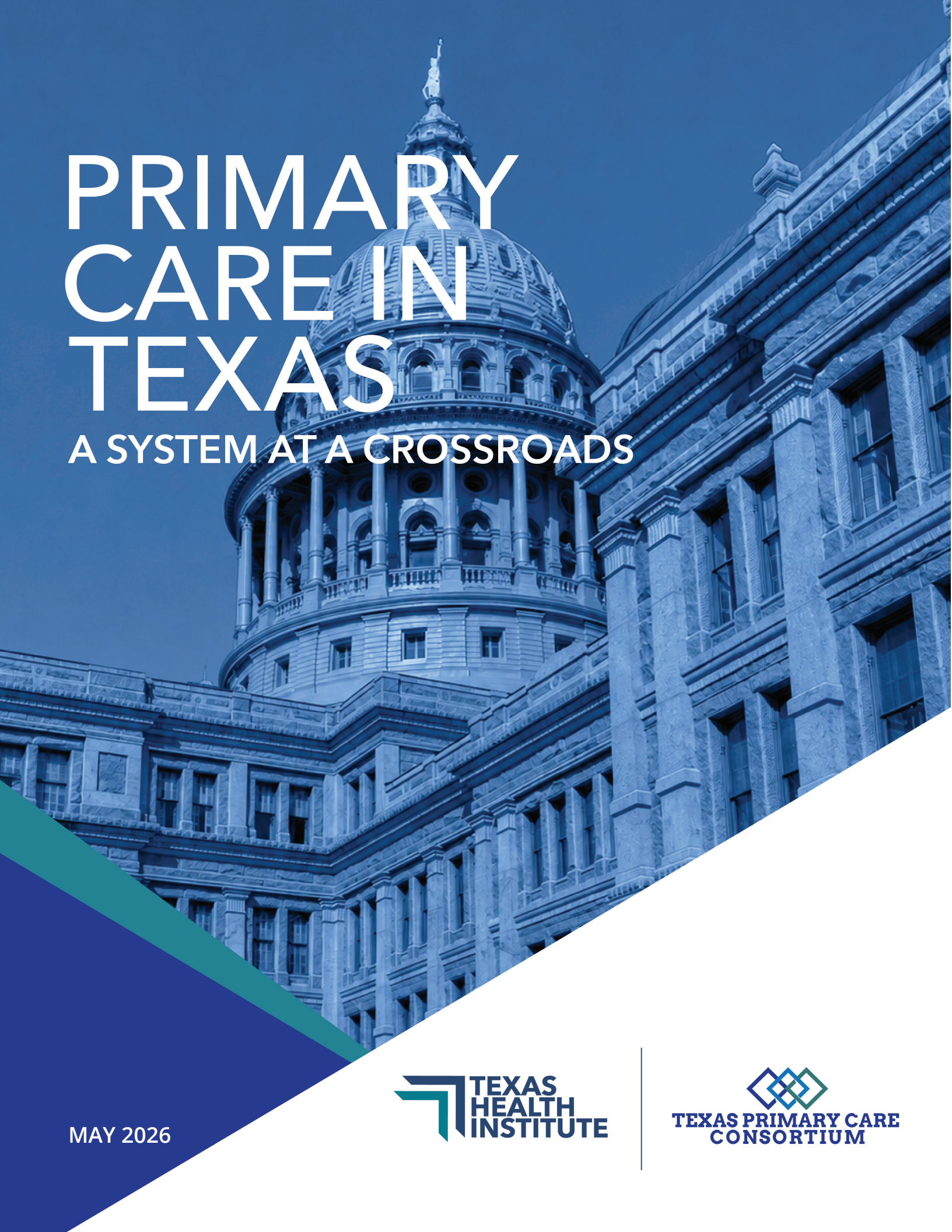

PRIMARY CARE IN TEXAS

A SYSTEM AT A CROSSROADS

MAY 2026

TEXAS HEALTH INSTITUTE

TEXAS PRIMARY CARE CONSORTIUM

Acknowledgements

This report was developed through the collaborative efforts of Texas Health Institute (THI) and the Texas Primary Care Consortium (TPCC), drawing on the insights, experiences, and leadership of partners and stakeholders across Texas.

TPCC is a statewide, multi-sector collaborative working to advance high-quality primary care for all Texans. TPCC brings together clinicians, health systems, payers, employers, policymakers, and community organizations to inform policy, align strategies, and support system-level improvement.

THI is an independent public health institute with a mission to advance the health of all Texans. Since 1964, THI has served as a trusted partner to public and private stakeholders, providing research, evaluation, and strategic insight to inform policy and systems change. THI serves as the backbone organization and co-lead for TPCC.

Funder and Partner Acknowledgement

We are grateful to TPCC partners for their continued leadership, collaboration, and support in advancing primary care across Texas. We extend special appreciation to the Commonwealth Fund, Driscoll Health System, and Center for Community Health at Cook Children's for their support of this report and statewide dashboard.

Contributors and Community Partners

This report reflects the perspectives of individuals and communities across Texas who generously shared their time and insights. We extend our sincere thanks to all key informant interviewees and listening session participants whose experiences and perspectives shaped this assessment.

We are especially grateful to the following community and clinical leaders who helped plan and host listening sessions across the state:

- **Adrian Billings, MD, PhD, FAAFP, FACU**
- **Jackson Griggs, MD, FAAFP**
- **Douglas Curran, MD**
- **Glen Robison, MBA**
- **Emily Briggs, MD, MPH, FAAFP**

Their leadership and partnership were instrumental in ensuring that this work reflects the realities of primary care across diverse communities.

We are also grateful to the many organizations and individuals across Texas who contributed to this effort, including those not individually named.

Advisory Committee

We thank the TPCC Advisory Committee members for their leadership and guidance in informing this effort (see Appendix for full list).

Report Team

This report was developed by the THI and TPCC team, with contributions across research, analysis, stakeholder engagement, and communications.

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We also recognize Blair Williams, DrPH, MPA, MPH, CPH, and Claire Rowan, MPH, for their leadership in developing the accompanying Texas Health Insights dashboard, a complementary data resource that provides county-level insights to support this report.

Suggested Citation

Texas Health Institute & Texas Primary Care Consortium. *Primary Care in Texas: A System at a Crossroads.* Austin, TX: Texas Health Institute; 2026.

Disclaimer

The views presented in this report are those of the authors and do not necessarily reflect the views of the funders, partners, advisory committee members, or contributions acknowledged above.

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Executive Summary

*Individuals with a **usual source of primary care** experience approximately **11% lower emergency department use** and **20% lower hospitalization rates**.*[4]

Primary care is the foundation of health in Texas and a critical pillar of the state's healthcare system. It supports prevention, chronic disease management, addressing behavioral health needs, and care coordination across a patient's lifespan.

Primary care works because it is relational. Clinicians who know patients over time catch what episodic care misses, manage conditions more effectively, and coordinate what fragmented care fails to connect. When primary care functions well, communities are healthier, costs are lower, and care happens earlier before illness becomes a crisis.[1]

Yet even as its importance grows, the system surrounding primary care is not consistently aligned with that role, particularly in how it is financed, measured, and supported.

> "If our healthcare system fails, it's a domino effect. Businesses will relocate. Families will move away. **Communities shrink.**"
>
> —LS participant

While total per capita healthcare spending in Texas increased by nearly 18% from 2018 to 2023,[2] the share invested in primary care declined, from 5.8% to 5.2%[3] of total healthcare spending, reflecting a persistent gap between cost and value. At the same time, national evidence shows that individuals with a usual source of primary care experience approximately 11% lower emergency department use and 20% lower hospitalization rates, underscoring its measurable impact on both outcomes and costs.[4]

Primary care refers to the **clinicians** and **care teams** who provide **first-contact, continuous,** and **comprehensive care** for individuals and families.

In many communities, it also serves as a **critical part of the broader healthcare infrastructure,** supporting **prevention,** managing **chronic conditions**, and **anchoring access to care.**

In many communities, primary care is not just a service. It is essential infrastructure. Without it, preventable conditions become emergencies, costs escalate, and communities struggle to attract employers, retain families, and sustain economic stability.

Across listening sessions and key informant interviews conducted by *Texas Health Institute* (THI) and the *Texas Primary Care Consortium* (TPCC) spanning rural, urban, and frontier communities, including communities such as Alpine, Athens, Waco, Hillsboro, and New Braunfels, a consistent picture emerged. Primary care in Texas is not under strain by accident, it is operating within a system designed around fragmented, episodic care, and short-term financial incentives. The resulting gaps in access, continuity, and workforce stability are not isolated failures but predictable outcomes of that structure.

Participants consistently described primary care using five words: Grit. Love. Overwhelming. Opportunity. Unfair.

Primary care in Texas is not under strain by accident, it is operating within ***a system designed around fragmented, episodic care, and short-term financial incentives.***

These perspectives reflect a system that is sustained by the commitment of those within it but strained by the financial and regulatory structures surrounding it. As one rural physician described:

> "Primary care shines in the continuity… when you know families across generations. **But the system around it makes that harder every year.**"
>
> —KII

Since TPCC's inaugural 2020 statewide assessment, Texas has made meaningful progress, including expansion of data infrastructure through the Texas All-Payer Claims Database, extension of postpartum coverage, investments in graduate medical education, advancing value-based care reform, and growth in behavioral health integration efforts. Across the state, additional innovation continues to emerge through community-based workforce programs, clinically integrated networks, and technology-enabled care models.

