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"IMPROVING HEALTH THROUGH DATA"

TEXAS ALL PAYOR CLAIMS DATABASE

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TX-APCD Biennial Report: Section Roadmap

A high-level guide to the report before the substantive topic slides

Foundation and operations

Sections 1–2 explain what the TX-APCD is, what data it can and cannot include, and the database-software transition.

Analytic findings

Sections 3–4 present analyses of primary care and commercial insurance spending, including regional payment variation.

Public health uses

Sections 5–7 show how the TX-APCD supports surveillance and local planning for specific populations and conditions.

1 Basic Description and Background
APCD purpose, submitters, statutory limits, ERISA limits, federal-program exclusions, and research-ready data development.

2 Transition to New Database Software
Greenplum-to-Citus transition, cost drivers, open-source architecture, and platform selection process.

3-4 Primary Care - Commercial Spending Group and Insurance
Commercial PMPY spending trends, sex and age differences, service-line shifts, geography, and allowed amounts.

5–7 Condition and Local Public Health Analyses
Sickle cell monitoring, complex medical conditions, and Harris County chronic disease prevalence dashboards.

8 Comparative Analysis
A Comparative Analysis of the data from 5-Agencies

9 Required Reporting
Required Reporting on data applications.

Source: Draft TX-APCD Biennial Report table of contents and section narratives.

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Report Sections 1–2: Foundation and Operations

What the database is, what it contains, and how the data platform is being sustained

1 Basic Description and Background of All-Payor Claims Databases

Explains the purpose of an APCD, required submitters, excluded data, limits of administrative claims, data submission, development of the research-ready resource, market concentration, and file-review workflow.

2 Transition to New Database Software

Describes the move from Greenplum to Citus after sharply rising vendor costs, with emphasis on open-source architecture, PostgreSQL compatibility, data ownership, scalability, and operational flexibility.

Source: Draft TX-APCD Biennial Report Sections 1–2.

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Report Sections 3–4: Health Care Trends and Commercial Spending

The first analytic sections connect TX-APCD data to policy-relevant spending and access questions

Analysis of Trends: Affordability, Availability, Quality, and Utilization

The TX-APCD is required to provide insight, through the biennial report, into trends in affordability, quality, and utilization. The Analytical sections of this report are intended to meet that statutory requirement. As time progresses we will be able to look back and revisit topics as well as develop a more standard set of measures that can be repeated year over year. The information in this report reflects months of analysis and work.

3 Commercial Spending Group and Insurance

Reviews commercial PMPY spending, sex and age differences, fully insured group plan comparisons, service-line spending, county variation, and procedure-level allowed amounts by hospital referral region.

4 Primary Care

This section reviews the primary care physician workforce (access) and primary health care delivery. Insight into, telehealth, primary care composition, payment levels, payor variation, and E&M complexity patterns.

Source: Draft TX-APCD Biennial Report Sections 3–4.

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Report Sections 5–7: Public Health and Special Populations

These sections show how TX-APCD data can support surveillance, planning, and population-level insight

5 Sickle Cell Disease Monitoring

Supports DSHS disease-surveillance work by identifying insured Texans with sickle cell disease and describing payor coverage, age distribution, utilization, readmissions, and spending.

6 Children and Adults with Complex Medical Conditions

Identifies Texans with selected medically complex pediatric and congenital diagnoses, tracks payor assignment by year, and examines age, coverage, PMPY spending, and service-category mix.

7 Harris County Chronic Disease Prevalence Project

Demonstrates local public health use of TX-APCD data through chronic disease dashboards with ZIP-code, payor, sex, race where available, and age detail.

8 Comparative Analysis of State-Funded Health Care Services and Major Cost Drivers Across State Agencies

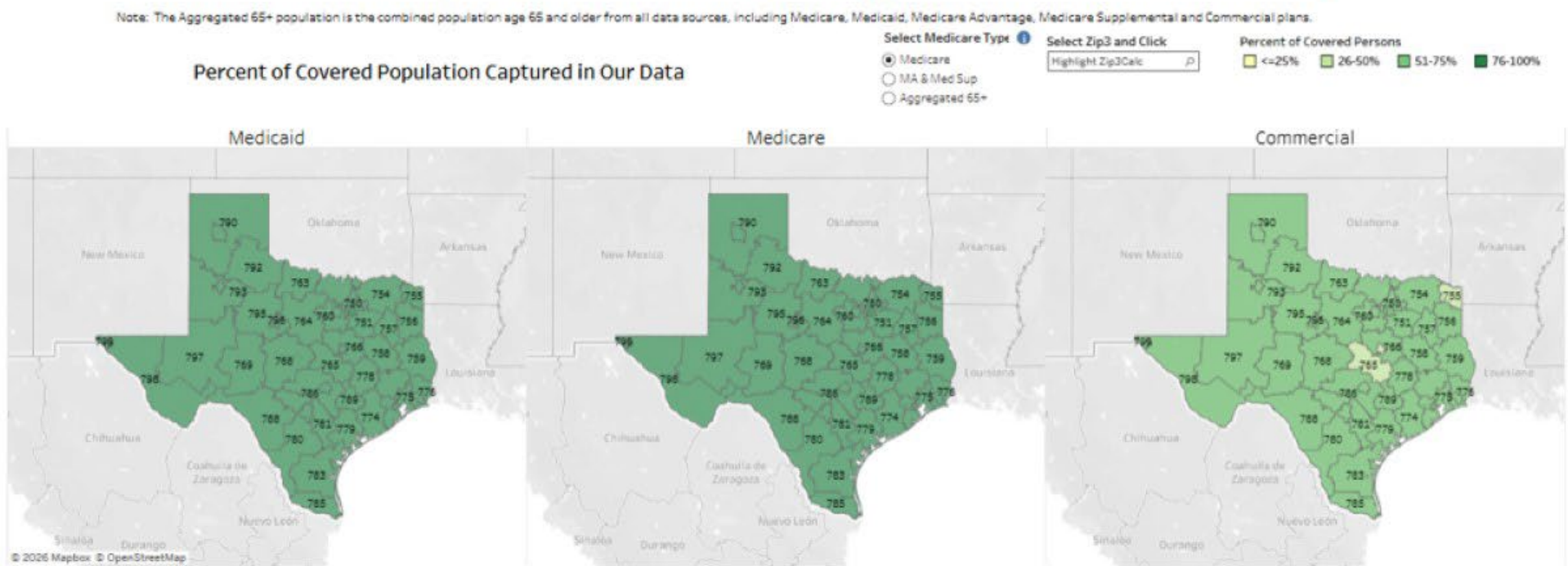
This contains a discussion of a program that was once a free-standing review for the benefit of 5-agencies. That was folded into the TX-APCD function.

Source: Draft TX-APCD Biennial Report Sections 5–7.

Who is in the data?

Every month we receive data on ~18 million Texans, this includes:

- **Texas Medicaid clients**
- **Texans in TX Medicare Advantage plans**
- **Texans in TX Medicare FFS (not part of TX-APCD, but supplemented with files from CMS)**



Submitters (Aggregated by Company)

Primary Medical Fiscal Year 2025

Submitter Distribution

Payors grouped under parent organizations



- BCBS
- Centene
- Cigna
- Humana
- Community Health Choice
- Amerigroup
- Devoted
- Sendero
- Loomis Insurance
- United
- Aetna/CVS
- Oscar Health
- Molina
- Curative
- Kelsey Seybold
- ELVNHLTH
- Southwestern Health Resources
- Moda Health

KEY TAKEAWAY

Majority of Texans are covered by relatively few payors.

The aggregation under parent organizations helps show market concentration more clearly than a payor-by-payor listing.

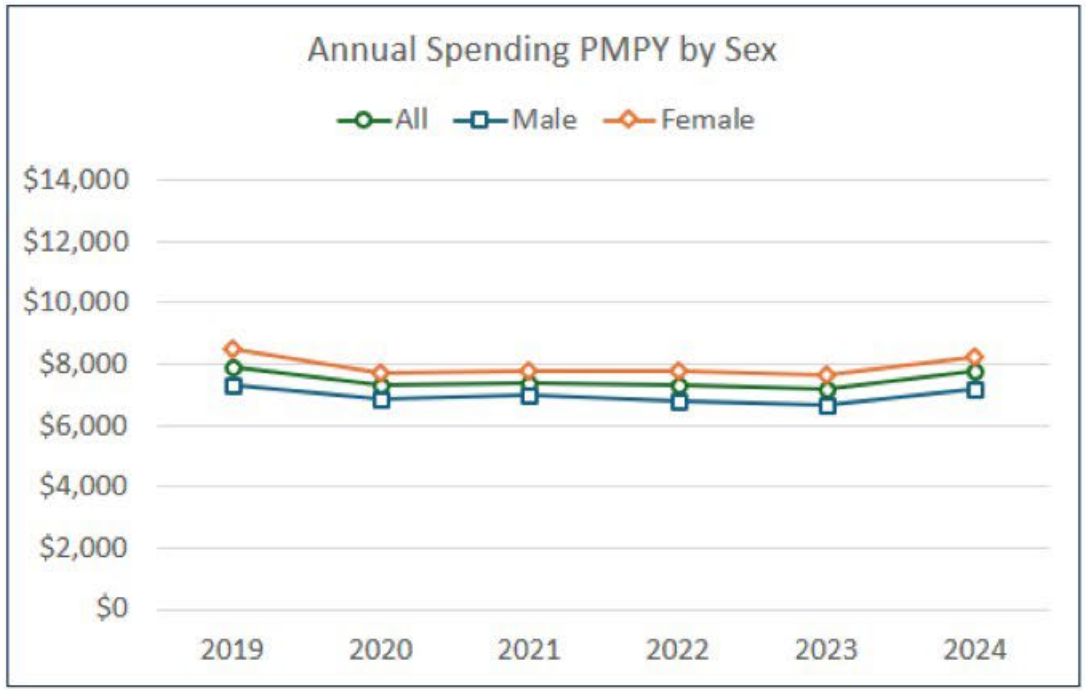
The Center of Health Care Data administers the Texas All-Payer Claims (TX-APCD).

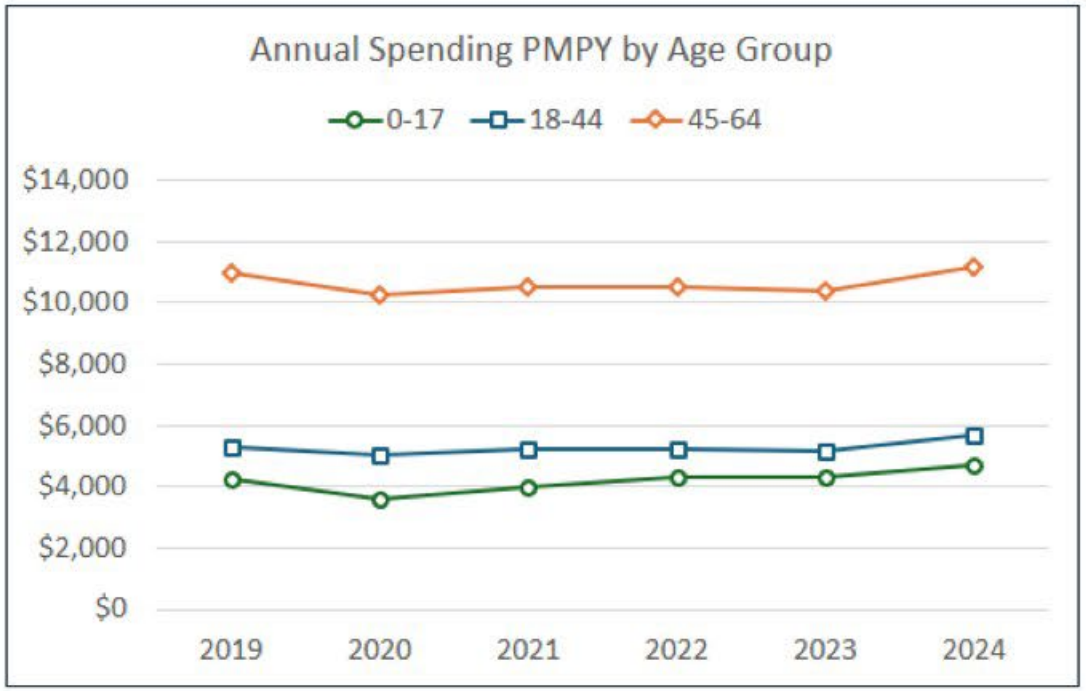
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Health Care Spending for Commercially Insured Texans

