

# **Improving Systems for Cost Recovery for Overseas Visitors**

**NHS Improvement and NHS England**

## **Improving Systems for Cost Recovery for Overseas Visitors**

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### **Equality and Health Inequalities Statement**

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- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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## 1 Purpose

- 1.1 The regulations that set the legal framework for cost recovery from chargeable overseas visitors changed on 23 October 2017, making it mandatory to collect payment upfront for any chargeable patient that is not in need of urgent or emergency care. This has changed the way the risk share arrangements will work in practice. The regulations also extended the scope of the rules to providers other than NHS trusts and foundation trusts. This revised guidance updates the relevant parts of the NHS England *Who Pays?* guidance.
- 1.2 This guidance is designed to support commissioners and providers with further practical arrangements for overseas visitor cost recovery. In particular, it explains:
- how the risk-share arrangements operate;
  - what actions by providers and commissioners are expected;
  - who will be the responsible commissioner for an overseas visitor; and
  - how commissioners should account for the risk share.
- 1.3 To further support arrangements for cost recovery, the newly-added **Annex B** sets out some practical steps that commissioners and providers might consider to help improve working practices and reduce bureaucracy.

## 2 Context

- 2.1 An initial version of this guidance was published in April 2015 to support commissioners and providers in implementing cost recovery legislation (the National Health Service (Charges to Overseas Visitors) Regulations 2015<sup>1</sup> (the Department of Health provided guidance on the Regulations<sup>2</sup> at the time they came into force), and in particular the risk share arrangements developed in support of those Regulations. This revised version has been produced to reflect changes made under the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017<sup>3</sup>.
- 2.2 The main effects of the new Regulations are:
- *to extend the application of the obligations imposed by the 2015 Regulations to all providers of NHS funded care (except primary care and some palliative care); and*
  - *to require providers to make and collect an initial estimate of the whole cost of the care or treatment before the care begins (except where the care is considered immediately necessary or urgent by a responsible clinician). These changes came into force from 23 October 2017.*

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<sup>1</sup> [www.legislation.gov.uk/uksi/2015/238/contents/made](http://www.legislation.gov.uk/uksi/2015/238/contents/made)

<sup>2</sup> [www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations](http://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations)

<sup>3</sup> [www.legislation.gov.uk/uksi/2017/756/contents/made](http://www.legislation.gov.uk/uksi/2017/756/contents/made)

- 2.3 The 2015 Regulations (as amended) require that chargeable visitors from non-EEA countries are to be charged at 150% of tariff for NHS services they receive (either (a) the national price (subject to any local modification approved or determined by Monitor (now known as NHS Improvement)), or (b) where there is no national price set by the National Tariff, the local price as agreed in accordance with the rules set out in the National Tariff).
- 2.4 NHS Improvement has developed a list of indicative prices, which can be accessed here: <https://improvement.nhs.uk/resources/overseas-patient-upfront-tariff>. This list has been developed for guidance purposes to support upfront charging. These are not mandatory and not designed to replace existing pricing practice where it is felt that the provider has a system in place that works. This price list will stay under review and NHS Improvement will ensure that any national pricing changes/adjustments are reflected as required.
- 2.5 To support providers to undertake their statutory duty to identify chargeable visitors<sup>4</sup>, to levy and collect the appropriate charges from them, and to tackle fraud, NHS England has put in place arrangements to share the risk of non-payment between providers and commissioners as set out in this updated guidance and the [NHS Standard Contract](#). This recognises that it is in the overall interests of the health system to ensure fairness and equity, and is designed to ensure that both NHS commissioners and providers of NHS services have an interest in driving change.

### 3 Overview of risk-share arrangements

- 3.1 **From 23 October 2017, the risk share arrangements described in this guidance will only apply where a clinician has decided that care is immediately necessary or urgent, and the care is not paid for up front.**
- 3.2 For care that is not urgent or immediately necessary, the patient or their representative must pay an initial estimate of the whole cost of the care or treatment before the care can begin. This guidance, therefore updates relevant parts of the *Who Pays?* guidance.
- 3.3 The Department of Health set out its proposed risk sharing mechanism in July 2014 in the Visitor & Migrant NHS Cost Recovery Programme Implementation Plan 2014–16<sup>5</sup>. It said:

*We recognise the current NHS payment flows present an active disincentive for providers to identify and seek to recover costs from chargeable, non-EEA patients. When providers identify an individual as chargeable, the full financial risk burden for recovering the debt sits with the trust. If providers – intentionally*

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<sup>4</sup> Some people that are not UK residents are exempt from charges for NHS care, including asylum seekers and refugees.