At the same time, structural pressures have intensified. Texas continues to have the highest uninsured rate in the nation.[5] Even among insured populations, coverage complexity, affordability challenges, and churn increasingly disrupt continuity of care.[6] Workforce shortages persist, particularly in rural and underserved areas,[7] while administrative and documentation requirements continue to expand. Meanwhile, primary care practices are expected to manage growing behavioral health needs and other non-medical drivers of health.[8]

These pressures are already shaping access, workforce stability, and care delivery across the state. Taken together, these dynamics point to a system that depends heavily on primary care, while placing increasing strain on the infrastructure required to sustain it.

Drawing on statewide insights and data, five structural findings emerge.

What's Holding Primary Care Back

These five structural findings reveal what's holding back primary care in Texas and point the way forward for our state.

1. Primary care functions as **critical health and community infrastructure,** yet **system design remains oriented toward episodic** rather than longitudinal care.
2. **Administrative burden** is a major constraint on clinical capacity and a leading contributor to workforce strain.
3. **Coverage complexity** and **affordability** increasingly impact access and continuity.
4. **Workforce challenges** reflect issues of distribution and practice sustainability as much as supply.
5. Policy progress is meaningful, but **impact depends on alignment** across financing, delivery, and implementation systems.

Primary care in Texas is ***neither failing nor fully secure.***

Primary care in Texas is neither failing nor fully secure. It remains resilient, innovative, and deeply rooted in communities but is operating within a system that places increasing pressure on the very foundation of care.

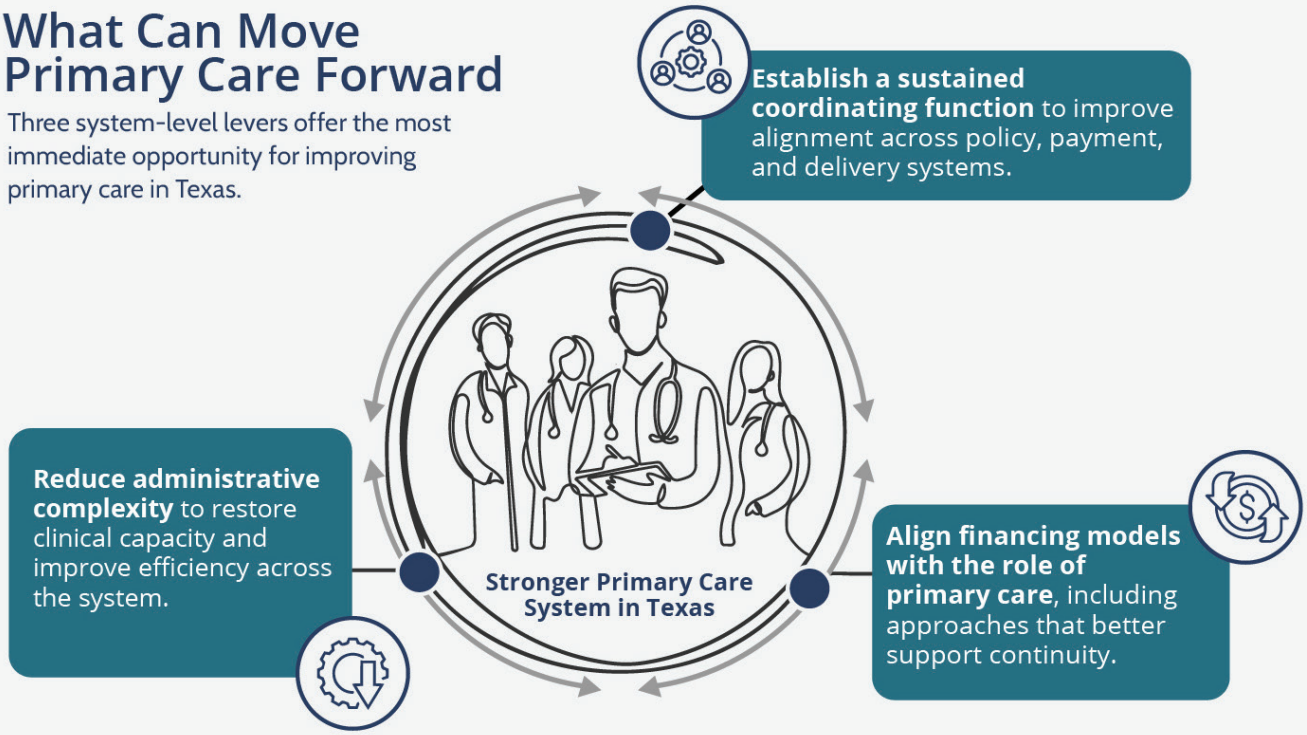
As Texas looks to address rising healthcare costs, workforce pressures, and the growing burden of chronic disease, strengthening primary care represents a practical and evidence-based pathway forward. While multiple factors contribute to these challenges, **three system-level levers offer the most immediate opportunity for impact.** Together, these levers address capacity, sustainability, and alignment, three conditions that shape how effectively primary care can function across the state.

The central message of this report is clear:

Primary care in Texas is both **indispensable and increasingly vulnerable.** The challenge is not a lack of effort or innovation; it is a lack of alignment between how primary care is expected to function and **how it is financed, measured, and supported.**

What Can Move Primary Care Forward

Three system-level levers offer the most immediate opportunity for improving primary care in Texas.



Why This Report, Why Now

*Primary care is expected to serve as the foundation of the healthcare system while **operating within** structures that were **not designed to support** that role.*

Primary care is widely described as the "front door" to the healthcare system. National evidence reinforces that characterization. The National Academies of Sciences, Engineering, and Medicine concluded in 2021 that high-quality primary care is the only component of healthcare where increased supply is consistently associated with improved population health and outcomes.[8]

Yet the United States continues to devote a smaller share of total health expenditures to primary care than peer Organization for Economic Co-operation and Development (OECD) nations, roughly half as much by some estimates.[9] The result is a persistent tension: primary care is expected to serve as the foundation of the healthcare system while operating within structures that were not designed to support that role.

Texas reflects that national tension within a context shaped by the state's size, geography, rapid population growth, and wide variation in access to care across communities. These dynamics create conditions where gaps in primary care are more pronounced and more consequential for communities, employers, and the broader health system.

In 2020, TPCC released Making Primary Care Primary, the first statewide assessment to examine the structural role of primary care in the Texas healthcare system. That report highlighted chronic underinvestment in primary care infrastructure, persistent workforce shortages, administrative complexity, and uneven access to care across communities.

Five years later, the environment surrounding primary care has continued to evolve. Healthcare costs continue to rise for families and employers. Insurance coverage has become increasingly complex to navigate. Workforce shortages remain unevenly distributed across the state. Administrative and documentation requirements have expanded across payers. At the same time, primary care clinicians are increasingly expected to address a broader range of needs, including behavioral health and non-medical drivers of health.

During listening sessions conducted for this assessment, one clinician summarized this contradiction clearly:

> "We're expected to solve everything. **But the incentives don't match the expectations.**"
>
> —LS participant

This report was developed to better understand how these dynamics are affecting primary care across Texas today and to examine the structural factors shaping its future. The assessment was conducted by THI, an independent non-profit public health institute that serves as the backbone organization and co-lead for TPCC, a statewide coalition of clinicians, health systems, employers, policymakers, and community organizations working to advance high-quality primary care in Texas.

Drawing on statewide listening sessions primarily in rural and small-town communities; key informant interviews with health system leaders, policymakers, and employers; and analysis of state and national data and research literature, this assessment provides a comprehensive view of the forces shaping primary care across the state.

In addition to this report, THI has developed a complementary data resource that provides county-level insights into the health system landscape across Texas. The accompanying dashboard includes more than 80 indicators spanning primary care capacity, workforce, coverage, health outcomes, and non-medical drivers of health for each of Texas's 254 counties. Together, the report and dashboard aim to provide policymakers, health system leaders, and community stakeholders with a clearer picture of both statewide trends and local realities.

Rather than focusing on a single issue or solution, the report examines the broader architecture surrounding primary care, specifically how payment structures, administrative requirements, coverage dynamics, workforce challenges, and data systems interact to shape the delivery of care.

Understanding these structural dynamics is particularly important at this moment as Texas continues to experience rapid population growth, rising healthcare costs, and increasing pressure on the primary care workforce. Decisions made today about workforce development, administrative simplification, payment models, and coverage stability will influence whether primary care can effectively serve as the foundation of healthcare across the state.

data.texashealthinstitute.org
Check out our new data dashboard.

State of Primary Care in Texas

Quantitative Baseline

***Insurance coverage alone** does not ensure affordable or timely access to primary care.*

Primary care in Texas operates within a set of reinforcing structural conditions that shape who can access care, where it is delivered, and how consistently it is experienced. Despite its central role in improving health outcomes and managing costs, Texas ranks near the bottom nationally on overall health system performance.[10] Available data across coverage, access, workforce, and spending point to a consistent pattern: demand for care is rising, while access, continuity, and system capacity remain uneven across regions and populations. These patterns are more pronounced in Texas than in many other states, reflecting both structural design and the scale and diversity of the population.

