

# Factors Influencing Health Care on the Texas-Mexico Border



Presented to the Texas Legislature and the Health and Human  
Services Commission

by the

Border Rates and Expenditures Advisory Committee

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# **Border Rates and Expenditures Advisory Committee (BREAC)**

## **EXECUTIVE SUMMARY**

Border region providers are serving poorer, less healthy people than the rest of the state. Demographics, socioeconomic and health indicators show that the border region lags behind the rest of the state and may contribute to a higher percentage of uninsured people. The border region has a higher percentage of those reporting fair to poor health including a higher rate of diabetes, obesity, and heart disease. In 2011, the poverty rate was twice that of the non-border region at 30.8 percent and the uninsured rate for all age groups for the border region is 34.7 percent compared with 24.7 percent for the rest of the state. The border region has a higher incidence of birth than the rest of the state. Even with the overall poor health of the border region, the per capita visits to the ER are 28.6 percent higher in the non-border region indicating the discrepancy in access to primary and prenatal care between the two regions. The border region has a higher percentage of children under 18 with 31.3 percent with the rest of the state having 26.8 percent.

The border region has a much higher proportion of Medicaid enrollees than the non-border region. In 2013, 10 percent of the Texas population lived in the border region (2,768,363), yet it had 17.4 percent (699,260 clients) of the total number of Medicaid Clients compared with 13.8 percent for the entire state.

In fiscal year 2013, more claims were made per client (22.5 percent of total) in the border region than in the non-border region translating to higher Medicaid expenditures per client. Medicaid spends more per capita and per client in the border region than in the non-border region. For all services including hospitals, physician services and dental plans, Medicaid paid out \$2,598,508,007 (19.5 percent) to the border region translating to \$3,716 spent per client compared with \$3,217 per client in the non-border region.

In fiscal year 2012, Border region hospitals relied on government payments at 61 percent, self-pay at 9 percent and third-party payers at 30 percent. This is in contrast to the non-border region having patient revenue coming from the government at 47 percent, self-pay at 4 percent and third party payers at 49 percent. Per capita revenue for the border region hospitals was approximately \$1,457 as compared with non-border per capita revenue of \$2,180. More admissions occur in the border region for people who were either uninsured at 35.8 percent or covered by government programs at 24.8 percent than in the non-border region at 27.2 percent uninsured and 14.0 percent from government programs. The border region is only receiving 7 percent of expenditures while serving 10 percent of the population.

In fiscal year 2012, Medicare reimbursements totaled \$1,485,463,322 or 9 percent in the border region. Reimbursements to the border region were: 10 percent from Medicaid, 4 percent from third-party payers and 13 percent from self-pay. The border region received \$198,435,605 or 20 percent of the total Disproportionate Share Hospital (DSH) payment in 2012. The Affordable Care Act (ACA) will cut back DSH in 2017 with the assumption that ACA will reduce the total number of uninsured people therefore reducing the need for it. Hidalgo County is estimated to lose \$28 million in Medicare DSH payment starting in fiscal year 2015. The Medicare rate parity for primary care physicians set to occur in 2013 and 2014 has been a success according to physicians at the border region and its elimination in 2015 may make PCPs less likely to treat Medicaid clients.

Data show fewer physicians in the border area. A higher dependence of providers on government payments may play a role in this. Per capita, there are 11.2 physicians / 10,000 residents in the border region compared with 19.8 physicians / 10,000 residents for the state. The majority of physicians at the border region or 92 percent serve Medicaid clients compared with less than half of the physicians or 49 percent in the non-border region. The border region has 6,675 or 9.4 percent of the hospital beds in the state showing that the border region has less hospital capacity than the non-border region. Many physicians (32 percent) in the border region work outside of normal work hours and 25 percent of the Medicaid claims at that time were made by border physicians. This shows that border doctors see more patients and hold office hours in the evenings, weekend, and holidays.

Recommendations include: Continue the ACA parity with Medicare for primary care physicians in the border region or implement a high volume rate increase for providers who serve a disproportionate share of Medicaid clients. Also, implement a pilot in the border region where partnerships are created between the managed care organization (MCO) and the provider.

