

MassHealth Primary Care Effort Model (PCEM)

Model Overview - 2025

The Massachusetts Executive Office of Health and Human Services has developed the Primary Care Effort Model (PCEM) as a risk adjustment tool for the Primary Care Sub-Capitation program as part of the MassHealth Accountable Care Organization (ACO) program. We have explored how medical complexity factors can be used to predict the level of effort primary care providers must maintain to deliver care for their member panel. While there have been earlier iterations of a primary care risk adjustment model, this is the first used to impact primary care payments at EOHHS. Implementation of PCEM will apply to prospective primary care sub-capitation rates starting on January 1, 2025.

This model overview document is intended to help Accountable Care Partnership Plans (ACPPs) and Primary Care Accountable Care Organizations (PCACOs) understand how MassHealth has constructed PCEM, which was built using State Fiscal Year 2022 (SFY22) data for 590,000 MassHealth ACO members whose average primary care cost was \$426 per year. This document will review the study population, dependent variable construction, model development, and model evaluation. There will be separate deliverables overviewing risk score calculations.

This model overview will cover these topics throughout the following sections:

1. Study Population
2. Model Development
 - 2.1 Dependent Variable Construction
 - 2.2 Independent Variables Construction
3. Model Evaluation
 - 3.1 Final Coefficients
 - 3.2 Validation
 - 3.3 Observed to Expected Ratios
4. Appendix
 - 4.1 Aggregate Condition Categories
 - 4.2 Independent Variable Definitions

1. Study Population

Table 1 – Modeling Pool Characteristics

	Member Count	Percent
Total	590,000	100%
Sex		
Female 1	7,277	1.2%
Female 2 to 3	15,436	2.6%
Female 4 to 6	23,934	4.1%
Female 7 to 12	47,729	8.1%
Female 13 to 17	39,495	6.7%
Female 18 to 24	30,875	5.2%

Female 25 to 34	49,872	8.5%
Female 35 to 44	41,773	7.1%
Female 45 to 54	29,363	5.0%
Female 55 to 60	15,072	2.6%
Female 60 plus	9,109	1.5%
Male 1	7,538	1.3%
Male 2 to 3	16,025	2.7%
Male 4 to 6	24,728	4.2%
Male 7 to 12	50,020	8.5%
Male 13 to 17	40,862	6.9%
Male 18 to 24	25,413	4.3%
Male 25 to 34	29,997	5.1%
Male 35 to 44	26,959	4.6%
Male 45 to 54	22,948	3.9%
Male 54 to 60	12,844	2.2%
Male 60 plus	7,588	1.3%
Normal - High Complexity Newborns	14,485	2.5%
<i>Aggregate Condition Categories</i>		
1 ACC (Child)	81,018	13.7%
2 ACCs (Child)	35,918	6.1%
3 ACCs (Child)	8,778	1.5%
4 Plus ACCs (Child)	9,433	1.6%
1 ACC (Adult)	48,092	8.2%
2 ACCs (Adult)	39,222	6.6%
3 ACCs (Adult)	30,331	5.1%
4 Plus ACCs (Adult)	66,826	11.3%
PMCA x Common Acute Conditions (1)	20,332	3.4%
PMCA x Common Acute Conditions (2)	16,812	2.8%
Adult Disability x Common Acute Conditions (1)	14,172	2.4%
Adult Disability x Common Acute Conditions (2)	12,662	2.1%
Developmental Disabilities	81,347	13.8%
Persistent BH (Child)	54,834	9.3%
Other BH (Child)	14,621	2.5%
Persistent BH (Adult)	113,871	19.3%
Other BH (Adult)	18,728	3.2%
Delivery	9,207	1.6%
OOD	7,673	1.3%
OOD + SMI	21,208	3.6%

Notes: the study population began with individuals aged 0-64 years enrolled with MassHealth during State Fiscal Year 2022 (SFY22) for at least 9 months. This resulted in 954,848 members being identified. To better reflect current enrollment, MassHealth limited membership in the study population to those who were still eligible as of April 1, 2023, removing 71,982 members. The pool was further reduced to create a representative holdout sample used in final model validation

(detailed further in the validation section). This holdout sample consisted of 292,876 members. The remaining pool of 590,000 members was used to build the PCEM model and is referred to as the modeling pool throughout this document. Table 1 illustrates key characteristics for this modeling pool.

