



Terms of Reference

Governance and financing models for the 3 REHs in Iasi, Cluj and Craiova

Ref nr: AA-012642-002

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ALOS	Average length of stay
ANDIS	National Agency for the Development of the Health Infrastructure (Agenția Națională pentru Dezvoltarea Infrastructurii în Sănătate)
ANMCS	National Authority of Quality Management in Health
APM	ANDIS Project Manager
Action Plan	The services delivery plan under the PASSA ANDIS that sets out the activities, sub-activities, tasks and technical deliverables
CaPeSSCost	EU funded project on hospitals costs evaluation and standardization
CNAS	National Health Insurance House
CJAS	County Health Insurance House
DRG	Diagnostic Related Groups
DSP	County Health Directorate
EIB (or “the Bank”)	European Investment Bank
EIB HPE (or “HPE”)	EIB Consultant: Health Policy Expert
EIB PE (or “PE”)	EIB Consultant: EU Projects & Project Administration Expert
EIB TL (or “TL”)	EIB Team Leader
EU	European Union
EMP	Experts Mobilization Plan
FS	Feasibility Studies that have been prepared and approved for each REH
ICU	Intensive Care Unit
ICD	International Classification of Diseases
INMSS	National Institute for Health Services Management
JASPERS	Joint Assistance for Preparing Projects in European Regions, EIB advisory programme supporting project preparation
KPI	Key performance indicators
MA	Managing Authority
MoH	Ministry of Health
MRD	ANDIS Main Recipient Department
NHIH	National Health Insurance House
NHIH-FC	Framework Contract which governs the relation between NHIH and providers
PAS Health Team (or “EIB PAS Team” or “PAS Team” or “the Team”)	EIB's project team for implementing various Health PASSAs comprised of members of the Permanent Support Services and of Third Party Experts
PASU	Project Advisory Support Unit
PJ	EIB's Projects Directorate
PNRR	National Plan for the RRF

Project	The project to plan, construct, equip, furnish and operationalize 3 REHs in Iasi, Cluj and Craiova
PST	PASSA Permanent Support Team
QCP	Quality Control Plan
REH	Regional Emergency Hospital
RRF	Recovery and Resilience Facility
SCM	EIB's Service Contract Manager
SJU	County Emergency Hospital (in Romanian: Spital Judetean de Urgenta)
Services	Technical Assistance services delivered under this PASSA
TA	Technical Assistance
TCP	ANDIS Technical Contact Person
Third Party	Consultant engaged by the EIB for delivery of a certain assignment under the PASSA ANDIS
TOR	Terms of Reference
UPU	Hospital Emergency Department

1. **Background information**

1.1. **The European Investment Bank**

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L-2950 Luxembourg

Grand Duchy of Luxembourg

The European Investment Bank (EIB or the Bank) is the financing institution of the European Union (EU). Created by the Treaty of Rome, its shareholders are the Member States of the EU, and its Board of Governors is composed of the Finance Ministers of these States. The EIB enjoys its own legal personality and financial autonomy within the Community system.

The mission of the EIB is to contribute, by financing sound investment, to the policy objectives of the EU, as laid down in its statutes and in decisions of the European Council.

The EIB has been active in Romania over the last 15 years both in terms of lending and technical assistance. Lending is concentrated in the transport, healthcare, environment, energy, banking and SME sectors. Since the first operations substantial advisory support has been provided, largely by the EIB, both through own staff and through the support of external Service Providers, at various stages of the project cycle. The Bank's advisory support has increased significantly since accession; first with the involvement of JASPERS in programme/project preparation of EU funded operations and, since 2012, with increased support during project implementation of the EIB Project Advisory Support Unit (PASU).

More background information about the EIB may be found on the website www.eib.org

1.2. **EIB Advisory Services**

The EIB offers a large range of advisory services that embrace all stages of the project cycle and beyond, to make investment projects happen inside and outside the European Union.

Advisory activities constitute the third pillar of the Lending, Blending, Advising strategy pursued by the EIB Group. Through this advisory function, the EIB Group supports the European Commission, Member States

and public authorities, private enterprises and financial intermediaries in pursuit of the overarching goals – to accelerate the green and digital transition and promote social and economic cohesion.

1.3. Mandate

The Assignment is funded under **PASSA ANDIS**.

1.4. Relevant project background

According to the National Institute of Statistics, in 2023 there were 554 hospitals in Romania, over two thirds of which were public (117.284 beds). The public hospitals infrastructure in Romania is outdated, as the vast majority were built in the 1970s and 1980s. Therefore, there is an acute need to replace or refurbish these buildings in accordance with the actual standards existing in the EU.

On the other hand, Romania is among the last in the ranking of EU Member States in terms of health expenditure as a share of GDP (according to Eurostat, in 2023 this share of GDP for health expenditure was 5,8%).

The National Health Strategy 2014-2020 has been prepared based on the needs assessment of the health services. The main objective of this Strategy was to "ensure equal access for all the citizens, especially the vulnerable groups, to quality and cost-efficient health care services". The main actions were the development the community-based health services, for vulnerable groups, increasing the effectiveness and diversification of the primary medical care services, strengthening the quality and efficiency of the services provided in the specialised ambulatory units, strengthening the integrated emergency system and ensuring equal access to emergency medical care, regionalization/concentration of hospital medical care and establishing regional reference networks with hospitals and labs with higher level competencies.

One specific objective for health services development was consolidation of the health infrastructure at national, regional and local level and building and equipping three regional emergency hospitals in Iași, Cluj and Craiova. Besides the regular role of tertiary care providers in the regions, another reason for building the regional emergency hospitals (REH) is to increase the level of preparedness of the regional health care system to respond to natural disasters and emergency situations.

In parallel, other operationalization measures include: development of human resources in the health sector, implementing quality and safety assurance mechanisms, promoting research and innovation in the health system, ensuring sustainable financial resources for health, cost control and financial protection for the population.

The vision for REHs is to be the tertiary level hub for the hospital network in their region, taking over from the clinical county emergency hospitals and other parts of the emergency network. The planned hospitals will become a hub for the hospital networks to deal principally with patients requiring acute emergency, secondary and tertiary level care cases that require high-level technology and expertise. The keys to the achievement of the new tertiary level emergency hub hospital concept will be the new management and organisational arrangements and the financing concepts and budgetary model, a human resource development investment to prepare the staff for working according to new methods of working and maximising the potential of major investment in new technologies to improve the effectiveness of patient care.

The construction of the 3 proposed regional emergency hospitals (Iași, Cluj and Craiova) has been included also in the new Romanian National Health Strategy 2023-2030. In line with the current legislation, the National Agency for Healthcare Infrastructure Development (ANDIS) is responsible for the construction of the three regional hospitals for Iasi, Cluj and Craiova. Construction of regional emergency hospitals in Iasi, Cluj and Craiova will be referred as "the Project" in this Terms of Reference. As a follow up of the previous strategy,

the current National Health Strategy provides directions for action and measures by which public health interventions and health services be properly planned and organized at the territorial level (regional /county).

