

# sharing the load – mitigating the impact of HRG Version 4

For a technical description of the detailed aspects of HRG V4, HFMA has produced a useful guide. See [www.hfma.org.uk](http://www.hfma.org.uk)

■ **Healthcare Resource Groups (HRGs) define how NHS trusts, foundation trusts, private hospitals and other providers will be paid for acute services. The implementation of HRGs for reimbursement of acute care is one of the key reforms of the NHS which underpins patient choice, the creation of foundation trusts and ensures financial transparency between commissioners and providers and the development of market management.**

HRGs cover most elective and emergency admissions to hospital, A&E and outpatient attendances. There is an international aspect in that a number of countries use a similar system for reimbursement, e.g. the USA uses DRGs, Australia uses AR-DRG and Canada uses CMG.

## granularity

One of the key aspects of developing HRGs is the degree of granularity, versus the requirement to have a workable system for clinical engagement and reimbursement. The basic code for all patient episodes is the International Classification of Diseases version 10 which contains more than 155,000 codes. If a patient has an operation then in addition the Office of Population, Censuses and Surveys Classification of Surgical Operations and Procedures (OPCS) where there are more than 6,000 codes is used. These coding systems are too detailed to use for reimbursement so a summary system (HRGs) was developed.

It is interesting to note the top five HRG admissions (version 3.5) for 2007/08 from the HESonline website are:

Derek Miller considers how the various organisations in the NHS can work together to ensure that complex and poorly defined HRG 4 guidance received at short notice is implemented, highlighting that the foundation trust model may jeopardise this spirit of co-operation.

Healthcare resource group code and description	Number of Admissions	Percentage of all Admissions
N12 Antenatal admissions not related to delivery event	721,302	5%
N03 Neonates with one minor diagnosis	476,784	4%
F06 Diagnostic procedures, oesophagus and stomach	383,904	3%
N07 Normal delivery w/o cc	370,846	3%
F35 Large intestine – endoscopic or intermediate procedures	366,112	3%

As shown, over 5% of all admissions are described as antenatal admissions not related to delivery events. These can range from a pregnant woman having her blood pressure checked and being reassured to a full-scale investigation and treatment.

The NHS moved from version 3.5 to version 4 for reimbursement purposes from April 2009. The main difference between HRG v3.5 and v4 are the number of codes: HRG v3.5 contained 650, whereas HRG v4 contains 1400 codes. This increase in the number of codes provided an increase in the granularity and also allows certain procedures to be carried out at different locations from hospital. This uses the term unbundling, where different parts of the patient care pathway can be provided by

different providers or in different locations (e.g. hospital, community services at home).

## complex and difficult

There were a number of factors that contributed to the complexity and difficulties of implementing HRG V4 for the 2009/10 contract:

- late distribution of road test and actual tariffs for HRG V4, published on 5 February 2009
- confusion about whether HRG V4 would actually be used for 2009/10 contracts
- PCTs' assumption that the implementation was a redistribution of resources
- trusts expecting to be reimbursed for unprofitable service lines

- the basis for the HRG tariffs was a set of reference costs that in some areas were not robust
- the final grouper which allocates ICD, OPCS and age to HRGs was not issued until April 2009.

**worked examples**

Some examples of the complexity and changes may be helpful.

In 2008/09 one of the tariffs was:

N12 Antenatal admissions not related to delivery event – £362

However, there was also guidance that where patients are in hospital for less than four hours then this should not be counted as an admission. Therefore in 2008/09 a significant number of PCTs paid for a proportion of about 50% of N12s as outpatient admissions.

The tariff for 2009/10 was far more complicated and detailed. The new HRGs for the same procedures are:

the impact then either PCTs and trusts, or the SHA, provided guidance on expected ratios of N12s or the minimum time that a patient should be in hospital to be counted as an admission.

**outpatients**

The change to outpatients was just as complex. In version 3.5 the entire outpatient costs were within one tariff. For version 4 the patient transport costs were treated as a different element and the diagnostic element was separately coded as a non-mandatory tariff. Again without any agreement on the adjustment the financial impact would have been significant, to the benefit of trusts and increasing expenditure by PCTs for no change in the delivery of patient care. In this case a number of SHAs produced a financial model to ensure that there were no significant financial gains or losses purely from the introduction of the new tariff.

aspects of the tariff was foundation trusts. FTs are authorised and regulated by Monitor and sometimes do not understand their role in the health economy.

To maintain or improve on the risk rating used by Monitor then either the FT has to achieve additional growth in income or make savings in excess of the standard efficiency requirements within the tariff. The financial risk rating is a key performance measure used by Monitor (see <http://tinyurl.com/oad3ex>).

This does change the priorities of FTs, and their approach to contract agreement with perhaps two views:

- either it makes the negotiations more real treating the provider as an arms-length commercial organisation
- conversely the commissioners cannot trust the motives of the provider, who has little interest in the overall health economy.

Where the PCT and FTs are on this spectrum depends on the maturity of the relationship. But in the 2009/10 contracting round there are still a number of outstanding areas where PCTs and FTs do not agree and there may still be arbitration.

With the expected squeeze on NHS funding in future years, and known increase in demand for services then this kind of fall out can only be expected. But with control of tariff prices and uplift within the NHS – and if PBC /PCTs control demand – then unless FTs are also performance managed on the state of the health economy any quick wins will represent short term gains at most. ■

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*The views expressed are Derek's personal views and do not necessarily reflect the position of Newham PCT.*

NZ04A	Clinical contact for observation (ante- or post-natal) 19 years and over	499
NZ04B	Clinical contact for observation (ante- or post-natal) 18 years and under	499
NZ05A	Clinical contact with investigation (ante- or post-natal) over 19 years	708
NZ05B	Clinical contact with investigation (ante- or post-natal) under 18 years	708
NZ06Z	Clinical contact with full investigation (ante- or post-natal)	731
NZ07A	Admission for observation only 19 years and over	798
NZ07B	Admission for observation only 18 years and under	798
NZ08A	Admission with investigation 19 years and over	1,040
NZ08B	Admission with investigation 18 years or under	1,040
NZ09Z	Admission with full investigation	1,450

If the full impact had been included then the potential additional cost to PCTs would have been about £250m, with a very differential impact on each PCT depending on the ratio of the number of (old) N12s to deliveries. This can vary from less than one to over 2.6. To mitigate

**foundation trusts**

In most cases commissioners and providers agreed on the proposed compromises and were able to finalise contracts by the end of March. However one group that was often difficult to engage in conversations about refining