2. Model Development

2.1 Dependent Variable Construction

The dependent variable represents the set of primary care sub-capitation-based service costs expected for the member. Specifically, the model is trained concurrently on costs reflecting the service codes in the Primary Care Sub-Capitation Included Services list and is intended to mirror the Primary Care Sub-Capitation payments that would ultimately be risk adjusted using PCEM. This set of costs was limited to services provided by a primary care provider based on the current specialty logic. This cost data was identified using State Fiscal Year (SFY) 2022 claims and encounter data. To better approximate costs following the end of the Public Health Emergency, MassHealth constructed the dependent variable on cost data specifically for members still eligible as of April 1, 2023.

Additional adjustments to the dependent variable include top-coding at the 99th percentile of costs and bottom coding to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visit schedule for all members. Top and bottom coding reduced data variation in the outcome variable, improving overall model performance. Additionally, bottom coding to the EPSDT visit schedule for all members acknowledges that members with little to no utilization in the modeling base data still require care coordination and outreach efforts.

The dependent variable also utilizes uniform pricing on all claims across provider types. Provider type fee schedules are fundamental to the MassHealth provider fee-for-service payment; however, those fee schedule differences do not correspond to proportional member acuity differences. To avoid confounding model prediction with external factors and to minimize statistical variation, all claim unit costs were repriced according to the EOHHS Physician fee schedule. CHC APM claims specifically were repriced based on a distribution of E&M codes from other claim lines for cases specifically where the T1015 was standalone and not a well visit. All others were repriced using the E&M on the line item. For example, if a CHC claim included a diagnosis for a well visit, the claim was considered equivalent to a 99XXX E&M claim and received the same corresponding MassHealth fee schedule amount. This uniform pricing methodology resulted in average primary care costs being more comparable between provider types for the purposes of modeling.

Under the above methodology, the average primary care cost per member per year across all rating categories and provider types is \$426 for the modeling pool.

2.2 Independent Variables Construction

The independent variables represent the inputs used to predict the set of costs defined by the dependent variable. Specifically, the final PCEM reflects the independent variables found to be the most significant predictors for primary care costs as defined by the primary care sub-capitation

program. This section serves as an overview for each independent variable. Table 6 in the Appendix further details how PCEM defines each independent variable.

PCEM includes several independent variables that are also found within the Social Determinants of Health (SDH) 4.0 model currently used in ACO/MCO risk adjustment (note: although representing similar populations, not all these variables are constructed the same between both models - please refer to respective definitions):

Age/sex bands: PCEM utilizes the same age/sex bands as SDH 4.0. These age/sex bands reflect experience for members aged 1 through 64. Females aged 2-3 are considered the reference population. Please note that age/sex bands for most members are negative coefficients, while the age/sex bands for 1-year-olds are positive, and for 2-3-year-olds the coefficients are semi-neutral. This reflects the higher number of primary care costs for members under 4, and especially under 1-years-old.

DxCG and RxCG: PCEM uses DxCG Intelligence software, licensed from Cotiviti, to measure medical risk. These models include DxCG model #88 (diagnoses codes) and RxCG model #86 (National Drug Code identifier). Both models are a part of the Commercial population models in the Budgeting and Underwriting Bundle and result in member-level risk scores predicting medical costs. Although the DxCG and RxCG models are total cost of care predictors, MassHealth found them to be significant at predicting primary care costs but to a much lesser extent than seen with SDH 4.0 predictions.

Delivery: MassHealth found that including a delivery coefficient, which represents a delivery occurring during the base period, to be predictive of primary care costs. This suggests that members experiencing a delivery incur higher primary care costs than those who do not.

Newborns: PCEM includes a single variable for newborns (members under age 1). This variable reflects costs for healthy newborns and through most medically complex newborns (through Level III NICU). Costs associated with the highest complexity level newborns (Levels IV/V NICU) are not reflected in the newborn coefficient and instead are considered the reference population. These highest complexity newborns represent a very small number of children whose services typically fall outside of the primary care setting for a significant portion of the 1st year of life.

Behavioral health: PCEM utilizes a behavioral health hierarchy structure including two distinct variables for both adults and children. The “persistent” behavioral health variable includes psychoses, Serious Emotional Disturbance, and Department of Mental Health clients. The “other” behavioral health variable includes a variety of conditions which are outlined in the Appendix in Table 6. The hierarchy structure means that, should a member flag for at least one condition under each behavioral health variable, then that member will receive the higher coefficient between the two.