In recent years, the hospital sector in Romania has been going through an extensive process of transformations and reforms, especially in the field of evaluating and improving the quality of hospital services, to better respond to the specific needs of the population. At the same time, public spending on health services and especially hospitals continued to grow at an accelerated pace, even if their level remained relatively low compared to developed countries. Under these conditions, it is even more important to adopt evidence-based tools for budgeting decisions, allocation and use of budgetary resources, so that the national health objectives and those of the health units are achieved in conditions of efficiency.

The finalised project CaPeSSCoST implemented by Ministry of Health, in partnership with the former National School of Public Health, Management and Continuous Development (SNSPMPDSB) (currently INMSS) ANMCS and NHIH, developed a set of tools in the field of health care costs and quality in order to improve the quality and performance of hospital services in Romania.

Relevant country background for Romania can be found on the following websites: <https://mfe.gov.ro/> and <https://andis.gov.ro/1/>.

Current situation in the relevant sector

Romania has an outdated public healthcare infrastructure. Iasi, Cluj and Craiova Regional Emergency Hospitals will be the first major tertiary care (public) providers built in the country in the last 30 years.

The Project is defined as to plan, construct, equip, furnish and operationalize the 3 Regional Emergency Hospitals (REHs) in Iasi, Cluj and Craiova. The project is phased over two programming periods. The Ministry of Health (MoH) was responsible for the implementation of phase I of the Project, until end of 2023. The second phase of the project is implemented in partnership with ANDIS (National Agency for Health Infrastructure Development), ANDIS being the leader of the project.

On 14 December 2023, EIB signed with ANDIS a PASSA agreement (PASSA ANDIS) to provide support to the Romanian authorities for implementation of the phase II of the Project for construction of the 3 REHs in Iasi, Cluj and Craiova, until its operationalization.

Under this agreement, the PAS Team shall provide ANDIS with technical assistance for the construction and operationalisation of three Regional Emergency Hospitals in Iași, Cluj and Craiova. The successful implementation of the Project will improve the health infrastructure in three regions in Romania on one hand and will strengthen ANDIS capacity to implement new hospital projects on the other hand.

The present assignment is part of the measures needed for the successful operationalization of the 3 REHs, which were articulated in two strategic documents: the Soft Measures Strategy for the 3 REHs, approved by the Ministry of Health on 6th September 2021, and the Soft Measures Procurement Strategy, approved by the Ministry of Health on 14th January 2022. The Service Provider, under this assignment, will provide advisory support to the National Agency for Healthcare Infrastructure Development (ANDIS) and PAS Team in preparing, planning and developing the governance and financing models that will be needed at the Iasi, Cluj and Craiova REHs.

ANDIS will coordinate with other public institutions, national or local level authorities, relevant professional associations and NGOs throughout the project implementation. To this effect, ANDIS is implementing a Stakeholder Engagement Mechanism, consisting of Stakeholder Coordination Committees and Technical

Working Groups which will ensure the engagement of decision makers of the stakeholders and final users, as well as other public stakeholders (e.g. National Health Insurance House, etc.).

Related programmes and other donor activities

Relevant for the assignment are the EU Regulations governing the 2012 – 2027 programming period, among which Regulation 1060/2021 for Common Provisions, Regulation 1058/2021 for ERDF and Cohesion Fund and Regulation 1057/2021 for FSE+ as well as the RO related legislation, as for example:

- Romania's Recovery and Resilience Facility (PNRR), under Reform 1, that focuses on efficient public healthcare spending and performance-based funding.
- National Health Strategy 2023–2030 that emphasizes hospital regionalization and infrastructure development.
- Health Services Regional Plans that provide strategic planning for hospital operations at the regional level.
- EU Structural and Investment Funds (ESIF), co-funding the REHs along with EIB loans.

2. Objective and purpose

2.1. Overall objective

The non-construction and/or non-hard investment activities to make the REHs operational are categorized as the "Soft Measures". This assignment has been identified as one of the operationalization actions under the "Soft Measures Strategy" developed for the Project and approved by the MoH.

Under this assignment, the Service Provider shall provide advisory support to the EIB PASSA ANDIS Team in providing high quality advice for reform and preparation for operationalisation of the 3 REH, and to enable ANDIS plan by preparing, and developing the governance and financing models of the 3 REHs. The deliverables of this assignment should be considered in the implementation of all the other "Soft measures".

The most relevant stakeholders for the implementation of this assignment include:

- National and local level administration and health agencies: MoH, CNAS, ANMCS, INMSS, CJAS, DSP,
- Iasi, Cluj and Craiova Emergency County Hospitals,
- Universities of Medicine and Pharmacy from Iasi, Cluj and Craiova.

The 3 new REHs will replace the 3 emergency county hospitals from Cluj, Craiova, Iasi, which shall be reorganized. A significant part of the acute tertiary care services that are now provided by the county hospitals and other tertiary care services from other specialised institutes or hospitals from each city will be transferred to the 3 REH. The old facilities' roles and its future roles will be assessed and decided in consultation with all the stakeholders. It is planned that most of the staff of the emergency county hospitals to be transferred to the new REHs.

Specific objectives for governance of the REHs

I. With regards to the *new structure of REH*, the feasibility studies, design plans and execution of the construction of REH are taking into consideration an operating model aiming to meet future needs and demands and reflect current best European practice. The proposed governance and finance model has important new features in connection with the new care and work environment: patient pathway implementation based on clinical protocols, facilitating a multi-disciplinary team-based approach to patient care, shared comprehensive range of diagnostic and therapeutic technologies, flexible utilisation of the bed capacities between specialties, holistic and patient centred approach to care delivery, extensive use of digital-

based information and communication technologies, continuous education and training, research and development conditions and a sustainable financing operational system.

The new governance model must ensure quality and efficiency, better coordination between levels of care, better accountability. The governance model framework should ensure that stewardship, accountability, transparency, participation and integrity are included in all decision-making processes.

As in other European countries, the new REHs, as publicly operated institutions, will need to achieve multiple objectives – from improving medical performance and ensuring financial sustainability, to fostering knowledge development, professional prestige and social cohesion. Achieving these goals will require adapting the REHs' governance arrangements to the new technological and health systems financing context.

The traditional, monolithic, command-and-control model of public hospital leadership will no longer be a viable approach.