## **Medicaid and CHIP Border Rates and Expenditures Advisory Committee Purpose and Role**

The purpose of the Medicaid and Children's Health Insurance Program (CHIP) Border Rates and Expenditures Advisory Committee is to advise the Health and Human Services Commission (HHSC) regarding eliminating the perceived disparities in payment rates between the Texas-Mexico border region and other areas of the state in:

- Medicaid and CHIP capitation rates for services provided to individuals under age 19.
- Medicaid and CHIP fee-for-service per capita expenditures for inpatient and outpatient hospital services provided to individuals under age 19.
- Total professional services expenditures per Medicaid and CHIP enrollee under age 19.

The HHSC executive commissioner appoints the committee, which must include nine members that:

- Represent the spectrum of geographic areas included in the Texas-Mexico border region.
- Include persons who are knowledgeable regarding Medicaid, including Medicaid managed care, and CHIP.
- Represent the interests of physicians, hospitals, patients, managed care organizations, state agencies involved in the management and delivery of medical resources, affected communities, and other areas of the state.

The committee must periodically analyze and compare the rates and expenditures in the Texas-Mexico border region and in other areas of the state and produce a report of its findings by the date specified by the HHSC executive commissioner. The report must include recommendations to the HHSC executive commissioner for addressing the problems created by disparities documented in the report, including recommendations for allocation of funds.

The Medicaid and CHIP Border Rates and Expenditures Advisory Committee serves at the pleasure of the HHSC executive commissioner. During the course of all meetings, the committee will be subject to the legal obligations and limitations governing HHSC's rules relating to advisory committees. HHSC staff will be responsible for advising committee members of any applicable statutes and regulations.

# Introduction

## Results from Past Work<sup>1</sup>

Previously, the S.B. 1299 and S.B. 1053 Task Force developed a final report that was submitted August 28, 2002. Task force recommendations included increasing the Medicaid fee schedule to be comparable to the Medicare fee schedule. After achieving this, the Medicaid reimbursement rates would be updated relative to the Medicare inflation factor.

In addition, the report called for targeted rate increases along the border, with the potential for premium payments to increase the number of providers available to Medicaid clients. The Physician Payment Advisory Committee was requested to review the definition of high-volume primary care and specialty care practitioners to ensure a meaningful rate increase for high-volume providers in the border, rural and inner-city communities.

The S.B. 1299 Task Force requested that the Legislature prohibit further funding reductions to the Medicaid and CHIP programs as a result of reductions in the Appropriations Act and cost containment strategies. Also, cost-based methodologies for rate setting should be determined and then followed, regardless of the consequential increases or decreases on rates. Finally, at the time, the task force recommended that the Health and Human Services Commission (HHSC) continue to examine potential changes in rate methodologies statewide as well as in the border area. A fundamental policy cited by the S.B. 1299 Task Force was that all Medicaid and CHIP rate methodologies promote the same outcomes in programs related to access, provider rates, HMO rates and motivation for high quality care to members.

Outside of the scope of S.B. 1299 and external to rate methodologies, the task force presented issues of concern relevant to and directly impacting the number of providers participating in the Medicaid and CHIP programs.