PCEM also includes unique variables that are not present in the SDH 4.0 model:

Acknowledge that managing chronic conditions is a major part of the primary care provider’s time/effort (and therefore, spend): MassHealth found that as the number of chronic conditions a member experiences increase, primary care costs also meaningfully increase. To account for this relationship, PCEM utilizes Cotiviti’s Aggregate Condition Categories (ACCs), a broad list of 31

clinical systems and conditions, to create several variables capturing chronic condition counts across members. These ACCs as well as any adjustments made to the original list can be found in the Appendix in table 4.

To identify chronic conditions within each ACC, MassHealth used the Cotiviti DxCG chronic conditions flag list, which maps to specific diagnoses codes considered chronic. These chronic conditions map to a Condition category (CC), then to a Relational Condition Category (RCC), and from there to the broadest level, an Aggregate Condition Category (ACC).

The resulting independent variables are binary indicators for the number of body systems (ACCs) affected: 1 ACC, 2 ACCs, 3 ACCs, and 4+ ACCs. For example, a member flagged as having two chronic conditions – one under the “Heart” ACC and one under the “Lung” ACC – and with no additional chronic conditions, would trigger the “2 ACCs” coefficient in PCEM.

MassHealth found primary care costs associated with chronic conditions to be meaningfully different between adults and children and therefore created separate coefficients for each.

Note: of the 31 original ACC groupings, MassHealth is addressing 28 in the ACC independent variable groupings. Those excluded are addressed through different independent variables (Mental Health and Developmental Disabilities). The “Complications of Care” ACC grouping is also excluded as a unique grouping – this is primarily to reduce confounding as the associated chronic conditions are also included in other ACC groupings. Additionally, Opioid Use Disorder (OUD) is removed as a condition under the Substance Use ACC and is instead addressed as a separate coefficient. Table 4 in the Appendix demonstrates these exceptions.

Comprehensive accounting of disability and pediatric medical complexity in primary care effort by including predictive factors not otherwise captured in the ACCs approach. These variables fall into two categories:

1. Children who are flagged by the Pediatric Medical Complexity Algorithm (PMCA) as complex chronic or non-complex chronic that are not being captured in the ACCs approach
2. Adults with a disability flag that are not being captured in the ACCs approach

PCEM includes two variables for each of the above groupings. Group 1 includes a subset of conditions under Ears, Nose, and Throat (ENT), eyes, and skin conditions. Group 2 includes a subset of conditions Gastrointestinal (GI), injuries, and various infections. Table 6 in the Appendix details this further. These two groupings capture a range of more acute conditions, and MassHealth found that the interaction of disability (for adults) or PMCA (for children) AND acute conditions yielded the best prediction. While MassHealth understands that the members experiencing acute conditions might vary from the base year to the performance year, our hypothesis is that it is important to capture a) which practices may generally have more of these complex members coming in for acute conditions and b) which practices may have more availability to see members with an acute need. It is expected that practices with these types of members in a prior year will serve similar members in the following year, and therefore is important to reflect with PCEM.

MassHealth also evaluated the inclusion of several social factors that impact health outcomes such as homelessness, housing instability, and a geographic index. These factors either yielded significantly negative coefficients in the model or were found to be insignificant. In the case of

homelessness in particular, the coefficient in the SDH 4.0 model is highly positive, while the coefficient in the PCEM modeling was highly negative, indicating underutilization of primary care services for these members. As a result, MassHealth decided to exclude these factors as PCEM independent variables as to not penalize providers for caring for more socially complex members. Additionally, MassHealth found that the final PCEM predicted primary care costs for homeless members well without the addition of an independent variable (Table 3).

3. Model Evaluation

3.1 Final Coefficients

Table 2: PCEM Final Prediction Coefficients

Intercept	287
DxCG	12
RxCG	43
<i>Aggregate Condition Categories (Child)</i>	
1 ACC	125
2 ACCs	229
3 ACCs	339
4+ ACCs	522
<i>Aggregate Condition Categories (Adult)</i>	
1 ACC	116
2 ACCs	196
3 ACCs	280
4+ ACCs	511
<i>Behavioral Health Hierarchy (Child)</i>	
Persistent BH	91
Other BH	62
<i>Behavioral Health Hierarchy (Adult)</i>	
Persistent BH	86
Other BH	91
PMCA x Common Acute Conditions (1)	61
PMCA x Common Acute Conditions (2)	59
Adult Disability x Common Acute Conditions (1)	8
Adult Disability x Common Acute Conditions (2)	18
Newborns (Normal to High Complexity)	201
Developmental Disabilities	19
Delivery	45
OUD (Only)	232
OUD + SMI	170
<i>Female age bands</i>	
1	227
2 to 3	