In line with recent European experiences, the main characteristics of the REH governance will need to ensure achievement of the following objectives:

- **Ensuring an inclusive governance** - the hospital's governance structure must be a combination of its key stakeholders: hospital management and financial experts, clinical leadership (doctors and nurses), representatives from the community, representatives of the central / local authorities, patients and their representatives.
- **Developing accountability and transparency** – as a public financed hospital, the REHs must operate under strong accountability framework that links resource use to performance outcomes. The operational REH is also viewed as a key government commitment to improving population health and addressing the population's health and social needs. This includes transparent reporting to the Ministry of Health and other central authorities, local authorities and the community, as well as internal mechanisms for monitoring safety, quality and efficiency. A formal system for quality management and safety should cover clinical governance, patient safety and continuous performance evaluation.
- **Autonomy and decentralised decision-making** – an independent or hybrid governance structure should balance managerial autonomy with external accountability to national and local health authorities. Clinical centres should have delegated management responsibilities, enabling responsive decision-making close to service delivery. Duties, responsibilities and authority must be clearly defined and documented.
- **Financial and managerial responsibility** - governance should ensure a clear delineation of clinical, managerial and financial accountability. Each clinical centre should operate as a cost centre with defined budgets and performance targets. The hospital's financial governance must support sustainability, efficient capital utilisation and alignment with national contracting and reimbursement frameworks.
- **Workforce and well-being governance.** Human resources governance should prioritise recruitment, retention and professional development. Measures include flexible shift models, family-friendly policies, continuous education and staff well-being programmes aimed at reducing healthcare professionals' burnout.
- **Governance for safety, quality and emergency preparedness.** Governance and management structures should ensure readiness for disaster and emergency response. This includes maintaining updated emergency protocols, command structures and ensuring a culture of safety and learning across the organization.
- The REHs governance boards should steer the hospitals' **digital transformation strategy**. This includes oversight of the integration of advanced technologies such as: AI enabled clinical decision-support systems, predictive analytics for flows and resource management, computer-assisted

diagnostics and imaging tools, robotic process automation in administrative and supply-chain workflows, natural language processing for automated medical documentation and coding.

- **The clinical operating model based around multidisciplinary clinical divisions/centres** comprising compatible patient groups and medical specialties, reflecting the need for close working relationships in the delivery of acute and emergency secondary and tertiary level care, as follows:
 - o Head and Neck Centre comprising specialties of neurology, neurosurgery, ophthalmology, ENT, Maxillo-facial surgery.
 - o Chest Centre comprising pulmonology, cardiology, thoracic surgery, cardio-vascular surgery.
 - o Abdominal Centre comprising gastroenterology, nephrology, urology, general surgery.
 - o Joint, Spine and Trauma Centre comprising trauma & orthopaedic, plastic surgery, burns unit, vascular surgery.
 - o Internal Medicine Centre comprising dermatology, internal medicine, metabolic diseases and endocrinology, immunology, haematology, psychiatry (acute).
 - o Mother and Child Centre comprising gynaecology, obstetrics, paediatrics and paediatric surgery, neonatology.
- **Strategic partnerships and research governance** – a structured partnership with the medical and technical universities from the corresponding regions, research institutes and innovation clusters shall be established. Governance arrangements should ensure coordination of research activities, technology transfer, and participation in national and internationally funded projects.
- **Strategic flexibility and adaptability.** Governance arrangements should embed flexibility to anticipate and manage changes in technology, service demand, and epidemiological trends, ensuring the REHs will remain resilient and sustainable over time.

Specific objectives for the financing model of the REHs

The analyses performed in the feasibility studies show that for ensuring the day-to-day operation and financial sustainability of the REH, updated conditions for hospital financing and financial management should be prepared, tested and approved, in closed connection with REH specific types of services. It is expected that the new hospitals will receive more complex cases, use clinical protocols for quality improvement, operate with multidisciplinary centres, use and maintain high tech interventions, share technology and staff flexibility, shift to ambulatory/day care, develop research and teaching projects.

Ensuring REHs financial sustainability and cash flow is a key objective for the design of its financial model. Financial sustainability implies having a cumulative positive cash flow for each year of operation. The conclusions of the cost-benefit analyses in the 3 REH cases is that the budget needed for the new hospital setup exists in the system, but the financing mechanism should be adapted to reimburse REH specific activities.

The financing model will support the new organizational structure arrangements, complex health services mix, including intensive care, different staff allocation, teaching, education and high level of research activities, continuous medical education, expensive input structure, complex technical ancillary services, IT equipment, and medical equipment maintenance and services, projects and developments.

The principles of good financing and budgeting should be incorporated in the model: to link the financing to health objectives, incorporate performance information within or alongside the budget (KPI), project revenues and expenditures over the medium-term, ensure sustainability. The model should be based on the following principles:

- Adequacy, meaning that sufficient funding is ensured to cover the costs of delivering the required services at the expected quality level
- Predictability, meaning that stable and foreseeable funding flows are ensured to allow planning
- Transparency, meaning that clear allocation criteria are used across the organisation
- Equity, meaning that the resources are allocated across the organization using fair principles
- Accountability, meaning that funding is linked to performance and outcomes.

Hospital budgeting is critical for decision-making across hospital departments and centers. To be effective, the budget process will allow the REH to align operational plans with financial planning targets, prioritize capital investments to align with strategic initiatives, effectively manage capital spend and cash flow, apply rules for the allotment of funding to clinical departments and minimize purchasing errors. The REHs should operate under multi-year financial planning frameworks.

According to the EU research studies most EU countries have introduced a combination of global budgets with activity-based financing, to combine the cost control incentive from global budget with the efficiency incentives from activity-based financing.

Considering the above there are several important purposes of the assignment, as follows:

- Develop a decentralized hospital governance framework to ensure health services integration, accountability, efficiency, and adaptability.
- Design a sustainable financing model for REHs, integrating cost-effective mechanisms such as activity-based financing, global budgets, and performance-based incentives.
- Ensure that the REHs will operate with full financial sustainability and regulatory compliance.

3. **Assumptions and risks**

3.1. **Assumptions underlying the project**

The overall assumptions upon which this Assignment is based are:

Assumption 1 – The Service Provider’s experts will be given by ANDIS and/or by other relevant stakeholders timely and complete access to all relevant documents and data that are related to REHs projects or activities to be carried out under this assignment.

Assumption 2 - The Service Provider’s experts will receive from ANDIS full support for the implementation of the tasks under the present assignment. When requested, the Service Provider shall be officially introduced to the Emergency County Hospital “Sf. Spiridon” Iasi and the Iasi University of Medicine and Pharmacy, to the Emergency County Hospital Cluj and the Cluj University of Medicine and Pharmacy, to the Emergency County Hospital Craiova and the Craiova University of Medicine and Pharmacy, and to other public authorities like the National Institute of Public Health, National Health Insurance House, College of Medical Doctors (national and local branches), as the Consultant of ANDIS and shall be empowered by ANDIS to lead the needed technical discussions.

Assumption 3 - ANDIS shall coordinate with other public institutions and local authorities throughout the project implementation. To this effect, ANDIS shall establish and coordinate Technical Working Groups with the Project’s relevant stakeholders and shall ensure the engagement of decision makers of the stakeholders via implementing a Stakeholder Engagement Mechanism.