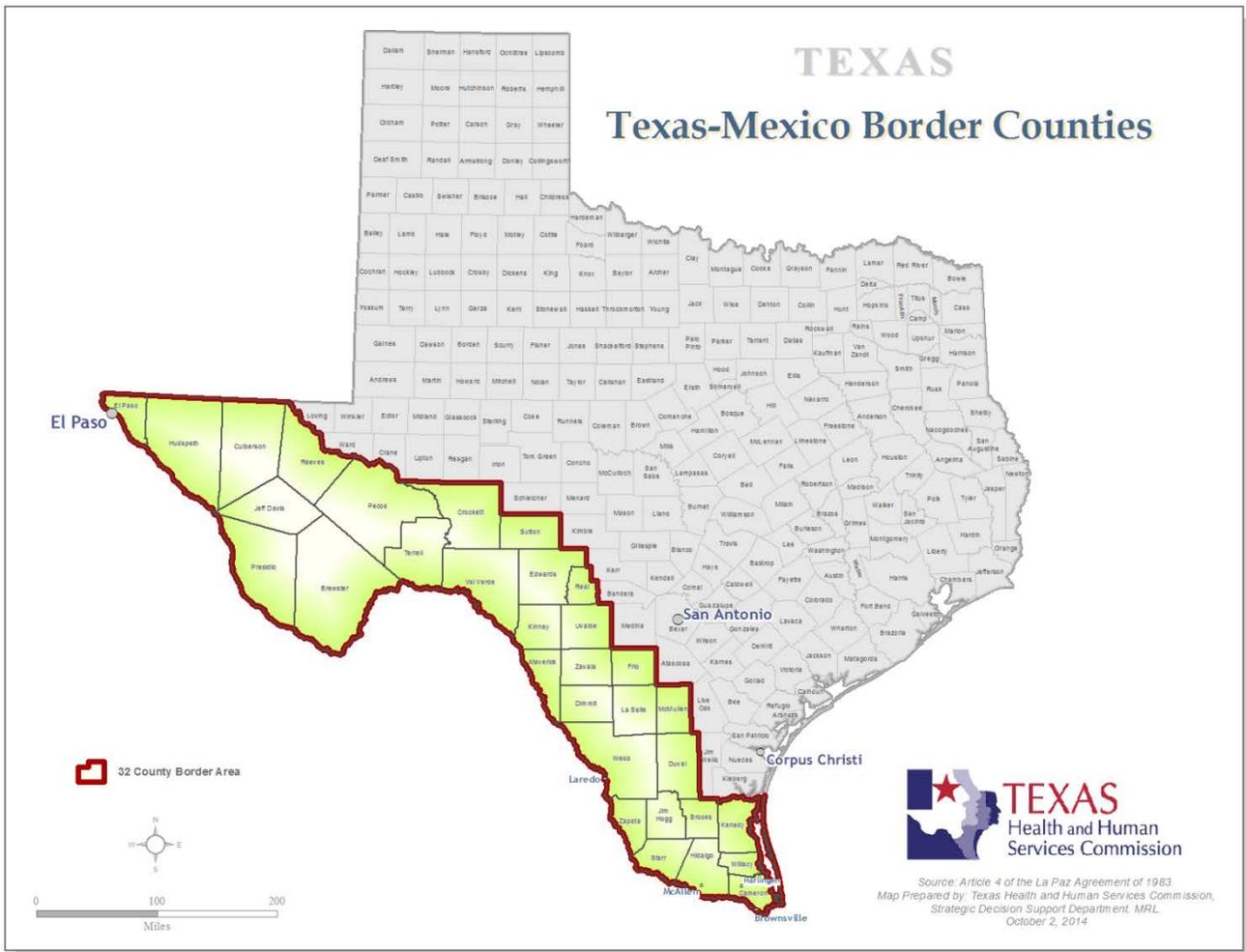
- (1) Administrative Complexity: Multiple contracts and sources for claims payments are required in order to participate in Medicaid and CHIP.
- (2) Interagency Cooperation: Strategies for increasing the number of Medicaid and CHIP providers could include encouraging new medical school graduates to work in underserved areas, increasing state funding for the Physician Shortage Area Loan Repayment Program, provide support for a medical school in the border area, physician tax incentives for accepting Medicaid patients, border residency and nursing programs and establishing an endowed border health fund.
- (3) Malpractice Insurance: The Health and Human Services Commission (HHSC) and Texas Department of Insurance can work together to address the high medical malpractice insurance rates in certain parts of the state, particularly in the Rio Grande Valley.
- (4) Increasing Number of Providers: HHSC, the Higher Education Coordinating Board and the Texas Education Agency can work together to increase the number of providers, including physicians, nurses, physician assistants and promotoras, who practice in the border region.
- (5) Study of Disparities: HHSC should continue to study border rate disparities through a funded university-based study with a special emphasis on access, utilization and care across the border as well as rate methodologies.