4 to 6	-82
7 to 12	-125
13 to 17	-129
18 to 24	-104
25 to 34	-92
35 to 44	-84
45 to 54	-81
55 to 59	-102
60 plus	-118
<i>Male age bands</i>	
1	230
2 to 3	4
4 to 6	-90
7 to 12	-138
13 to 17	-142
18 to 24	-177
25 to 34	-189
35 to 44	-176
45 to 54	-190
55 to 59	-197
60 plus	-189

3.2 Validation

The preliminary PCEM was developed using State Fiscal Year 2022 (SFY22) data as described in the dependent variable construction section. Prior to modeling, MassHealth constructed a representative holdout sample to be set aside and used in validating the final model. MassHealth considered several validation options before proceeding with the SFY22 representative holdout sample. This was found to be the best option primarily due to SFY22 data being the most recent period available at the time of modeling that also had sufficient run-out and had been thoroughly vetted. The SFY22 representative holdout sample was created across a variety of strata to ensure that as many pools of members as possible were included. As a result, PCEM is trained on the original SFY22 modeling base data and then validated on the SFY22 representative holdout sample.

The final PCEM validated strongly when ran on the SFY22 representative holdout sample. As a result, none of the model coefficients were updated based on validation findings. The following section details more on PCEM performance when ran on the combined SFY22 data set including both the modeling and validation pool as well as any members excluded for redeterminations.

3.3 Observed to Expected Ratios

The following table illustrates the accuracy of the final PCEM using observed to expected cost ratios across a variety of member subpopulations. An O:E ratio of less than one indicates overprediction of the model, whereas an O:E ratio of more than one indicates underprediction. Most populations evaluated yielded O:E ratios close to 1.0, with minimal populations being

underpredicted by greater than 10 percent. The O:E ratios shown below are for both the modeling pool as well as the representative holdout sample (i.e., the entire SFY22 member pool).

Table 3: PCEM Observed to Expected Cost Ratios for Full SFY22 Member Pool

	Member Count	Observed Cost (O)	Predicted Cost (E)	O:E Ratio
Total	954,858	\$ 412	\$ 412	1.00
Sex				
Female 1	11,834	\$ 657	\$ 685	0.96
Female 2 to 3	24,730	\$ 391	\$ 426	0.92
Female 4 to 6	37,949	\$ 304	\$ 324	0.94
Female 7 to 12	75,365	\$ 275	\$ 292	0.94
Female 13 to 17	61,738	\$ 333	\$ 341	0.98
Female 18 to 24	50,160	\$ 396	\$ 406	0.98
Female 25 to 34	83,891	\$ 472	\$ 465	1.01
Female 35 to 44	68,101	\$ 542	\$ 530	1.02
Female 45 to 54	48,125	\$ 630	\$ 609	1.03
Female 55 to 60	25,095	\$ 650	\$ 623	1.04
Female 60 plus	15,330	\$ 643	\$ 612	1.05
Male 1	12,185	\$ 689	\$ 713	0.97
Male 2 to 3	25,746	\$ 435	\$ 469	0.93
Male 4 to 6	39,513	\$ 328	\$ 349	0.94
Male 7 to 12	79,415	\$ 289	\$ 304	0.95
Male 13 to 17	63,893	\$ 291	\$ 300	0.97
Male 18 to 24	40,745	\$ 252	\$ 250	1.01
Male 25 to 34	50,996	\$ 313	\$ 296	1.06
Male 35 to 44	44,629	\$ 406	\$ 382	1.06
Male 45 to 54	38,211	\$ 480	\$ 440	1.09
Male 54 to 60	21,446	\$ 533	\$ 478	1.12
Male 60 plus	12,710	\$ 561	\$ 508	1.10
Normal - High Complexity Newborns	22,087	\$ 624	\$ 680	0.92
Aggregate Condition Categories				
1 ACC (Child)	125,305	\$ 393	\$ 417	0.94
2 ACCs (Child)	54,923	\$ 519	\$ 542	0.96
3 ACCs (Child)	13,649	\$ 737	\$ 734	1.00
4 Plus ACCs (Child)	14,231	\$ 960	\$ 888	1.08
1 ACC (Adult)	82,406	\$ 381	\$ 380	1.00
2 ACCs (Adult)	64,458	\$ 491	\$ 480	1.02
3 ACCs (Adult)	50,139	\$ 600	\$ 580	1.03
4 Plus ACCs (Adult)	114,414	\$ 941	\$ 855	1.10
PMCA x Common Acute Conditions (1)	30,850	\$ 350	\$ 372	0.94
PMCA x Common Acute Conditions (2)	25,438	\$ 360	\$ 379	0.95

