Briefing Note 1

Marginal Rate Emergency Tariff (MRET) - rebasing the financial baseline

This briefing, covering MRET and the rebasing of financial baselines, is aimed at covering the most common areas of difficulty and describing how we arise at a response. It is intended to give our joint view of how we think guidance might be applied to these areas and is based on our experience of the issues described by our clients.

We hope you find it useful.

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1. Introduction

Context

1.1 The marginal rate emergency rule was introduced in 2010/11 in response to a growth in emergency admissions in England which exceeded that which could be explained by population growth and A&E attendance growth alone. This growth in emergency admissions was made up primarily of emergency spells lasting less than 48 hours.

1.2 The purpose of the marginal rate rule is twofold. It is intended to incentivise:

- lower rates of emergency admissions; and
- acute providers to work with other parties in the local health economy to reduce the demand for emergency care

1.3 The marginal rate rule sets a baseline value (specified in GBP) for emergency admissions at a provider. A provider is then paid a percentage (set at 70%) of the national price for any increases in the value of emergency admissions above this baseline. Overall, commissioners must set aside sufficient budget to pay for 100% of emergency admissions. Commissioners are then required to spend the retained balance on managing the demand for emergency care.

When must a review of the baseline take place?

1.4 For the 2014/15 National Tariff Payment System (NTPS), NHS England and Monitor conducted a joint review of historical evidence on emergency care and the operation of the marginal rate rule[1].

1.5 This review identified that, in some localities, change is needed to ensure the policy works more effectively. For example, where there have been major changes to the pattern of emergency care in a local health economy, or where insufficient progress towards demand management and discharge management schemes.

1.6 In 2014/15 the marginal rate rule was updated with more explicit stipulations as follows:

- to require baseline adjustments where necessary to account for significant changes in the pattern of emergency admissions faced by providers in some localities; and
- to ensure retained funds from the application of the rule are invested transparently and effectively in appropriate demand management and improved discharge schemes.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300862/Monitor_and_NHS_England_U2019s_review_of_the_marginal_rate_rule.pdf

1.7 Guidance is clear that, where a provider has requested a review of the baseline, commissioners and provider must work together to deliver this process; commissioners do not have the option to refuse a reasonable request for review. Although not explicitly stated in the guidance, our view would also be that:

- Commissioners may request a review of the baseline in the same way as providers;
- Reasonable notice should be given by the party requesting a review

1.8 This does not imply an adjustment must be accepted; this would be dependent on the review concluding that the criteria set out in national guidance are met.

What guidance applies?

1.9 The main guidance is set out in section 5.3.1 of the 2016/17 National Tariff Payment System (NTPS) - extract shown at **Appendix 1** for ease of reference[2]. In particular **table 11** at section 191 describes the circumstances in which adjustments may be appropriate.

1.10 Related guidance is also contained within Appendix 3 of the Dispute Resolution Policy (DRP). This specifies certain contract dispute resolution principles to assist organisations in understanding the likely outcome of any arbitration cases. Regarding MRET, it sets out that the NTPS guidance must be followed and also that there must be a robust evidence base to support any proposed adjustments. It should be noted that the DRP is mandatory guidance issued jointly by NHS England, the Trust Development Authority and Monitor and, as such, would apply to any provider of care under the NHS Standard Contract.

2. Carrying out the review

What are the key indicators that a review is needed?

2.1 A review should take place following a request to review the baseline. In our view, good practice would require that the party requesting the review would already have collected and shared sufficient preliminary evidence that significant changes to the pattern of emergency admissions and/or material changes to patient flows to a provider have occurred.

Basic principles applied

2.2 The key considerations in completing a review are to understand:

- Is there a valid reason for adjusting the MRET baseline?
- Is the valuation methodology for any such adjustments reasonable and robust?
- Is the calculation of the original baseline correct?

2.3 Guidance on MRET rebasing identifies principles and enquiries must also be considered, and these are as set out below.

2.4 The guidance for MRET sets out that baseline adjustments must be made where "*there have been **material changes in the patterns of demand for or supply** of emergency care in a local health economy, or when material changes are planned.*" It should be noted that other parts of the guidance refer to *"significant changes in the pattern of emergency admissions faced by providers"*. For the purposes of a baseline review, our view is that "*material*" and "*significant*" can be taken to have the same meaning.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/509697/2016-17_National_Tariff_Payment_System.pdf

2.5 Examples of the **criteria and drivers of change** that would indicate adjustment to MRET baseline as appropriate are as set out in table 11 of the NTPS. Our view is that, whilst this list is probably not intended as exhaustive, other scenarios that lead to adjustment would be unlikely.