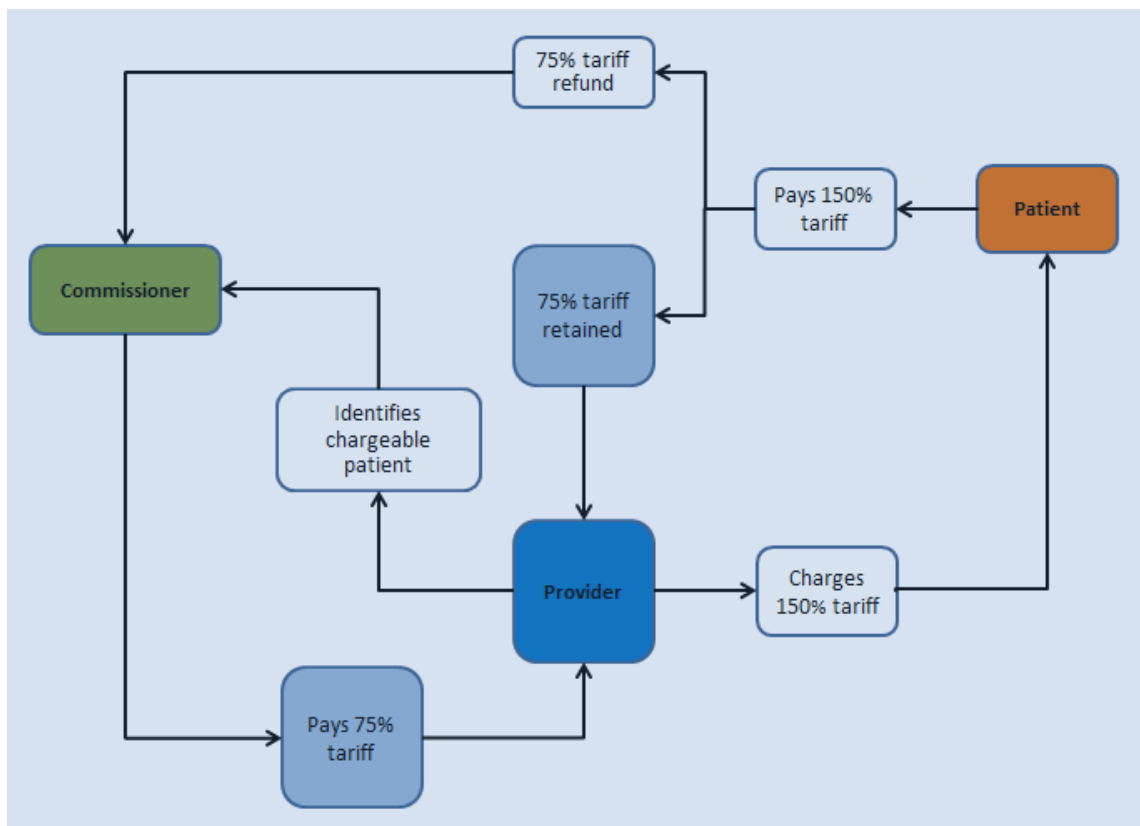
<sup>5</sup>

[www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/329789/NHS\\_Implementation\\_Plan\\_Phase\\_3.PDF](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/329789/NHS_Implementation_Plan_Phase_3.PDF)

or otherwise – avoid identifying patients as chargeable, the costs of healthcare continue to be borne in full by the commissioner.

To support the recovery of costs from chargeable non-EEA visitors and migrants (ie patients who are charged directly) we will be introducing a new mechanism. It will share the risk of unpaid debt to provide a direct financial incentive to encourage trusts to invest in identification and cost recovery processes. This will deliver a major step change in behaviour and process.

Under the new mechanism, when a provider identifies a chargeable patient, their commissioner will pay the provider 75% of the standard NHS tariff for the cost of the patient’s care. This means that for any such patient, the provider is guaranteed a minimum level of income. The patient will then be billed by the provider at a rate of 150% of tariff. On payment by the patient, the 150% tariff fee received will be split equally between the provider and the commissioner. This means the commissioner is reimbursed and the provider balance would be worth 150% of tariff. The flows will be as follows:



Under section 175(4) of the National Health Service Act 2006, the Secretary of State for Health has the power to set the level of charges for healthcare provided to chargeable patients on any basis he considers to be the most appropriate commercial basis. The charges must be set in secondary legislation. As such, the Department will lay regulations before Parliament in the autumn<sup>6</sup> setting out how NHS providers must calculate their charging. This

<sup>6</sup> Regulations were in fact laid in February 2015

*affects only patients seeking NHS healthcare rather than private healthcare provided by NHS hospitals.*

*The increase of charging to 150% of the NHS standard tariff for non-EEA patients recognises that there is a significant additional workload for providers when identifying chargeable patients and seeking to recover costs. The programme has reviewed comparable direct charges for healthcare under other care provisions and found that 150% of tariff still represents very good value for the extent and quality of NHS healthcare provided.*

*The non-EEA incentive mechanism will also be reviewed after 12 months to ensure its success. The Department will continue to work with NHS England, Monitor, the NHS Trust Development Authority, NHS providers and CCGs to ensure that the changes to financial flows are not detrimental to patient care and hospital budgets.*

- 3.4 Given the effect of the 2017 Regulations, references in the above extract should now be read as if referring to all providers of relevant services, and not only NHS providers or NHS hospitals.