Adult Disability x Common Acute Conditions (1)	19,873	\$	557	\$	522	1.07
Adult Disability x Common Acute Conditions (2)	17,665	\$	576	\$	524	1.10
Developmental Disabilities	119,873	\$	548	\$	535	1.02
Persistent BH (Child)	81,946	\$	464	\$	480	0.97
Other BH (Child)	22,804	\$	387	\$	337	1.15
Persistent BH (Adult)	173,879	\$	681	\$	631	1.08
Other BH (Adult)	30,147	\$	607	\$	595	1.02
Delivery	14,545	\$	654	\$	579	1.13
ODD (Opioid Use Disorder)	11,962	\$	563	\$	547	1.03
ODD + SMI (Serious Mental Illness)	29,872	\$	890	\$	760	1.17
RC I - Adult*	194,540	\$	463	\$	446	1.04
RC I - Child*	474,169	\$	339	\$	358	0.95
RC II - Adult*	71,443	\$	669	\$	614	1.09
RC II - Child*	26,698	\$	480	\$	490	0.98
RC IX*	180,227	\$	422	\$	416	1.02
RC X*	7,781	\$	703	\$	630	1.12
DMH (Department of Mental Health) Client*	4,110	\$	546	\$	597	0.92
DDS (Department of Disability Services) Client*	3,440	\$	477	\$	513	0.93
DCF (Department of Children and Families) Client*	10,408	\$	383	\$	405	0.95
Homelessness*	16,833	\$	664	\$	665	1.00
Housing Instability*	69,722	\$	414	\$	425	0.97
SED (Severe Emotional Disturbance)*	196,850	\$	621	\$	588	1.06
SUD (Substance Use Disorder)*	83,693	\$	698	\$	671	1.04

*Populations are not PCEM independent variables but are shared for additional context on the model's performance.

4. **Appendix**

4.1 Aggregate Condition Categories

Table 4: PCEM Aggregate Condition Categories Approach

Aggregate Condition Categories	Status in ACC Groupings
Benign/In Situ/Uncertain Neoplasm	Included
Cardio-Respiratory Arrest	Included
Cerebro-Vascular	Included
Cognitive Disorders	Included
Complications of Care	Excluded to avoid confounding variables; associated chronic conditions are included in the other ACCs.
Developmental Disabilities	Excluded, addressed as independent variable
Diabetes	Included
Ears, Nose, and Throat	Included
Eyes	Included

Gastrointestinal	Included
Genital System	Included
Heart	Included
Hematological	Included
Infectious and Parasitic	Included
Injury, Poisoning	Included
Liver	Included
Lung	Included
Malignant Neoplasm	Included
Mental Health	Excluded - addressed as independent variable
Musculoskeletal and Connective Tissue	Included
Neonates	Included
Neurological	Included
Nutritional and Metabolic	Included
Pregnancy-Related	Included
Screening/History	Included
Skin and Subcutaneous	Included
Substance Abuse	Included except for OUD, which is addressed as an independent variable
Symptoms, Signs and Ill-Defined Conditions	Included
Transplants, Openings, Other V-Codes	Included
Urinary System	Included
Vascular	Included

Table 5: SFY22 ACC Counts for DxCG Chronic Conditions Flags

Adult				
# ACCs Affected	Frequency	% of Total	Cum Frequency	% of Cum Total
0	142,561	31.4%	142,561	31.4%
1	82,406	18.2%	224,967	49.6%
2	64,458	14.2%	289,425	63.8%
3	50,139	11.0%	339,564	74.8%
4	37,689	8.3%	377,253	83.1%
5	26,413	5.8%	403,666	88.9%
6	18,187	4.0%	421,853	92.9%
7	11,966	2.6%	433,819	95.6%
8	7,910	1.7%	441,729	97.3%
9	5,077	1.1%	446,806	98.4%
10+	7,172	1.6%	453,978	100.0%

Child				
# ACCs Affected	Frequency	% of Total	Cum Frequency	% of Cum Total
0	285,040	56.9%	285,040	56.9%
1	125,305	25.0%	410,345	81.9%
2	54,923	11.0%	465,268	92.9%
3	21,379	4.3%	486,647	97.2%
4	8,040	1.6%	494,687	98.8%
5+	6,191	1.2%	500,878	100.0%