2.6 Guidance also introduces a principle of changes being outside the **provider's control** – *"Baseline values (specified in £s) should…be updated to account for material changes that the affected provider cannot directly control"*

2.7 A provider may request a **joint review** where it considers the criteria for adjusting MRET baseline has been met *"Baseline values must … be set according to 2008/09 activity levels, but where a provider requests a review of the baseline, a joint review must be undertaken involving both the provider(s) and the commissioner(s)."* As previously stated in note 1.7, our view would be that this is also extended to commissioner requests.

2.8 The **scope of the review** should not be limited to specific areas unless both parties agree – *"when calculating baseline values, **both increases and decreases** in the value of activity should be considered equally according to the criteria in table 11."*

2.9 Although not explicitly stated in mandatory guidance or the NHS Standard Contract, it is our view that **reasonable notice** should be given where there is a request to rebase the MRET, given the likelihood of it resulting in material change to the annual contract value.

2.10 The Dispute Resolution Process 2016/17 (DRP) states that *"Commissioners and Providers must consider whether the **evidence base is robust** and in line with the National Tariff guidance provided for appropriate baseline changes"* [3]

2.11 In summary, the guiding principles to be used are that, where a MRET baseline review is requested (under appropriate notice) it must:

- be jointly undertaken
- only adjust for changes that are both material and outside the provider's control
- refer to the drivers and examples listed in table 11
- cover the total emergency admissions baseline, both increases and decreases
- rely on a robust evidence base for changes

3. The review process

3.1 The review is undertaken using a series of steps, set out in more detail in the sections below, which are:

- Establish a starting point – 2008/09 emergency activity regrouped and priced to the relevant year's rules and tariff
- Map movement of demand between providers:
    - acute providers
    - out-of-hospital care and acute care
    - secondary and tertiary providers
- Map changes in the provision of emergency services at a provider
    - Changes in the emergency services commissioned by CCGs
        - Specific pathway changes
        - Commissioning requirements such as NICE guidance

[3] https://www.england.nhs.uk/wp-content/uploads/2015/12/joint-dispute-resolution-process-1617.pdf

        - Changes to provider designations (eg HASU)
    - Changes in the method for coding and counting emergency admissions
- Assess changes in total demand in the locality due to demographic changes
- Assess changes in other factors outside provider control

Movement of demand between providers

3.2 Guidance (table 11) is clear in the case of movement between acute/tertiary providers that commissioners must be able to enact an equal and off-setting baseline adjustment between providers. In the absence of any specific and identifiable service transfer between 2 or more providers, to form a basis for transfer, the adjustment cannot be made.

3.3 In cases of movement between acute and non-acute providers (e.g. decommissioning/ reduced commissioning of community step down beds or other out-of-hospital care) an equal and offsetting baseline adjustment will not be possible, as community services are outside the scope of NTPS. However, the requirement to identify a specific and quantifiable service transfer would nonetheless apply.

Changes in emergency services commissioned – specific pathway changes

3.4 A newly commissioned pathway would be a valid reason for an adjustment to the baseline under table 11 of NTPS which refers to "changes in the emergency services commissioned by CCGs" as a valid reason to adjust the baseline, if found to be material.

3.5 However there should be evidence that the service/service change was explicitly commissioned by commissioners, and whether this is part of an agreed commissioned pathway.

Changes in emergency services commissioned – commissioning requirements

3.6 Changes in commissioning requirements may also give rise to an adjustment to the MRET baseline. For example, the impact of the Cancer Drugs Fund may cause a material increase to emergency admissions in clinical haematology and clinical oncology. This constitutes an implicit change in emergency services commissioned.

3.7 Similarly, NICE recommendations could, in principle, satisfy the requirement to demonstrate change in emergency services commissioned by CCGs. as the requirement to meet changing NICE recommendations is included in the NHS Standard Contract under SC2.1.6.

3.8 Any such adjustment would need to be evidenced by an analysis based on the specific diagnoses and/or treatments affected by these commissioning changes. High-level data, looking at whole specialties for example, is unlikely to provide the necessary specificity to allow the baseline to be adjusted.