This section provides a high-level baseline to contextualize the findings that follow.

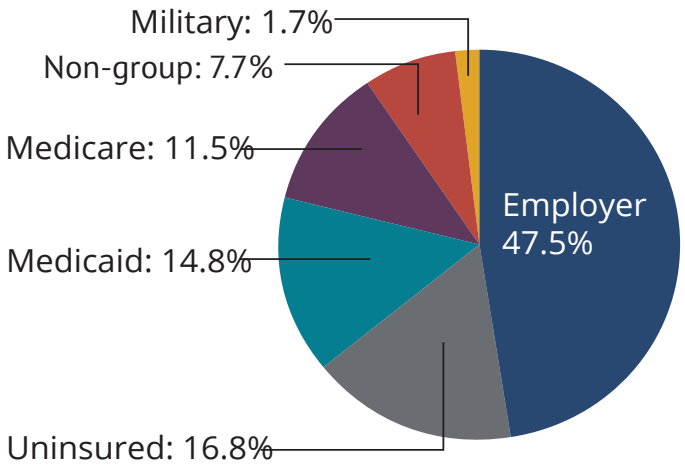
Coverage and Affordability

Coverage in Texas is shaped by a mix of public and private sources, with the majority of Texans (47.5%) receiving insurance through employer-sponsored plans. Notably, insurance premiums for family coverage have increased 53% since 2015, rising from $17,680 to $26,993, with average worker contributions covering 37% of this increase.[6] This dynamic has important implications and contextualizes how primary care is accessed, financed, and experienced across the state, even among insured Texans. This indicates that insurance coverage alone does not ensure affordable or timely access to primary care, particularly as out-of-pocket costs and benefit design increasingly shape utilization decisions.

Additionally, Texas continues to have the highest uninsured rates in the nation. Recent estimates indicate that approximately 1 in 5 adults and more than 1 in 10 children in Texas are uninsured, compared to significantly lower national averages. Provisions in the recently passed One Big Beautiful Act are projected to negatively impact this trend and possibly contribute to a growing uninsured and underinsured population.

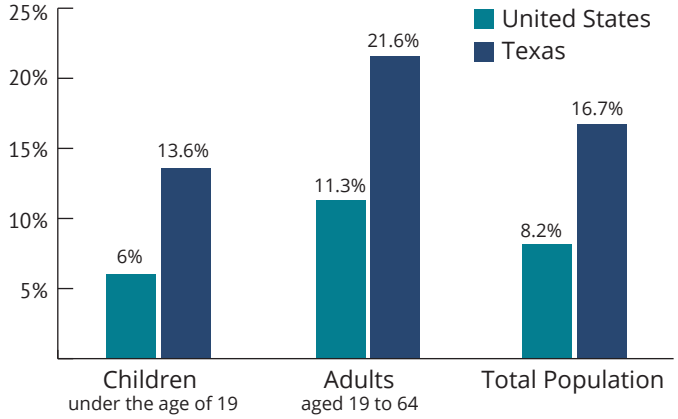
DISTRIBUTION OF TEXANS BY COVERAGE TYPE[A]

Nearly half of Texans receive health insurance through their employer, while public programs like Medicaid and Medicare cover over a quarter of the population. Yet roughly 1 in 6 remain uninsured.



TEXAS VS U.S. UNINSURED RATES[B]

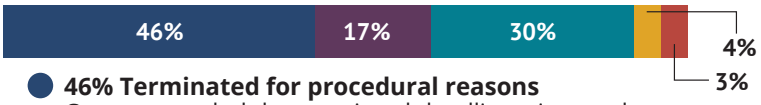
Across every age group, Texans are significantly more likely to be uninsured than the national average, especially adults, where the gap is nearly double.



8.9% of Texans have medical debt in collections[C]

Coverage instability further compounds these challenges. Medicaid enrollment churn and administrative barriers contribute to disruptions in coverage continuity, particularly among low-income populations.

Beyond insurance coverage, financial strain remains a significant barrier to accessing care. A substantial share of Texans report avoiding or delaying needed care due to cost, and rates of medical debt in collections remain elevated compared to national averages. These dynamics reflect the combined effects of uninsurance, underinsurance, and rising out-of-pocket costs.



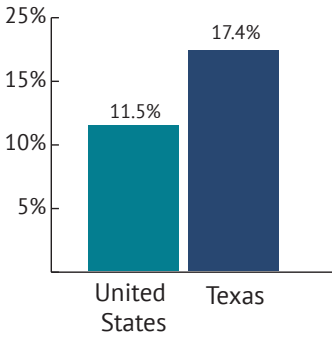
- **46% Terminated for procedural reasons**
  Coverage ended due to missed deadlines, incomplete forms, or other administrative issues.
- **17% Determined Ineligible**
  No longer met program eligibility requirements
- **30% Renewal Packet**
  A renewal form was sent and must be completed.
- **4% Pending**
  Case is still being processed.
- **3% Ex-parte (auto-renewed)**
  Coverage was renewed automatically based on available data

DISTRIBUTION OF MEDICAID RENEWAL OUTCOMES[D]

While 17% of renewals result in ineligibility, 46% of coverage losses stem from procedural barriers, underscoring the role of administrative friction in Medicaid disenrollment.

DELAYING CARE DUE TO COST[E]

A higher share of Texans report delaying care due to cost compared to the national average (17.4% vs. 11.5%).



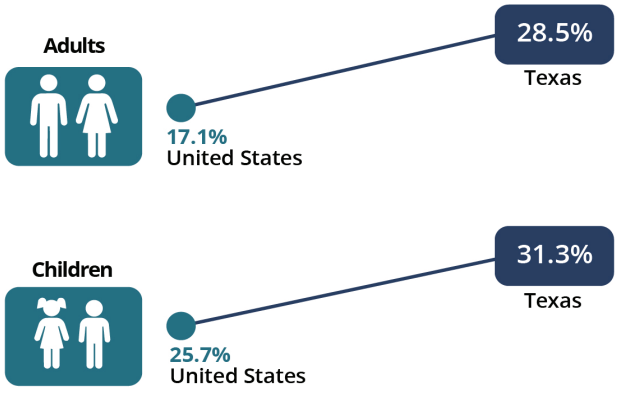
Access and Continuity of Care

Measures of access to primary care reflect both supply constraints and patterns of care utilization. Texans are less likely than residents in many other states to report having a usual source of care or a consistent relationship with a primary care clinician.

Preventable emergency department utilization and hospitalization remain elevated in several regions of Texas, suggesting gaps in timely access to primary care services and reliance on ER as a source of care. While multiple factors contribute to these patterns, elevated emergency department utilization[11] and preventable hospitalizations are widely recognized indicators of insufficient access to timely and continuous primary care. These access challenges are also reflected in health outcomes. Rates of preventable or avoidable mortality, conditions for which timely and effective healthcare can reduce risk, remain elevated in several regions of Texas, with disproportionate impact in rural and underserved communities

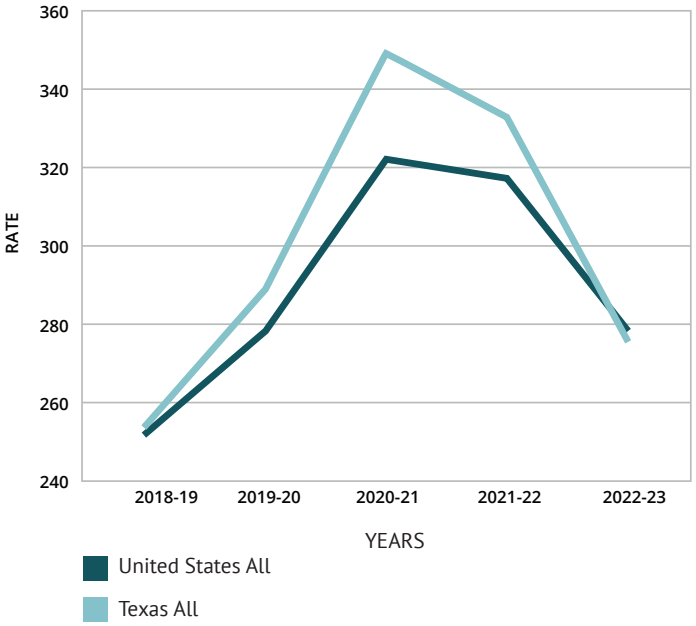
LACK OF USUAL SOURCE OF CARE [G,H]

Texas exceeds the national rate for both adults and children without a usual source of care, highlighting persistent gaps in access to consistent healthcare.



