National Tariff Payment System – FAQs

This document presents answers to frequently asked questions relating to the 2022/23 National Tariff Payment System (NTPS). We welcome enquiries about any aspect of the payment system. Please contact pricing@england.nhs.uk

Last updated: March 2023

Q: What is the cost uplift factor for the 2022/23 National Tariff?

A key part of the development of each national tariff is deciding the cost uplift and efficiency factors. These factors adjust tariff prices and local pricing arrangements (including aligned payment and incentives agreements) – the cost uplift factor reflecting inflation and the efficiency factor reflecting expected improvements in efficiency. Providers and commissioners can agree to use different price or payment levels, either as a local variation (for prices) or as a departure from aligned payment and incentive default arrangements.

Sections 6.5 and 6.6 of the 2022/23 NTPS set out the cost uplift factor (2.8%) and efficiency factor (1.1%). However, following publication of the 2022/23 NTPS, the cost uplift factor has been changed:

- In May 2022 to reflect additional funding for non-pay inflation. This increased the cost uplift factor to 3.5%.
- In August 2022 to reflect the 2022/23 NHS pay award. This further increased the cost uplift factor to 5.2%.
- In November 2022 to reflect the reversal of the Health and Social Care Levy and reduction in level of national insurance contributions. This reduced the cost uplift factor to 4.7%

The efficiency factor has remained at 1.1%.

For each of these increases, a revised set of prices has been published, with accompanying guidance setting out how the prices should be used. It is expected that the prices are used for most non-NHS provider activity. The tariff itself has not been updated (which would have required a separate consultation process), but the guidance makes clear that:

- non-pay inflation prices (published May 2022) are expected to be used for all price-based activity between 1 April and 31 August 2022.

- post-pay award prices (released August 2022) should be used for all price-based activity from 1 September. Following discussions between NHS England, Department of Health and Social Care and the Treasury, it has been agreed that these prices should not be backdated for activity undertaken earlier in the year. However, local areas are able to agree to backdate the prices where appropriate.
- prices reflecting the reduction in national insurance contributions (published November 2022) should be used from the date of the NI changes coming into effect (6 November), although providers and commissioners may locally agree to use them for a full month where helpful for operational reasons.

For more details, see Revenue finance and contracting guidance.

Q: Please clarify the relationship between the aligned payment and incentive approach and independent sector (IS) providers?

The 2022/23 aligned payment and incentive (API) rules means the following for independent sector providers:

- Under the tariff rules, providers (including IS) and commissioners must use an API agreement, including a fixed element, if their annual contract value is over £30 million.
- If the contract value is below £30 million but the provider and commissioner are members of the same ICS (ie they map to the same ICS for finance purposed), an API agreement is still required.
- If the contract value is below £30m and the provider and commissioner are members of different ICSs, there is no mandated payment approach and providers and commissioners should agree the approach they wish to use (eg activity-based, block contract, etc). The unit prices published as part of the tariff should be used as the default prices for any activity-based payment agreements.
- If the activity is covered by the Increasing Capacity Framework, this will be reimbursed using the national and unit prices published in the tariff, as indicated in the framework guidance.
- If the activity is sub-contracted, this should be reimbursed using the national and unit prices published in the tariff, subject to the national variations which would have applied if they were national prices.

For more detail on the API rules, see Section 3 of the 2022/23 National Tariff Payment System and the supporting document *Guidance on the aligned payment and incentive approach*, both available from: National Tariff Payment System.

Q: How should provider-to-provider payment for maternity services operate?

In almost all circumstances, we do not expect provider-to-provider recharging for maternity services to be required during 2022/23.

Activity should either be covered by aligned payment and incentive fixed elements, or the low volume activity (LVA) payments. Commissioners make LVA payments directly to providers and these are intended to cover all provider/commissioner activity with an annual value of less than £0.5m. The Aligned payment and incentive guidance document includes an illustration of how the payment approach should work for maternity services.