Changes in emergency services commissioned – provider designation

3.9 Changes to the designation or status of a provider may have an impact on the level of emergency services commissioned and NTPS table 11 gives the specific examples of designation as a trauma centre or Hyper-Acute Stroke Unit. Where material, this would give a valid reason for adjustment of the baseline.

3.10 However, as noted in section 3.8 above, evidence that is sufficiently specific to demonstrate the service change would need to be provided to support any adjustment to the baseline.

Demographic changes

3.11 Table 11 of the NTPS allows for adjustments to the baseline for reasons of "change in total demand in the locality due to demographics", but these need to be "exceptional and demonstrable".

3.12 This should be supported by a comprehensive and compelling analysis of demographic change, both in total and within specific segments of the population having shared characteristics (such as by age).

3.13 Examples of such analysis would include an analysis of ONS data from 2008 to current date[4] and data from local authority publications of changes to housing stocks, such as new developments, increase in retirement properties.

Other factors outside provider control

3.14 Other factors causing a material change in demand for emergency admissions outside the provider's control may be relevant, if they can be demonstrated with reasonably robust evidence. Normally these would be exceptional once the factors above have been identified, analysed and quantified.

3.15 A residual unexplained rise in A&E attendances, for example, may indicate further issues still need to be considered but is unlikely on its own to provide sufficient evidence to support the calculation of a baseline adjustment as required according to the principles set out in the NTPS.

3.16 In order to consider adjustment on the grounds of a material increase in A&E activity, there would need to be a demonstration that the analysis took into account:

- the acuity of the increased activity compared to the comparator year, and
- with the same or lower A&E to Admission Conversion rate for that acuity of patients, and
- the increase was not due to the factors described in paragraphs 3.1 to 3.13 above.

3.17 In these circumstances there is indication of a "change in demand for admissions at a provider" or "material changes in the patterns of demand for or supply of emergency care in a local health economy" which would suggest a further adjustment may apply but should be considered on a case by case basis.

3.18 However it should be noted that the national commentary on assessing growth on HES A&E statistics states that *"PbR… has provided a major financial incentive for hospitals to ensure all of the activity they perform and the clinical coding is fully recorded. This improved recording of information captured by HES could be one of the factors leading to the reported increase in activity."*[5] Therefore, when considering whether an adjustment based on A&E increase is appropriate, improvements in coding and counting must be excluded.

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[4] http://www.ons.gov.uk/ons/rel/sape/health-geography-population-estimates/mid-2002-to-mid-2010-revised/rft---ccg-table.xls, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/clinicalcommissioninggroupsinenglandtable3

[5] http://content.digital.nhs.uk/hesdata

4. Checklist of steps & principles

4.1 Stage 1: Establish starting point – 2008/09 emergency activity regrouped and priced to the relevant year's currencies and tariff

Select the data to be used

a) Provider and commissioner agree data source. This will normally be 2008/09 freeze data as this represents the contractual outturn position. Alternatively, provider and commissioner may have a local agreement to use more recent data. If the Trust provides data, commissioners need to confirm it reconciles to their recognised SUS freeze position.
b) Data to include all finished consultant episodes where the hospital provider spell ended in 2008/09 with methods of admission 21-28 and a NHS commissioner (excluding private patients (VPP00) or overseas visitors (TDH00) commissioner codes).
c) Data to be provided in the form ready for input into the HRG grouper, with the additional fields of GP Practice Code, GP Code and Post Code (of patient's address) appended to assist with any attribution queries (see below).

Regroup the data

d) Ensure data is suitable to be re-run eg strip out all hyphens, daggers and asterisks as these are not processed by the grouper.
e) Data to be run through the HRG grouper and the output files form the basis for the costed baseline value.
f) Any spells that fail to group (i.e. group to a UZ code) purely because diagnosis and/or procedure code(s) are no longer valid in the relevant year to have their diagnosis codes remapped to the latest edition of ICD/OPCS using the HSCIC's Tables of Coding Equivalence. These spells then run through the grouper again.