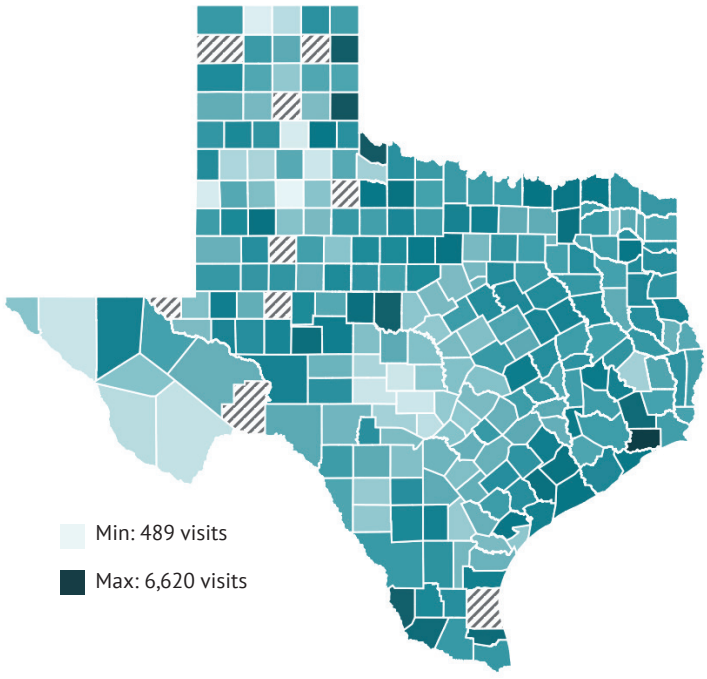
DEATHS BEFORE AGE 75 FROM TREATABLE AND PREVENTABLE CAUSES PER 100,000 POPULATION [F]

Indicator Description: Number of age-adjusted deaths before age 75 per 100,000 population that resulted from causes that can be mainly avoided through effective public health and primary prevention interventions (i.e., before the onset of diseases/injuries, to reduce incidence), termed "preventable" mortality; and timely and effective health care interventions, including secondary prevention and treatment (i.e., after the onset of diseases, to reduce case-fatality), termed "treatable" mortality.



PREVENTABLE HOSPITALIZATIONS BY REGION [C]

Higher rates of preventable hospital stays highlight gaps in access to primary and preventive care across Texas.



Workforce Distribution

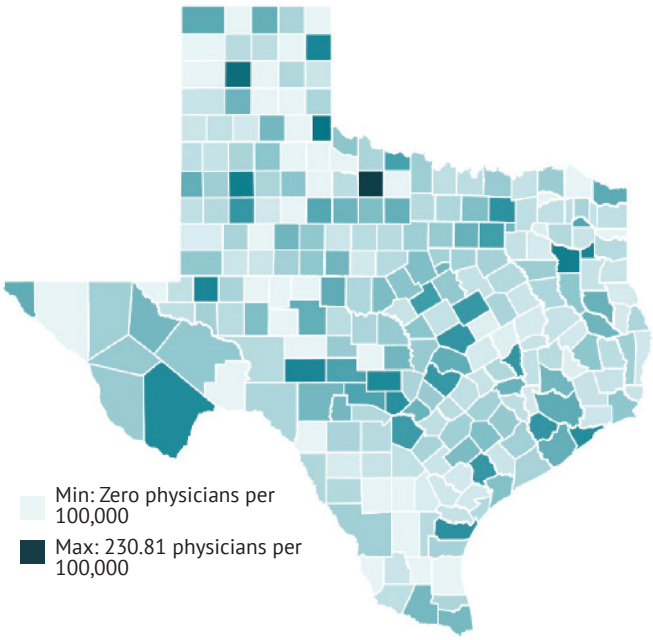
Workforce availability remains one of the most significant structural constraints on primary care access in Texas. The state ranks among the lower tier nationally in primary care physicians per 100,000 population, reflecting both overall supply constraints and uneven distribution across regions. As of 2025, 224 of Texas's 254 counties are designated primary care Health Professional Shortage Areas (HPSAs), affecting more than six million residents.

Shortages are not evenly distributed. Rural and frontier counties face persistent gaps in access, while rapidly growing suburban regions are experiencing increasing demand that strains existing capacity. These dynamics suggest that workforce challenges are not only about supply, but also about distribution, retention, and the ability of existing delivery models to absorb growing demand. Lastly, state workforce projections indicate continued growth in demand for primary care clinicians over the next decade, driven by population growth, aging, and rising chronic disease burden.

> "I had such a draw to medicine and quite frankly, **primary care seemed to be the dream...** I loved the relationships. I loved the colleagues. I loved how central primary care is not just healthcare but really growing healthy and happy people leading fruitful lives."
>
> —LS participant

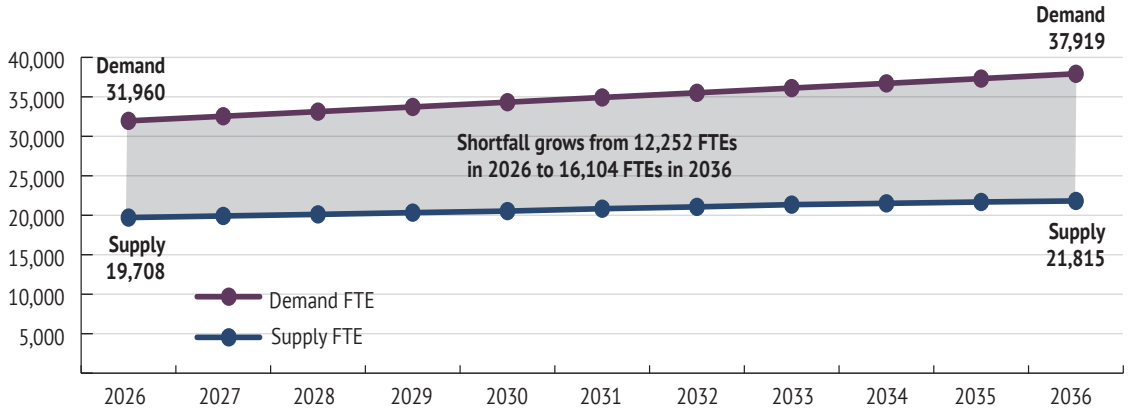
COUNTY-LEVEL RATE OF PRIMARY CARE DOCTORS[c]

Access to primary care is uneven across Texas, with some regions facing significantly lower physician availability.



PRIMARY CARE SUPPLY AND DEMAND OVER TIME[l]

The growing imbalance between provider supply and patient demand highlights a structural shortage in primary care capacity.



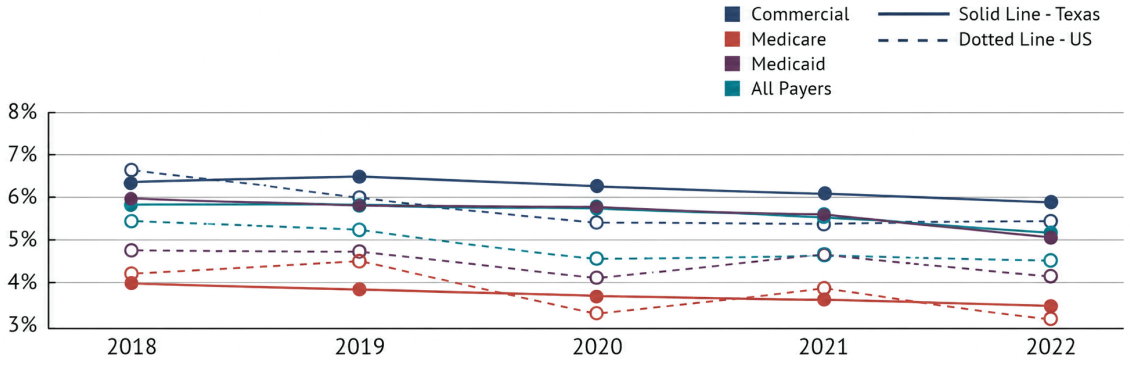
Primary Care Investment and System Efficiency

International comparisons show that the United States allocates a smaller share of total healthcare spending to primary care than peer OECD countries, approximately half, by some estimates. Within the U.S., states that have increased the proportion of spending directed toward primary care have demonstrated improvements in selected utilization and quality measures, including reductions in avoidable hospitalizations.[12] While total per capita healthcare spending in Texas increased by nearly 18% from 2018 to 2023,[2] the share invested in primary care declined, from 5.8% to 5.2%[3] of total healthcare spending, reflecting a persistent misalignment between cost and value.

For Texas, the establishment of the All-Payer Claims Database presents an opportunity to better define, measure, and track primary care investment and system performance over time.

PRIMARY CARE SPENDING AS PERCENTAGE OF TOTAL HEALTHCARE EXPENDITURES[J]

Primary care spending per the narrow definition of primary care remained higher in Texas than the U.S. across most payer types; however, the share of healthcare spending directed toward primary care has declined over time.



> "...hospital care, **specialist care are getting a proportionally bigger piece of the pie**. Although I would tell you, you know in terms of value you can be more effective with putting more emphasis on primary care."
>
> —KII

Taken together, these data points describe a system under structural strain:

What's Shaping Primary Care

This set of four reinforcing conditions shape how primary care is accessed, delivered, and experienced across Texas.

Coverage instability influences when and where patients seek care.

Workforce distribution shapes access at the community level.

Utilization patterns suggest gaps in timely primary care access

Spending patterns reflect misalignment between investment and value

In summary, the current landscape does not point to a single constraint, but to a set of reinforcing conditions that shape how primary care is accessed, delivered, and experienced across Texas.

FINDING 1 | Primary care functions as critical health and community infrastructure, yet system design remains oriented toward episodic rather than longitudinal care.

Across interviews, listening sessions, and analysis of available data, primary care in Texas is increasingly performing functions that extend beyond episodic clinical services and are central to how individuals and communities access the healthcare system.