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<sup>1</sup> Final Report of the Senate Bill 1299 Task Force. Presented to the Texas Legislature and the Health and Human Services Commission. Prepared by S.B. 1299 and S.B. 1053 Task Force. Submitted August 28, 2002. (pp. 28-31).

## Description of Border Region

Counties are designated as border or non-border according to Article 4 of the La Paz Agreement of 1983, which defines a county as a border county if that county is within 100 kilometers of the U.S./Mexico border. There are 32 counties in Texas designated as Border counties by this definition: Brewster, La Salle, Brooks Maverick, Cameron, McMullen, Crockett, Pecos, Culberson, Presidio, Dimmit, Real, Duval, Reeves, Edwards, Starr, El Paso, Sutton, Frio, Terrell, Hidalgo, Uvalde, Hudspeth, Val Verde, Jeff Davis, Webb, Jim Hogg, Willacy, Kenedy, Zapata, Kinney, and Zavala.



## **Factors Influencing Health Care on the Texas-Mexico Border**

### Demographics

We start with a brief description of the demographic characteristics of the border region that are important references for analyzing the differences in Medicaid expenditures between the border region and other areas of the state.

*Population:* According to the U.S. Census Bureau, the 2013 population of Texas is 26,664,574, with 2,768,363 people residing in the 32 border region counties, and the remainder, 23,896,211, residing in

the other 222 Texas counties. The people residing in the border region represent approximately 10 percent of the Texas population.

*Age:* Table 1 illustrates the differences in age distribution in the border region compared to the rest of the state. The border region has a higher percentage of children under 18 years old.

**Table 1 - Population Age Distribution (2013)**

	<b>Texas</b>	<b>Border Region</b>	<b>Non-Border Region</b>
Age 0- 17	26.8%	31.3%	26.3%
Age 18 - 34	24.6%	24.5%	24.6%
Age 35 - 64	37.5%	33.4%	38.0%
Age 65+	11.1%	10.8%	11.1%

Source: Census Bureau.

*Ethnicity:* The border region is predominantly Hispanic as shown in Table 2.

**Table 2 - Population by Ethnicity (2013)**

	<b>Texas</b>	<b>Border Region</b>	<b>Non-Border Region</b>
White	43.4%	9.8%	47.3%
Black	11.5%	1.1%	12.7%
Hispanic	39.1%	87.7%	33.5%
Other	6.0%	1.4%	6.5%

Source: Census Bureau.

*Language:* According to the US Census Bureau’s American Community Survey 2007-2011, the population age 5 and older that speaks a language other than English at home is higher in the border region compared to non-border region (78.7 percent and 29.3 percent respectively). In the state, 34.4 percent of the population age 5 and older speaks a language other than English at home. In Texas, for those who speak a language other than English at home, Spanish is spoken most often. There is a higher proportion of the Spanish-speaking population residing in the border region (12.9 percent) compared to 6.3 percent in the non-border region and 7.6 percent statewide.

Socioeconomic and Health Indicators in the Border Region

The link between higher income, education levels and better health has been widely documented. In the special feature of *Health United States, 2011* the Center for Disease Control and Prevention reports that more educated people with higher income have a lower incidence of chronic diseases, have a longer life expectancy and are less likely to be smokers. The Bureau of Labor Statistics reports that people that are more educated are less likely to be unemployed and have higher salaries.<sup>2</sup> This is important since according to the Texas Medical Association<sup>3</sup> people in families in which the adults worked either part-time or only part of the year have a higher likelihood of lacking health insurance.

<sup>2</sup> [http://www.bls.gov/emp/ep\\_chart\\_001.htm](http://www.bls.gov/emp/ep_chart_001.htm).

<sup>3</sup> [http://www.texmed.org/uninsured\\_in\\_texas/](http://www.texmed.org/uninsured_in_texas/)

Therefore, socioeconomic status is a good indicator of a population's overall health, health habits and ability to pay for health care. The following tables show that the border region has a higher percentage of uninsured (Table 3) and worse socioeconomic indicators (Table 4) than the rest of the state. This indicates that providers are serving a less healthy population with less means to pay for health care.