Average Per member Per Year Spending in TX-APCD All Commercial Insurance

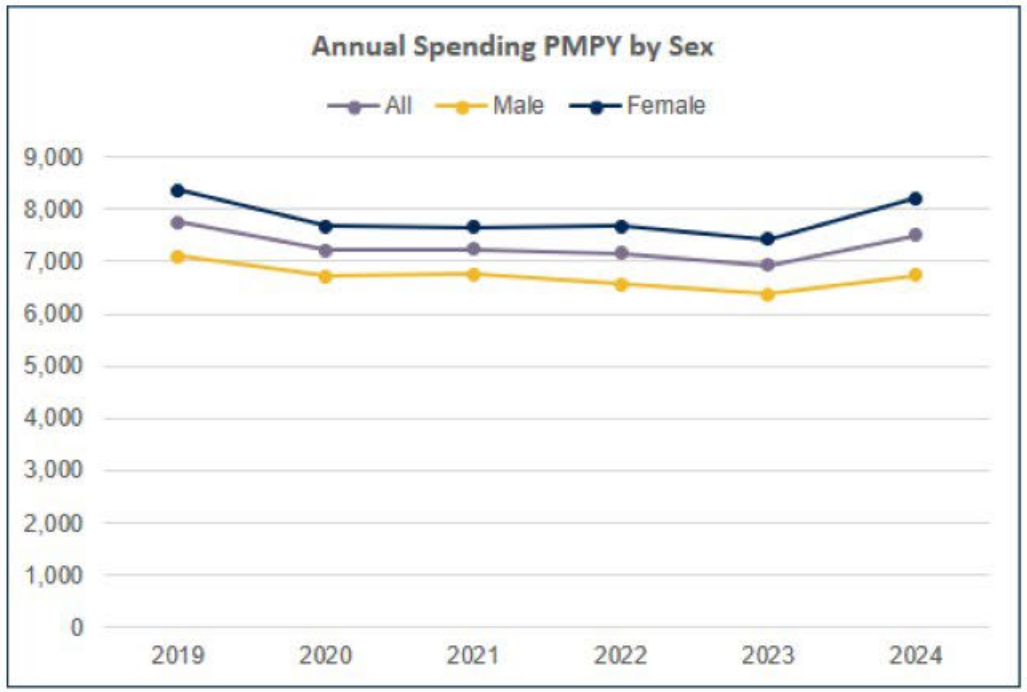


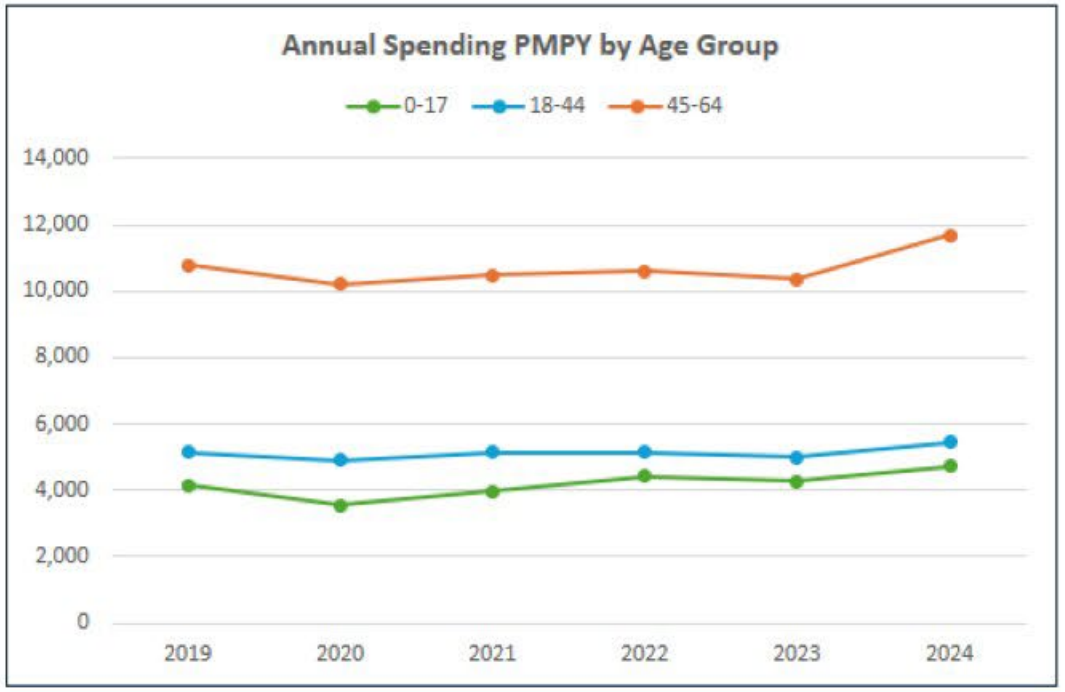


Includes individuals in the Texas APCD enrolled in fully insured plans, State-sponsored and other public-sector employer health plans as well as individual and ACA marketplace plans. *Some individuals in self funded ERISA plans are present. All dollar amounts are adjusted to 2024 dollar values. PMPY: Per Member Per Year.*

Average Per member Per Year Spending in TX-APCD ONLY Fully Insured Group Commercial Coverage

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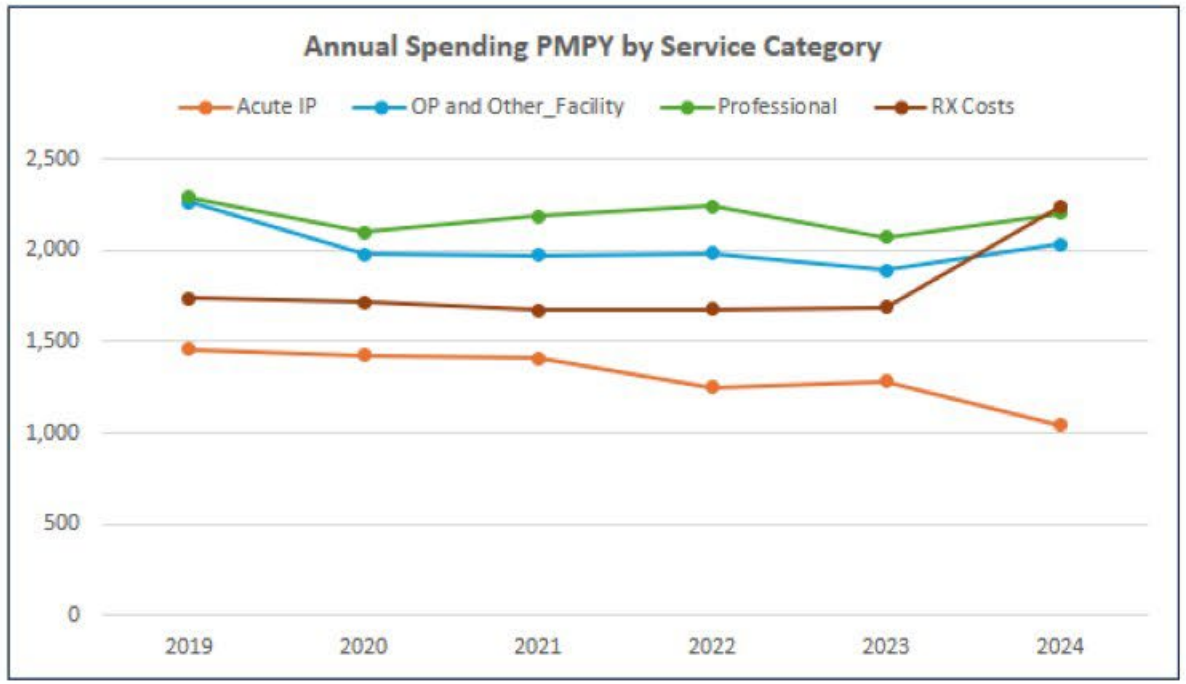


There are no significant differences in overall PMPY spending among the overall commercially insured population and those in fully insured group based plans. Women had higher PMPY spending consistently across time. PMPY spending increases significantly with age.

Includes individuals in fully insured group plans in Texas. Excludes self-funded ERISA plans. State-sponsored and other public sector employee health

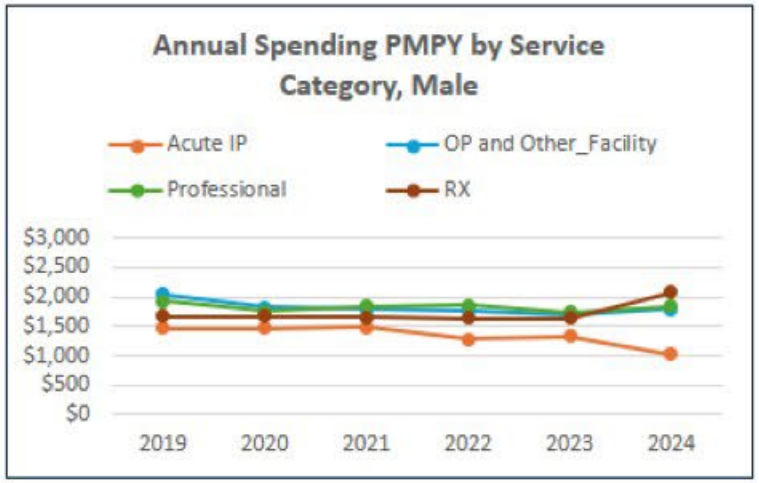
Average Spending (PMPY) by Service Line, Fully Insured Group Commercial plans

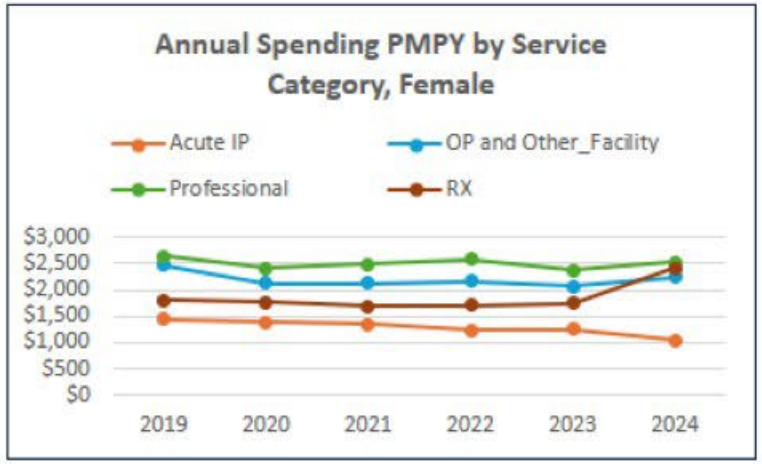
Includes individuals in fully insured group plans in Texas. Excludes self-funded ERISA plans, State-sponsored and other public-sector employer health plans, as well as ACA marketplace plans. All dollar amounts are adjusted to 2024 dollar values. PMPY: Per Member Per Year.



- Largest relative decline: Acute IP (~−29%).
- Largest relative increase: RX (~+29%), driven by a strong 2024 uptick.
- Most stable: Professional spending (small net change: -4%).
- The shift away from inpatient toward outpatient/professional settings appears to continue.

Average Spending (PMPY) by Service Line & Sex, Fully Insured Group Commercial plans



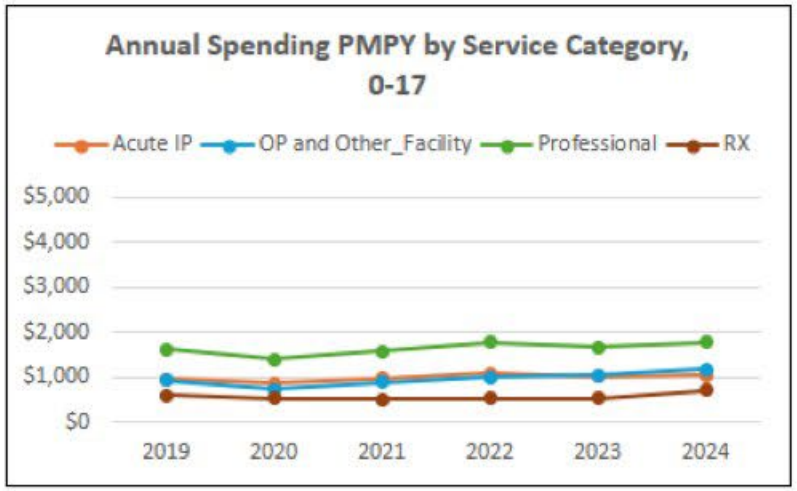


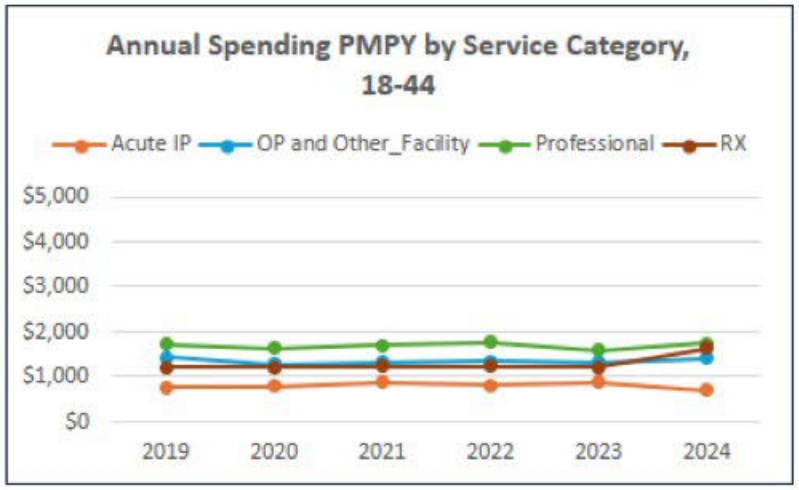
Includes individuals in fully insured group plans in Texas. Excludes self funded ERISA plans, State-sponsored and other public-sector employer health plans as well as ACA marketplace plans. All dollar amounts are adjusted to 2024 dollar values. PMPY: Per Member Per Year.

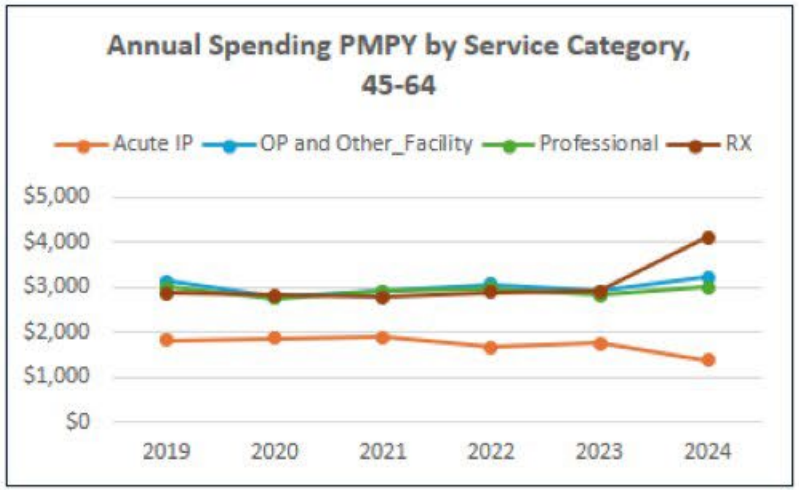
- Women drive higher outpatient and professional spending throughout the period; these categories are the primary source of sex-based spending differences.
- Inpatient spending has declined substantially for both sexes. Prescription drug spending surged in 2024 for both sexes.
- Implication: The pattern suggests shifting utilization away from inpatient care and toward outpatient/professional services.

Average Spending (PMPY) by Service Line & Age, Fully Insured Group Commercial plans

Includes individuals in fully insured group plans in Texas. Excludes self-funded ERISA plans, State-sponsored and other public-sector employer health plans, as well as ACA marketplace plans. All dollar amounts are adjusted to 2024 dollar values. PMPY: Per Member Per Year.

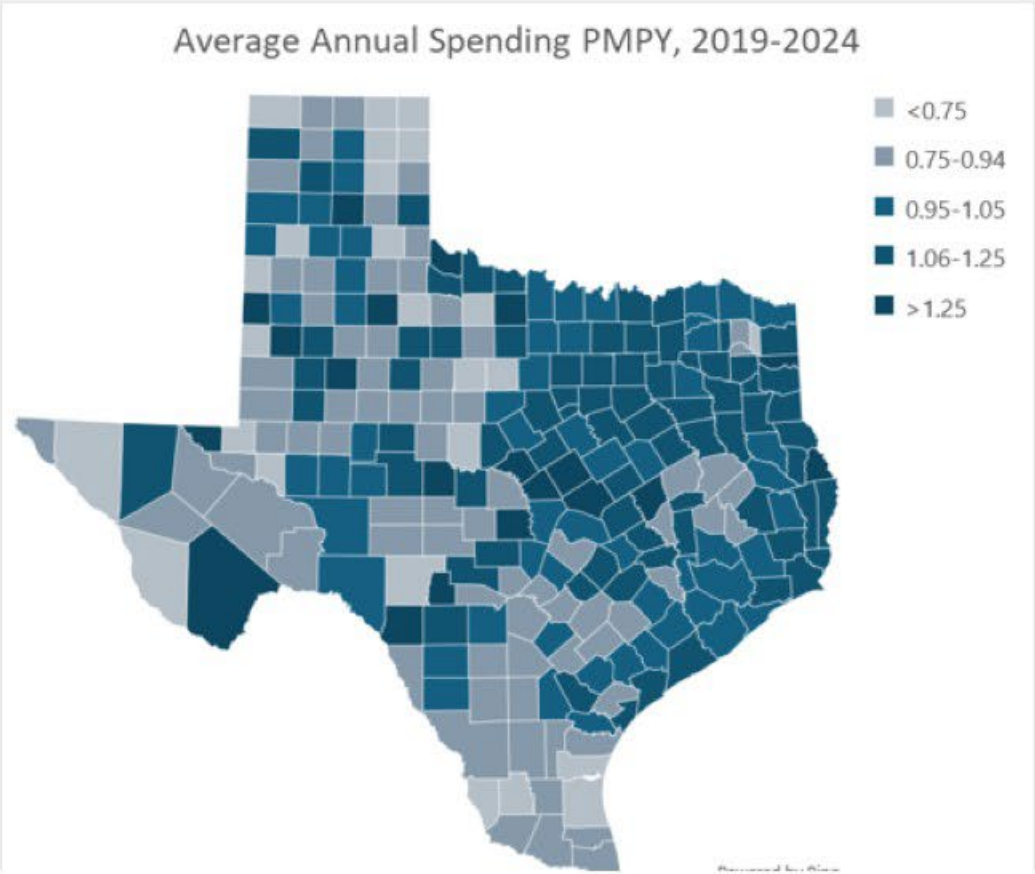






- Age 45-64 drives the highest per-person spending and shows the largest 2024 RX surge.
- Younger groups experienced pandemic-era dips (2020) in outpatient and professional spending, with recovery by 2024.