However, where commissioners have rolled over the funding arrangements for 2022/23 from previous years, without adjustment for provider-to-provider payments, the funding will continue to sit with the lead provider. As such, the lead provider should either pay the other providers in the pathway, or move the funding back to the commissioner. Where the fixed payment has been adjusted to account for provider-to-provider payments, the funding remains with the commissioner and they should be billed.

Q: What are the reimbursement arrangements for homecare drugs?

The national tariff covers almost all secondary care. Activity in scope of the tariff is either paid for by local payment arrangements (including API, which is a form of local payment arrangement) or by tariff prices.

Allocations include funding for all activity in scope of the tariff, regardless of payment mechanism used (ie API, activity-based payment, etc).

All home care drugs are excluded from price calculations irrespective of the payment mechanisms. Therefore, for activity-based payments, drugs that are listed on the high-cost drugs list should be paid for on pass-through. Items that are not on the high-cost drugs list are not included in tariff prices and so reimbursement is subject to local agreement.

For API payment arrangements, the high-cost drugs exclusion list applies regardless of where the activity is delivered and who the commissioner is. This means that items on the high-cost drugs list are either excluded and paid for on pass-through or included in the API fixed element (as indicated in the list).

As such, funding for home care drugs should be included in the API fixed element unless the drugs are:

- included on the high-cost drugs list, and
- not specified as 'include in API fixed element' in that list.

If the drugs are included in the high-cost list, and not specified as 'include in API fixed element', they should be paid for on pass-through.

These arrangements can be summarised as follows:

Reimbursement of homecare drugs in the 2022/23 tariff		
	Drugs on the high-cost list	**Drugs not on the high-cost list**
API	Excluded (pass-through payment) unless Anenx A indicates funding included in fixed payment	Included in API fixed payment
Activity-based payment	Excluded	Not included in tariff prices; locally agreed payment required

Q: Where can the Spinal surgery best practice quarterly report be accessed?

The reports can now be viewed at provider level, or by region and they include both NHS Trusts and independent sector providers. Reports have now been published to the NCDR Portal.

To access the reports, you need to register for the NCDR Portal via the following link: https://apps.model.nhs.uk/register

Once registered and set up, the BPT Spinal report is available from the Provider Analytics container on the portal: https://www.ardengemcsu.nhs.uk/services/business-intelligence/ncdr/

Q: For MRI scanning, are providers supposed to charge based on the number of areas they are scanning? Can you clarify which body parts 'one area' could consist of?

Please note the following points:

- If the MRI is part of an HRG for admitted patient care (APC) or outpatient procedures then the costs are included in the core HRG price.
- If the scan is undertaken as part of a direct access (ie referred by GP) or outpatient attendances then this is 'unbundled' (ie not included in a core HRG price) and has a separate national price.
- The price will depend on the type of scan, whether it was with or without contrast and the number of body areas scanned.
- The price for each of the MRI scans is shown in tab 0, National prices, in Annex A. The tab includes prices for the scan including reporting and a separate cost of reporting.

For information on coding activity using OPCS codes, contact NHS Digital at: enquiries@nhsdigital.nhs.uk. NHS Digital are responsible for coding and can also provide assistance with HRGs, including how these are calculated by the HRG grouper.

Q: If using prices, when delivering an outpatient procedure, should a provider receive payment for an outpatient attendance as well as for the procedure?

Annex A of the 2022/23 National Tariff contains prices for outpatient procedures (HRG prices included in tab 1, column D) and outpatient attendances (TFC prices in tab 2). Outpatient activity should be grouped to either the HRG or TFC price – not both. As such, only one price should be paid for any outpatient activity:

- Where the activity involves a procedure that is grouped to an HRG with an outpatient procedure price, that is the price used.
- Where the activity does not include a procedure with an outpatient procedure price, this should group to the attendance TFC, which would be the price paid.

National variations (MFF and specialist top-ups) should be applied to the prices to determine the amount paid.