Primary care clinicians and care teams are managing chronic disease, coordinating care across clinicians, supporting preventive services, and addressing behavioral health needs. In many parts of the state, particularly in areas with limited specialty access, primary care also serves as the primary point of entry into the healthcare system and operates in close connection with local hospitals, pharmacies, and community services.

Primary care is the only component of healthcare ***consistently associated with improved population health outcomes,*** *greater equity, and more efficient use of healthcare resources.*

This expanded role is consistent with national evidence. The National Academies of Sciences, Engineering, and Medicine have identified primary care as the only component of healthcare consistently associated with improved population health outcomes, greater equity, and more efficient use of healthcare resources.[8] Multi-state analyses further demonstrate associations between stronger primary care capacity and lower rates of avoidable hospitalizations and emergency department utilization.[13]

Texas data reflect these dynamics within a context of uneven access. As of December 2025, 224 of 254 counties are designated as primary care Health Professional Shortage Areas, affecting more than six million residents, and at least 35 Texas counties have no practicing physicians.[7] Texans are also less likely than residents in many other states to report having a usual source of care, and rates of ambulatory care–sensitive hospital utilization remain elevated in several regions.[5]

Stakeholders consistently described the implications of these conditions in operational terms. Primary care was characterized as relationship-based and continuous, yet constrained by systems that do not fully reflect that model.

> **Primary care shines in the continuity, in the connection with the patient.** Again, when you know your families, when you know about what's going on in the 20 year old's world or the 25 year old's world because you take care of their parents. You take care of their uncle, aunt, their grandparents, and you know somebody just passed away. That informs your care of the 20 something year old who's going through an anxiety episode … So it's that that continuity, that's where we shine. We shine in continuity.
>
> —KII

These observations point to a structural dynamic. The predominant fee-for-service model continues to prioritize volume and discrete encounters, even as expectations for primary care have expanded to include longitudinal care management, prevention, and coordination across settings. This model shapes both the pace and nature of care delivery.

Clinicians and patients alike noted that the emphasis on visit volume can constrain time for relationship-building, care coordination, and preventive services, functions that are central to the role primary care is increasingly expected to play. This dynamic contributes to pressure on clinicians to see more patients in less time, with implications for both patient experience and workforce sustainability.

While alternative payment approaches that emphasize quality and outcomes are expanding nationally, the transition remains uneven and incomplete. As a result, many primary care practices continue to operate within a financing structure that does not fully support the broader scope of services they are expected to deliver.

The effects of this misalignment extend beyond clinical care. Participants described situations in which limited access to primary care influenced decisions about where individuals live and whether communities can retain residents:

> "I said, I know your day sucks. Your dog died, you live by yourself, and you're selling your house. Why are you selling your house? He said, I got to get closer to health care. And I was like, man, I'm just not doing my job. That's when I became really involved in pushing primary health care, because these folks need to stay here. **We need to take care of our people that are living here.** They don't need to be leaving at 75 years old to get health care."
>
> —LS participant

In several regions, stakeholders also described connections between primary care access and local economic conditions, including the ability to recruit employers and sustain community growth:

> "You know, in these rural areas, **we need businesses, we need development.** And what we're seeing is that if we cannot provide healthcare, businesses are not going to relocate to East Texas. So there is a huge economic disincentive, you know, for companies to relocate here."
>
> —LS participant

While these relationships are shaped by multiple factors, the findings suggest that access to primary care is closely linked to continuity of care, healthcare utilization patterns, and broader community stability—particularly in areas with limited alternative access points.

Participants also discussed potential approaches to strengthening primary care capacity in underserved areas, including community-based efforts to reduce the financial barriers associated with establishing or sustaining a practice. These discussions reflected emerging ideas rather than widely implemented models and pointed to a broader recognition that sustaining primary care may require approaches that extend beyond traditional healthcare financing structures.

Together, the evidence reflects a gap between how primary care is currently functioning and how it is supported within the healthcare system. Primary care is increasingly operating as a continuous, coordinating component of care delivery, while financing and administrative structures remain oriented toward episodic services. Moreover, these dynamics play out differently across practice settings, including independent practices, federally qualified health centers (FQHC), and health system–affiliated clinics, each of which operates under distinct financial and operational constraints.

Addressing this gap is primarily a question of alignment. The long-term sustainability of primary care in Texas may depend on how effectively system structures, including payment, administrative processes, and reporting requirements, evolve to support the functions primary care is already performing across communities.

The fee-for-service payment model that we're on... **really emphasizes churn and speed of visit...** We just haven't found that openness or accessibility. It isn't an easy problem to solve for because there's a lot of challenges in the way.

—LS participant

You go in and they're like, **'OK, you've got three minutes. That's all the insurance paid for,'** and you know, in and out. And you don't feel like you got your story told or what's going on with you was heard.

—LS participant

If our health care system fails, it's a domino effect. Our educational system fails next because of the outmigration. Then our businesses fail. And then we return to what the Spanish conquistadores refer to this region as the despoblado, the unpopulated area in Spanish, the despoblado. That's what this region becomes. And the food, the fiber, and the fuel are produced in this region, and that has **national and state, national, and global economic consequences.**

—LS participant

In order to attract physicians some rural communities have provided startup funds, or sometimes a very low or no interest loan to set up an office... If they're trying to go out and solo practice and so they are trying to figure out how the community can assist with those type of things to take that financial burden off the new recruit.

—KII

FINDING 2 | Administrative burden is a major constraint on clinical capacity and a leading contributor to workforce strain.

Physicians spend nearly ***two hours on electronic health records*** *and administrative tasks* ***for every one hour of direct patient care.***

Administrative complexity has become a defining operational feature of primary care delivery in Texas, with measurable effects on capacity, workforce stability, and access to care. Participants described a growing volume and complexity of non-clinical tasks associated with delivering care, including prior authorization requirements, credentialing and enrollment processes, reporting variation across payers, and documentation requirements embedded within electronic health record systems. While these activities are not new, their scale and variability were described as having increased over time and now represent a substantial component of practice operations.

National evidence supports these observations with estimates suggesting that 15 to 30 percent of total healthcare spending in the United States is attributable to administrative functions, with approximately half of that (~$285 to $570 B in 2019) considered potentially avoidable.[14] Studies have also linked administrative burden to clinician burnout, reduced job satisfaction, and workforce attrition.[15]

Time-use analyses further illustrate the magnitude of this burden. Physicians spend nearly two hours on electronic health records and administrative tasks for every one hour of direct patient care, with additional documentation often completed outside of clinic hours.[16]

Participants consistently described similar dynamics in Texas:

> "How much does the administrative cost actually cost the system? I think it's assumed around 30 percent of the total healthcare spend is not services—**it's things that add no clinical value.** It's checking boxes, it's making sure somebody is eligible for services."
>
> —KII

These administrative demands are further compounded by variation. Primary care practices often contract with multiple payers, including Medicaid, Medicare, and commercial insurers, each with distinct reimbursement rates, billing rules, documentation standards, and approval processes. For the same clinical service, practices may receive different payment rates and be required to comply with different administrative requirements depending on the payer. When practices participate across multiple plans within each payer category, this variation increases further, requiring parallel workflows for similar services.

Furthermore, in Texas, this variation is intensified by payment differentials. Medicaid reimbursement for primary care averages approximately 52% of Medicare rates, compared to a national average closer to 66%.[17]

Participants noted that in some cases, reimbursement falls below the cost of delivering care, particularly when administrative overhead is considered.

> "For most primary care doctors that are participating in a third-party insurance fee for service environment, about **72% of the dollars** that they bring in go **right out the door to administrative costs** for staff that are filing claims, chasing claims, doing prior authorization. That's the game they have to play if they want to get paid."
>
> —KII

The combination of lower reimbursement and higher administrative requirements creates a structural dynamic in which practices must absorb additional operational costs while managing increasingly complex workflows.

Credentialing and enrollment processes were identified as an additional source of strain, particularly in Medicaid managed care, where these could take anywhere between 60 to 180 days.

*Administrative burden in primary care is not solely an issue of efficiency, but one that **affects capacity, workforce stability,** and **access to care.***

Furthermore, administrative complexity is amplified by fragmented data systems and a lack of interoperability across payers and vendors. Administrative processes were also described as directly affecting access to care. For example, prior authorization requirements, while intended to manage utilization, were frequently cited as contributing to delays in treatment and increased administrative workload. These factors collectively reduce effective clinical capacity.

Time and resources devoted to administrative processes limit the availability of clinicians to provide direct patient care, even when the workforce supply remains constant. This dynamic is not always visible in traditional workforce metrics. Headcounts may remain stable, but the amount of time available for patient care declines as administrative demands increase.

Participants also described how administrative burden influences workforce decisions. For small and independent practices, the cost of hiring and retaining skilled staff to manage billing, prior authorization, and compliance requirements can be prohibitive. These pressures disproportionately affect primary care compared to other specialties and, in some cases, contribute to consolidation, with physicians moving toward larger health systems that can absorb administrative functions.

Over time, these dynamics can reduce access to care even without a change in the number of clinicians, as fewer appointment slots are available and practices limit participation in certain insurance programs, particularly those with lower reimbursement and higher administrative burden.