**Table 3 - Uninsured Rates by Age (2011)**

	<b>Texas</b>	<b>Border Region</b>	<b>Non-Border Region</b>
Under 18	13.2%	14.5%	13.1%
18-39	37.8%	51.1%	36.3%
40-49	29.3%	46.0%	27.5%
50-64	21.1%	35.0%	19.8%
All Age Groups	25.7%	34.7%	24.7%

Source: Census Bureau.

**Table 4 – Socioeconomic Indicators (2011)**

	<b>Texas</b>	<b>Border Region</b>	<b>Non-Border Region</b>
Percent of population over 25 years old with GED or high school diploma or higher	80.4%	64.7%	82.1%
Percent of population over 25 years old with bachelor's degree or higher	26.1%	16.4%	27.1%
Percent of counties with median income below state level	--	88.0%	52.0%
Poverty rates	17.0%	30.8%	15.5%
Unemployment rates	6.8%	9.8%	6.5%

Source: Census Bureau.

Further evidence of the worse health status of the population in the border region is shown in the Table 5 that compares the percentage of people 18 years old and older that report being diagnosed with diabetes, obesity, heart disease and having overall fair to poor health<sup>4</sup>.

<sup>4</sup> <https://www.dshs.state.tx.us/chs/brfss/default.shtm>.

**Table 5 - Health Indicators (2010)**

	<b>Texas</b>	<b>Border Region</b>	<b>Non-Border Region</b>
Diabetes	9.7%	13.1%	9.5%
Obesity	31.8%	33.8%	31.6%
Heart disease*	6.6%	6.8%	6.7%
Reporting fair to poor health	17.4%	24.2%	16.5%

\* The percentage of people diagnosed with heart disease in Texas is lower than that of the two regions because the state sample accounts for people who did not provide information on county of residence.

Source: Department of State Health Services.

*Births:* In 2012, 13 percent of the babies born in Texas were born in the border region and 87 percent in the non-border region. In Texas, 4.7 percent of births were to mothers 19 years of age or younger, while 15 percent of babies born in the border region were born to mothers 19 years of age or younger. Given that in the demographics section it is reported that 10 percent of the Texas population lives in the border region, we conclude that there is a higher incidence of births in the border region than in the rest of the state. The border region also presents a high concentration of the population that have characteristics associated with late or inadequate prenatal care, such as low educational attainment or maternal age of less than 20 years old.<sup>5</sup> This indicates that although the border region presents a higher incidence of births that does not necessarily mean higher use of prenatal care.

*Emergency Department Visits:* Looking at emergency department utilization is another way to examine the differences in health status and access to primary care between the border and non-border region. Table 6 shows that there are more visits per 1,000 people in the non-border region.

**Table 6 - Emergency Department Visits (2012)**

	<b>Texas</b>	<b>Border Region</b>	<b>Non-Border Region</b>
Total emergency room visits per 1,000 population	382	304	391
Emergency room visits admitted to hospital per 1,000 population	54	50	54
Emergency room visits not admitted to hospital per 1,000 population	328	254	337

Source: Annual Hospital Survey.

<sup>5</sup> Women's Perception of Access to Prenatal Care in the US  
<http://onlinelibrary.wiley.com/doi/10.1016/j.jmwh.2009.01.002/abstract;jsessionid=504B00ABB88542912E330B559F6C16F9.f03t03?deniedAccessCustomisedMessage=&userIsAuthenticated=false>

## Medicaid Enrollment

As a result of the poor economic outcomes in the border region, they have a higher Medicaid enrollment. As of February 2013, there were 3,669,565 people enrolled in the Texas Medicaid program. The border region contains 17.4 percent of the total number of Medicaid clients while the remaining 82.6 percent reside in the non-border region. As indicated in the demographics section, 10 percent of the total Texas population lives in the border region. This means that proportional to population, the border region has a much higher proportion of Medicaid enrollees than do non-border counties.