Geographic Variation in Average Spending (PMPY) Fully Insured Group Commercial Plans



	Average PMPY
Texas	$7514
County	
Harris	$7288
Dallas	$8395
Tarrant	$7890
Travis	$6932
Bexar	$6818
Hidalgo	$6409
Cameron	$6374
Bell	$9595

There is significant variation by region in PMPY spending

Footnote: Map shows county-level variation in **annual PMPY spending**, averaged across **2019–2024**. Colors indicate each county's spending relative to the **Texas PMPY mean,** where **1.00 = Texas mean**. Values below 1.00 indicate spending less than the Texas mean; for example, **0.75** means the county spent **25% less** PMPY than the Texas mean. Values above 1.00 indicate spending more than the Texas mean; for example, **1.25** means the county spent **25% more** PMPY than the Texas mean. Darker colors correspond to higher ratios (greater spending relative to the Texas mean) and lighter colors correspond to lower ratios

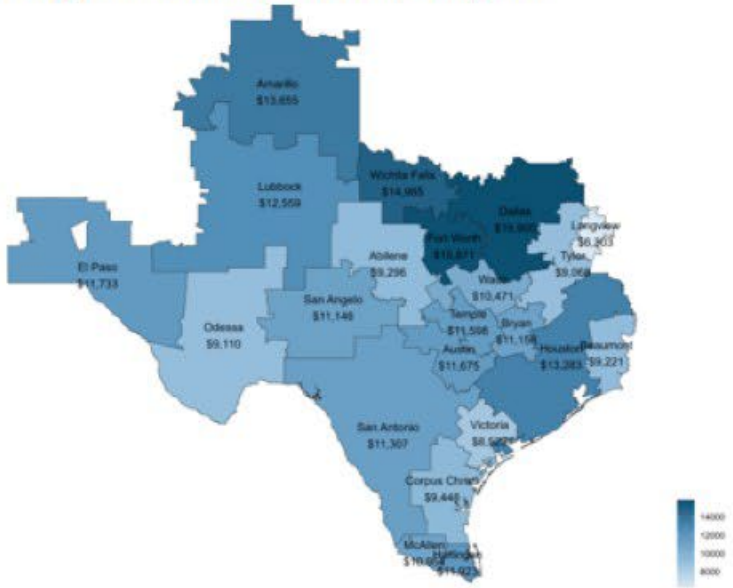
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Variation in Average Allowed Amounts
Fully Insured Group Commercial Plans
Selected Inpatient Procedures (Facility)

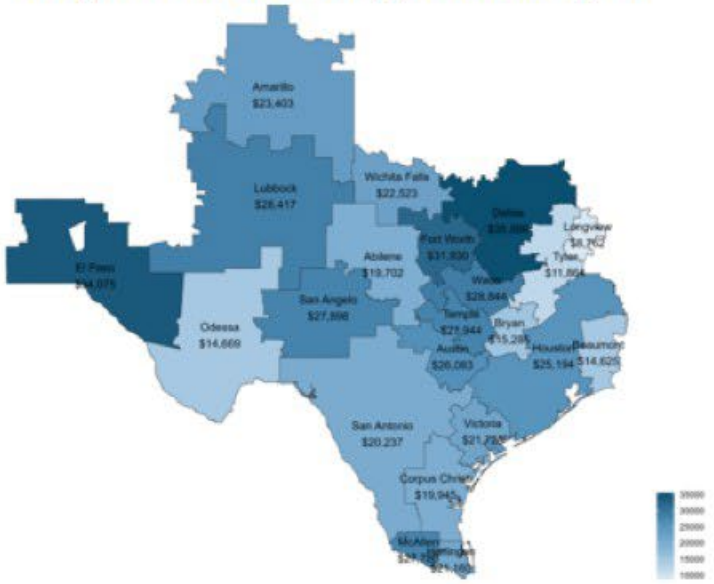
Darker blue indicates allowed amounts above the Texas mean for the specified procedure; lighter blue indicates allowed amounts below the Texas mean. Values are shown as actual dollar amounts.

2024 Data

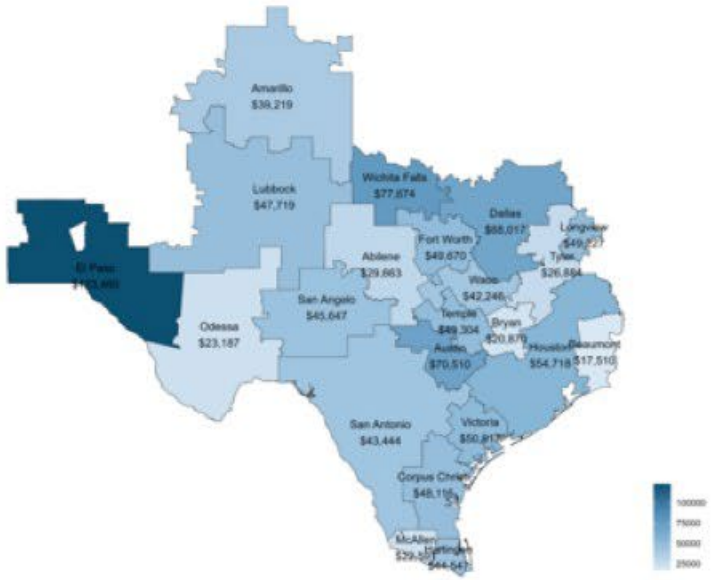
Average Allowed Amount for C-Section by HRR



Average Allowed Amount for Appendectomies by HRR



Average Allowed Amount for Total Knee Replacement by HRR



Substantial geographic variation exists for all three procedures. **Some HRRs** are **consistently above or below the Texas mean** across multiple procedures (e.g., Dallas and El Paso tend to have higher average Allowed amounts; Longview and several smaller regions tend to be lower than the Texas average). **Variation is not uniform**: all procedures show both high-cost and low-cost regions, indicating regional market effects. Several high-average HRRs have low volume, so high averages in those places may be driven by a few expensive cases.

Allowed Amounts for Surgical Procedures by Hospital Referral Region

Hospital Referral Regions (HRRs) are geographic areas that define regional markets for tertiary or referral medical care, created by grouping smaller hospital service areas based on where patients travel for major specialty procedures.

HRRs are widely used to study regional variation in utilization, spending, and outcomes for specialized care because they mirror actual referral flows.

***Allowed amount:** "*the maximum payment the insurer or plan will pay for a covered health-care service.* This term is also commonly labeled "eligible expense," "payment allowance," or "negotiated rate". https://www.healthcare.gov/glossary/allowed-amount

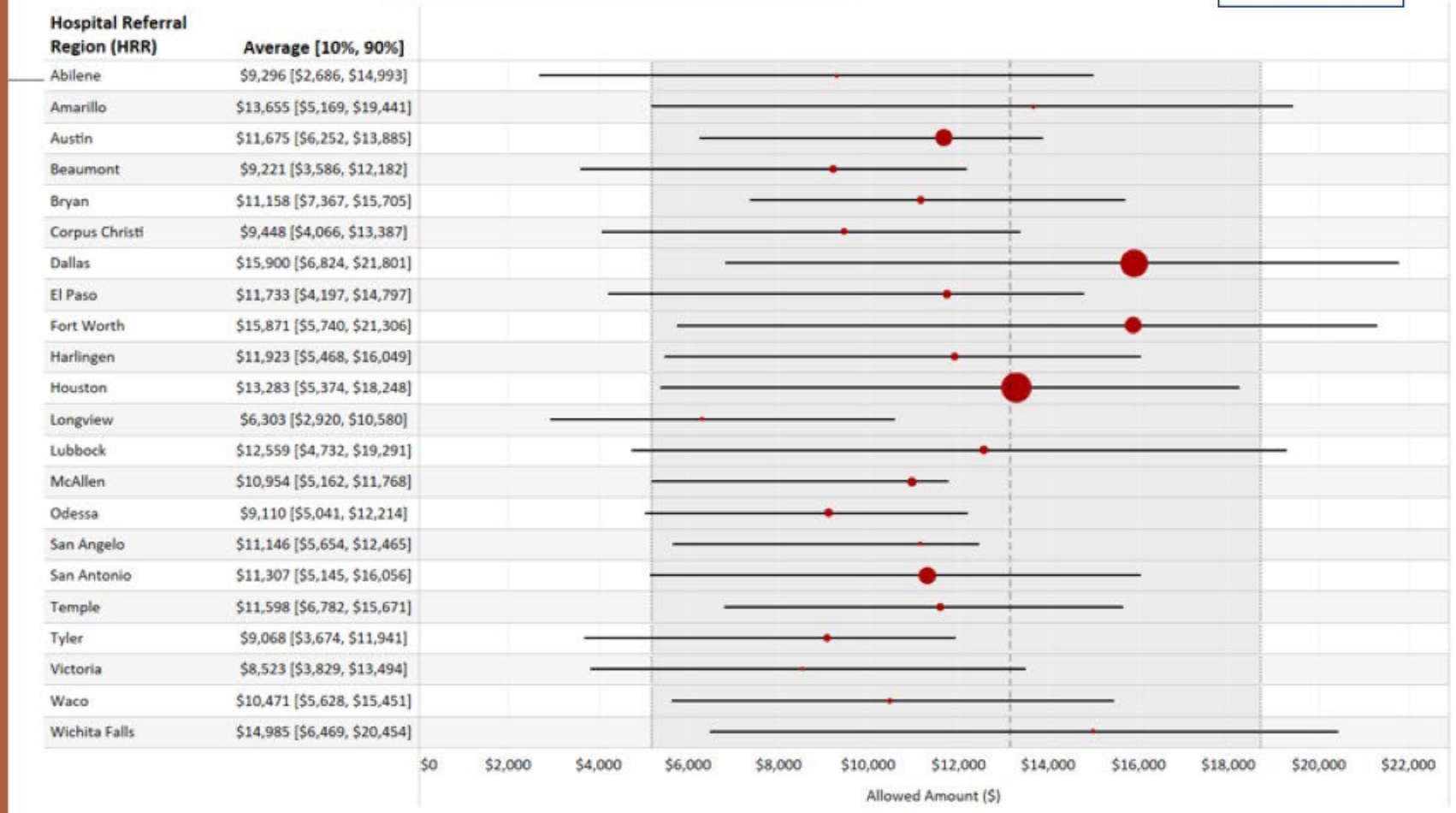
Variation in Average Allowed Amounts Fully Insured Group Commercial Plans

Cesarean Sections

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2024 Data

Hospital Referral Region (HRR)	Average [10%, 90%]
Abilene	$9,296 [$2,686, $14,993]
Amarillo	$13,655 [$5,169, $19,441]
Austin	$11,675 [$6,252, $13,885]
Beaumont	$9,221 [$3,586, $12,182]
Bryan	$11,158 [$7,367, $15,705]
Corpus Christi	$9,448 [$4,066, $13,387]
Dallas	$15,900 [$6,824, $21,801]
El Paso	$11,733 [$4,197, $14,797]
Fort Worth	$15,871 [$5,740, $21,306]
Harlingen	$11,923 [$5,468, $16,049]
Houston	$13,283 [$5,374, $18,248]
Longview	$6,303 [$2,920, $10,580]
Lubbock	$12,559 [$4,732, $19,291]
McAllen	$10,954 [$5,162, $11,768]
Odessa	$9,110 [$5,041, $12,214]
San Angelo	$11,146 [$5,654, $12,465]
San Antonio	$11,307 [$5,145, $16,056]
Temple	$11,598 [$6,782, $15,671]
Tyler	$9,068 [$3,674, $11,941]
Victoria	$8,523 [$3,829, $13,494]
Waco	$10,471 [$5,628, $15,451]
Wichita Falls	$14,985 [$6,469, $20,454]



Average Allowed amounts for C-sections (Inpatient Hospital) across Texas by HRR. Circle size depicts volume of procedures in that area. Line show the variation within the area (10-90th percentile). Dotted line" Texas Average.

Allowed Amounts for Surgical Procedures by Hospital Referral Region

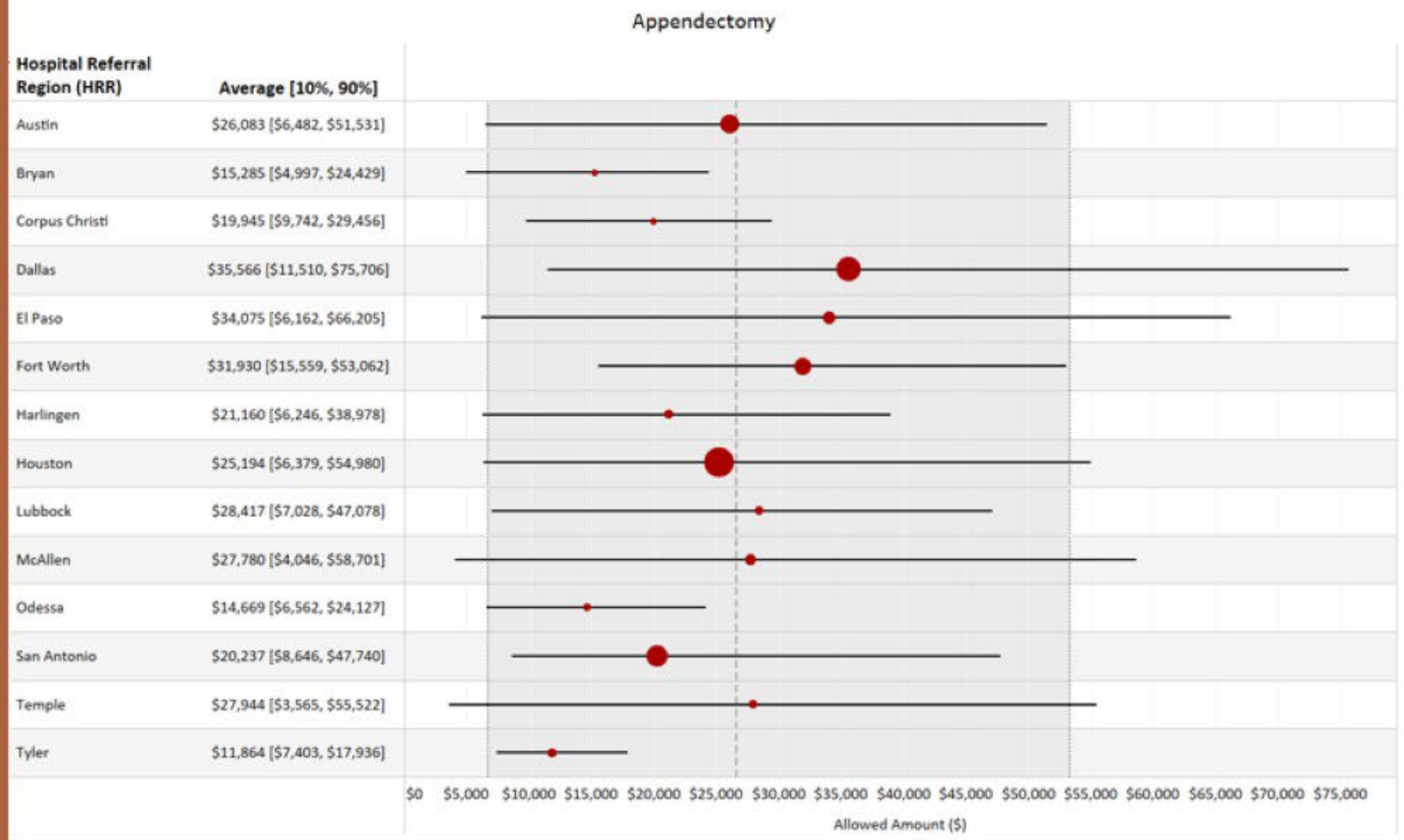
Hospital Referral Regions (HRRs) are geographic areas that define regional markets for tertiary or referral medical care, created by grouping smaller hospital service areas based on where patients travel for major specialty procedures.