Taken together, the findings suggest that administrative burden in primary care is not solely an issue of efficiency, but one that affects capacity, workforce stability, and access to care. The combination of payment variation, reporting requirements, and fragmented systems creates a level of operational complexity that is difficult to manage, particularly for smaller and independent practices. If these dynamics persist, they are likely to contribute to continued workforce attrition, reduced participation in lower-paying coverage programs, and further constraints on access to care, particularly in communities already facing limited primary care availability.

National efforts have begun to address this issue. For example, the Core Quality Measures Collaborative has developed consensus-based measure sets for primary care and accountable care organizations to promote alignment across payers.[18] These efforts reflect growing recognition that standardization of measures and reporting requirements may reduce unnecessary administrative burden while maintaining accountability.

In closing, addressing this issue may depend less on eliminating individual requirements and more on improving alignment across payers, standardizing processes where feasible, and reducing unnecessary variation in administrative expectations for the same clinical services.

This is the most rewarding specialty of any specialty. Primary care—we become a member of the household. That is the highest satisfaction. What reduces our satisfaction is all **the hoops we have to jump through** to get patients the care that they deserve.

—KII

Let's say it's a physician we hire them, we're paying their salary, we're paying their overhead, but because of the delays in enrollment and credentialing through managed care organizations, you just can't get reimbursed. T**he process that we have in Texas is overly burdensome and time-consuming.**

—KII

Just getting prior authorizations for medications that patients need or even doing paperwork - it takes a long time. When I was training, I was taught to do it myself, and I didn't know how I was going to do that as a primary care physician.

—LS participant

You can't get paid $25.00 for a patient visit by Medicaid and keep your doors open when you see as many Medicaid patients as I see. I've fought that change for a decade, but in the future I **might have to move to something like a membership model.**

—KII

FINDING 3 | Coverage complexity and affordability increasingly impact access and continuity.

Coverage instability, affordability, and usability increasingly ***shape access even among insured populations****.*

Coverage status alone does not fully capture how individuals access and experience primary care in Texas. Analysis of statewide data, interviews, and listening sessions indicates that while Texas' high uninsured rate remains a central challenge, coverage instability, affordability, and usability increasingly shape access even among insured populations.

Texas continues to have the highest uninsured rates in the nation, with substantial regional variation. In some counties, uninsured rates exceed 40%. Recent estimates indicate that approximately 21.6% of Texas adults and 13.7% of children remain uninsured, nearly double national averages.[5] These gaps are compounded by coverage instability. Following the unwinding of Medicaid continuous eligibility provisions after the COVID-19 public health emergency, only 46% of Texans eligible for renewal maintained coverage, compared to 73% nationally. Among those disenrolled, approximately 68% lost coverage due to administrative or procedural reasons.[19]

Even among insured populations, participants described growing challenges related to affordability and usability of coverage. High deductibles, narrow networks, and formulary restrictions influence whether and how individuals seek care. At the same time, the expansion of plan options and market entrants has increased complexity, making it difficult for many consumers to understand and effectively use their coverage.

This complexity has direct implications for continuity of care. Patients may enroll in plans that do not include their existing clinicians or may experience frequent coverage changes that disrupt established care relationships. These dynamics are particularly pronounced in Texas, where eligibility thresholds and program design can result in individuals cycling between insured and uninsured status.

Affordability pressures also shape clinical decision-making. Clinicians reported adjusting treatment plans based not only on clinical considerations, but on what patients can realistically access under their coverage. The consequences extend beyond individual encounters. Participants described how gaps in coverage and delayed access to primary care can lead to preventable acute events and higher-cost utilization.

> "They're so **confused, they don't know what they have**, what they're going to do. They get calls about different plans, and they don't understand what they're signing up for."
>
> —LS participant

In some cases, delays in accessing care can result in worsening health conditions and broader socioeconomic consequences, including loss of employment and financial instability. Coverage instability also has implications for continuity in areas requiring sustained engagement, including behavioral health and maternal care, where interruptions in coverage can disrupt treatment, follow-up, and long-term outcomes.

*Premium growth has **outpaced wage growth** in many sectors, **increasing cost-sharing responsibilities** and influencing how individuals utilize care.*

At the same time, employer-sponsored coverage, representing the most significant share of insurance in Texas, is evolving.[20] Premium growth has outpaced wage growth in many sectors, increasing cost-sharing responsibilities and influencing how individuals utilize care.[6] As such, even among Texans with coverage, cost exposure can function as a barrier to accessing primary care.

Participants also described the emergence of alternative approaches to accessing and financing care in response to affordability and administrative complexity. These include models such as Direct Primary Care, increased use of transparent pricing arrangements for medications and services, and employer-driven approaches that provide employees with greater flexibility in how healthcare dollars are used. While these models vary in structure and are evolving, their presence reflects broader efforts by patients, clinicians, and employers to navigate challenges related to cost, predictability, and complexity within the current coverage landscape.

Nationally, recent regulatory proposals affecting marketplace plan design, including changes to catastrophic and standardized plan options, signal ongoing shifts in how coverage is structured and accessed.[21] These changes, alongside recent coverage transitions, point to a period of continued evolution and uncertainty.

> “When you have ten different products and none of them clearly tell you whether your doctor is in-network, **patients don’t know the full picture until it’s too late.**”
>
> —LS participant

***Insurance coverage,** as currently experienced, **does not consistently translate** into **reliable access** to primary care.*

Collectively, these dynamics suggest that insurance coverage, as currently experienced, does not consistently translate into reliable access to primary care. Stability, affordability, and usability of coverage have become as important as coverage itself in determining whether individuals can engage in continuous, relationship-based care. This has implications for both system performance and long-term costs.

Disruptions in coverage and care continuity reduce the effectiveness of preventive care and chronic disease management, increasing the likelihood of higher-cost interventions over time.

> “We’ll get a patient stable, and then they switch plans or lose coverage, **and you’re starting over again.**”
>
> —LS participant

Texas has made meaningful efforts to address aspects of this challenge, including investments in postpartum coverage continuity and ongoing work to better understand coverage dynamics and access across the state. These efforts underscore both the scale of the issue and the opportunity to strengthen how coverage functions in practice.

Moving forward, addressing these challenges may depend less on expanding coverage alone and more on improving the stability, transparency, and usability of coverage across programs and plans. Aligning coverage design with the realities faced by patients and clinicians may be an important consideration for strengthening continuity of care and improving overall system performance.

> “Instead of addressing high blood pressure or other risks early, **which would be much more cost-effective,** you end up treating the heart attack or the stroke.”
>
> —KII

As an organization, we talk about person centeredness in a whole array of ways, and we keep mission first. In FQHC realities, if you're not person centered …if we're not identifying where individuals' resource **limitations are and what their values are and how they're going to be able to navigate their particular challenges associated with poverty,** then there's just, then it just becomes an entire exercise in meaninglessness. And worse, it's an insult. It's an insult to the patient. ..clinicians have to calibrate, to focus on the patient's actual lived experience.

—LS participant

I mean, there is this reality, too, that insurance premiums, that people pay, an employer paid insurance premiums, being a huge benefit to employees…primary care safety net or other things collapse. And acute care costs go increase for a specific given area. Those premiums are going to increase. And so all of a sudden **we're talking about 1000000s and 1000000s of dollars in additional expenses that either the consumer or the employer is having to cover.** So I do think that there is this ripple effect that just sometimes goes completely unnoticed, and unappreciated…huge discrepancies in who it affects and how it affects people, but it's going to be felt everywhere.

—LS participant

FINDING 4 | Workforce challenges reflect issues of distribution and practice sustainability as much as supply.

*Workforce supply is **not expected to keep pace,** and the estimated unmet need for primary care physicians is estimated to grow from 38% currently to 41% by 2036.*

Primary care workforce challenges in Texas are often framed in terms of shortages. However, analysis of statewide data, workforce projections, and stakeholder input underscore that current constraints are driven as much by distribution, retention, and practice conditions as by overall supply.

State projections, including recent analyses from the Texas Department of State Health Services and the 2024 Texas Health Improvement Network workforce report,[22] indicate continued growth in demand for primary care services driven by population growth, aging, and increasing prevalence of chronic disease. At the same time, workforce supply is not expected to keep pace, and the estimated unmet need for primary care physicians is estimated to grow from 38% currently to 41% by 2036, with wide variation across counties.[23]

As of 2025, 224 of Texas's 254 counties are designated as primary care Health Professional Shortage Areas,[7] affecting more than six million residents. In 35 Texas counties, there are no practicing physicians at all. These geographic disparities underscore that workforce challenges are not solely about total supply, but about where clinicians practice and the conditions that support sustained practice.

Participants consistently emphasized that recruitment alone is insufficient to address these gaps. Retention and the conditions that support long-term practice was identified as a central factor shaping workforce stability.

These decisions are influenced by structural factors, including compensation differences between primary care and specialty care, administrative burden, and perceptions of long-term practice sustainability. Furthermore, as described in earlier findings, increasing non-clinical demands and operational complexity further shape these choices by affecting day-to-day practice experience.

