Appendix A: Ten Principles of Risk Adjustment

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Principle	Description
1. Clinically meaningful diagnostic categories	Each diagnostic category is a set of ICD-10-CM codes that relate to a reasonably well-specified, clinically meaningful disease or medical condition that defines the category.
2. Diagnostic categories should predict medical (and/or drug) expenditures	Diagnoses in the same HCC should be reasonably homogeneous with respect to their effect on both current year costs (for concurrent risk adjustment) or next year's cost (for prospective risk adjustment).
3. Adequate sample size of diagnostic categories	Diagnostic categories that will affect payments should have adequate sample sizes to permit accurate and stable estimates of expenditures.
4. Hierarchies apply only within related disease processes	Costs are additive across hierarchies and disease groups, but not within hierarchies. Thus, in creating an individual's clinical profile, hierarchies should be used to characterize the person's illness level within each disease process, while the effects of unrelated disease processes accumulate.
5. Encourage diagnosis code specificity	Vague diagnostic codes should be grouped with less severe and lower-paying diagnostic categories to provide incentives for more specific diagnostic coding.
6. Repeated use of diagnoses is not rewarded	The model should not measure greater disease burden simply because more diagnosis codes are present. Predicted costs are not increased by the number of times a particular code appears or the presence of additional, closely related codes indicative of the same condition.
7. Repeated use of diagnoses is not penalized	Providers should not be penalized for recording additional diagnoses. This requires that no HCC should carry a negative payment weight and higher-ranked diseases in the hierarchy should have at least as large a payment weight as lower-ranked disease.
8. Consistency in ranking diagnostic categories	If diagnostic category A is higher-ranked than category B in a disease hierarchy, and category B is higher-ranked than category C, then category A should be higher-ranked than category C.
9. All ICD-10-CM codes included	Because each diagnostic code potentially contains relevant clinical information, the model should categorize all ICD-10-CM codes.

10. Exclude discretionary diagnostic categories	Diagnoses that are subject to discretionary coding variation, inappropriate coding, or that are not credible as cost predictors should not increase cost predictions.

Source: Centers for Medicare and Medicaid Services. "March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting Discussion Paper." March 24, 2016. www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf.

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