HRRs are widely used to study regional variation in utilization, spending, and outcomes for specialized care because they mirror actual referral flows.

Variation in Average Allowed Amounts Fully Insured Group Commercial Plans **Appendectomies**

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2024 Data



Average Allowed amounts for Appendectomies (Inpatient Hospital) across Texas by HRR. Circle size depicts volume of procedures in that area. Line show the variation within the area (10-90th percentile). Dotted line" Texas Average.

Allowed Amounts for Surgical Procedures by Hospital Referral Region

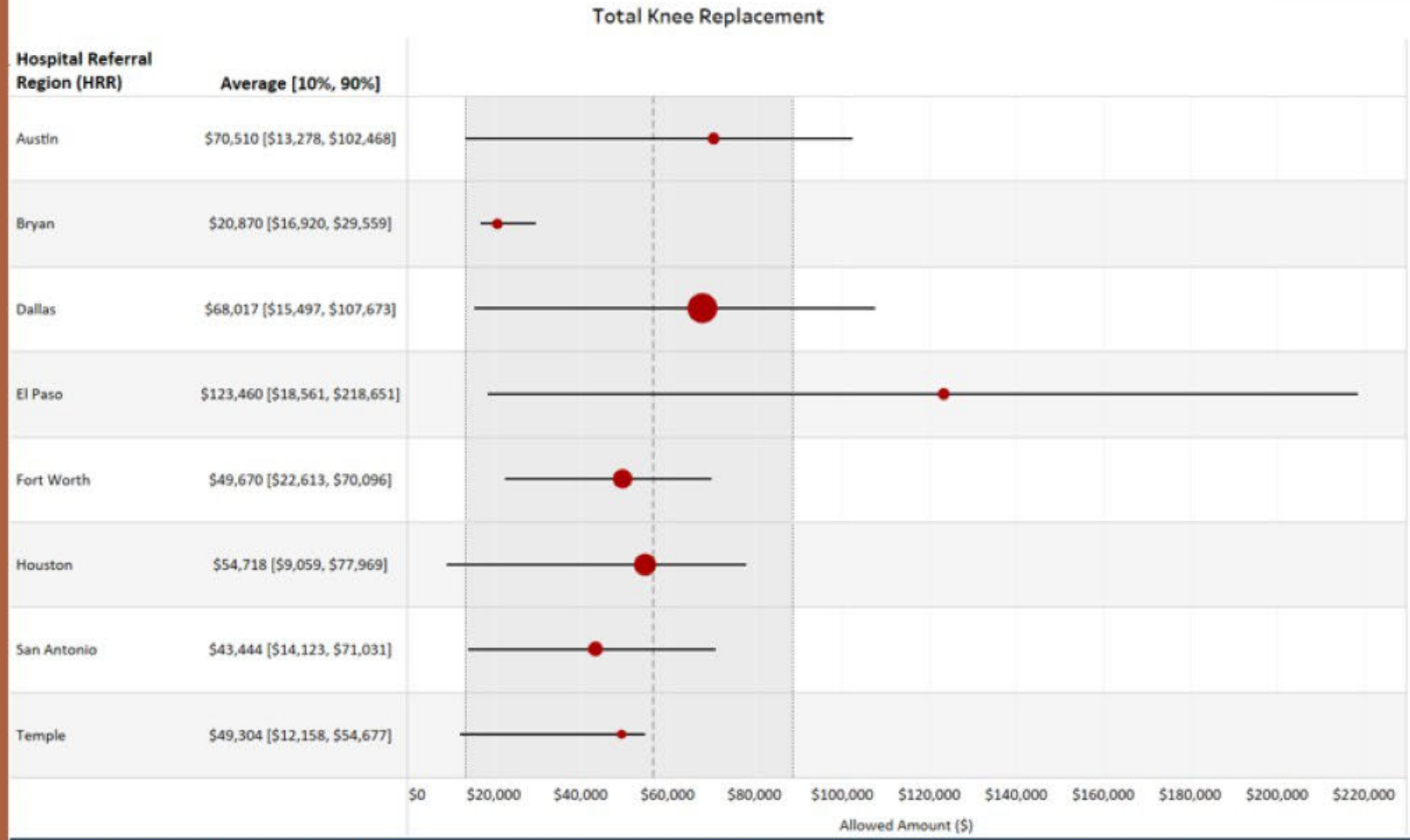
Hospital Referral Regions (HRRs) are geographic areas that define regional markets for tertiary or referral medical care, created by grouping smaller hospital service areas based on where patients travel for major specialty procedures.

HRRs are widely used to study regional variation in utilization, spending, and outcomes for specialized care because they mirror actual referral flows.

Variation in Average Allowed Amounts
Fully Insured Group Commercial Plans
Total Knee Replacement (TKR)

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2024 Data



Average Allowed amounts for TKR (Inpatient Hospital) across Texas by HRR. Circle size depicts volume of procedures in that area. Line show the variation within the area (10-90th percentile). Dotted line" Texas Average.

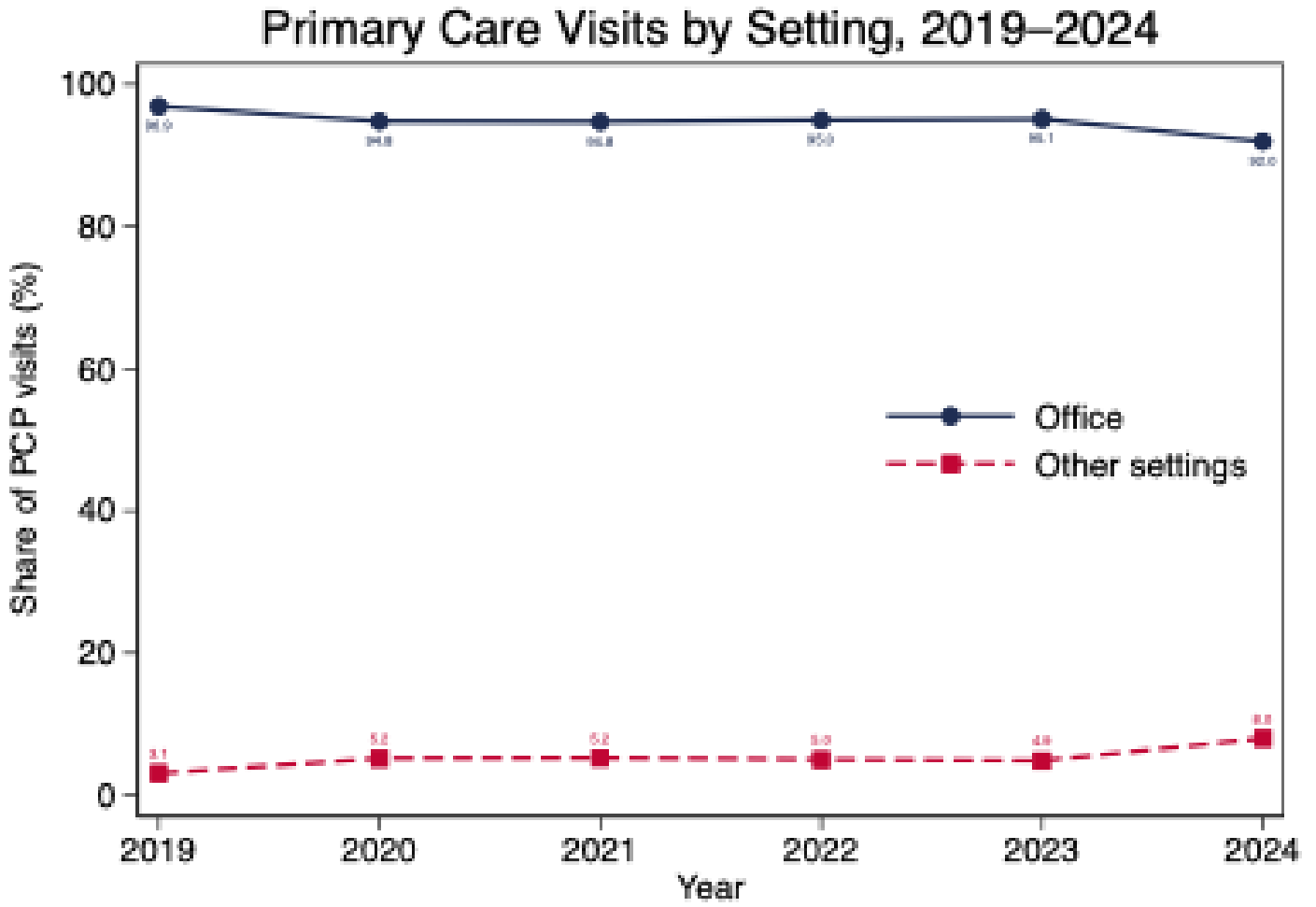
Current State of Primary Care in Texas

Who provides primary care and where Texans receive it

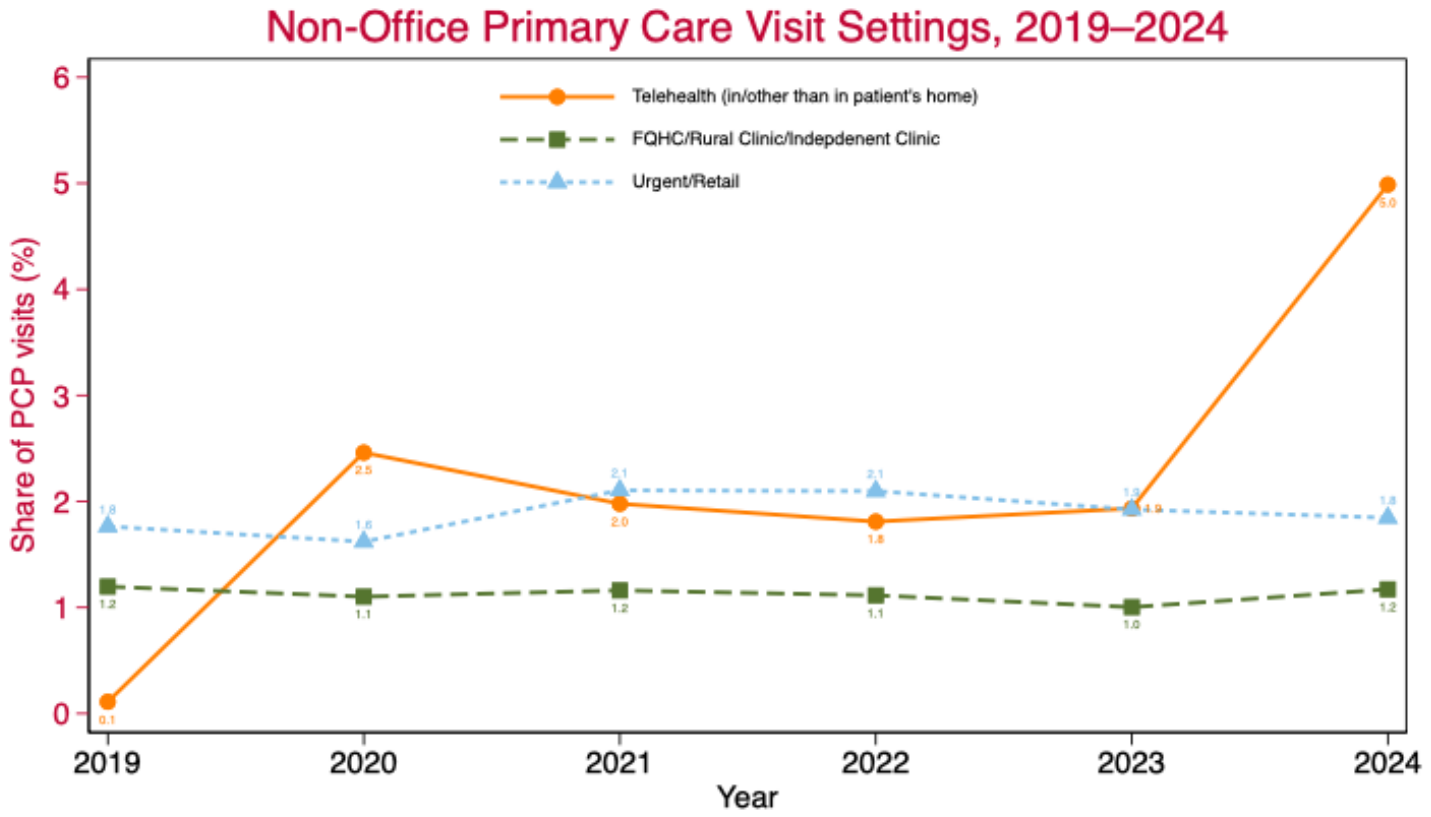
Primary care is overwhelmingly office-based

Other settings:

1. FQHC
2. Independent Clinic
3. Rural Health Clinic
4. Telehealth Provided in Patient's Home
5. Telehealth Provided other than in Patient's Home
6. Urgent Care Facility
7. Walk-in Retail Health Clinic