Workforce dynamics are also influenced upstream by how clinicians are trained. Evidence indicates that specialty selection and geographic distribution are shaped by training pathways, residency availability, and exposure to community-based practice settings.[24,25]

> "That also translates into workforce and **how physicians or medical students make decisions about the specialties** they want to practice in. You'll see that reflected in where medical students choose to specialize."
>
> —KII

Physicians are significantly more likely to practice near where they complete residency training, making graduate medical education a critical lever for influencing long-term workforce distribution.

Texas has made meaningful investments in this area. Over the past decade, the state has expanded graduate medical education capacity and supported new residency positions,

including programs with a focus on primary care and community-based training. Complementary efforts, including pathway programs, accelerated or "fast-track" training opportunities, and partnerships between educational institutions and local communities, are intended to strengthen the pipeline of clinicians more likely to serve in high-need areas.

However, participants noted that expanding training capacity alone may not translate into sustained primary care practice in underserved regions without corresponding attention to practice conditions.

Long-term retention *depends on whether communities can offer stable, livable environments for clinicians and their families.*

In rural and underserved communities, these conditions extend beyond clinical practice. Participants emphasized that workforce stability is closely tied to broader community infrastructure, including housing availability, school quality, transportation, and local economic opportunity. These factors influence whether clinicians and their families can establish long-term roots in a community.

Participants noted that while incentives such as loan repayment programs may support initial recruitment, long-term retention depends on whether communities can offer stable, livable environments for clinicians and their families.

> "I think of **primary care ideally is available, accessible within your own neighborhood or own community...** and then the final A would be affable. You like your primary care physician and he or she is somebody that you want to interact with...who meets the patients where they are, which may not necessarily be in a clinic or in a hospital setting, but you know, very much needed out in the community, whether that be through home visits or just being present in the community."
>
> —KII

Professional isolation, limited specialty support, and constrained staffing resources further shape decisions to remain in practice.

> "**If you don't fix the environment** they're walking into, it doesn't matter how many people you train."
>
> —KII

Financial and operational constraints also play a role. Lower reimbursement rates, administrative burden, and the cost of maintaining practice infrastructure can make independent or community-based practice more difficult to sustain, particularly in smaller markets. These pressures contribute to a shift toward employment in larger health systems, which can absorb administrative and operational complexity but may also change how care is organized and delivered at the local level.[26]

These factors operate as a system. Workforce shortages increase workload for existing clinicians, contributing to burnout and further attrition. At the same time, pipeline investments without corresponding improvements in practice conditions may have limited impact on long-term workforce distribution. In areas with limited primary care capacity, patients may experience longer wait times, reduced access to preventive services, and increased reliance on emergency or specialty care. Over time, these patterns contribute to higher costs and poorer health outcomes.

Cumulatively, these findings suggest that workforce challenges in Texas primary care are not solely a function of insufficient supply, but of how the system shapes where clinicians practice, whether they remain in practice, and under what conditions care is delivered.

As these structural dynamics persist, workforce shortages are likely to continue in high-need areas despite ongoing investments in training and recruitment. Aligning workforce strategies with the realities of primary care practice, including administrative demands, financial structures, training pathways, and community context, are critical to improving retention and strengthening long-term capacity.

Our job is already very difficult …but it magnifies that difficulty and makes it so that the low hanging fruit of stuff that we can just kind of take care of is no longer that low hanging fruit. And so **the two-minute discussion in a 5 minute visit becomes a 20 minute discussion still in a 5 minute visit…** because I wanted to make sure that she understood that we follow science, we follow evidence-based care.

– LS participant

I was actually there at my office till 7:00 PM with this kid while waiting for all the process to go through and the police officer came and and took him … but you know that's mental health…**you know the problem, it takes a lot of time.**

– LS participant

We've never had a state or national plan on what sort of workforce we want. We've essentially delegated that to the market in the medical schools. So again, the schools are not held accountable to the type of doctors they produce, they're not rewarded for, you know, producing more primary care doctors or more doctors that go into rural areas or more doctors that that go and, you know, care for the underserved.

– KII

FINDING 5 | Policy progress is meaningful, but impact depends on alignment across financing, delivery, and implementation systems.

Texas has advanced a range of policy, programmatic, and market-based efforts intended to strengthen primary care over the past several years. These include investments in workforce development, FQHC incubator programs, expansion of data infrastructure through the Texas All-Payer Claims Database, extension of Medicaid and CHIP postpartum coverage to twelve months, behavioral health integration initiatives such as CPAN and PeriPAN, and legislative action enabling alternative payment arrangements.

Effectiveness of recent policy** advances will depend not only on their individual design but on **how they are implemented, connected, and sustained over time.

In parallel, health systems, payers, academic institutions, and community-based organizations are advancing initiatives to improve access, care delivery, and population health outcomes. These efforts reflect growing recognition of the role primary care plays in supporting health, workforce stability, and economic vitality across Texas communities.

However, these activities are occurring within a broader system that remains structurally fragmented across payers, programs, and regulatory frameworks. This fragmentation is reflected in variation across administrative requirements, reporting expectations, payment structures, and data systems. While individual initiatives are often well-designed, they are not consistently connected or aligned in ways that allow them to operate as a coordinated system.

The effectiveness of recent policy advances will depend not only on their individual design but on how they are implemented, connected, and sustained over time. For example, the extension of postpartum coverage creates important opportunities to improve continuity of care but does not fully address underlying challenges related to coverage transitions and access beyond the coverage period. Similarly, the Texas All-Payer Claims Database expands the state's capacity to analyze healthcare spending and utilization, but its impact will depend on how effectively data are used to inform decision-making, including efforts to better understand and track primary care investment.

Existing programs and models, including behavioral health access initiatives and community-based primary care expansion efforts, demonstrate practical approaches to care integration, workforce support, and service delivery. These efforts provide actionable insights that could inform broader system improvement if applied more consistently across payers and regions.

Fragmentation is particularly evident in data and administrative systems. Differences in how information is captured, shared, and used across entities create gaps in care coordination and limit the ability of clinicians to manage patient care effectively.

> "You've got very siloed data where the pharmacy may know whether the patient filled their prescription or not, but **that information is not getting back to the doctor** who wrote the prescription. You've got a big problem with adherence that you could probably solve for."
>
> —KII

***Sustained progress** in primary care transformation is often supported by a **coordinating function,** formal or informal, that **aligns stakeholders,** reduces variation where appropriate, and **maintains focus across policy, payment,** and **delivery system efforts** over time.*

Similar patterns are observed across payment and reporting structures. Variation across payers and programs requires practices to navigate multiple, and often inconsistent, requirements for the same clinical services. As described in earlier findings, this contributes to administrative burden, reduces efficiency, and diverts time and resources away from patient care.

This fragmentation is not unique to Texas. However, it is amplified by the state's size, regional diversity, and mix of public and private sector entities. Initiatives are often designed to address specific local or programmatic needs, but without consistent alignment, they may not integrate into a cohesive statewide system.

The result is a system in which multiple efforts to strengthen primary care are advancing simultaneously, but do not consistently reinforce one another. This dynamic increases activity without producing commensurate system-level improvement.

Evidence from national multi-payer alignment initiatives indicates that coordination across payment models, quality measures, and data systems is associated with improved system performance and reduced administrative burden.[27] The experience of states such as Washington[28] and Colorado[29] further demonstrates that sustained progress in primary care transformation is often supported by a coordinating function, formal or informal, that aligns stakeholders, reduces variation where appropriate, and maintains focus across policy, payment, and delivery system efforts over time.

In the absence of such alignment, even well-designed policies and programs may operate in parallel rather than in concert, limiting their collective impact. This creates a system in which complexity persists, implementation varies, and the full value of existing investments is not realized.

In closing, these dynamics indicate that the next phase of primary care improvement in Texas will be shaped less by the introduction of new initiatives and more by the degree to which existing efforts are aligned, coordinated, and sustained over time.

I think part of the issue as these bills come out is going to be is when it gets into the sausage making. OK, I've got legislation. But how does that get implemented?...**So the intent of a bill may not necessarily end up meeting the intent** because to operationalize it may have gone sideways or we find it's a lot more difficult than we think.

- KII

Partially a function of **the state not having a statewide health information exchange infrastructure network** where you know data should be available for a clinician to log on and see, hey, when was my patient discharged from the hospital? What was their,...You know when? Why haven't they come to see me since that discharge?

- KII

Primary care is also expected to solve a lot of problems, which I think is fine... But at the same time, **you know we don't have the time, tools or resourcing that we would otherwise need given how we are looked at and viewed as the problem solvers...** So I just think that the need to invest forward in primary care, in personnel, in pipeline management, in financial sustainability and things of the like, I'm very hopeful that we will continue to drive in a positive direction

- LS participant

We've made adjustments and we've made a push toward addressing some of the problems, but we've never really tackled the tough ones. ... that we did not predict, you know, 40 or 50 years ago. **And we're dealing with those decisions that we didn't invest in back then and it just the hole kept getting deeper and deeper**. And you know, the first rule of holes is to stop digging. And we haven't.

- KII

Where Texas Is Leading

Signals of Innovation and Progress

*Different parts of the system are **responding to shared challenges** in locally grounded and often novel ways.*

Across Texas, communities, institutions, and organizations are advancing a range of innovative approaches to strengthening primary care. These efforts span workforce development, care delivery, community partnerships, and the use of emerging technologies to address access challenges.