Identify the appropriate commissioner

g) Where a valid GP Practice code was given, this is mapped to their parent organisation (i.e. a CCG or to identify that the practice was from the devolved nations)
h) Where the GP Practice ceased to exist before 1/4/13 and therefore has never been mapped to a CCG, the post code of the practice address is used to map them to a CCG
i) Where the GP practice was not known (i.e. coded V81999), if a valid GP code was given, this is mapped to a GP practice and steps (a) and (b) attempted again
j) Where there was neither a valid GP or GP practice that could be identified, the post code of the patient's address is used to map to a CCG
k) Any spells mapped to a devolved nation but where the patient post code showed they were resident in England are re-mapped to the appropriate CCG
l) Any spells mapped to a CCG but where the patient post code showed they were resident in the devolved nations are re-mapped to the devolved nation
m) Any spells mapped to a CCG but falling within the dental specialties (treatment function codes 140-144) are re-mapped to NHS England as dental commissioning
n) Data to be run through the Prescribed Specialised Services Identification Tool to identify any spells that potentially fall within specialised commissioning and hence commissioned by NHS England. Spells to be reconciled to contractual arrangements to determine which definitely fall within NHS England contracts, e.g. where NHS England only contracts with designated providers for certain services.
o) If exercise being done for multiple CCGs, provider to confirm which CCGs they hold contracts for emergencies with, so non-contract activity (not subject MRET) can be identified.

Price the data according to latest National Tariff Payment System rules

p) Spells falling outside the scope of NTPS identified by HRG, including spells from HRG sub-chapter NZ included in the maternity pathway tariff, and left at zero price
q) Remaining spells priced at national price for non-elective admission, including any ungrouped spells at zero price
r) Any spells that are eligible for any best practice tariffs not in the scope of the marginal rate tariff to be excluded (currently stroke; fragility hip fracture; diabetic ketoacidosis; pleural effusion; heart failure).
s) Short-stay emergency tariff applied where applicable
t) Best practice tariffs applied where applicable
u) Excess bed day payment applied where applicable
v) Specialised service top-ups applied where applicable
w) Market Forces Factor applied
x) Any emergency readmissions within 30 days to be identified and any contractual penalty to be deducted from the baseline using the arrangements set out in the provider's 2016/17 contract.

4.2 Stage 2: Analyse Service Changes

Movement of demand between providers

a) Any change in emergency demand between acute providers (e.g. downgrading of A&E units) must be material and result in an equal and offsetting adjustment to MRET baselines across affected providers
b) Any change in commissioning between acute providers (e.g. centralisation of emergency stroke provision) must also be material and result in an equal and offsetting adjustment to MRET baselines across affected providers

Changes in emergency services commissioned

c) Other factors causing emergency admissions to rise must be demonstrably outside the control of the provider for any baseline adjustment to be considered, e.g. a new service explicitly commissioned by commissioners, change in ambulance route, or change in social care referrals to A&E.
d) New emergency services instigated by providers, e.g. urgent care centres or rapid access admissions units, would not normally result in a baseline adjustment, as it would be assumed that the provider would have planned on only receiving marginal rate tariff for the service.

Other considerations

e) Changes in counting and coding since 2008/09 should result in the 2008/09 activity being recalculated according to the new basis/methodology
f) Any changes in clinical thresholds or conversion rates would not normally be considered for baseline adjustment as they are under the control of the provider.
g) Changes to staffing establishments to meet the impact of CQC reviews, Francis, Keogh, etc. would not normally be considered for a baseline adjustment as they were funded within the tariff adjustment for 2014/15 and hence included in tariff prices from 2014/15 onwards.
h) Note that changes to the MRET baseline can be non-recurrent/ time-limited in nature, for example for pilot schemes, disasters etc. Our recommendation would always be that an explicit analysis of the potential impact on MRET should take place when changes to the service provision occur or are proposed.

4.3 Stage 3: Analyse Demographic Changes since 2008/09

a) Calculate the relevant commissioner's demographic growth since 2008/09 from the ONS tables and compare to England average
b) This can be further broken down into age groups, sex, ethnicity, etc. if necessary but all CCG figures must be compared to the England average to form a view of 'exceptionality'
c) Only demographic growth in excess of the England average should be taken into account
d) Any specific housing developments can be verified on the relevant local authority web site, but must be judged to be 'exceptional and demonstrable'

2016/17 National Tariff Payment System (extract)

5.3.1 Marginal rate emergency rule

179. The marginal rate emergency rule was introduced in 2010/11 in response to a growth in emergency admissions in England that could not be explained by population growth and A&E attendance growth alone.[47] This growth in emergency admissions was made up primarily of emergency spells lasting less than 48 hours.

180. The purpose of the marginal rate rule is twofold. It is intended to incentivise:

   a. lower rates of emergency admissions
   b. acute providers to work with other parties in the local health economy to reduce the demand for emergency care.