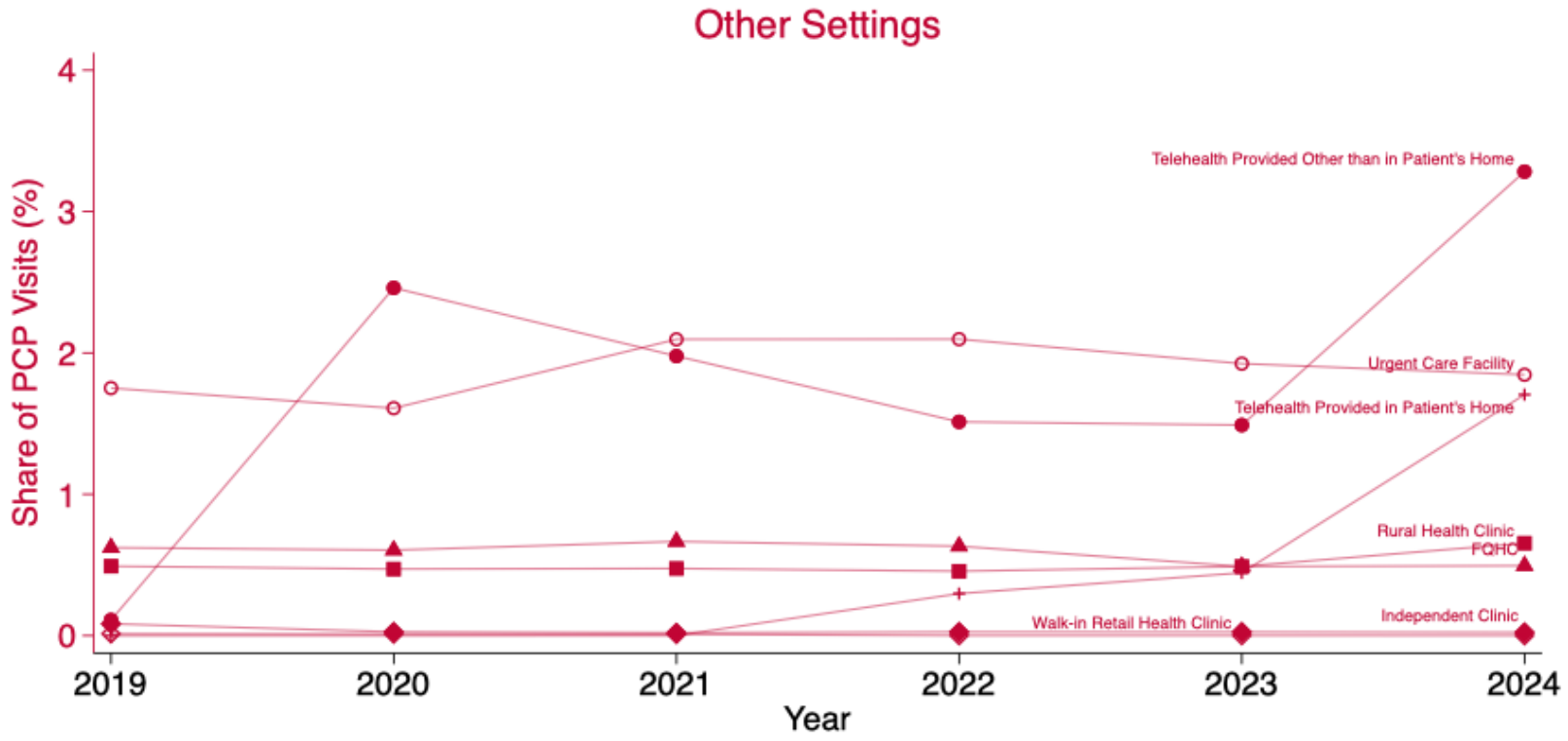


Non-office care remains limited but evolving (telehealth in particular)



Growth of Telehealth PCP visits over time

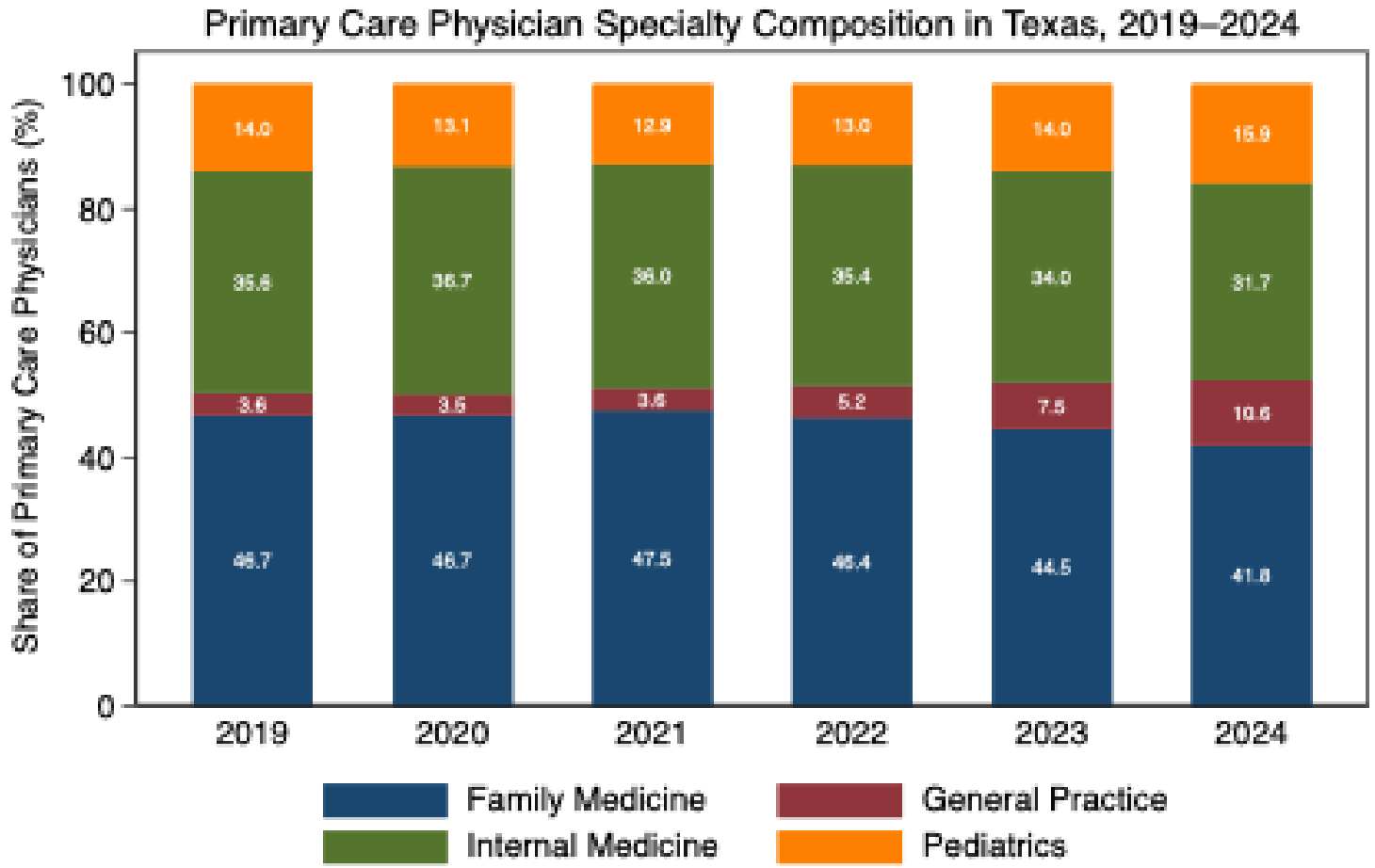
The telehealth spike between 2019 and 2020 is driven by services provided outside the patient's home, while the increase from 2023 to 2024 is driven primarily by growth in telehealth provided in the patient's home.



Composition of Primary Care (office visits)

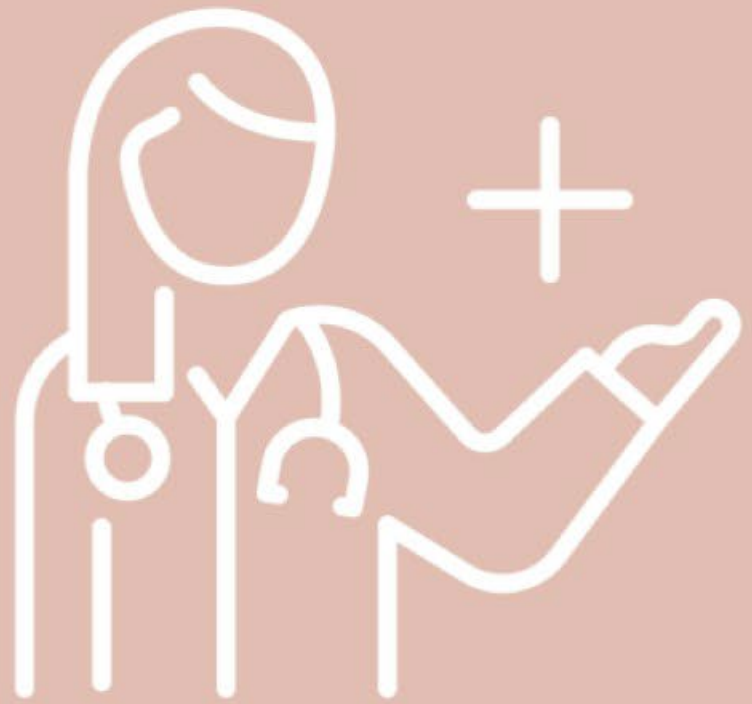
Primary care workforce composition is stable over time

Modest increases in Pediatrics and General Practice



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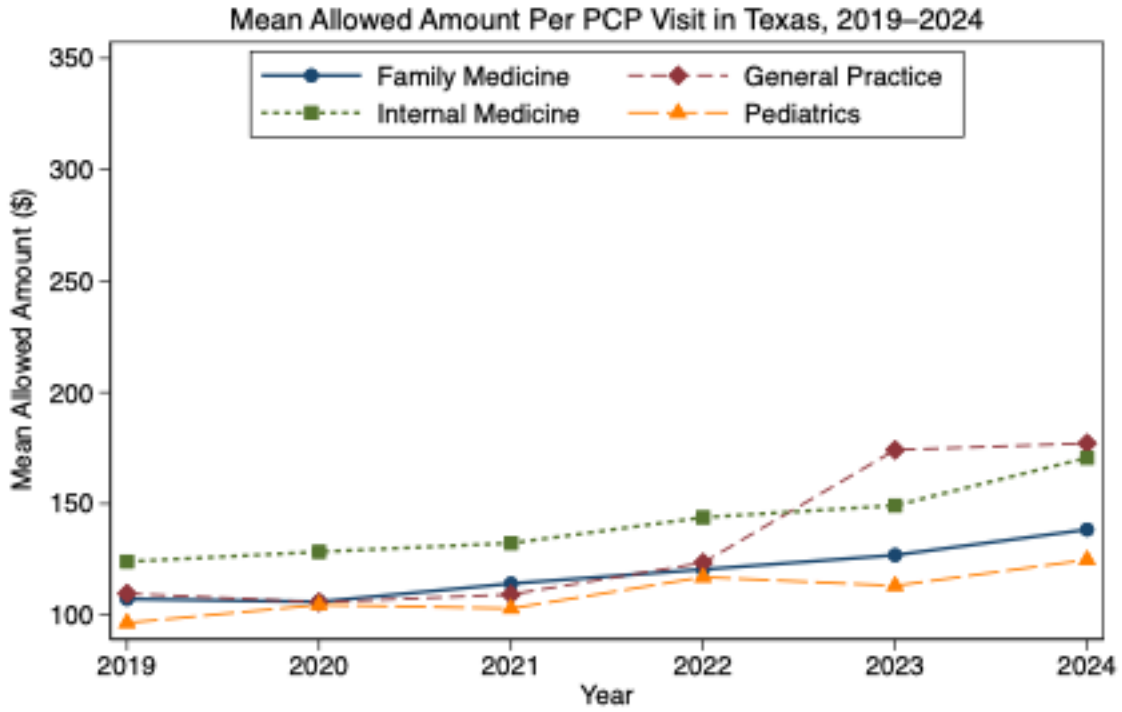
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Primary Care Payment and Visit Complexity

Allowed amounts, specialty comparisons, and E&M coding

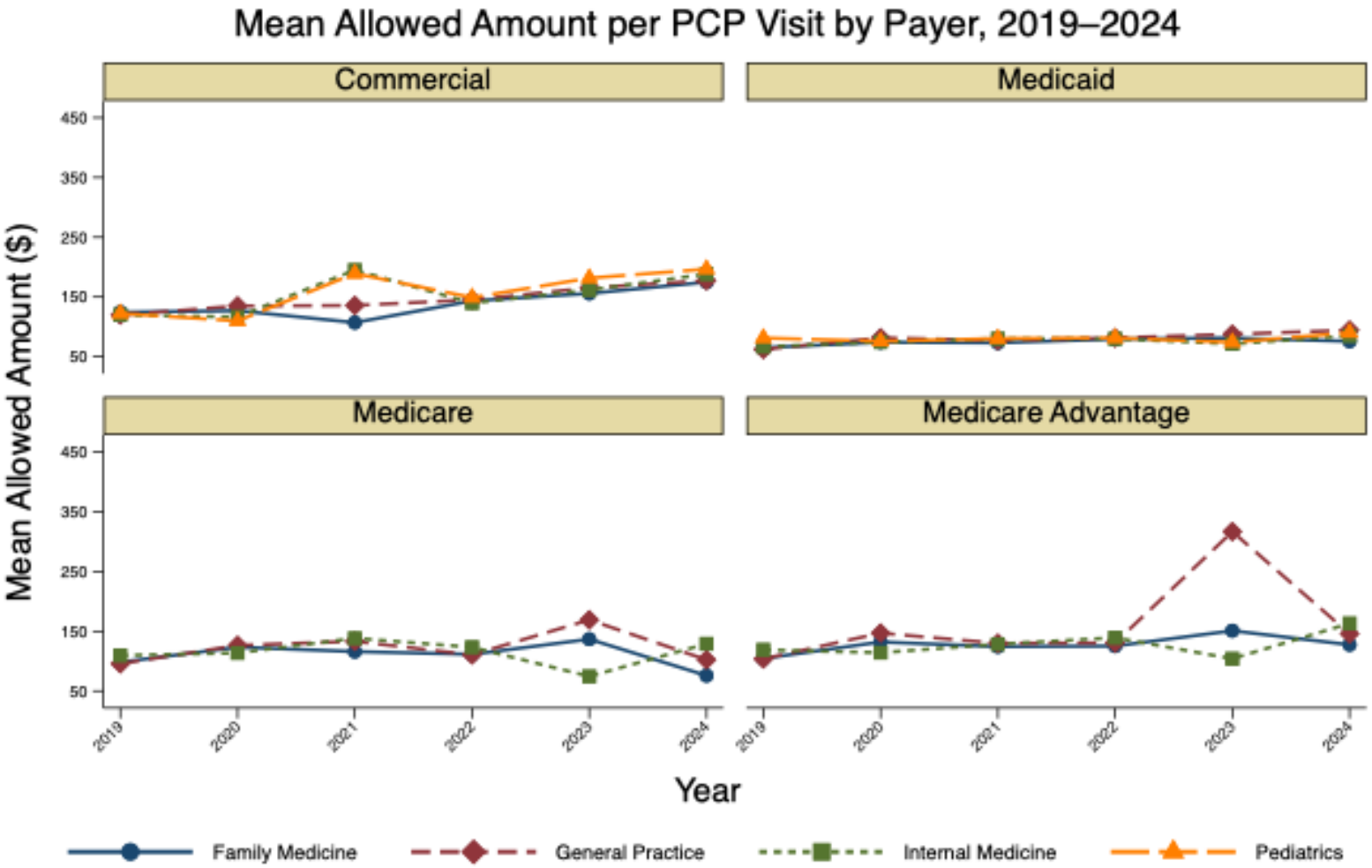
Mean payments increase over time across PCP specialties (office visits)