Assumption 4 - The Service Provider's experts will be invited to all relevant meetings in the context of this assignment.

Assumption 5 - There will be no institutional, financial and/or legal modifications that could adversely affect the objectives of the present assignment.

Assumption 6 - The EIB PAS Team, including the Service Provider's experts, will act as an independent advisor to ANDIS. Hence, the role of the EIB PAS Team will be to advise and complement, but not to replace, displace or fulfil the roles and responsibilities of the relevant counterparts in ANDIS. The EIB PAS Team will play a supporting but not an active nor a predominant role in the decision making related to these activities. Final performance of the Project will remain the responsibility of ANDIS, as per their specific roles and accountabilities.

Assumption 7 - ANDIS will finalise the legal package and the legal documents based on the service provider draft legal proposal deliverables and will send them to the MoH in order to initiate – if needed - the process of updating the current Romanian legislation for including the specific recommendations needed for the new governance and financing models for the Iasi, Cluj and Craiova REHs.

Assumption 8 - The list of participants to the workshops with the Technical Working Groups under task 6 of this Assignment will be provided by ANDIS.

3.2. Risks

The main risk is that any of the above assumptions materialize the successful outcome of the assignment be jeopardized.

Another risk that could affect the successful implementation of the assignment is the lack of cooperation with the main stakeholders involved from which technical input will be needed so that the outputs of the Assignment are tailored for the specific Romanian context. This risk should be mitigated by ANDIS, who will conduct negotiations over such difficulties, seeking the advice of the Service Provider when necessary.

Also lack of interest from various stakeholders (e.g. hospital key leaders from the emergency county hospitals) regarding the present assignment and its results, imperfect legal framework (under modification, unfinished or with contradictions) could delay the expected added value.

Changes in government may shift priorities away from the proposed financing model and the NHIH may not have the needed resources to implement the proposed contracting mechanisms specific for the REHs. Such risks shall be mitigated by early and consistent involvement of the MoH and NHIH technical leadership in consultation on the proposals resulting from the tasks.

Delays in providing to the Service Provider with the requested information or sets of data timely and in readable clean format could hinder the performance of the activities on time. This risk should be mitigated by ANDIS, who will conduct negotiations over such difficulties, seeking the advice of the Service Provider when necessary.

4. Specific services, tasks to be performed and technical deliverables to be produced

4.1. Specific activities and tasks to be performed

General

This Assignment is to implement the following activity of the PASSA ANDIS Action Plan:

- “Technical Assistance for Operationalisation on the Iasi, Cluj, Craiova Regional Emergency Hospitals and the Transition Plan”

Sub-Activity:

- “Development of the governance and financing models”

The Service Provider’s team of experts shall work under the day-to-day technical monitoring and guidance of the EIB Consultant: Health Policy Expert (HPE) and administrative monitoring of the EIB Consultant: EU Projects & Project Administration Expert (PE).

Considering the complexity of the assignment, the Service Provider will ensure appropriate communication and cooperation with all the bodies involved, with ANDIS counterparts. The Service Provider will participate to meetings with the other Service Providers that will be mobilised under this Project when called by ANDIS or PAS Team but also when he/she will consider it necessary.

Task 1: Development of the assignment work plan

Purpose: The Service Provider will present for approval the detailed assignment work plan alongside the Gantt chart, aligned with the deadlines set out in this document for each Deliverable, starting from the service commencement date.

Context: This is a key pre-requisite to ensure structured planning, facilitate systematic monitoring of progress and support the timely delivery of all deliverables in accordance with established deadlines.

Deliverable 1.1 Assignment work plan

An updated assignment work plan, alongside a detailed Gantt chart, shall be submitted to the EIB PASSA for approval and presented to the Beneficiary during the assignment kick-off meeting. The assignment work plan will also set out a detailed work plan for completion of the activities in the operation period of execution, together with a detailed work plan for interrelated, sequential and complex activities with an agreed project log-frame matrix. Any revision to the work plan deadlines during implementation must be supported by a detailed justification and presented at a technical meeting. The Beneficiary's agreement, as recorded in the meeting minutes, shall constitute approval of such changes.

Due date of submission of the deliverable: No later than 10 days after the start of the Implementation Period.

Task 2: Perform the assessment of the current situation and update the forecast of health services needs

Purpose: The development of the new Governance and Financing models and the transition towards the Governance and Financing models of the REHs from the current models of the SJUs is a complex change project which will require proper time for implementation and the setup of clear milestones. For this purpose, an initial situation and trend analysis must be performed.

Context: ANDIS is responsible for the construction and operationalization of the three REHs in Iasi, Cluj and Craiova, but key for the success in the medium and long term of these projects will be to empower the local stakeholders (mainly the SJUs and the medical universities) to take ownership of the project. The Service Provider will have to guide and support ANDIS in this process of transferring the ownership to the local teams.

Deliverable 2.1 Assessment Report - the “As is” report

The **Assessment Report** should include at least the 4 following sections:

- Description of the stakeholders who will be involved/consulted in the development of the deliverables, how they will be involved, including proposed procedures for their involvement, with clear milestones for the consultations related to the Project deliverables.
- A Project Introduction document describing the project, the goals, the set of data and documents needed, estimated number of technical meetings (with topics) and proposed dates, identified results of the project.
- A situational analysis, with details of the populational health needs and trends in the 3 regions NE, NW, SW, and the main elements which may have a significant forecasted impact on the REHs governance and financial model. The demographic trends and forecast of health services needs based on estimated future volume of patients, estimated changes in tariffs and costs of health services, should be part of the situational analysis. The methodology used in the Feasibility Studies for services demand calculations and costs shall be used and updated, but the Service Provider may propose another methodology and use it, after prior approval of EIB PASSA TL. The time horizon for the updated demand forecast should be of ten years from the moment of REH operationalization and shall be granular enough to include volume of specific services for each specialty within each REH multidisciplinary center, including for each type of care (e.g. outpatient, day surgery, day care, emergency, ambulatory, exploratory and laboratory services, etc.).
- The first draft of the master table presenting the legal/regulatory updates needed for the implementation of the REHs governance and financing model.

The Service Provider should research and include in the report the list of other relevant projects or public policies developed/implemented in the last 3 years to identify inputs which can further serve for the development of the situational analysis.