## **4 Overview of governance issues**

- 4.1 Both commissioners and providers are reminded of the need to consider clinical and information governance issues around this process. Procedures and practice should appropriately account for these issues and this begins at the design stage:
- Any process of identification must incorporate identity validation checks to ensure that any individual is who they say they are.
  - Patients need to be advised of what personal data your organisation requires, what it is intended to be used for and with whom it might be shared.
  - Contracts do not, in themselves, provide a lawful basis to access personal confidential data. Commissioners will need to ensure that their methods to scrutinise providers are appropriate and lawful.
  - It is recommended that both commissioners and provider organisations engage with their information governance and clinical governance leads as early as possible, particularly as they design processes and protocols.
  - Early discussions between providers and their host CCG may help in designing an end-to-end process covering both organisations' needs. Any process must provide sufficient assurance to commissioners that reasonable steps have been taken.

## **5 Chargeable EEA visitors**

- 5.1 Where there is a patient from the EEA who does not qualify for NHS-funded care and is unable to present a European Health Insurance Card (EHIC), or a

Provisional Replacement Certificate, they must be charged by the provider at the normal NHS price (ie 100% of tariff as defined above).

- 5.2 The risk share arrangements outlined above are to apply on the same basis in respect of EEA visitors who are liable to charges (ie as with non-EEA visitors, the commissioner shares the risk with the provider on the recovery of the charge income). A table of examples is provided in **Annex A**.

## 6 NHS Standard Contract provisions

- 6.1 The NHS Standard Contract<sup>7</sup> includes provisions (at Service Condition 36) to support the delivery of the risk share. These provisions require that commissioners and providers must comply with the new regulations and with this and other guidance issued in support of those regulations.
- 6.2 The NHS Standard Contract and Contract Technical Guidance make it clear that, where the care has been judged to be either immediately necessary or urgent by a relevant clinician, commissioners are required to make payments to providers in respect of services delivered to a chargeable overseas visitor only where the provider has taken all reasonable steps to:
- identify the individual as a chargeable overseas visitor, and
  - recover charges from the chargeable overseas visitor or other person liable to pay those charges (for example, a parent or guardian).
- 6.3 Therefore, as long as the provider has taken or is taking all reasonable steps to identify an urgent patient as a chargeable overseas visitor and to collect charges from him or her, the responsible commissioner must pay to the provider the “appropriate contribution” on account – that “appropriate contribution” being half of the appropriate charge for the service (ie 75% of tariff for non-EEA patients and 50% of tariff for EEA patients).
- 6.4 On recovery of the relevant charge from the chargeable overseas visitor, the provider must refund to the responsible commissioner the payment made on account.
- 6.5 Under General Condition 15, commissioners can require an audit of the provider’s identification of chargeable overseas visitors and the collection of charges from them. The regulations make it clear that providers must collect full payment of an estimate of the total cost from the chargeable overseas visitor in advance of treatment (unless the care is urgent or immediately necessary). Otherwise, in determining locally what reasonable steps providers should be taking to identify chargeable overseas visitors and to collect charges from them, it may be helpful to consider:
- Whether new protocols are introduced to verify the status of patients before the start of treatment. This could be a requirement to present photographic

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<sup>7</sup> [www.england.nhs.uk/nhs-standard-contract/](http://www.england.nhs.uk/nhs-standard-contract/)



ID and proof of residence (eg a utility bill) at the first outpatient appointment, referring where appropriate to Overseas Visitor Managers.

- When it is appropriate to demand full payment in advance of treatment and when it is acceptable to proceed with treatment without having secured any payment (ie when there is a clinical decision that treatment is immediately necessary or urgent).
- What resources should be deployed to aid the identification of chargeable patients, to gather appropriate information to facilitate the charging of patients and any further debt recovery and what capacity is in place to recover debts (noting the specific obligation in Service Condition 36 to make full use of existing mechanisms designed to increase rates of recovery).