	2019	2020	2021	2022	2023	2024
Family Medicine	$ 107	$ 106	$ 114	$ 120	$ 127	$ 138
General Practice	$ 110	$ 106	$ 109	$ 124	$ 174	$ 177
Internal Medicine	$ 124	$ 128	$ 132	$ 144	$ 149	$ 171
Pediatrics	$ 97	$ 105	$ 103	$ 117	$ 113	$ 125

Commercial showing highest payment level and variability across specialties (office visits)

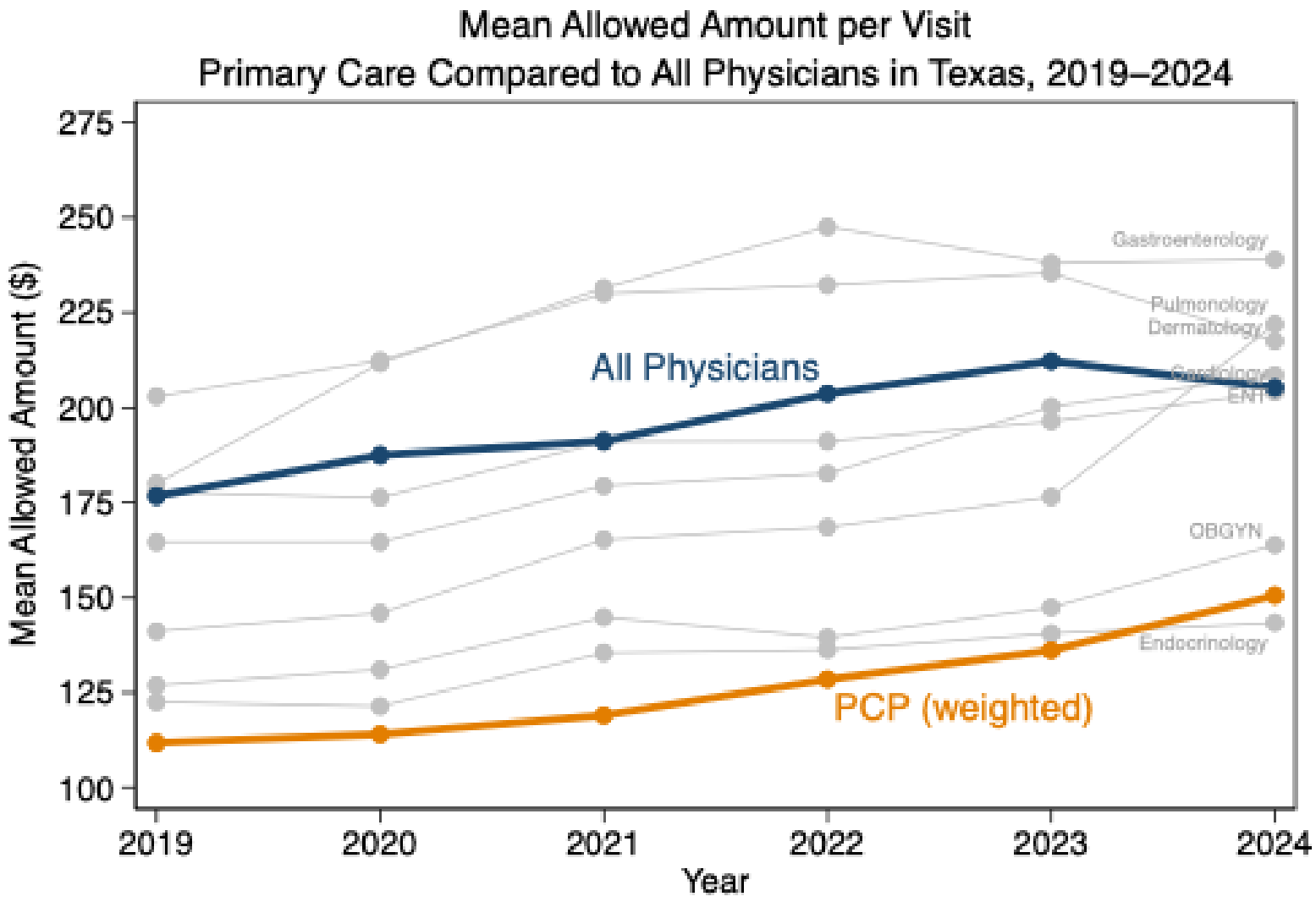
Medicaid brings down the Mean



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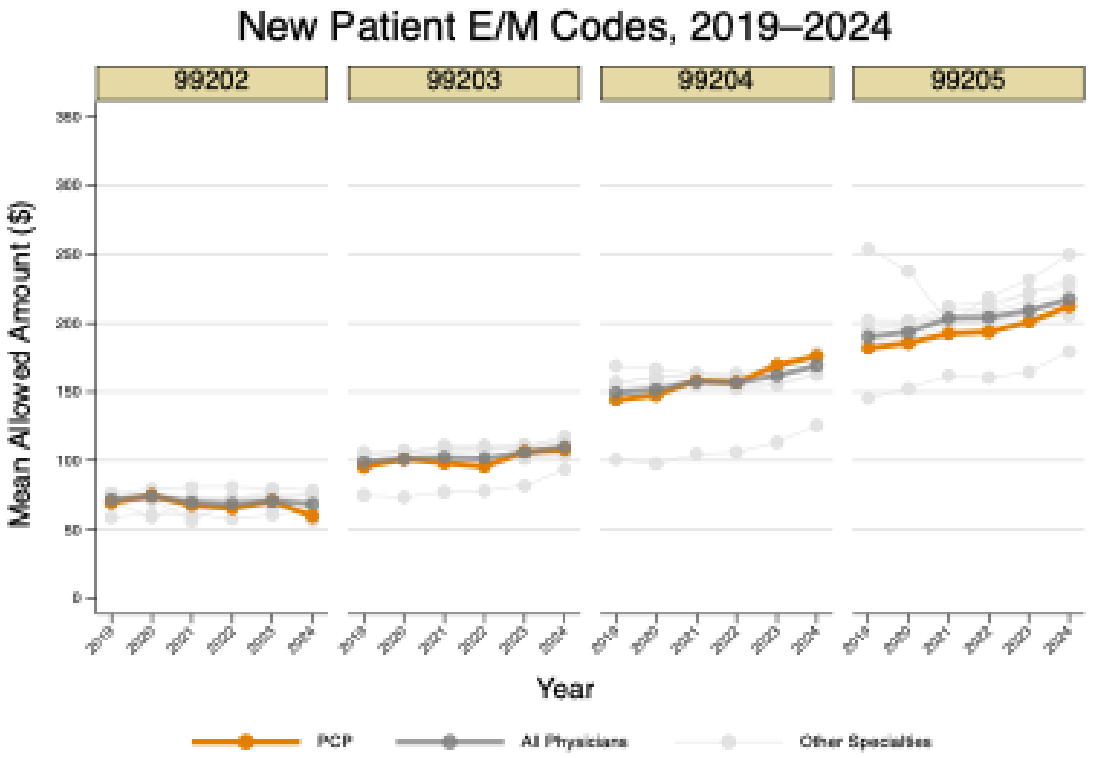
PCP mean allowed amount per visit consistently below all physicians (office visits)

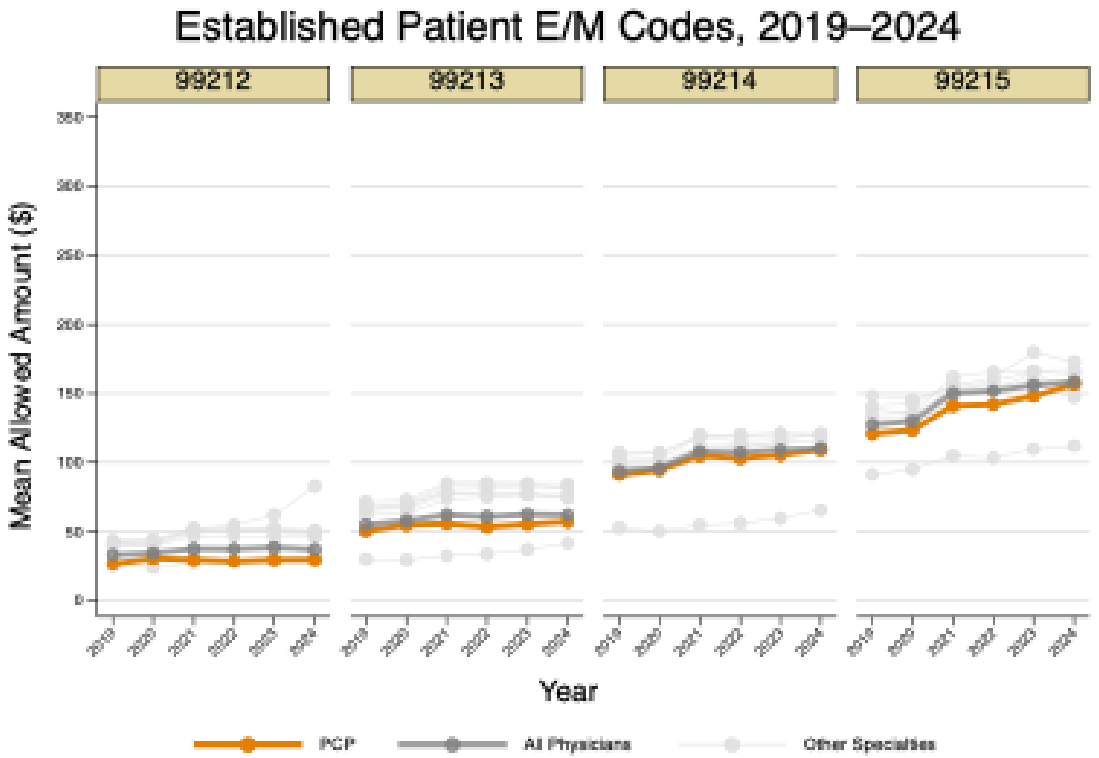
MEAN ALLOWED AMOUNT PER VISIT	2024
PCP (weighted)	$ 150.55
Cardiology	$ 204.03
Dermatology	$ 217.50
Endocrinology	$ 143.38
ENT	$ 208.55
Gastroenterology	$ 238.96
OBGYN	$ 163.90
Pulmonology	$ 221.89
ALL PHYSICIANS (ALLOPATHIC AND OSTEOPATHIC)	$ 205.25



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Payments increase with visit complexity





Summary

Stable workforce composition

Primary care workforce composition is broadly stable over time.

Office-based care remains dominant

Primary care delivery is still overwhelmingly office-based, although telehealth continues to evolve.

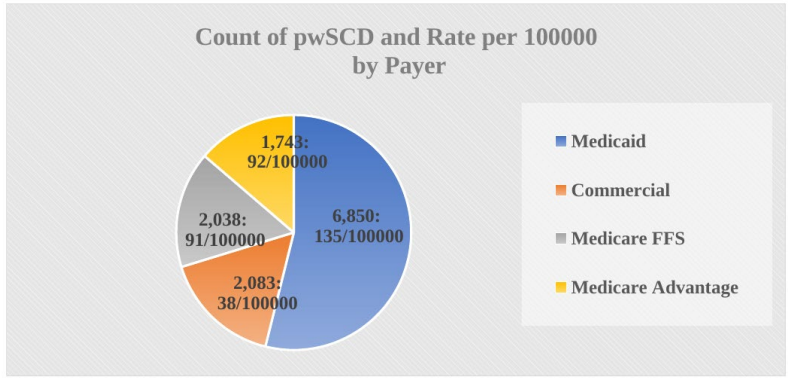
Payment patterns are nuanced

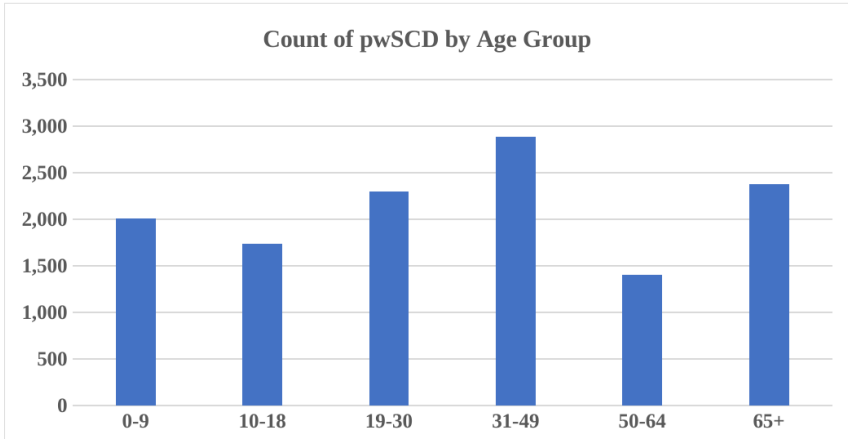
Primary care payments for full office visits are lower than all physicians overall, but E&M-code comparisons are closer across specialties.

Overall message: primary care remains central, office-based, and relatively lower paid than many physician categories.

Sickle Cell Disease Monitoring

Claims-based information to support statewide disease surveillance





Non-technical summary

- TX-APCD identified 12,713 insured Texans with sickle cell disease in 2023.
- The condition appears across all age groups, with the largest count among adults ages 31–49.

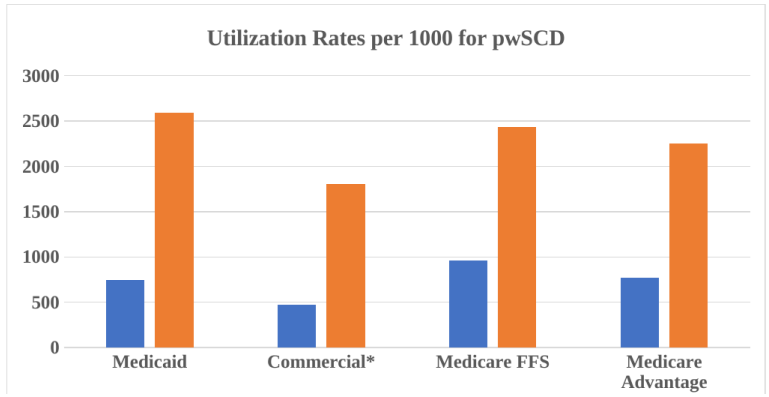
- Medicaid covered the largest number of identified persons, but Medicare and Medicare Advantage rates were also elevated.