The Service Provider should research and include in the report the recent legislative changes/updates on hospitals financing regulations and review of the Romanian legal framework on hospital governance and review of the reforms/plans to update the legislation for the time horizon considered. This review shall serve to develop the first draft of a master table for legal updates needed for the REHs governance and financing model. This review shall include but not limited to:

1. Law 95 / 2006 ('the Healthcare law'), with its most recent updates, with specific attention granted (but not limited) to:
 - a. Title 1 on public health
 - b. Title 4 on the national emergency healthcare system, with specific attention to article 92.1.I
 - c. Title 5 on ambulatory care
 - d. Title 7 on hospitals, with specific attention to:
 - i. Chapter 2 on hospitals' organisation and functioning
 - ii. Chapter 3 on hospitals' management

iii. Chapter 4 on hospitals' financing

2. MoH Order 1085 / 2012 which provides rules for the organisation and functioning of regional emergency hospitals and emergency functional units at regional level, the latest being an inception form of the wider regional referral networks.
3. MoH Order 1408 / 2010 updated version which provides hospitals' classification on levels of competence.
4. MoH Order 4201 / 2023 for the approval of the methodology for selection of hospitals which will be beneficiary of the Fund for the Quality of Medical Services.
5. MoH Order 1764 / 2006 which provides rules for the organisation of regional emergency hospitals and specifically describes the structure of a regional emergency hospital needed to provide emergency care and critical patients care (Annex 1).
6. MoH Order 323 / 2011 which provides the conditions and rules for the clinical structure of hospitals so that they can be classified according to their level of competence. This MoH Order is particularly relevant for the REHs placement in the wider regional referral network because it provides the thresholds of patients treated from other counties, as well as the proportion of patients readmitted (see Annex 2).
7. MoH Order 914 / 2006 which provides the requirements for a hospital to get the sanitary authorization for operating (different from the hospital accreditation) and includes norms for the functional organisation of the hospital (Annex 2) and structure of clinical departments (Annex 3).
8. Several legal acts provide regulations specifically for some clinical specialties related to their organisation, functioning and roles of the clinical leaderships, as follows:
 - a. MoH Order 1500 / 2009 on ICU
 - b. MoH Order 1322 / 2012 on cardiac critical care units (USTAC)
 - c. MoH Order 1408 / 2015 on stroke units
 - d. MoH Order 476 / 2017 on burn units.
9. MoH Order 1224 / 2010 which provides general rules for hospitals' staffing. The Service Provider must grant special attention to this regulation and its updates since it can have a considerable impact on organisation structure of the REHs.
10. MoH Order 1384 / 2010 updated by Order 887 / 2025 which provides rules for hospital management and a list of key performance indicators. The Service Provider must grant special attention to this regulation and its updates since it can have a considerable impact on the leadership structure of the REHs.
11. MoH Order 1567 / 2007 which provides the average national values for hospitals management key performance indicators.

12. MoH Order 446 / 2017 provides the rules for hospitals accreditation, including the specific standards (under the remit of the National Authority for Quality Management in Health).
13. Government Decision 115 / 2017 and MoH Order 1111 / 2021 provide the so-called national plan of hospital beds.
14. MoH orders which are regulating the responsibilities and functioning and various governance structures of a public hospitals, such as (but not limited to):
 - a. MoH Order 921 / 2006 on legal tasks of the board of public hospitals
 - b. MoH Order 863 / 2004 on legal tasks and responsibilities of the medical board of public hospitals
 - c. MoH Order 320 / 2007 on the management contract of the heads of clinical departments/laboratory of public hospitals and MoH Order 1406 / 2006 and MoH Order 1470 / 2011 on rules for competitions for the position of heads of clinical departments/laboratory and hiring of healthcare professionals in public hospitals.
15. The most recent updated form of the Government Decision No. 521/2023 for the approval of service packages and the Framework Contract regulating the conditions for the provision of medical assistance, medicines and medical devices, within the social health insurance system.
16. General legislation which may impact the governance and structure of the future REHs, such as: Order 600 / 2018 of the Government General Secretariat on managerial internal control of public institutions or others.
17. Other primary, secondary legislation and norms which provide regulations for public hospitals' governance and functioning.

The Service Provider shall evaluate how the above regulations will impact the functioning of the future REHs and, if the case, propose modifications or a specific set of rules for REHs.

The Service Provider shall review any other relevant Romanian legislation on hospital financing, including the Regional Plans for Health Services for North-East, North-West and South-West regions, approved by orders of the Ministry of Health.

The Service Provider shall review the current governance model, the current organisational chart and the current financing and budgeting models of the three SJUs in Iasi, Cluj, Craiova, from which the future REHs will take over the most significant part of its activities.

The Service Provider shall review the up-to-date international best practices and identification of potential international models to follow in the implementation of the Governance and Financing models.

The deliverables developed under the EIB PASSA-ANDIS agreement shall be consulted by the Service Provider and the results will be integrated in the governance and financing model proposed.

Due date of submission of the deliverable: No later than 8 weeks after the start of the Implementation Period.

Task 3: Develop the public governance model to allow the effective functioning of the REHs

Purpose: To ensure that the public governance of the new REHs is fit for their purpose, in line with the feasibility studies and modern public hospitals governance models in use across the European Union.

Context: To allow REHs to operate at their full potential and respond to their roles, a revision of the legal framework will be needed. Any regulatory change should allow flexibility so that adaptation and future evolution of the REHs will be possible. These changes should help REHs reach the following main objectives which are mentioned in the REHs feasibility studies:

- O.1. REHs role as the tertiary care provider at regional level will be enhanced by its governance structures.
- O.2. REHs organisation should be based on a multi-specialty/multi-disciplinary form of management.
- O.3. Management responsibilities should be delegated as close to the actual operational level as possible.
- O.4. The managerial autonomy should be increased, and managerial performance measurement strengthened so that quality improvement activities could be easily incentivized at organisational level.
- O.5 The REHs structure should allow for the development of a value-based organisational model.

Deliverable 3.1: Methodology for developing the public governance model to allow the functioning of the REHs

Purpose: The Service Provider shall develop a methodology describing the detailed approach and methods it will use to develop the public governance model. The methodology should be submitted for review and validation to the EIB PASSA, before continuing with the other Task 3 deliverables.

The methodology must refer to, at least, the following:

- a description of the reform elements introduced by the REH structure (based on multidisciplinary clinical centres), correlated with the detailed workforce structure developed under the “Human Resources Strategy and Training Needs Assessment for the 3 REHs in Iasi, Cluj and Craiova” assignment;
- the relevant international best practices and their compatibility with the current models in Romania;
- other public policy measures/deliverables from projects implemented by the Ministry of Health and/or other public authorities with competences in the field of public health (if any), which propose optimisations of current public governance models and which may be applied to the REHs.

Due date of submission of the deliverable: No later than 10 weeks after the start of the Implementation Period.

Deliverable 3.2: Public governance model for the REHs

Following the completion of the Task 2, the Service Provider will develop a thorough public governance framework for the future REHs, considering the objectives O1 to O5 mentioned above. The public governance model will be developed based on international best experiences and practices. Good governance arrangements acknowledge the inter-dependencies between organisational arrangements and clinical practice and integrate these to deliver high quality, safe and reliable care and support. When implemented effectively, good governance creates a culture of accountability, transparency, and patient-centeredness within health and social care organisations.

