National Tariff Payment System – FAQs

This document presents answers to frequently asked questions relating to the 2021/22 National Tariff Payment System. We welcome enquiries about any aspect of the payment system. Please contact pricing@england.nhs.uk

Last updated: March 2022

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

The 2021/22 aligned payment and incentive rules means the following for independent sector providers:

- Under the tariff rules, providers (including IS) and commissioners must use an aligned payment and incentive (API) agreement, including a fixed element, if their annual contract value is over £10 million.
- If the contract value is below £10 million but the provider and commissioner are members of the same ICS, an aligned payment and incentive agreement is still required.
- If the contract value is below £10m 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.

The API variable element supports elective activity and achievement of best practice tariffs and CQUIN criteria. Providers and commissioners may also choose to agree additional variable elements. Where an IS provider is delivering services under a sub-contract from an NHS provider, these rules (and other rules of the national tariff) would not apply.

For more detail on the API rules, see Section 3 of the 2021/22 National Tariff Payment System and the supporting document *Guidance on the aligned payment and incentive approach*, both available from: National Tariff Payment System.

Q: Regarding Maternity recharging between providers of the new born hearing screening element of postnatal care.

Is there any guidance on this for invoicing? Is there a way of quantifying how much is chargeable for each hearing screening?

For the first half of 2021/22, payment arrangements were similar to 2020/21 and cross-charging would not be expected.

For the second half of 2021/22, the block payment arrangements introduced in response to Covid-19 remain in place. However, it is a local decision as to whether provider-to-provider payments are required. It may be possible to avoid this unpopular transactional burden through the aligned payment and incentive (API) arrangements introduced in the 2021/22 national tariff (although these have not been implemented in practice).

Under the API payment arrangements, providers and commissioner should agree a fixed payment that reflects the costs of providing services within the system plan. This is different to the previous default payment arrangement for maternity services (maternity payment pathway) as historic trends in patient flows between providers should be taken into account (and would be expected to be reflected in historic costs) when setting this fixed payment.

Under the 2021/22 tariff rules, API will be the default payment arrangement within a system or where the contract value is over £10m.

Where the contract members are in different systems and the total value is less than £10m, an activity-based payment approach could be used. However, this would be commissioner to provider, not provider to provider. We would therefore not expect there is a significant amount of, or need for, provider to provider payments.

Please note: although the aligned payment approach within a system should mean that providers and commissioners are able to eliminate provider-to-provider payments for maternity, we aren't mandating that as an approach, for maternity or any other services. The relevant tariff payment rule says that "provider and commissioner must agree an initial fixed element representing funding for the provision of secondary care services for the payment period, applying the principles for local pricing specified in Section 4.1". We have produced some guidance and worked examples to show that if this is done systematically across an ICS it would be possible for the system to eliminate provider to provider payments (see *Guidance*

on the aligned payment and incentive approach). However, this need not be the case if the system decide to agree their fixed payments in another way, for maternity or any other service.

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. What is the guidance/price for non-face-to-face outpatient appointments?

Section 3 of Annex B of the 2021/22 national tariff contains guidance on outpatient attendances. In Section 3.4, it clarifies the arrangements for non-face-to face appointments as follows:

> The 2020/21 NTPS set non-mandatory prices for non-face-to-face outpatient attendances. These were based on a subset of activity reported in 2016/17 reference costs. For 2021/22, these prices were not published due to:
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> - the wider adoption of non-face-to-face services due to COVID-19 meaning the prices may not be representative of current activity

- the requirement in the aligned payment and incentive rules for providers and commissioners to agree a fixed element to cover an agreed level of activity. This does not make a distinction between delivering activity face-to-face or non-face-to-face, which should be driven by local agreement. Local agreements should also be used for activity outside the scope of aligned payment and incentive agreements to support the most appropriate method of delivering care.

Where local agreement on prices for non-face-to-face activity is not possible, the 2020/21 non-mandatory prices should be used.[1] A non-mandatory price of £23 for non-face-to-face outpatient attendances was included in previous tariffs. However, this price was removed in the 2017/19 NTPS and should not be used.