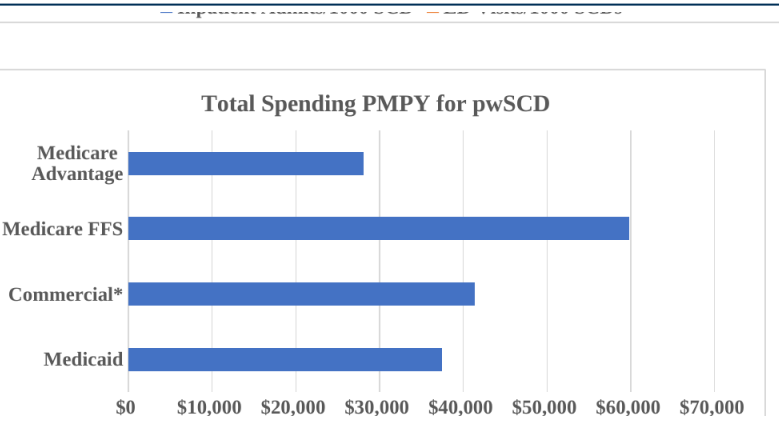
- The project complements registry work with payor, age, utilization, and spending information.

Illustrations reproduced from the Sickle Cell Project Summary and TX-APCD Biennial Report source materials.

Sickle Cell Disease: Utilization and Spending

High acute-care utilization and large spending differences by payor





Key interpretation

- Emergency department visit rates were especially high across payor groups.
- Inpatient admission rates were also substantial; readmissions ranged from 26% to 32% of admissions.

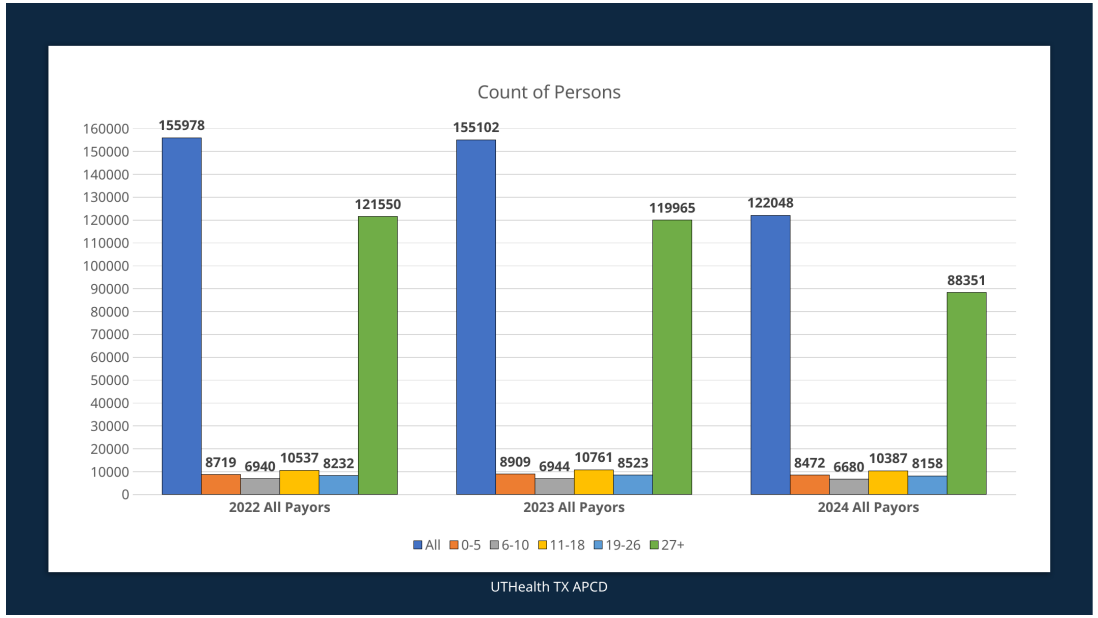
- PMPY spending was highest for Medicare fee-for-service and lowest for Medicare Advantage in the displayed chart.

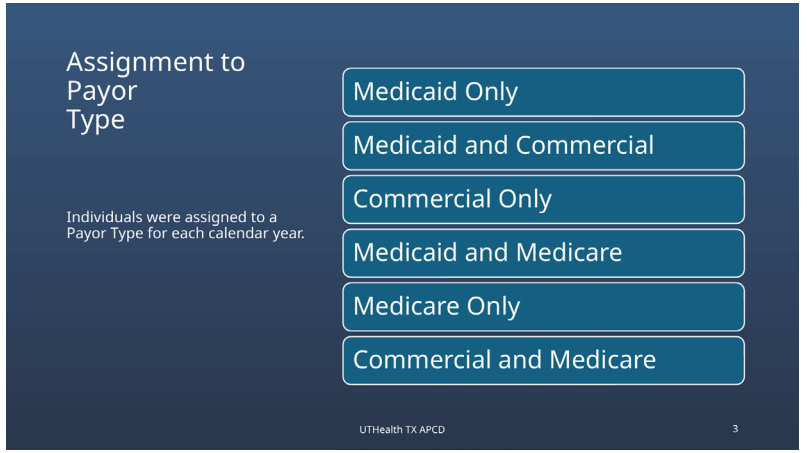
- The results highlight ongoing care coordination and transition needs.

Illustrations reproduced from the Sickle Cell Project Summary and TX-APCD Biennial Report source materials.

Children and Adults with Complex Medical Conditions

Diagnosis-based cohort across the full age spectrum





Non-technical summary

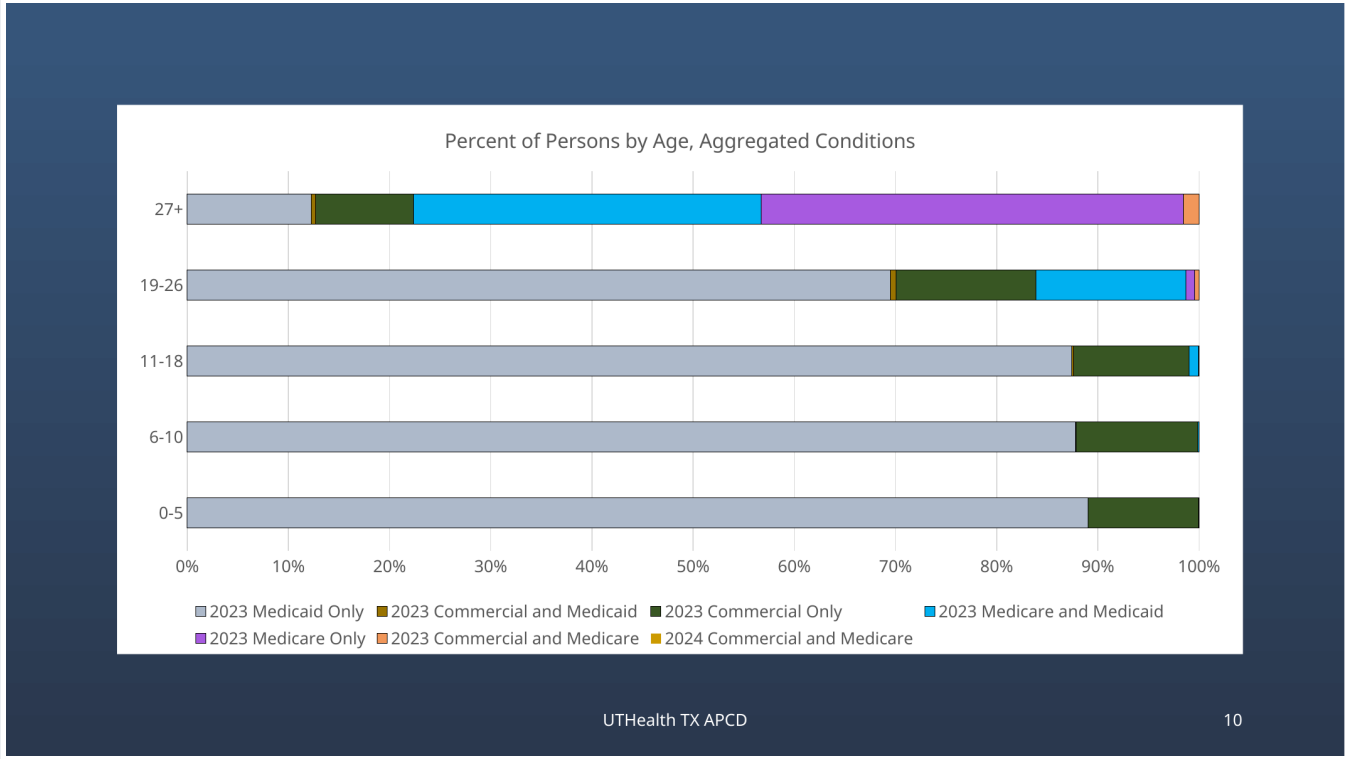
- About 155,000 persons were identified in 2023; the 2024 decline is concentrated among adults 27+ and may reflect missing Medicare data.
- Each person is assigned to one diagnosis category and one payor type per calendar year.
- The framework compares pediatric coverage patterns with adult continuation of childhood-onset or congenital conditions.

Illustrations reproduced from the Fragile Kids source deck and revised narrative.

Adults and Children with Complex Medical Conditions

Complex Conditions: Coverage Shifts by Age

Medicaid dominates in childhood; Medicare becomes prominent after age 26



What the chart shows

- In 2023, Medicaid-only coverage accounts for most persons under age 19.
- Medicaid remains the largest category through ages 19–26.

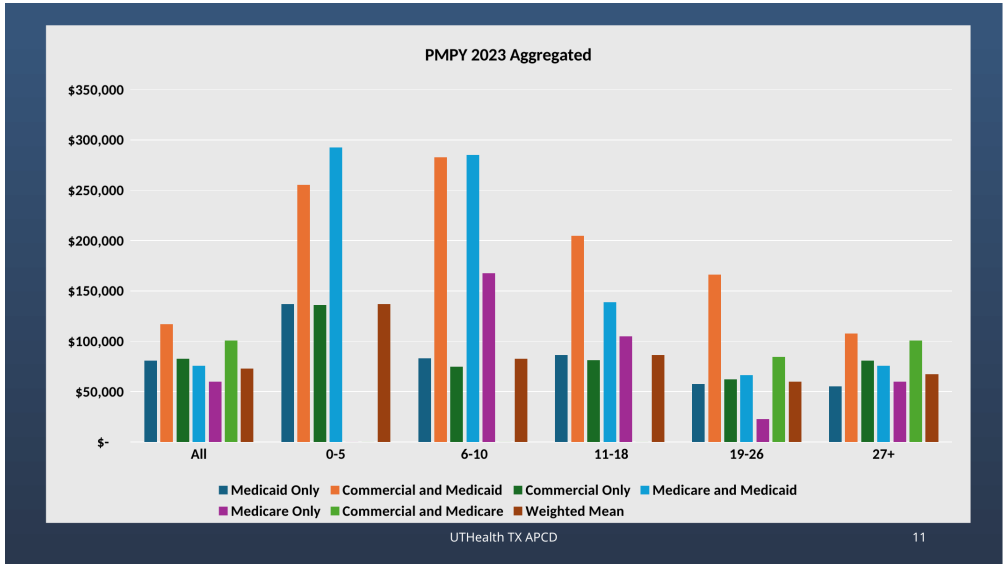
- By age 27+, Medicaid-only falls to roughly 12%, while Medicare-only and Medicare–Medicaid become dominant.

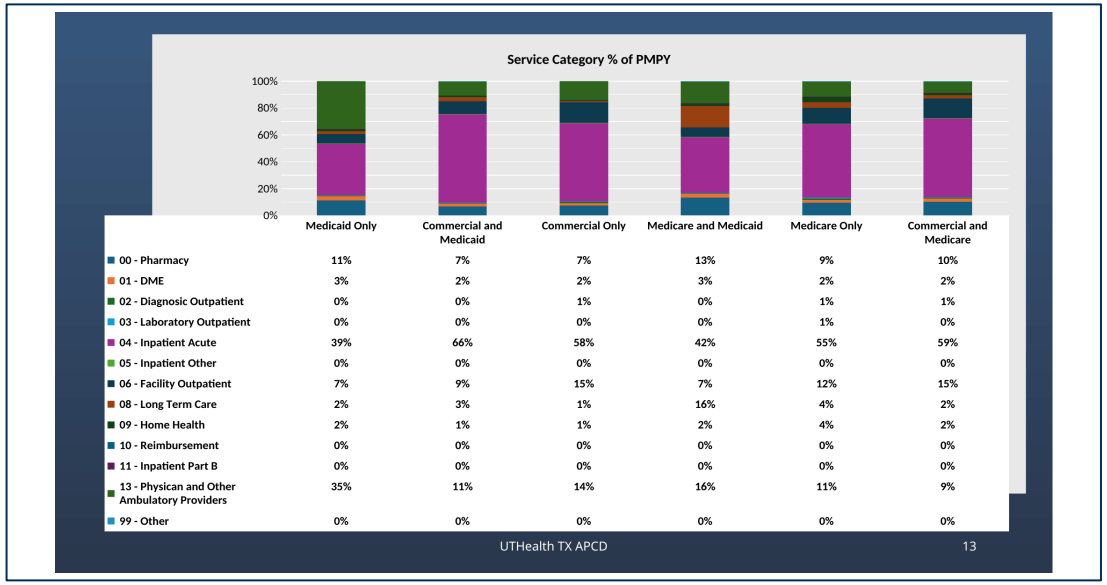
- The pattern reflects lifelong needs and disability-related coverage pathways.

Illustration reproduced from the Fragile Kids source deck and revised narrative.

Complex Conditions: Spending and Service Mix

High PMPY spending varies by age, payor, diagnosis, and service category





	Medicaid Only	Commercial and Medicaid	Commercial Only	Medicare and Medicaid	Medicare Only	Commercial and Medicare
00 - Pharmacy	11%	7%	7%	13%	9%	10%
01 - DME	3%	2%	2%	3%	2%	2%
02 - Diagnosic Outpatient	0%	0%	1%	0%	1%	1%
03 - Laboratory Outpatient	0%	0%	0%	0%	1%	0%
04 - Inpatient Acute	39%	66%	58%	42%	55%	59%
05 - Inpatient Other	0%	0%	0%	0%	0%	0%
06 - Facility Outpatient	7%	9%	15%	7%	12%	15%
08 - Long Term Care	2%	3%	1%	16%	4%	2%
09 - Home Health	2%	1%	1%	2%	4%	2%
10 - Reimbursement	0%	0%	0%	0%	0%	0%
11 - Inpatient Part B	0%	0%	0%	0%	0%	0%
13 - Physican and Other Ambulatory Providers	35%	11%	14%	16%	11%	9%
99 - Other	0%	0%	0%	0%	0%	0%

Non-technical summary

- Average annual spending exceeded $73,000 per person in 2023, with some condition/payor cells over $100,000 PMPY.
- Major cost drivers include inpatient care, physician and ambulatory services, outpatient facility care, pharmacy, DME, long-term care, and home health.