The examples highlighted below are illustrative, not exhaustive, and are included to reflect signals of innovation and leadership emerging across the state. Inclusion does not imply formal evaluation or endorsement. Rather, these examples offer insight into how different parts of the system are responding to shared challenges in locally grounded and often novel ways.

Workforce Innovation and Community-Based Training

Texas has developed several promising approaches to strengthening the primary care workforce pipeline, particularly in rural and underserved communities.

Programs such as the accelerated family medicine track at Texas Tech University Health Sciences Center have demonstrated measurable success in increasing the number of physicians entering primary care and practicing in high-need areas.[30] Similarly, initiatives like the rural medical pipeline programs led by Texas A&M University System, including regional rural med camps, are engaging students early and exposing them to careers in medicine in community-based settings.

At the training level, models such as Waco Family Medicine illustrate the potential of integrating clinical training with community-oriented care. By embedding residents in team-based, patient-centered environments that address whole-person needs, these programs align workforce development with the realities of primary care practice.

TAKEAWAY: Workforce **strategies that are rooted in community** context from early exposure through residency appear more likely to influence long-term practice patterns and retention in underserved areas.

Care Coordination and Value-Based Models

Across Texas, clinically integrated networks and community-based organizations are advancing approaches that align care delivery with value, coordination, and population health.

The Texas Association of Community Health Centers has supported the development of the My Texas My Health Clinically Integrated Network, which connects community health centers across the state to coordinate care, improve quality, and address non-medical drivers of health. These models position primary care as a trusted hub not only for clinical services, but for navigating broader needs such as housing, transportation, and food access.

Similarly, organizations such as Catalyst Health Network demonstrate how clinically integrated networks can support independent practices and health systems in transitioning toward value-based arrangements, including achieving shared savings for their communities.

TAKEAWAY: Models that **strengthen coordination across providers** and **align incentives around outcomes** offer a pathway to improving both quality and efficiency, particularly when paired with community-based infrastructure.

TAKEAWAY: While still early, these approaches reflect a broader recognition that **expanding access,** particularly in rural areas, **may require rethinking** not only **care delivery** models, but the **infrastructure that supports them.**

Innovation in Access and Technology

In geographically large and diverse states like Texas, innovation in access often requires new approaches to overcoming distance and infrastructure barriers.

Emerging efforts, such as pilot programs led by Texas Tech University Health Sciences Center exploring the use of drones to deliver medical supplies and lab samples in rural and frontier regions, highlight how technology may help bridge gaps in access where traditional models face limitations.

Connecting Innovation to System Transformation

These examples reflect a common theme: innovation in primary care is already occurring across Texas, often in response to local needs and constraints. They demonstrate the potential of community-based training, coordinated care models, and emerging technologies to address longstanding challenges.

At the same time, these efforts remain unevenly distributed and variably supported. Their long-term impact will depend on whether they can be sustained, aligned, and scaled within a broader system that currently operates with significant variation across regions and stakeholders.

Conclusion

From Activity to Alignment

*Texas is **not** starting from a place of **inaction**... there is **clear momentum** to strengthen primary care.*

Texas is not starting from a place of inaction. Across policy, delivery systems, and communities, there is clear momentum to strengthen primary care. The findings in this report suggest that the central challenge is no longer identifying what needs to be done. It is ensuring that the many efforts already underway function together as a coherent system.

Primary care in Texas is operating within an environment where expectations have expanded faster than the structures designed to support it. As a result, progress is often unevenly visible in pockets, but difficult to sustain or scale.

Strategic Directions

The following directions reflect opportunities to strengthen system performance by improving alignment across existing efforts.

1. Modernize how primary care is financed to better reflect its role

As expectations for primary care expand, financing approaches may need to better support longitudinal care, prevention, and care coordination. This includes exploring ways to align payment structures with outcomes, stability, and community impact while ensuring that financing mechanisms are practical, sustainable, and responsive to the diverse contexts across Texas.

2. Simplify where possible to restore capacity

Complexity has become a defining feature of the current system. Efforts to reduce variation and streamline processes, particularly where they do not add clinical value and may allow existing resources to be used more effectively.

3. Focus on continuity as a system-level outcome

Continuity of care is influenced by multiple factors, including coverage stability, care coordination, and patient experience. Strengthening continuity may serve as a unifying objective across policy and delivery system efforts.

4. Align workforce strategies with long-term practice viability

Workforce investments are most effective when they are matched with conditions that support sustained practice. This includes attention to practice environments, community context, and the broader systems that influence retention.

5. Establish a sustained coordinating function to align primary care efforts across Texas

Texas has developed many of the foundational elements needed to strengthen primary care. The opportunity ahead lies in how these elements are connected and sustained over time.

Experience from other states proves that primary care transformation is most effective when there is a clearly defined function, whether within government, through public-private partnership, or via a shared collaborative that maintains focus, aligns stakeholders, and supports implementation across initiatives.

For Texas, such a function could help translate existing investments into more consistent, system-wide impact by strengthening coordination across policy, payment, data, and delivery system efforts.

Looking Ahead

Primary care in Texas reflects both resilience and strain. It continues to serve as a critical point of access for patients, a stabilizing force for communities, and a key driver of long-term health outcomes.

At a time when attention is increasingly focused on chronic disease, affordability, and workforce sustainability, primary care represents one of the most practical pathways to address these challenges in a coordinated way. The question is no longer whether primary care should play this role. It is whether the system surrounding it will evolve in ways that allow it to do so effectively.

Methodology and Technical Notes

Methods

This mixed-methods statewide study, conducted by Texas Health Institute (THI), co-lead of the Texas Primary Care Consortium (TPCC), updated findings from the 2020 Primary Care Report and incorporated the perspectives and lived experiences of Texans across practitioner, patient, business, legislative, and academic perspectives. A basic qualitative design centered participant insights from leaders, clinicians, and patients. Publicly available secondary data were synthesized with qualitative themes to provide context and strengthen interpretation. The study aimed to better understand the realities of primary care in Texas and inform efforts to improve affordability, access, and quality.

Participants and Data Collection

Qualitative data were collected through seven key informant interviews (KIIs) and six listening sessions conducted between October 2025 and January 2026. Key informants were purposively selected from physicians, academic leaders, policy advocates (including legislative and employer representatives). Semi-structured interviews were conducted virtually, recorded with permission, and transcribed.

Listening sessions were co-designed with host collaborators, primarily physicians or clinical directors, who assisted with recruitment. Six sessions were facilitated by the research team with 56 participants and conducted virtually or in person across Texas. One session was intentionally held virtually to broaden recruitment, and another shifted to a hybrid format due to a regional snowstorm. Sessions were recorded with participant permission and supplemented with staff observation notes. In total, 60 unique individuals participated across KIIs and listening sessions.

Analysis

Interview and listening session transcripts, along with observation and debrief notes, were cleaned, organized, and stored on a secure server. Data were analyzed using inductive and comparative thematic analysis. Researchers coded transcripts using qualitative analysis software, grouped related codes into categories, and synthesized them into broader themes and subthemes reflecting shared experiences across participants.

The codebook and themes were iteratively refined throughout the analysis process. Final themes were confirmed through team discussion when patterns appeared across a substantial portion of participant responses.

Trustworthiness and Transparency

To ensure trustworthiness and transparency in the process, in vivo method was embedded in the analysis to preserve participant voice (Saldaña, 2022). Additionally, the THI and TPCC teams engaged with the data through multiple analytic cycles, conducted calibration sessions periodically, and maintained an audit trail as the codebook was adapted through iterative cycles.

Ethical Considerations

Ethical safeguards included obtaining informed consent prior to participation, ensuring that participants understood the purpose of the project, the voluntary nature of participation, and their ability to ask questions or withdraw at any time without consequence. Participant confidentiality was protected using assigned IDs, secure data storage, and appropriate data-sharing practices. Throughout the study, the research team prioritized respect and sensitivity toward participants' perspectives and lived experiences.

Limitations

A purposive sample is not meant to be generalizable nor representative, but rather to shed light on specific areas and insights through multiple lenses to form a comprehensive understanding of interconnected underlying influences on advancing primary care. In an effort to capture more patient experiences across Texas, a statewide online survey was designed and distributed to key partners across the state. While the response rate was initially low, the survey remained open for an additional 30 days (until February 2026) as there was an uptick in responses. The results are being analyzed as of this writing.

Texas Primary Care Consortium Advisory Committee

The TPCC Advisory Committee provides strategic guidance and diverse perspectives to inform the consortium's priorities and activities. Members represent a range of sectors, including clinical care, health systems, payers, employers, policy, and community organizations across Texas.

- Mark Chassay, MD, MEd, MBA
  Blue Cross Blue Shield of Texas
- Janet Hurley, MD, FAAFP
  CHRISTUS Trinity Clinic
- Karl Serrao, MD, MBA, FAAP, FCCM
  Driscoll Health Plan
- Douglas Curran, MD, FAAFP
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- Chris Skisak, PhD
  Houston Business Coalition on Health
- Daniel Crowe, MD, FACP
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  Texas Academy of Family Physicians
- Jana Eubank
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Note: Advisory Committee members provide guidance and perspective but do not necessarily endorse the findings or conclusions presented in this report.

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