6.6 However, it should be stressed that immediately necessary/urgent treatment cannot be withheld pending payment.

## 7 Responsible Commissioner

7.1 This guidance supersedes and replaces the relevant sections of the August 2013 *Who Pays?* Guidance.

7.2 Paragraph 50 is replaced by the following:

*“50. Patients who are not ‘ordinarily resident’ in the UK (eg they are overseas visitors), and to whom no exemption from charges under Regulations applies, will be personally liable for the cost of any treatment with which they are provided. In such circumstances (and where treatment is considered urgent or immediately necessary by a relevant clinician), where providers have taken reasonable steps to identify chargeable overseas patients and to recover charges, the Responsible Commissioner is responsible for funding up to half of the patient charge. The commissioner must pay to the provider, on account, half of the patient charge in a timely manner, consistent with payment for normal NHS activity. The provider is required to advise the commissioner on the recovery of patient charge income on a regular basis and, on receipt of payment from the overseas visitor or on his behalf, to refund to the Responsible Commissioner in a timely manner that income on a 50:50 basis. However, a CCG is wholly responsible for funding the entire cost of care of those visitors to the UK who are exempt from charges and those services that are free to all overseas visitors.*

*The responsible commissioner for chargeable overseas visitor is determined as follows:*

- *First by paragraph 1 of the Who Pays? Guidance, but*
- *If the chargeable overseas visitor is not usually resident within a CCG geography, then the host CCG<sup>8</sup> for the provider is the responsible commissioner.*

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<sup>8</sup> The host CCG will be the CCG in which the provider is sited.

- *If the service received is one usually commissioned by NHS England, then NHS England is the responsible commissioner”*

7.3 Paragraph 6 of Annex A of the *Who Pays?* Guidance is replaced by the following:

*“6. If a person is not ordinarily resident in the UK, they are subject to the Charging Regulations, which place a legal duty on NHS providers to make and recover charges from overseas visitors who they have provided with treatment unless an exemption from charges applies as listed within the Charging Regulations. **Where such a patient is liable for the charge, the provisions of paragraph 50 will apply.**”*

## 8 Accounting for the risk share

- 8.1 This accounting guidance considers both the commissioner and provider entries required for accounting for chargeable overseas visitors. In accordance with the Regulations, it supports the principle of a risk share and effectively cash backs the debt whilst the provider continues to recover the debt from the patient. Within I&E, the provider initially recognises the income from the patient and does not recognise any income from the commissioner. The provider recognises income from the commissioner once all reasonable steps to recover the debt have been taken and the provider has written off any remaining unrecoverable debt from the patient, providing assurance to the commissioner in that respect. At this point, the commissioner also recognises expenditure for its share (50%) of the unrecoverable debt.
- 8.2 The provider initially recognises a payment on account as NHS deferred income from the commissioner and the commissioner initially recognises a payment on account as a NHS prepayment with the provider. Where the patient settles the debt, the provider returns the funding and transactions in both the provider and commissioner are effectively reversed. Where the provider writes off the debt, the provider and commissioner will recognise income and expenditure respectively at this point in time. No income or expenditure, in respect of the payment on account, is recognised in either the provider or commissioners’ books until the patient debt is written off: this is the income recognition trigger.
- 8.3 To enable effective administration, we advise commissioners to work with providers to ensure activity is invoiced on a monthly basis for all cases, rather than on an individual case by case basis. As illustrated below, this invoice should include the following two sections:
- new patients treated and associated cost at 75% of tariff; and
  - refunds of monies to commissioners in respect of previous amounts received on account where patients have settled their debts.
- 8.4 As such, we advise providers to issue a net invoice to commissioners for all new activity less refunds.

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- 8.5 We advise that the provider should provide case by case information on a monthly basis to support the invoice and provide detailed breakdowns of any debts from patients written off in the period to enable appropriate accounting entries to be made to recognise the income and expenditure in the providers' and commissioners' books respectively.
- 8.6 As such, the accounting can be broken down into the following three steps (using the non EEA tariff as an example):

**(i): Provider treats patient and issues invoice to patient**

At the point of treatment, the provider should raise an invoice to the patient for 150% of tariff (£150x). The accounting transactions will be:

Dr	receivables	£150x
Cr	income	£150x

**(ii): Provider notifies CCG of treatment of patient and raising of invoice**

The provider will raise an invoice for 75% of tariff (£75x) to the commissioner. The provider will code this as deferred income and the commissioner as a prepayment. For commissioners, a new subjective code will need to be set up to enable this coding. No income or expenditure will be recognised at this point. However, it is expected that the cash will transfer from the commissioner to the provider at this time. The accounting transactions will be:

Provider		Commissioner	
Receivables/Cash	£75x	Prepayments	£75x
Deferred income	£75x	Payables/Cash	£75x
To recognise the payment on account from the commissioner to the provider			

**(iii) (a) Patient pays provider debt owed; or (b) provider taken all reasonable steps to recover debt and has been unable to, leading to debt write off**

Only one of these steps will occur. In the event the patient pays the debt, the accounting will follow (iii)(a) and in the event the provider writes off the debt, the accounting will follow (iii)(b).