181. The marginal rate rule sets a baseline monetary value (specified in GBP) for emergency admissions at a provider.[48] A provider is then paid a percentage of the national price for any increases in the value of emergency admissions above this baseline. Further guidance for commissioners on investing retained funds can be found here.[49]

182. While the original design of the marginal rate rule set a national baseline expectation, our review of the policy in 2014/15 identified that in some localities, change is needed to ensure the policy works more effectively. For example, where there have been major changes to the pattern of emergency care in a local health economy, or where there has been insufficient progress towards demand management and discharge management schemes. In 2014/15 we therefore updated the marginal rate rule to:

   a. require baseline adjustment where necessary to account for significant changes in the pattern of emergency admissions faced by providers in some localities.
   b. ensure retained funds from the application of the rule are invested transparently and effectively in appropriate demand management and improved discharge schemes.

183. The rule for 2016/17 continues to include the changes to local baseline setting and reinvestment transparency introduced in 2014/15, but also includes one further change – the marginal rate to be applied is 70%, not 30%.

184. This change is being made in recognition of the efforts that providers have made to manage the pressures of rising numbers of emergency admissions and also seeks to address some of the financial challenges for smaller providers where emergency admissions are a significant share of their activity.

[47] Over 70% of emergency admissions are patients who are admitted following an attendance at A&E.
[48] As defined in the NHS Data Model and Dictionary. These codes are: 21-25, 2A, 2B, 2C or 2D (or 28 if the provider has not implemented CDS 6.2).
[49] https://www.gov.uk/government/publications/nhs-national-tariff-payment-system-201617-a-consultation-supporting-documents

2016/17 National Tariff Payment System (extract)

5.3.1 Marginal rate emergency rule

185. The 2014/15 changes to baseline setting and reinvestment transparency are discussed, in turn, below.

Setting and adjusting the baseline

186. A provider's total baseline value must be assessed as the value of all emergency admissions at the provider in 2008/09 according to current 2016/17 national tariff prices.[50] A contract baseline value must be calculated for each contractual relationship.

187. We recognise that changes to HRGs since 2008/09 and the introduction of BPTs[51] cause difficulties in setting baseline values. Therefore, we expect providers and commissioners to take a pragmatic approach in agreeing a baseline value, for example, by applying an uplift to a previously agreed baseline to reflect average changes in price levels.

188. We know that some providers have seen material changes to the volume and value of emergency admissions. Where changes to admission volumes and values result from changes in the local health economy, adjustments to the baseline value continue to be necessary for 2016/17. Examples of relevant changes to consider include:

- a. a service reconfiguration at a nearby hospital
- b. a change in the local population because of a newly built housing development or retirement community
- c. a change in the relative market shares of local acute providers, where an increase in admissions at one provider is offset by a decrease at another.

189. Making local adjustments may therefore be necessary to ensure a balance between maintaining the positive incentives to manage demand and ensuring providers receive sufficient income to provide safe and sustainable emergency care. Baseline values must therefore be set according to 2008/09 activity levels, but where a provider requests a review of the baseline, a joint review must be undertaken involving both the provider(s) and the commissioner(s). Following a review, baseline adjustments must be made where there have been material changes in the patterns of demand for or supply of emergency care in a local health economy, or when material changes are planned for 2016/17.

190. Baseline values (specified in £s) should then be updated to account for material changes that the affected provider cannot directly control. For example, a change in demand at a provider resulting from a reduction of a nearby hospital's A&E department opening hours will be considered a change outside the control of the provider and hence may require an adjustment to the baseline. On the other hand, changes in the number of admissions that result from a reduction in consultant presence in the A&E department will not necessitate an adjustment to the baseline.

[50] Some emergency activity is excluded from the marginal rate rule and should not be included in the calculation of baseline values, including: activity which does not have a national price, non-contract activity, activity covered by BPTs (with the exception of the BPT that promotes same-day emergency care), A&E attendances, outpatient appointments, and contracts with commissioners falling within responsibility of devolved administrations.

[51] Activity reimbursed by BPTs is not subject to the marginal rate, with the exception of the BPT for same-day emergency care.

2016/17 National Tariff Payment System (extract)

5.3.1 Marginal rate emergency rule

191. When assessing supply and demand for emergency admissions, commissioners should consider the factors set out in Table 11.