Q: Where can the Spinal surgery best practice quarterly report be accessed and what data do they contain?

In 2019/20, NHS England and NHS Improvement introduced a BPT to improve the proportion of spinal surgery cases entered into the British Association of Spinal Surgeons (BASS) British Spine Registry (BSR).

This BPT aims to support meaningful comparison and analysis of spinal surgery and help to reduce variation in the treatment and outcomes for patients.

The BPT price is made up of two components: a base price and a BPT price (based on a conditional top-up payment added to the base price). The base price is payable for all activity, irrespective of whether the provider has met best practice characteristics. The BPT conditional top-up price is payable only if the provider meets the 50% case ascertainment rate.

Provider compliance data is available within Arden & GEM CSU's GEMIMA and NCDR data portals. Achievement is measured at provider, not patient, level. Reports at provider level will be published on a quarterly basis. To access the reports:

- On GEMIMA (for CCGs) – if CCGs do not already have access to GEMIMA, they will need to request it.
- On the NCDR portal (for providers) – if not already in place, providers can register at https://apps.model.nhs.uk/register and request access to the provider container.

[1] The 2020/21 NTPS documents and prices are available from: www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/

Providers that do not achieve the criteria will not be eligible for the BPT conditional top-up and will only be able to claim the base price for all activity within the period.

There was an intention stated in the 2019/20 and 2020/21 national tariffs to increase the 50% case ascertainment threshold to 80% in the future – that is, 80% of a provider's relevant patient spells would need a corresponding BSR entry in order to be eligible for the BPT top-up payment. However, this change has not yet been made (see below for more information).

Operational

Provider performance was calculated and published quarterly for 2019/20. This was done by matching individual records in BSR with corresponding records of patient spells in SUS. The total number of matched records was divided by the total number of relevant spells in SUS to derive the ascertainment rate.

When the quarterly data for 2019/20 in 2020/21 was refreshed, the overall case ascertainment levels fell. Upon investigation this was found to be due to the way patient consent for data use in the BSR is obtained and recorded.

A patient may give consent for their data to be used in BSR in two ways:

- active consent which is recorded at the time of procedure/admission, or
- consent which is given by interacting with patient questionnaires and the entering of PROMS data at set points after the procedure/admission.

Equally, patient consent may not be given/attained in two ways:

- actively opting out at the time of procedure/admission or
- not further interacting with the patient questionnaires and PROMS data.

It has also been reported that although a patient may have given consent for their data to be used, there is variable recording of this in the correct way in BSR, which shows as patient consent not obtained.

Further information around patient consent with the BSR can be found at https://www.britishspineregistry.com/patients/

As such, when the data for 2019/20 was refreshed, a number of records which had previously been counted in the ascertainment rate had now defaulted to patient consent not obtained as the patient had not interacted with the service post

discharge and the initial patient consent had not been obtained and/or recorded in BSR. This had the effect of slightly reducing the ascertainment rates for providers.

While the issue was investigated, the previous reports were removed from the portal.

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Given the issues around consent, NHS England and NHS Improvement have decided to change the basis on which the ascertainment rate is calculated. This means that only patients who have actively given consent, recorded correctly in BSR, for their data to be used will be counted in the numerator. All patient spells in SUS will continue to be counted in the denominator.

As this will be very slightly harder for providers to achieve, compared to the previous calculation, the increase in the attainment threshold to 80% has been suspended until a future tariff year. This should also encourage the correct recording of patient consent in BSR.

All provider ascertainment rates from 2019/20 Q1 have been recalculated so that a comparable times series is available for providers and commissioners. NHS England and NHS Improvement do not recommend reopening payments that have already been made based on the previous calculation.

To provide more certainty around reporting timelines, the publication of compliance reports will be standardised. Relevant BSR records will be extracted four weeks after quarter end and matched with relevant SUS post reconciliation data to produce compliance rates. BPT reports will not be updated later in the year – the report for each quarter will be the final report upon which to base payments. The reports will be available around 2 months after the end of the relevant quarter.