**(iii)(a):** The provider will notify the commissioner of the recoverability of the debt and raise a credit on the next invoice issued to the commissioner, supported by case information. The accounting transactions will be:

Provider		Commissioner	
Dr	Cash	£150x	
Cr	Receivables	£150x	
To recognise receipt of monies from patient			
Dr	Deferred income	£75x	Payables/Cash
Cr	Receivables/Cash	£75x	Prepayments
			£75x

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	Provider	Commissioner
To return monies received on account by the provider to the commissioner		

**(iii) (b):** The provider will write off the debt from the patient and recognise the income from the commissioner. The commissioner will recognise the expenditure. The accounting transactions will be:

	Provider		Commissioner	
Dr	Expenditure	£150x		
Cr	Receivables	£150x		
To recognise write off of patient debt				
Dr	Deferred income	£75x	Expenditure	£75x
Cr	Income	£75x	Prepayments	£75x
To recognise the commissioner risk share Income in the provider's books and expenditure in the commissioner's books				

- 8.7 In the event that the patient part pays the debt, then the amounts should be pro-rated. The provider will recognise the amount received and return a proportionate amount of the payment on account to the commissioner (ie half the amount received from the patient). If the provider expects to recover the remaining debt, the remaining deferred income and prepayments will remain on the provider's and commissioner's accounts. If at this point the provider writes off the remaining debt, the remaining payment on account from the commissioner will be recognised as income in the provider's accounts and expenditure in the commissioner's accounts.
- 8.8 From an Agreement of Balances (AOB) perspective, the transaction should not be included on the I&E AOB statement until the debt has been written off but any outstanding invoices should be included on the payables statement.

## 9 Further information

- 9.1 **Annex A** sets out worked examples of where and how the risk share arrangements should be implemented.
- 9.2 The purpose of **Annex B** is to share with commissioners and providers good working practices that might help make their relationships around chargeable overseas visitors more efficient and reduce bureaucracy. It has been specifically developed for:
- commissioners with responsibility for checking and paying invoices, or auditing providers to ensure they are taking reasonable steps to identify and recover costs from chargeable overseas visitors; and
  - staff working in providers of NHS funded care, with responsibility for identifying chargeable overseas visitors and invoicing commissioners for their care under the risk share arrangements.

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**Annex A: Illustrated examples**

Patient category	Treatment type	Identified as part of residential population?	Charging whom?	Charging how much?	Commissioner risk share of half patient charge <sup>9</sup>	Patient type
UK ordinarily resident	Regular	YES	Responsible Commissioner (CCG)	100%	n/a	NHS resident
UK ordinarily resident	Specialist	YES	Responsible Commissioner (NHS England)	100%	n/a	NHS resident
UK resident, surcharge payee	Regular	YES	Responsible Commissioner (CCG)	100%	n/a	NHS resident
UK resident, surcharge payee	Specialist	YES	Responsible Commissioner (NHS England)	100%	n/a	NHS resident
EEA visitor with EHIC/S2	Regular	YES	Responsible Commissioner (CCG)	100%	n/a	CEOV/ EEA
			EHIC only: Department of Health <sup>10</sup>	25%	n/a	
EEA visitor with EHIC/S2	Regular	NO	Responsible Commissioner (Host CCG)	100%	n/a	CEOV/ EEA
			EHIC only: Department of Health	25%	n/a	
EEA visitor with EHIC/S2	Specialist	YES	Responsible CCG	100%	n/a	CEOV/ EEA
			EHIC only: Department of Health	25%	n/a	
EEA visitor with EHIC/S2	Specialist	NO	Host CCG	100%	n/a	CEOV/ EEA
			EHIC only: Department of Health	25%	n/a	
EEA visitor without EHIC/S2 but exempt from charges	Regular	YES	Responsible Commissioner (CCG)	100%	n/a	CEOV/ EEA
		NO	Responsible Commissioner (Host CCG)	100%	n/a	
EEA visitor without	Specialist	YES	Responsible Commissioner (CCG)	100%	n/a	CEOV/ EEA

<sup>9</sup> The risk share will apply to the full cost of care carried out without up-front payment in the case of immediately necessary or urgent.

<sup>10</sup> The Department of Health – as part of the EHIC incentive launched on 1 October 2014 – pays NHS providers an additional 25% of the value of Tariff for any EHIC activity reported on the Overseas Visitors' Treatment portal. This incentive only applies to EHIC, not S2 forms.