## Payer Mix

In addition to high rates of Medicaid enrollment and lacking health insurance coverage, another consequence of the poor economic conditions in the border region is the difference in revenue sources between hospitals in the border and non-border regions. Border region hospitals rely more on government revenue.

In fiscal year 2012, Texas hospitals received \$56,130,942,390 in total revenue. Of this revenue, about 48 percent came from governmental programs (e.g., Medicare, Medicaid, military, etc.), 48 percent was paid by third-party payers (private and employer-sponsored health insurance), and the remaining 4 percent was self-pay.

These data show that hospitals in the border region rely more heavily on government programs and self-pay for payment than do non-border counties. In border counties, government programs make up 61 percent of patient revenue, third-party payers make up 30 percent, and self-pay clients make up 9 percent. However, in the non-border region, third-party payers' account for 49 percent of patient revenue, while government and self-pay represent 47 percent and 4 percent, respectively.

Hospitals are reimbursed approximately \$2,105 per capita, statewide. When separating expenditures geographically, the border region hospitals receive revenue of approximately \$1,457 per capita and the non-border region received revenue of \$2,180 per capita.

Data from the Annual Hospital Survey, presented in in Table 7 below, show that markedly more hospital admissions occur in the border region by persons covered by government programs or are uninsured than in non-border counties.

**Table 7 - Hospital Patients by Payment Source (2012)**

	<b>Texas</b>	<b>Border Region</b>	<b>Non-Border Region</b>
Public (Medicaid, Medicare,...)	16.4%	24.8%	14.0%
Private	50.1%	32.8%	53.2%
Uninsured	28.1%	35.8%	27.2%

Source: Annual Hospital Survey.

Hospitals in the border region rely more heavily in government healthcare revenue than providers in the rest of the state. Besides having to care for a population with more health problems, hospitals are in an especially precarious situation as they are serving 10 percent of the state's population, but only receiving \$1,457 of expenditures.

## Healthcare Financing

In this section we give a more detailed account of the revenue sources. We focus on payments to hospitals because data are available that show payments to hospitals from all revenue sources.

*Government:* Medicare and Medicaid make up the majority of hospital revenue contributed by the government.

*Medicare:* Hospitals in Texas received reimbursements totaling \$17,260,645,009 from Medicare in 2012. Of this, \$1,485,463,322 (9 percent) was spent in the border region. The remaining, \$15,775,181,687 (91 percent) was spent in non-border counties.

*Medicaid:* Revenue from Medicaid includes client service payments (fee-for-service and managed care payments) and supplemental payments including Disproportionate Share Hospital (DSH), Upper Payment Limits (UPL). In fiscal year 2012, Texas hospitals received \$8,347,724,412 in Medicaid reimbursements. Of that, \$794,537,810 (10 percent) of the total went to the border region and \$7,553,186,602 (90 percent) went to the non-border region. According to results from the 2012 American Hospital Association Annual Survey, DSH payments totaled \$980,277,737 with \$198,435,604 (20 percent) paid to border region hospitals. Hospitals outside of the border region received \$781,842,133.

*Non-government:* *Non-governmental payments* are self-pay patients and third-party payers, which include private and employer-sponsored health insurance.

*Third-party Payers:* Texas hospitals received a total of \$26,964,575,718 in third-party payer reimbursements; with \$1,199,976,172 (4 percent) paid to hospitals in the border region.

*Self-pay:* Texas hospitals received a total of \$2,131,058,173 from self-pay patients. Of this, \$272,664,848 (13 percent) was paid to border-region hospitals.

## Affordable Care Act (ACA) Impact

One of the supplemental Medicaid payments that greatly contribute to hospital financing is the Disproportionate Share Hospital (DSH) payment. The DSH program compensates hospitals that provide care to a disproportionate number of low income and uninsured individuals with a lump sum payment. Health care reform will impact Medicaid DSH payments starting in 2017. The assumption is that when the individual mandate takes effect the need for supplemental payments to cover the uninsured is less. The ACA requires HHS to reduce DSH payments. As noted in the last section, border hospitals receive 20 percent of all DSH payments in the state of Texas. This is expected given the disparate number of Medicaid-enrolled and uninsured individuals living in the border region. Hospitals in the border will be greatly affected by reduction in Medicare and Medicaid DSH payment. It has been estimated that Hidalgo county hospitals will lose \$28 million in Medicare DSH payments starting in fiscal year 2015.