Table 11: Examples of where adjustments to baseline values may be required

Driver of change	Reason for change	Adjustment necessary?
Change in demand for admissions at a provider	Movement of demand between acute providers, resulting in altered market shares	Yes, if material, and offsetting between providers
	Movement of demand between out-of-hospital care and acute care, or between secondary and tertiary providers	Yes, where this reflects a change in commissioning patterns[52]
	Change in total demand in the locality due to demographics	Yes, if exceptional and demonstrable
Changes in the provision of emergency services at a provider	Changes in clinical threshold for admissions for certain procedures, for example due to increased risk-aversion in clinical assessment in A&E[53]	No, unless this reflects a change in commissioning patterns.
	Changes in the emergency services commissioned by CCGs (e.g. designation as trauma centre or hyperacute stroke unit)	Yes, if material
	Changes in the method for coding or counting emergency admissions.	Yes, re-calculate 2008/09 activity according to new method.

192. When calculating baseline values, both increases and decreases in the value of activity should be considered equally according to the criteria in Table 11.

193. Where emergency activity moves from one provider to another in a local health economy (for example, due to service reconfiguration, changing market share or changes in commissioning patterns), the baseline of each provider should be adjusted symmetrically so that, as far as possible, the sum of their baseline values remains constant, all other things being equal.

[52] We expect commissioning patterns to reflect best clinical practice, including where this results in the decommissioning of any out-of-hospital activity (eg closure of a walk-in centre) or a change in the arrangements of emergency after-care for post-discharge complications by tertiary providers (eg of cancer patients).

[53] We recognise that establishing a definitive change to clinical practice may be difficult. We suggest that providers and commissioners examine available data, for example any trends in the casemix or age-adjusted conversion rate, admissions patterns by time of day, or changes to staffing levels or patterns (eg use of locums, consultant cover for A&E). Clinical audits and/or insight from the local system resilience group may also help facilitate agreement.

2016/17 National Tariff Payment System (extract)

5.3.1 Marginal rate emergency rule

194. The agreed baseline value (specified in £s) must be explicitly stated in 2016/17 NHS Standard Contracts and in the plans that set out how retained funds are to be invested in managing demand for emergency care. A rationale for the baseline value should also be set out clearly, along with the evidence used to support agreement, for example the support from their local system resilience group.

195. Acute providers or other parties in the local health economy should raise any concerns about baseline agreements with NHS England, through its local offices. Where local consensus cannot be reached, the local NHS England office will provide mediation, in the context of NHS England's CCG assurance role, to ensure CCG plans are consistent with this guidance. Where necessary, Monitor and NHS England will consider enforcing the rules set out in this guidance through their enforcement powers. Where the local NHS England office is the commissioner, the NHS England regional team will provide mediation. In all cases, Monitor must be notified (via pricing@monitor.gov.uk) where concerns have been raised, and whether (and how) plans were changed as a result.

Application of the rule

196. The marginal rate rule is applied individually to each contractual relationship. It is applied to any contract where the value of emergency admissions has increased above the baseline value for that contract.

197. Some providers may have seen an overall reduction in their emergency admissions against their baseline value; this reflects a reduction in admissions in some contracts that is offset by small increases in admissions in other contracts. Such small increases may be due to annual fluctuations in admission numbers over which the provider has limited control. Therefore, small contracts[54] are not subject to the marginal rate rule, provided that the overall value of emergency admissions at the provider has decreased relative to their overall baseline value across all of their contracts.

198. The marginal rate should be applied to the value of a provider's emergency admissions after the application of any other national adjustments for MFF, short-stay emergency spells, long-stay payments, or specialised service top-ups. Where more than one commissioner is involved in a particular contractual relationship, arrangements should be agreed locally according to the payment flows to each commissioner set out in the contract.

[54] A small contract is one where the baseline value is less than 5% of the provider's total baseline value across all contracts.

2016/17 National Tariff Payment System (extract)

5.3.1 Marginal rate emergency rule

199. The marginal rate does not apply to:

a. activity which does not have a national price
b. non-contract activity
c. activity covered by BPTs, with the exception of the BPT that promotes same-day emergency care[55]
d. A&E attendances
e. outpatient appointments
f. contracts with commissioners falling within responsibility of devolved administrations.

[55] The marginal rate policy will apply to activity covered by the BPT for same-day emergency care only. Although the BPT is designed to encourage providers to care more quickly for patients who would otherwise have had longer stays in hospital, it may also create an incentive for providers to admit patients for short stays who would otherwise not have been admitted.