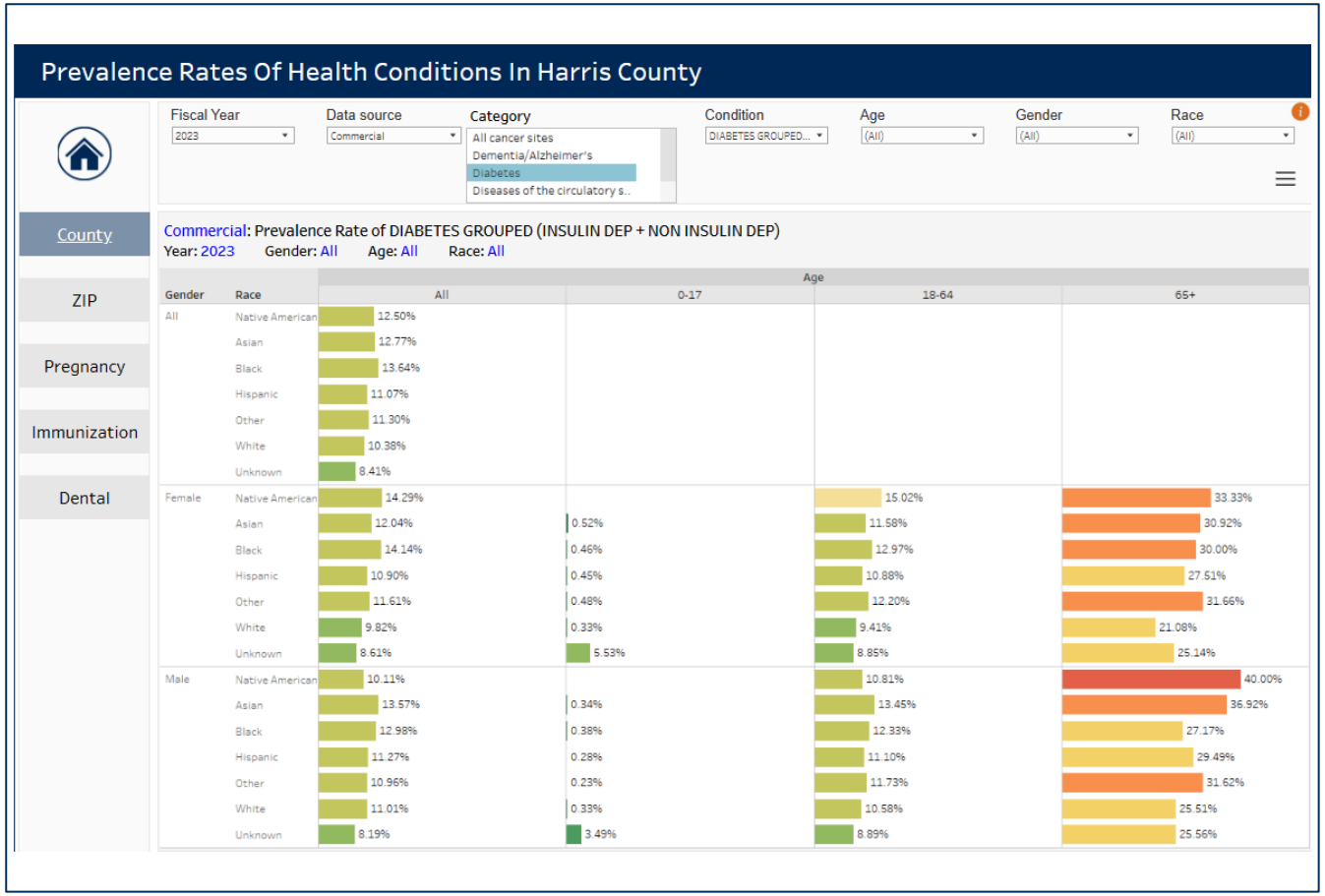
- Medicaid, Medicare, and commercial insurance each play significant roles across the life course.

Illustrations reproduced from the Fragile Kids source deck and revised narrative.

Harris County Chronic Disease

Harris County Chronic Disease Monitoring

Local prevalence dashboards for public health planning



How the output is used

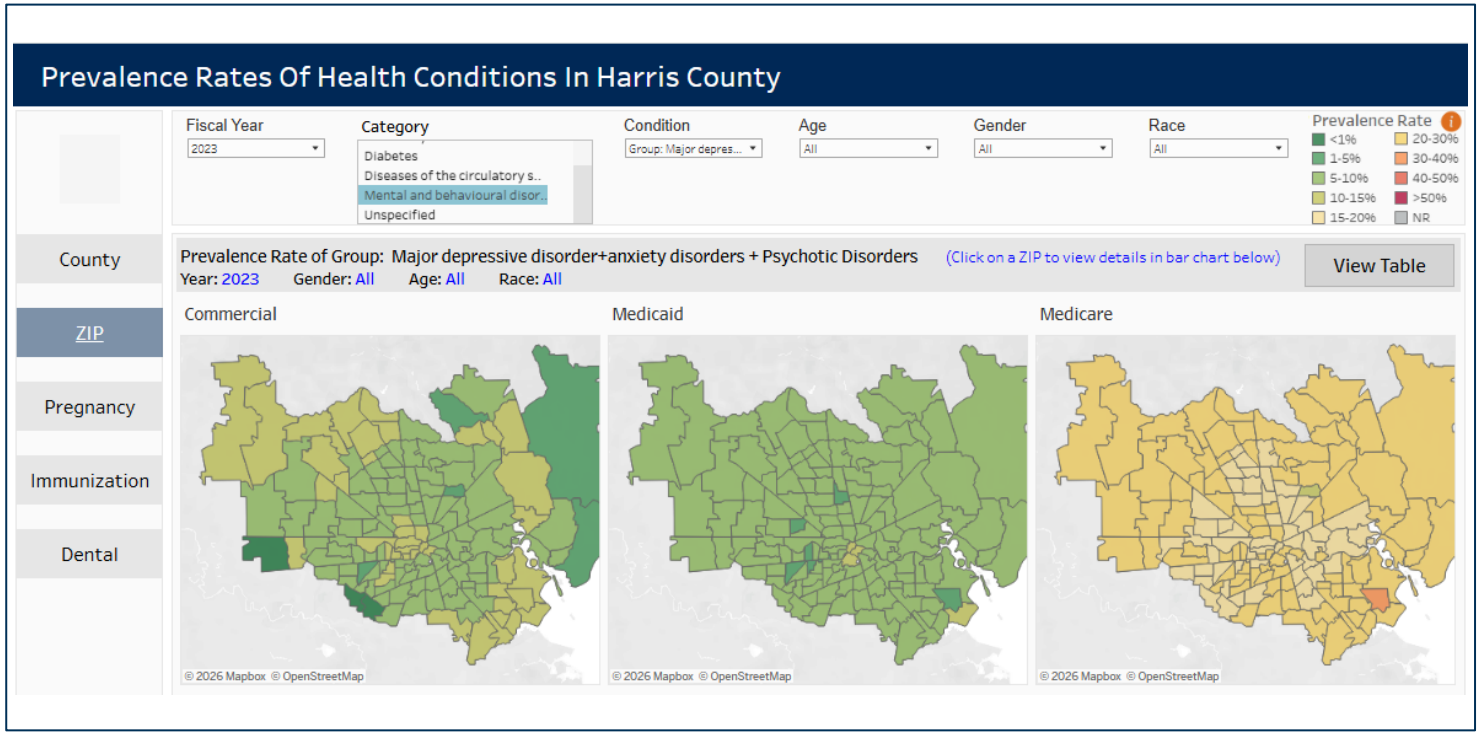
- Harris County requested TX-APCD analysis of selected chronic illnesses among county residents.
- The diabetes view compares prevalence across sex, race, and age for a defined insured population.

- This helps public health staff move beyond a single countywide rate and identify groups where targeted prevention or management strategies may be needed.

Illustration reproduced from the Harris County Health Department narrative.

Harris County: Place-Based and Payor-Specific Patterns

ZIP-code maps show where chronic disease burden may differ by coverage source



Planning value

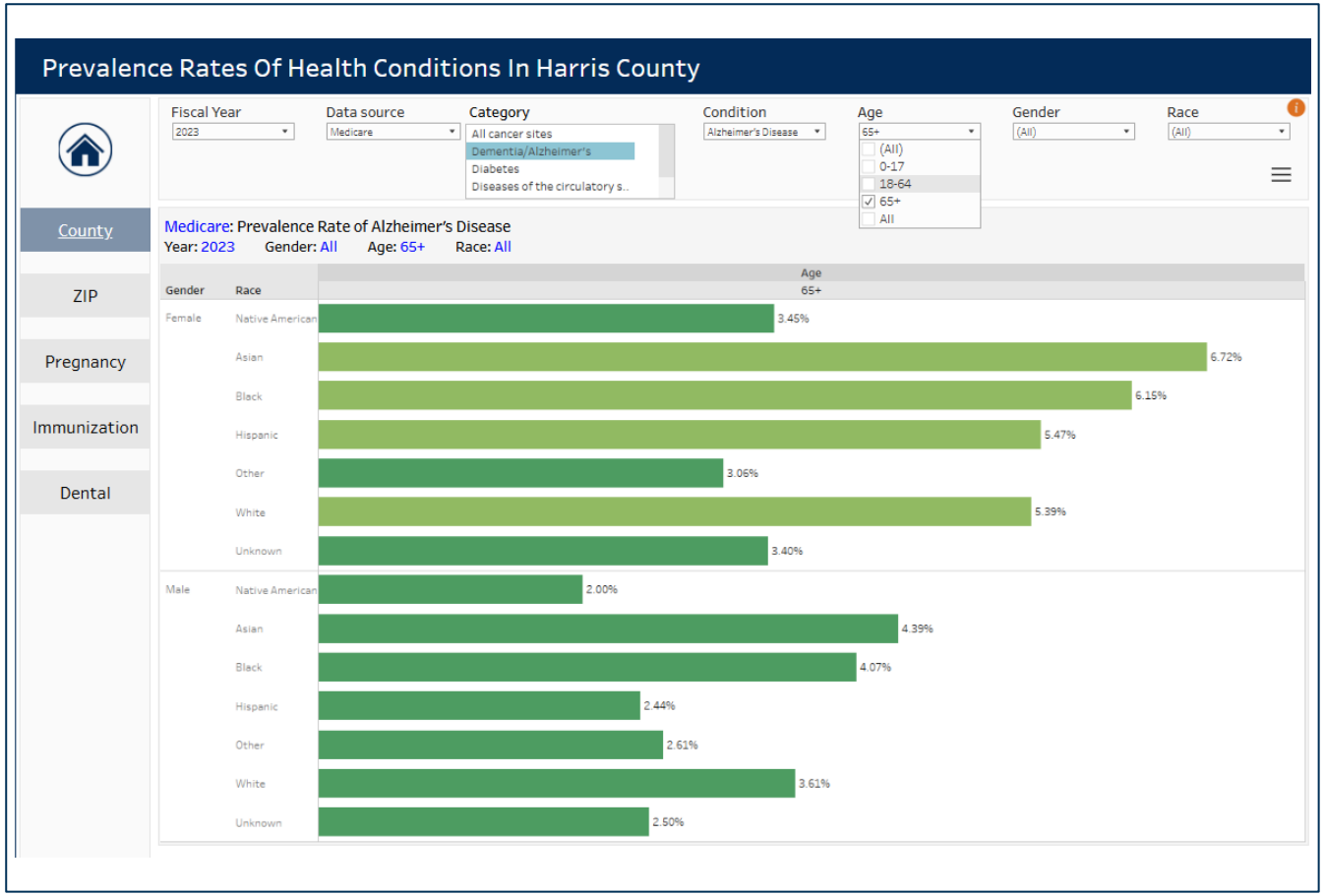
- Side-by-side maps show prevalence by primary insurer: commercial, Medicaid, and Medicare.
- ZIP-code variation can suggest where outreach, prevention programs, or follow-up analysis may be most appropriate.

- The same framework can be adapted to other conditions and local planning questions.

Illustration reproduced from the Harris County Health Department narrative.

Harris County: Actionable Public Health Information

Demographic detail supports resource allocation and ongoing monitoring



Public health significance

- The Alzheimer's example focuses on a Medicare population where older-adult needs are directly relevant.
- Reporting by place, payor, sex, race, and age gives the Health Department a more detailed basis for identifying disparities.
- Outputs can inform planning decisions, guide resource allocation, and monitor whether patterns change over time.

Illustration reproduced from the Harris County Health Department narrative.

Data Enhancements

UTHealth Houston
School of Public Health
Center for Health Care Data

Data Enhancements: Clinical & Utilization Enrichment

Standardized variables that reduce custom coding and improve consistency in utilization and quality studies.

Admissions & Readmissions

Standardized flags for acute inpatient admissions and readmissions.

✓ **Research value:** Supports utilization studies, quality measurement, and avoidable readmission analysis.

Chronic Condition Measures

40–50 person-level chronic condition measures derived for analytic use.

✓ **Research value:** Speeds cohort definition, population segmentation, and risk adjustment.

Emergency Dept. Severity

Emergency department severity classification created using published methodology.

✓ **Research value:** Improves consistency in emergency care analyses.

Stronger data. Smarter research.

These enhancements make research faster, more consistent, and easier to scale across populations and study designs.

Key benefit

- Less custom coding
- Faster utilization studies
- More consistent research outputs

UTHealth Houston
School of Public Health
Center for Health Care Data

Data Enhancements: Cost & Pharmacy Enrichment

Curated provider, cost, and pharmacy enhancements that simplify attribution, spending analysis, and drug research

Master Provider Registry (MPR)

Registry of providers and consolidated provider reference data.

✓ **Research value:** Creates a standardized provider reference layer for research and reporting.

Rendering Provider Attribution

Identifies the rendering provider on the claim and indicates PCP vs. non-PCP along with specialty.

✓ **Research value:** Makes provider attribution and referral pattern analysis easier.

Aggregated Spending Table

Summarized claim table with spending and cost data.

✓ **Research value:** Reduces processing time and lowers analytic burden for cost studies.

Pharmacy Classification

Translates drug codes into broader therapeutic or classification groups.

✓ **Research value:** Simplifies pharmacy analyses and reduces manual code mapping.

Key benefit

- Cleaner provider analysis
- Faster cost studies
- Simpler pharmacy research

Data Enhancements: Identity, Privacy & Linkage

UTHealth Houston
School of Public Health
Center for Health Care Data

Foundational enhancements being worked on that simplify cohort creation, linkage, and more efficient lower-cost research workflows.

Master Patient Index (MPI)

Persistent person-level identifier that supports linking the same individual across files and over time.

✓ **Research value:** Simplifies longitudinal analysis and reduces repeated record-matching work.

De-identified Data Set

Data are de-identified and potentially identifying values masked to support privacy-protective analysis

✓ **Research value:** Enables broader research use and may reduce cost for projects that do not require identified data.

Family ID

In the process of developing algorithms to link subscribers and dependent as well Medicaid case number clients to support research

✓ **Research value:** Supports unit-like utilization, coverage, and spending studies.

Mother/Newborn Matching

In the process of developing algorithms to link mothers and infants in commercial and Medicaid data.

✓ **Research value:** Makes maternal-child health research more practical and accurate.

Key benefit

- Faster cohort construction
- Less custom linkage work
- More accessible data for research

Thank You