Physicians in the border region have reported that the Medicare rate parity for primary care physician mandated by the ACA to occur in 2013 and 2014 has been very beneficial. The rate increase allows physicians (PCP) to treat Medicaid clients that they would not have seen otherwise. Its elimination in 2015 will cause many PCPs to be even more reluctant to treat Medicaid clients.

## Health Care Infrastructure

The availability of appropriate health care professionals can have a profound effect on both the health status of its residents and the cost of health care. In this section, we examine the availability of physicians and hospitals in the border region as it compares to the state. Data show that there are fewer hospital beds and fewer physicians in the border area. While there are fewer physicians in the border region, proportionally more physicians in the border region accept Medicaid than in the non-border region. It is likely that the high number of uninsured and the higher dependence of providers on government payments play a role in the lower availability of health providers in the border region.

*Hospital Bed Capacity:* In Texas, there are 70,384 staffed hospital beds, with 6,675 in the border region (9.4 percent) and 63,709 in the non-border region (90.6 percent). Table 8 below shows the number of staffed beds in acute care and psychiatric facilities, adjusted for population. It is clear from the data that the border region has less hospital capacity than non-border counties.

**Table 8 - Number of Staffed Beds per 100,000 People (2012)**

	<b>Texas</b>	<b>Border Region</b>	<b>Non-Border Region</b>
Acute Staffed Beds	236	221	237
Psychiatric Staffed Beds	28	20	29
Total Staffed Beds	263	241	266

Source: Annual Hospital Survey.

*Physicians:* There are 52,698 physicians licensed to practice in the state. Based on the population of Texas, there are 19.8 physicians for every 10,000 residents. Medical Board data indicate that fewer physicians practice in border counties (11.2 physicians/10,000 residents) than in the non-border region. Statewide, 40.6 percent of doctors practice primary care, while the rest are specialists. A little more than half of all physicians (54 percent) of all physicians in the state are active Medicaid physicians. The vast majority of physicians in the border region (92 percent) serve Medicaid clients, while less than half of physicians (49 percent) in non-border counties do so.

Due to the scarcity of physicians in the border as well as the abundance of uninsured and underinsured clients, physicians in border counties tend to have office hours outside of normal work hours. Statewide, there were 23,541 Medicaid claims made by physicians in the evenings, during weekends or on holidays, 25 percent of those claims were made in the border region. Of the 23,541 claims 4,780 were made by physicians that regularly provide evening, weekend and holiday services and 32 percent of those claims were made at the border. We conclude that border doctors tend to see more patients and hold office hours in the evenings, weekends and holidays.

## Medicaid Rates and Expenditures

The objective in this section is to explain how reimbursement rates are set and compare how much Medicaid actually spends in total and on average by region.

## Medicaid Rates

In this subsection we give a brief overview of how reimbursement rates are set.

*Physicians and Other Practitioners:* Medicaid rates for FFS services delivered by physicians and other practitioners<sup>6</sup> are calculated in accordance with title 1 of the Texas Administrative Code (TAC) §355.8085. Rates are uniform statewide.

*Inpatient Hospital:* General acute care hospital reimbursement rates for FFS Medicaid clients are set using a prospective payment system (PPS) based on Medicare's diagnosis related groups (DRGs). Under PPS, each patient is classified into a DRG on the basis of clinical information and then hospitals are paid a pre-determined rate for each DRG (admission), regardless of actual service provided. The rate is calculated using a formula based standardized average cost of treating a Medicaid inpatient admission and a relative weight of each DRG<sup>7</sup>.

*Outpatient Hospital:* Outpatient hospital services provided to FFS clients are reimbursed at a portion of the hospital's reasonable cost.