The public hospital governance model integrates corporate and clinical governance. The hospitals experiences show that there are many connections, intricate links and boundaries between the two, but they must align their goals and work in the same direction. The corporate governance will need to ensure the business performance and sustainability, the legal and ethics compliance, the accountability to the stakeholders and patients, effective risk management, while the clinical governance will ensure the enhancing of patient safety and quality of care. The proposed model will have to define the corporate governance and clinical governance areas, their links, collaboration to ensure that the REH achieve their business goals, ensure quality of services and manage resources well.

The governance framework of the future REHs should include a “Fundamentals” section describing:

- The mission of the REHs at national and regional levels,
- The vision laying down the REHs foundation,
- The values on which the organization of REHs will be based upon and REHs functions,
- REHs relations with other healthcare providers in the region,
- REHs relations with healthcare central and local authorities,
- Principles on which the framework for decision-making will be made within the healthcare organisation.

The following sections will detail all the needed arrangements.

1. Legal status of the Iasi, Cluj and Craiova REHs. This section must include details related to:
 - a. amending the regional emergency hospitals legal definition to be aligned with the functions and structure of the Iasi, Cluj and Craiova REHs,
 - b. definition of REHs purpose and objectives,
 - c. definition of the REHs ownership,
 - d. providing a detailed description of REHs internal management structures and functions, in accordance with the detailed workforce structure developed under “Human Resources Strategy and Training Needs Assessment for the 3 REHs in Iasi, Cluj and Craiova” assignment (outputs developed under a different EIB PASSA assignment to which the Service Provider will be provided access to)
 - e. providing a detailed description of REHs catchment area.
2. Decision making mechanisms of the REHs. This section must include details related to:
 - a. specification of the authorities involved in decision making,

- b. detailed description of the regional representation mechanism in the decision processes at REHs level,
 - c. detailed description of the involvement of clinical staff leadership in the decision processes at REHs level,
 - d. detailed description of REHs organisational map.
- 3. Leadership structures at REHs level. This section must include an analysis regarding the opportunity to amend or update the national legislation by adding new structures or updating existing leadership structures, as well as the details regarding:
 - a. the membership of the REHs Board, its functions, and responsibilities, separation of supervisory and executive functions, competency requirements for board members, its terms and rotation mechanisms, as well as conflict of interest management procedures,
 - b. the REHs Management Committee: form of contract (employees/ management contract / outsourced third party provider), membership, functions, responsibilities,
 - c. the membership of the REHs Medical Council, its functions, and responsibilities,
 - d. the membership of the REHs Administrative Council, its functions, and responsibilities,
 - e. the membership of the REHs Ethical Council, its functions and responsibilities,
 - f. identification of other leadership structures at REHs level, with description of membership, functions and responsibilities,
 - g. description of relations with stakeholders, patients and professional organisations/unions,
 - h. selection rules for each leadership structure,
 - i. development of processes for the activities of REHs leadership structures and relations between leadership structures,
 - j. description of standard operating procedures for REHs leadership structures.
- 4. Accountability mechanism at REHs level. This section must include details related to:
 - a. institutional accountability at local, regional and national level,
 - b. updating of the current performance assessment framework benchmarks and hospital management performance indicators,
 - c. setting areas of accountability and subsequent consequences,
 - d. setting public reporting and transparency provisions.

At the end of each section, the Service Provider will develop a detailed table (starting from the master table developed under Deliverable 2.1), listing all the legal documents which need to be updated, each article which needs to be updated, and the text proposed for each updated article.

The Service Provider will present the first version of the REHs Governance model in a technical workshop common for all three REHs. Feedback from participants will be collected, prioritized, analyzed for its relevance and integrated in the final version of the deliverable. For more details, see Task 6.

After the due date of the submission of the deliverables but within the timeframe of its contract, the Service Provider will support ANDIS for following up on the feedback from MoH and from the other authorities involved on the proposed legislation changes and for aligning and integrating this feedback in the proposed package of legislative changes.

Due date of submission of the deliverable: No later than 20 weeks after the start of the Implementation Period.

Deliverable 3.3: Transition plan from the current SJU governance framework towards the new model for REH public governance

The Transition Plan should describe how the nascent management structures of the REHs should be integrated gradually into the Governance structure and the optimal timeline for the appointment of management structure of REHs, including its membership.

The Transition Plan should be developed in coordination with the National Health Strategy 2023-2030 and with any other relevant legal or strategic documents.

The Transition Plan shall connect, use, integrate the results of the other relevant projects developed under EIB – PASSA ANDIS Agreement and identify strategies and/or high-level decisions impacting the projects of the REHs which are beyond the responsibilities of ANDIS and require interinstitutional collaboration.

For the development of the Transition Plan, relevant stakeholders shall be identified and their roles/functions described.

Due date of submission of the deliverable: No later than 24 weeks after the start of the Implementation Period.

Task 4 Drafting the REHs operating model concept proposal

Purpose: To provide a concept note for the REH operating model, based on the concepts described in the REHs feasibility study and considering European hospital organization best practices, the national context, and the need for integration with the proposed governance and financing models. The concept note must be based on the REHs design flows and functionalities and will be further used for future assignments related to REHs clinical procedures development.

Context: Since the feasibility study for the three REHs has been done, there have been significant developments at international level of the hospital operating models, focused on patient centred services, integrated services, or value-based care principles. The last years' experience indicates that shifting towards these operating models requires long time, know-how and resources. Therefore, ANDIS and the main stakeholders of the 3 REH projects should learn from this experience and adjust the changes incurred by these operating models in line with the administrative capacity of the Romanian public healthcare system.

Deliverable 4.1: Methodology for developing an updated operating model for the three REHs

The Service Provider shall review the best European practices on integrated care, optimization of hospital organisation and clinical flows and processes improvement.

The Service Provider shall develop a methodology describing the detailed approach and methods that it will implement to perform the requested review and development of the operating model. The methodology should be submitted for review and validation to the EIB HPE.

Due date of submission of the deliverable: No later than 28 weeks after the start of the Implementation Period.

Deliverable 4.2: The concept of the REH operating model (Concept note)

The Service Provider will prepare a concept note on the operational model of the future REHs. This concept note will be based on the framework provided by the REHs feasibility study and REHs soft measures strategy and literature review of best practices and should describe the following:

- The clinical centres concepts of working
- The multidisciplinary approach, including resource sharing between specialties which are part of the multidisciplinary clinical centres
- Hospital processes optimization
- Integrated patient pathways based on clinical protocols
- The integration of inpatient-outpatient care
- Integrate financial solutions for generating value and quality and propose a pay-for-performance approach
- The way clinical goals should be set and the achievements measured (PREMS, PROMS, other system).

The Service Provider will present the results to the stakeholders during three technical workshops (one per each REH region), as follows:

- The final version of the REHs Governance model (Deliverable 3.2)
- The transition plan, customized for each REH, from the current SJU framework towards the new model for REH governance (Deliverable 3.3)
- The concept of REH operating model (Deliverable 4.2)

For Deliverable 4.2, feedback from participants will be collected, prioritized, analyzed for its relevance and integrated in the final version of the deliverable.