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Patient category	Treatment type	Identified as part of residential population?	Charging whom?	Charging how much?	Commissioner risk share of half patient charge <sup>9</sup>	Patient type
EHIC/S2 but exempt from charges		<b>NO</b>	Responsible Commissioner (Host CCG)	100%	n/a	
EEA visitor without EHIC/S2 and not exempt from charges	Regular	<b>YES</b>	Patient	100%	Responsible Commissioner (CCG)	Chargeable EEA
		<b>NO</b>	Patient	100%	Responsible Commissioner (Host CCG)	
EEA visitor without EHIC/S2 and <u>not</u> exempt from charges	Specialist	n/a	Patient	100%	Responsible Commissioner (NHS England)	Chargeable EEA
Non-EEA visitor exempt from charges	Regular	<b>YES</b>	Responsible Commissioner (CCG)	100%	n/a	CEOV/ Non-EEA
		<b>NO</b>	Responsible Commissioner (Host CCG)	100%	n/a	
Non-EEA visitor exempt from charges	Specialist	<b>YES</b>	Responsible Commissioner (CCG)	100%	n/a	CEOV/ Non-EEA
		<b>NO</b>	Responsible Commissioner (Host CCG)	100%	n/a	
Non-EEA visitor <u>not</u> exempt from charges	Regular	<b>YES</b>	Patient	150%	Responsible Commissioner (CCG)	Chargeable Non-EEA
		<b>NO</b>	Patient	150%	Responsible Commissioner (Host CCG)	
Non-EEA visitor <u>not</u> exempt from charges	Specialist	n/a	Patient	150%	Responsible Commissioner (NHS England)	Chargeable Non-EEA

## Annex B: Practical steps to support cost recovery

### Introduction

- 1 Commissioners and providers of NHS-funded services are responsible for ensuring that money and resources are being used appropriately. This includes ensuring that the NHS only funds care for eligible patients.
- 2 The National Health Service (Charges to Overseas Visitors) Regulations 2015 (2015 Regulations) placed a legal obligation on NHS trusts, NHS foundation trusts and local authorities to make reasonable enquiries to establish whether a person is an overseas visitor to whom charges apply, or whether they are exempt from charges.
- 3 The 2015 Regulations were amended in 2017 to:
  - extend the requirement to identify and recover costs from chargeable patients to all providers of NHS funded care (with the exception of primary care and care within an A&E setting).<sup>11</sup> From 23 October 2017, this includes any provider of NHS-funded community and secondary care, including non-NHS organisations; and
  - include a legal requirement to recover an estimate of the full cost of the treatment before the care starts to be delivered. Please refer to the Department of Health's [guidance on implementing the overseas visitor hospital charging regulations](#) for further information.
- 4 This means from 23 October 2017, CCGs will need assurance that all the treatment they are being billed for under the risk share scheme (for chargeable overseas visitors) is immediately necessary or urgent.
- 5 Commissioners are reliant on providers to identify chargeable overseas visitors (or to demonstrate their eligibility for NHS funded care). They must have confidence that they are not paying for patients who are not eligible. At the same time, they need to recognise the process of identification and charging should be proportionate, as it is not always easy for providers to reach a decision on residence status with absolute clarity, and sometimes requires a judgement call. In particular, commissioners should bear in mind that providers (particularly those that have not been required to identify and charge patients before) will be bedding in new systems, and should consider a reasonable, proportionate, flexible approach to operationalising the new requirements during the first few months.
- 6 Some health communities have already agreed and implemented a robust and proportionate approach in their interactions for recovering costs from chargeable overseas visitors. For example, some NHS trusts and CCGs have agreed resources and processes in place, including regular contract meetings

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<sup>11</sup> Cases that are judged by a relevant clinician to be immediately necessary or urgent are exempt from the requirement to pay in advance of commencing treatment.



and an agreed approach to reconciliation of monies included under the overseas visitors risk share scheme. However, we know that for other areas more support to embed robust and streamlined processes might be welcomed.

- 7 This annex is intended to help providers and commissioners to develop good working practices that are proportionate and flexible, with the aim of providing assurance that an agreed reasonable process is being used to identify and recover costs from chargeable patients. Based on feedback from commissioners and providers about how they are developing transaction processes, it gives advice on how local areas can enhance their processes, sharing learning from health communities with robust and proportionate processes in place.
- 8 Whilst the recommendations in this document are not mandatory, all commissioners and providers are strongly encouraged to:
  - review their processes to ensure they meet the requirements of the amended 2015 Regulations; and
  - include a written description of the procedure they use in Schedule 2G of their NHS Standard Contract, to facilitate commissioner/provider interaction. The procedure should set out how the provider will implement a proportionate and streamlined approach to the identification, charging, invoicing and recovery of costs from chargeable overseas visitors.