4.2 Independent Variable Definitions

Table 6: PCEM Independent Variable Definitions

Variable	Description
DxCG	DxCG v6.0, Model 88. Developed using commercial insurance data to predict concurrent total risk, top-coded at \$250k, from diagnoses.
RxCG	RxCG v 6.0, Model 86. Developed using commercial insurance data to predict concurrent total risk from pharmacy data.
Normal – High Complexity Newborn	APR DRG 626, or 640 or R&B code of 170 - nursery APR DRG of 625, 633, 634, 636, 639 or R&B code of 171, or 179 APR DRG of 607, 608, 612, 614, 621, 622, 623, 631 or R&B code of 172 - Level II NICU APR DRG of 589, 603, 611, 613 or R&B code of 173 - Level III NICU
Delivery	DxCG V6.0 DXG of 799 - normal delivery, 784 - cesarean delivery, or 783 - premature delivery or DRG indicating vaginal or cesarean delivery
1 ACC	Member is flagged as having one ACC affected by at least one chronic condition, as defined by the DxCG chronic conditions list, during the base period
2 ACCs	Member is flagged as having two ACCs affected by at least one chronic condition, as defined by the DxCG chronic conditions list, during the base period
3 ACCs	Member is flagged as having three ACCs affected by at least one chronic condition, as

	defined by the DxCG chronic conditions list, during the base period
4+ ACCs	Member is flagged as having four or more ACCs affected by at least one chronic condition, as defined by the DxCG chronic conditions list, during the base period
Persistent BH	Schizophrenia spectrum disorders, affective psychosis, and other psychotic disorders identified by ICD10 diagnosis codes F20.x, F21.x, F22.x, F23.x, F24.x, F25.x, F30.2, F31.2, F31.5, F32.3, F33.3 Personality disorders, eating disorders, mood and anxiety disorders, suicide attempts, psychoses not captured in the Psychosis variable defined by DxCG v6.0 Dx Groups 391, 392, 402 – 411, 417, 418, 420 Serious mental illness defined by DxCG v6.0 Dx Groups 403, 403, 405, 408, 410
Other BH	Remaining BH conditions not addressed in other BH hierarchy groupings, such as dementia, mild depression, PPD, sleep disorders, attachment disorders, traumatic brain injury, impulse disorders, neglect, abuse, trauma, and unspecified non-psychotic disorders identified by DxCG v6.0 Dx Groups: 375, 391-397, 399, 400, 405, 407, 411, 413, 416, 419, 423, 424, 428, 433, 434, 914, 916, 917, 923 or by ICD10 diagnosis codes: F53.x, P03.x, R45.x, S06.x, T14.x, T41.x, T42.x, T64.x, Z91.x
Opioid Use Disorder (Only)	ICD10 procedure codes: F1110 F11120 F11121 F11122 F11129 F1113 F1114 F11150 F11151 F11159 F11181 F11182 F11188 F1119 F1120 F11220 F11221 F11222 F11229 F1123 F1124 F11250 F11251 F11259 F11281 F11282 F11288 F1129
Opioid Use Disorder + Serious Mental Illness	Same definitions as OUD plus SMI defined as DxCG v6.0 Dx Groups 403, 403, 405, 408, 410
Developmental Disabilities	Member is a client of DDS, has a diagnosis of ASD or IDD (F70, F71, F72, F73, F78, F79, and F84), or flags for RCCs 46 - chromosomal and developmental disorders or 47 - severe developmental disabilities
PMCA x Common Acute Conditions (1)	Member has flags as PMCA chronic or PMCA non-complex chronic and has one of the following: musculoskeletal conditions (RCC 27),

	other ENT disorders (RCC 85), eye conditions (RCC 82), or skin ulcers (RCC 97)
PMCA x Common Acute Conditions (2)	Member flags as PMCA chronic or PMCA non-complex chronic and has one of the following RCCs: infections (1), excess weight (12), other GI conditions (21), lower leg & foot conditions/injuries (30), injuries (31), or forearm & hand disorders/injuries (32)
Adult Disability x Common Acute Conditions (1)	Member is RC II-Adult at any time during the year and has one of the following: musculoskeletal conditions (RCC 27), other ENT disorders (RCC 85), eye conditions (RCC 82), or skin ulcers (RCC 97)
Adult Disability x Common Acute Conditions (2)	Member flags is RC II Adult at any time during the year and has one of the following RCCs: infections (1), excess weight (12), other GI conditions (21), lower leg & foot conditions/injuries (30), injuries (31), or forearm & hand disorders/injuries (32)