Due date of submission of the deliverable: No later than 36 weeks after the start of the Implementation Period.

Task 5: Develop the Financing and Budgeting model to allow the effective functioning of the REHs

Purpose: To develop a financing model fit for the purpose of the REHs profile and in line with the feasibility studies and with the updated operating model defined under this assignment. The major objectives will be ensuring a sustainable financing basis for the functioning of the REHs on medium and long term to provide high quality health services for the patients.

To develop a budgeting model so that the cost drivers and cost baseline will be identified at a granular level (per multidisciplinary centre) and will be tested against the results of the financing model to identify funding gaps and feasible solutions to adjust for these gaps.

Context: The public hospitals payment model currently in use in Romania consists of a heterogeneous mixture of methods, with multiple financing sources, prospective setting of the payments linked to a budget cap and for specific type of cases (i.e. ambulatory care) to volume caps. In the classification of hospitals by level of competence, REHs will be at the highest level, because it provides the most complex and competent services for difficult and emergency cases that cannot be solved by other hospitals in the region.

The main financing source for a Romanian public hospital is the National Health Insurance House (NHIH) based on a national framework contract (NHIH-FC) which provides the rules governing the signature of the contract between the public hospital and the county health insurance house. Currently the financing sources for healthcare professionals working in public hospitals are ensured from a different financing line from the state budget, but budgetary integration is currently under consideration by the Romanian authorities.

The main type of services which are financed under the NHIH-FC provisions are the following:

- DRG case-based payments for inpatient acute cases (for non-DRG acute cases, payments are fee-based),
- Negotiated fee per day of hospitalization (but not higher than the maximum cap) for chronic patients,
- Services provided for patients eligible to be treated under the national curative health programs (governed by a completely different set of rules than the NHIH-FC),
- Services for patients who need dialysis,
- Ambulatory care services,
- Lab and imaging investigations,
- Day care services (including day surgery),
- Emergency services, if not financed already by the MoH.

It must be noted that separate contracts governed by different rules are signed between the healthcare provider and the county health insurance house for each of the above-mentioned type of services.

The formula currently in use to determine the maximum amount a public hospital can contract under the NHIH-FC provisions for inpatient acute cases is:

$$TCP * ICM * [(Number\ of\ beds * Bed\ Utilization\ Index) / Average\ length\ of\ hospitalization]] * reference\ percentage$$

where,

TCP = weighted rate case, expressed in RON and yearly set for each category of hospital by the NHIH

ICM = complexity case mix index, derived from the relative values of the complexity of cases treated by the public hospital in the previous year

Number of beds = the fixed number of beds for inpatient acute cases in the public hospital

Bed utilization index = a pre-determined value in number of days established each year by the NHIH

Average length of hospitalization = the average of the length of hospital stays for all patients in the public hospitals in the previous year

Reference percentage = determined by the NHIH-FC in line with the public hospital category

For new hospitals which are entering the NHIH-FC without previous years available data on complexity of treated cases and number of treated patients, a specialty-based tariff could be negotiated for each clinical department which will represent the payment for each treated case. The maximum cap for these tariffs is published in the NHIH-FC.

Other sources of public financing for public hospitals are provided from the MoH budget (e.g. under priority action programs, capital investments, etc.) and local authorities budget (if the respective healthcare provider is owned by that local authority). Public hospitals can attract funding also from donations and sponsorships, out-of-pocket payments, clinical studies or research activities, renting of spaces, EU funds or other private sources of revenues, but it is estimated that currently this secondary source of revenue average around 3% of the public hospitals' total revenues.

The future REHs will replace the role of the current emergency county hospitals in Iasi, Cluj and Craiova and will take over the majority of their current sources of financing for the provision of healthcare services. Also, additional sources of funding will come from taking over some activities (tertiary care services) from other hospitals in Iasi, Cluj and, to a smaller extent in Craiova, which will be transferred to REH.

The feasibility studies identified a significant gap between the financing obtained by the current emergency county hospitals and the future estimated operational expenditures of the REHs.

The Service Provider shall complete this Task through a phased process, as follows:

- **Phase 1.** The Service Provider shall develop a detailed financing model for each of the three regional emergency hospitals, based on the current regulations, legislation and legally possible revenue streams. The main purpose of the effort is to simulate, at the highest level of granularity possible, the revenues structure for each of the three REHs, based on the forecasted clinical activities of the REHs and on the current payments systems in use in the Romanian healthcare system.
- **Phase 2.** The Service Provider shall develop a detailed budgeting model, structured around the REHs multidisciplinary clinical centres, for each of the three regional emergency hospitals. The main purpose of the effort is to simulate as accurate as possible the expenses structure for each of the three REHs, based on the current activities of the corresponding county hospital, on the forecasted personnel structure and clinical structure of the REHs, while carefully mapping it to the current coding structure used for hospital accounting and ledger system. The budgeting model shall comply to a certain degree to the current regulations and legislation and consider the new specific clinical structure of the REHs when determining the cost centres. It also shall consider as one of the scenarios simulated the possibility for each cost centre to be financially accountable and hold a certain degree of independence in its budget administration.

- **Phase 3.** Using the results of the REHs financing model and budgeting model, the Service Provider should identify the financing gap and shall start to test various updates to the currently financing tools/payment methods to identify the most feasible combination that can compensate for the identified financing gap.

This phased approach shall follow the model described in Table 1, below:

Phase	Corresponding deliverables	Due date of submission (from start of the Implementation Period)
1	5.1 Methodology for the development of the financing and budgeting model	16 weeks
	5.2 Financing model for the 3 REHs	26 weeks
2	5.3 Budgeting model for the 3 REHs	32 weeks
3	5.4 Recommendations for new payment methods	48 weeks
	5.5 Results of the advanced financing simulation for the 3 REHs	54 weeks
	5.6 Transition Plan from current SJU financing to the new financing model	60 weeks

The development of all the deliverables under Task 5 will be done in close consultation with MoH and NHIH.

The services provider could organise the work for Task 5 in parallel with tasks 2, 3 and 4.

Deliverable 5.1 Methodology for the development of the financing and budgeting model

The Service Provider will develop a methodology describing the detailed approach used when building the two models. The methodology should be common for the three REHs and it will be submitted for review and validation to the EIB HPE, before continuing with the other Task 5 activities.

The results of recent healthcare financing projects should be explored to identify the potential opportunity to use such results for the REHs modelling. For this, the Service Provider should explore the work done in the past years by at least the following Romanian agencies: CNAS, ANMCS, The National School of Management in Public Health, academic institutions like the main universities of medicine and pharmacy (at least from Cluj, Iasi and Craiova) and the economic faculties.