### **Practical steps to support cost recovery**

- 9 We have identified four key areas which providers and commissioners could focus on to support the cost recovery process:
  - **Have a proportionate procedure in place:** ie the steps that providers could take to identify chargeable patients and collect payment from them that will help give assurance to commissioners that they are only paying for eligible patients.
  - **Agree what information providers will collate and how it will be shared with commissioners:** ie advice on the types of information providers could share with commissioners to demonstrate that they have undergone a reasonable investigation to determine whether someone is eligible for NHS funded care.
  - **Agree how charges will be calculated:** ie suggestions for commissioners and providers on how to simplify the invoicing and reconciliation process.
  - **Undertake regular audits:** to give assurance to both commissioners and providers that their processes are robust and being implemented appropriately, and any areas for improvement are identified.
- 10 Our intention is that these steps will help:

- providers to give enough information to the commissioner to justify a decision on an individual patient's residency status;
  - commissioners in dealing with invoices for amounts that are unclear, without enough information to understand what part of the process the numbers relate to, or why an individual patient is being funded by the NHS.
  - save time and resources for commissioners and providers to focus resources better on engaging with patients, which in turn will improve the efficacy of identification; and reduce the need for commissioners to request additional information from providers about individual patients.
- 11 Commissioners should be careful to treat all providers consistently, but also fairly and proportionately. It is possible that further processes may need to be agreed at a local level to reflect the volume and complexity of cases which present at individual providers. In addition, as policies evolve over time, and new technological solutions emerge, commissioners and providers will need to work together to adapt their approach accordingly.

### **A proportionate procedure**

- 12 Providers are strongly recommended to develop and set out a reasonable and proportionate procedure that they will go through to identify and charge overseas visitors, setting out the resources the provider will put into identifying chargeable patients and pursuing cost recovery<sup>12</sup>, which can be added to Schedule 2G (Other Local Agreements, Policies and Procedures) of the provider's NHS Standard Contracts with its commissioners.
- 13 Drawing from good practice, providers might find it helpful to develop a procedure that covers:

#### **Identification of chargeable patients:**

- identifying EEA nationals, confirming their EHIC/S2 status and submitting the information through the DWP portal;
- identifying non-EEA nationals, their visa status and notifying NHS Digital;
- identifying UK passport holders who are not ordinarily resident in the UK;
- establishing the reason why overseas visitors are in the country;
- agreeing the data that the commissioner will want to see when it carries out an audit (see below).

#### **Cost recovery activities:**

- calculating the costs to be charged to the patient;
- issuing invoices and regular reconciliation;
- cost recovery activity (debt collection);

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<sup>12</sup> All patients should be asked baseline questions which are consistent and fair, unless the chargeable status is already known/trusted eg through the green banner on the Spine. These baseline questions should provide a general indicator of whether a person is a UK resident or not. Providers should decide what questions to use, but they should be consistent and non-discriminatory. The Department of Health has provided recommendations in its guidance. If the patient's answers suggest they are not a UK resident, the provider should investigate further.

- a process for writing off debt.

**Resources and training:**

- ensuring there are enough resources in place to undertake the process;
- providing training for reception and clinical staff about when to engage the overseas visitors team.

- 14 If providers set out a proportionate procedure that they will go through to confirm that patients are eligible for NHS funded care and insert it into their NHS Standard Contract, this should be enough to give the commissioner confidence that providers are making reasonable efforts to identify and charge patients who are not eligible for NHS funded care. Commissioners can therefore be reassured that they are being asked to pay for patients that are eligible for NHS funded care, and fulfil any commitments under the risk share arrangements. This should in turn help providers and commissioners reconcile funding, and reduce the overall bureaucracy.

**Collating and sharing information**

- 15 We have identified a relatively small set of easily available information which providers could share with commissioners to give them assurance that they have gone through a reasonable and proportionate procedure to identify chargeable patients and invoice accordingly. Routine sharing of this information should help to avoid the need for commissioners to require other detailed information from providers.
- 16 The information should confirm why the commissioner is being invoiced, which may be because, for example:
- the patient is eligible for NHS funded care<sup>13</sup>; or
  - the care was judged to be immediately necessary or urgent.
- 17 CCGs have told us it would be useful if providers could share the following information (over and above routine invoice information):
- chargeable status;
  - clinical decision on urgency of care.
  - evidence of ID confirmation;
  - nationality/country of origin;
  - country of residence;
  - reciprocal agreement status (eg from an EEA country or other country/crown dependency with a reciprocal arrangement);
  - visa status (ie has IHS been paid);

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<sup>13</sup> The Department of Health's [Ordinary Residence Tool](#) gives providers a detailed methodology to use to inform a decision on chargeable status but the commissioner does not need to see all of the information the provider collates in order to make the decision. The Tool explains that: "normally, no one factor on its own will determine that a person is, or is not, ordinarily resident. While answering "yes" to a question may be an indicator that a person is ordinarily resident and vice versa, a decision will need to be made according to all the circumstances of the particular case."