*Managed care:* Managed care rates are set by program, geographical service area and risk group. Rates must be certified by an external actuary and found to meet actuarial soundness guidelines established by the Centers for Medicare and Medicaid Services (CMS). Consistent methodology is used across all programs.

*Medicaid Managed Care Rollout:* During the 82<sup>nd</sup> Legislature, Senate Bill (S.B.) 7 removed the HMO prohibition in Cameron, Hidalgo, and Maverick counties.

## Medicaid Expenditure

*Claims:* During fiscal year 2013, there was a monthly average of 3,658,537 Medicaid clients in Texas, with roughly 18 percent enrolled in a fee-for-service (FFS). In the border region there was a monthly average of 699,260 clients (17.4 percent of the caseload). There were 74,345,858 Medicaid claims paid statewide during fiscal year 2013; about 22.5 percent of claims were for services provided to border region residents.

In conclusion, the border region has a higher proportion of Medicaid clients than the non-border region and more claims are made per client in the border region. This, as we show in the next subsection, translates in higher Medicaid expenditures per client in the border region.

*Medicaid – All Services:* Including hospitals, physician services and dental claims, Medicaid health plans paid out \$13,356,084,612 in reimbursements for Texas Medicaid clients during fiscal year 2013, with an average of \$3,326.25 per client and \$179.65 per claim. The border region received 19.5 percent of payments (\$2,598,508,007), and in the non-border region \$10,648,925,982 was reimbursed. In the border region, \$3,716 was spent per client while \$3,217 per client was paid in the non-border region.

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<sup>6</sup> Include payments for laboratory services, physical and occupational therapists' services, physician services, podiatry services, chiropractic services, optometric services, dentists' services, psychologists' services, certified respiratory care practitioners' services, maternity clinics' services, tuberculosis clinic services, and certified nurse midwife services.

<sup>7</sup> Rates paid to freestanding psychiatric hospitals, in-state children's hospitals, and rural hospitals and state-owned or operated teaching hospitals are set using a different methodology.

Medicaid spends more per capita and per client in the border region than in the non-border region. This difference is likely to be due to the worse health status of the population in the border region since it is well documented in the literature that health status of the population explains 75 percent to 85 percent of cost variations in geographical regions<sup>8</sup>.

## Conclusion

It is clear from the data presented, that providers in counties along the Texas-Mexico border face a number of issues that are less significant in non-border counties. Providers practicing in the border counties have panels with larger proportion of clients covered by lower paying government program or that are uninsured than found in non-border counties. These clients tend to be less healthy overall, are burdened with higher levels of chronic disease, and are at greater risk for lower health outcomes. In short, providers practicing in the border counties face a sicker, poorer, less educated client base, and these clients are generally enrolled in government programs that provide poorer reimbursement rates.

## Recommendations

In order to increase provider participation in the Medicaid program, the Border Rates Expenditure and Advisory Committee proposes the following recommended options. HHSC should adopt:

--Either--

1. Continue the Affordable Care Act (ACA) parity with Medicare for primary care physicians practicing in the border region.

--Or--

2. Implement a high volume rate increase for providers who serve a disproportionate share of Medicaid clients. This rate increase would be based on the percentage of Medicaid clients within the provider's overall panel. For example, a practice that has 20 percent of its client enrolled in Medicaid would receive a 4 percent increase and a practice that has 50 percent of its patients under Medicaid would receive a 10 percent increase.

--And--

3. Implement a pilot in the border region where partnerships are created between the managed care organization (MCO) and the providers, especially institutions that could draw expanded federal dollars that could be passed through to the providers. One of these models is the Model 1 that Superior Health Plan implemented in the El Paso area. There are many other possible programs, such as bundled payments or outcome-based payments that can be designated to specific populations (e.g., high cost or high needs clients), which could include case management, case coordination, and development of medical homes.

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<sup>8</sup> Zuckerman S, Waidman T, Berenson R and Hadley J (2010) *The New England Journal of Medicine* Clarifying Sources of Geographic Differences in Medicare Spending.