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- category of overseas visitor (eg tourist, asylum seeker, travelled to have access to the treatment).
- 18 This list is not exhaustive, but is intended to be a helpful starting point for discussions between commissioners and providers to agree what information is required to meet their specific situation and needs. It may be that providers and commissioners agree to use a subset of this information or design something different. For example, one trust advised us that the only additional information required by its main CCG was a single field setting out why the patient was chargeable under the risk share arrangement.
- 19 Providers should confirm that they have checked the data on the Spine, and routinely updated it when a chargeable overseas visitor is clearly identified or their status changes.
- 20 Once agreement has been reached on the data requirements and how this will be reported, this could be included within the procedure that is added to Schedule 2G of the NHS Standard Contract. If commissioners are content that the information is sufficient, it should make it easier for the commissioner to have the confidence it needs to pay the provider.

### Calculation of charges

- 21 Discussions with trusts and CCGs have highlighted that there can be challenges in calculating the cost of treatment and invoicing and reconciling the (initial estimated and final) costs of the treatment, the amount included under the risk share arrangement and the amount of costs recovered or written off. We should not underestimate how complex this can be, and the impact that has on the whole process of cost recovery.
- 22 From 23 October 2017, when patients, identified as chargeable, receive care that is not judged to be immediately necessary or urgent (see the Department of Health's [Upfront Charging Operational Framework](#)) and are required to pay an estimated total cost of their care up front, commissioners will not need to be invoiced at all (and the risk share arrangements won't apply). NHS Improvement has produced a [recommended price list that can be used to calculate the initial estimated cost](#).
- 23 However, where up-front cost recovery is not required or sometimes possible or appropriate (eg the care/treatment was considered by a clinician to be immediately necessary or urgent, but not carried out in an A&E department), the responsible commissioner is required to pay the provider half of the inflated tariff value, which is returned to the commissioner as and when the costs are recovered from the patient.
- 24 There is clearly a risk that this could lead to a complex bureaucratic administrative process from:
- calculating the initial estimate (at tariff times 150% where appropriate);
  - invoicing the patient and the commissioner (50% of the initial estimate);

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- calculating the actual cost at the end of the course of treatment;
  - issuing another invoice of the balance to the patient;
  - issuing another invoice to the commissioner (50% of any additional cost);
  - returning the risk share amount to the commissioner when payment is received, which can cause reconciliation challenges (eg the invoice or reconciliation may be in a different financial year to the treatment).
- 25 To be confident that they should be paying invoices, commissioners need to be able to understand how the cost has been calculated. It needs to be transparent and there should be routine reconciliation, at agreed intervals, of:
- amounts owed by patients;
  - costs recovered;
  - debts written off; and
  - refunds to commissioners under the risk share arrangement.
- 26 Providers and commissioners can minimise the bureaucracy involved in the invoicing and reconciliation process for patients where the risk share arrangement applies.
- 27 Instead of issuing an invoice to the commissioner at the time of the initial estimate charged to the patient, providers could agree to wait until the final costs to have been calculated before invoicing the commissioner for 50% of the final total, easily reconciled back to the respective HRG. This will make it easier for the commissioner to identify the costs (only once rather than twice, and specifically related to costs of the care that has been delivered), and reconcile the total position, without greatly affecting the provider financially. However, it should be made clear that in all options the Trust will need to conduct its own reconciliation process as they will need to produce two invoices for the same patient across the same episode.
- 28 The process used should be set out in the procedure set out in the NHS Standard Contract.

### **Use of Audits**

- 29 Commissioners have powers under the regulations to audit providers' investigation of overseas visitors. Many commissioners already carry out audits for various transactions as a way of providing assurance that processes are working effectively. We would encourage commissioners and providers to consider this approach to auditing in relation to the provider's assessment of whether a patient is eligible for NHS funded care, but to minimise the burden as much as possible. Some commissioners already do this, and it can help to support a good relationship with the providers.
- 30 The audit might seek to answer the following two questions:
- Has the provider followed the procedure set out in Schedule 2G of their NHS Standard Contract, where there is a potentially chargeable patient? and

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- Has the provider come to a reasonable conclusion as a result of its investigation?
- 31 Rather than checking every invoice, we recommend that commissioners consider auditing a random sample of invoices to ensure that the procedures set out in the NHS Standard Contract have been followed.
- 32 The key for providers is to be transparent about:
- What resources they have in place;
  - What measures they take to identify chargeable patients;
  - What data they use to make a decision (without having to share that data with the commissioner for every patient); and
  - What efforts the provider makes to recover costs.
- 33 Benchmarking of types of providers, grouped by the expected volume of overseas visitors, could also help increase commissioners' confidence if the numbers were within reasonable parameters.

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NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

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