The methodology for the financing model should identify at least the following elements/variables and explain if they will be used, how they will be used and the main sources of information and assumptions made for each type of variable:

- All types of revenue streams, including but not limited to activity-based inpatient revenue, outpatient tariffs, revenues from emergency patients, earmarked public subsidies, other types of revenues (out-of-pocket payments, renting, etc)

- The identified core variables of the model which could fall under the following categories:
 - Volume and case-mix variables (e.g. number of admissions by major ICD categories, ICU share of cases, emergency admission ratio, monthly multipliers, etc.)
 - Tariff policy-driven variables which should consider all the elements of the formula currently in use to determine the maximum amount a public hospital can contract under the NHIH-FC provisions for inpatient acute cases, but also other tariff variations (e.g. for ambulatory cases, day surgery, etc.)
 - Subsidy variables (e.g. revenue streams from vertical programs, weighted case rate values, etc.)
 - Cash-flow related variables, like the maximum amount a public hospital can request from NHIH for the provided services.
- Several model sensitivity analyses to stress-test at least the following scenarios: decrease or removal of subsidies, testing the elasticity of funding to the volume of patients treated per major type of financing method (e.g. shifting to day-care/ambulatory services), sensitivity of revenues to changes in the complexity case-mix index, tariff freeze versus inflation indexation, mass-casualty surges (abnormal share of ICU and ER cases)
- The time horizon of the model should simulate the phased operationalization model of the REHs: first year-of-operations, short-term operations years 2 to 3 of operations, medium-term operations year 4 to year 6 and long-term operation up to year 10 after REHs operationalization
- A comprehensive assumptions table presenting all the indicators range values, based on current emergency county hospitals structure of services, epidemiological and demographic trends and forecast as estimated in the specialized literature or feasibility studies (sources shall be presented for each indicator).

The model output shall provide at least the following results:

- Total revenue (annually) by source type aggregated for the whole REHs but also granular at the level of each multidisciplinary clinical centre and REH revenue centre
- Share of activity-based revenues and critical care-based revenues
- Revenue volatility scenarios: best / as-is and conservative scenarios
- Sensitivity analyses results.

The methodology for the budgeting model should mirror the level of detail required for the financing model and should be grounded in internationally validated frameworks for hospital budgeting.

The methodology shall address at least the following core components:

- Conceptual framework for hospital budgeting

The Service Provider shall present the conceptual framework underpinning the budgeting model. The budgeting model should be positioned as the instrument that translates the financing model outputs (revenues by source) into operational resource allocation decisions at the level of each clinical centre, support unit, and administrative function. The framework shall explain how the budgeting model supports the four phases of the budget cycle:

- budget formulation (setting budget ceilings and allocating resources),
- budget execution (spending control and cash management),
- budget monitoring and reporting (variance analysis, real-time tracking),
- budget evaluation (ex-post performance assessment against targets).

The framework should explain how the REH budgeting model can be designed within the constraints of the Romanian public accounting system, while introducing elements of managerial accounting for internal management purposes.

- Cost centre structure and cost classification

The Service Provider shall propose a detailed cost centre taxonomy for the REHs aligned with the multidisciplinary clinical centre structure defined in REHs technical projects and operating model. The taxonomy shall distinguish between:

- Direct clinical cost centres: one for each of the six multidisciplinary centres plus the Emergency Department (UPU), Intensive Care Units, Operating Theatres, and any other direct patient care units;
- Clinical support cost centres, including diagnostic imaging, clinical laboratories, pharmacy and others;
- Non-clinical support cost centres, including facility management, catering, laundry, medical waste management, and others;
- Administrative cost centres, including general management, IT/digital health, and others;
- Revenue centres, aligned with the payers' contract structure.

For each cost centre, the cost classification shall follow the OECD International Classification of Health Accounts, adapted to Romanian fiscal regulations.

- Budget development methodology by clinical centre

The Service Provider shall describe the methodology for developing the budget of each multidisciplinary clinical centre, combining top-down and bottom-up approaches. The Service Provider shall present at least two approaches to budget construction: incremental budgeting (adjusting from historical county hospital baseline) and zero-based budgeting (building from scratch based on planned activity). The advantages and disadvantages of each approach for the REH context shall be discussed, and the Service Provider shall recommend the preferred approach with justification.

- Overhead allocation methodology

The Service Provider shall propose a methodology for allocating overhead and support costs to clinical cost centres. The Service Provider shall also address the treatment of joint costs: costs shared between teaching/research and clinical service delivery.

- Budget scenarios and stress testing

The budgeting model shall incorporate scenario analysis and stress testing capabilities analogous to those required for the financing model. The Service Provider shall describe the methodology for developing at least the following budget scenarios:

- Baseline scenario, based on the central estimates of activity, unit costs, and staffing from the Feasibility Studies and/or the Major Project Application updates;
- Conservative scenario, testing the budget impact of lower patient volumes (eg 80% of forecast), higher unit costs (eg 10–15% inflation above forecast), delayed operationalization of certain services, and staffing shortfalls;
- Optimistic scenario, testing the budget impact of higher-than-expected activity, faster shift to day care/ambulatory care and successful implementation of efficiency measures;
- Stress scenario, testing the budget resilience to extreme events such as pandemic surges (referencing COVID-19 experience), natural disasters and conflict emergencies or sudden fiscal austerity.

For each scenario, the Service Provider shall quantify the impact on key budget aggregates (total expenditure, expenditure per clinical centre, cash flow position) and propose trigger points and corrective actions.

The Service Provider shall propose a comprehensive budget monitoring and variance analysis framework for the REHs.

- Alignment with the Romanian regulatory framework

The Service Provider shall describe how the budgeting model methodology aligns with, and where necessary proposes modifications to the Romanian regulatory instruments. Where the proposed budgeting model requires functionalities not currently supported by the Romanian regulatory framework (e.g. multi-annual commitment authority, internal transfer pricing, or clinical centre budget delegation), the Service Provider shall flag these and add them to the legal reform master table developed under Deliverable 2.1. The Service Provider shall list all the legal documents which need to be updated, each article which needs to be updated, and the text proposed for each updated article.

- Data Requirements and Quality Assurance

The Service Provider shall list all data inputs required for building and operating the budgeting model, specifying: the data sources, the expected data format and granularity, data quality assessment criteria and procedures for handling missing or unreliable data. The assumptions to be applied where data is unavailable or of insufficient quality shall be presented in a separate table. Given that the REHs are new hospitals without historical operational data, the Service Provider shall explain how it will construct synthetic budget baselines from the combination of current SJU financial data adjusted for scope and scale differences, Feasibility Study/Technical Project projections, and other national and international comparators from similar tertiary hospitals.

The above structures can be varied according to the Service Provider expert advice and will be submitted it for approval to the EIB PASSA.

Due date of submission of the deliverable: No later than 16 weeks after the start of the Implementation Period.

Deliverable 5.2: The Financing model for the three REHs

The model for the REHs financial simulation will be common for the three REHs, considering that they are based on the same concept, while the Service Provider will have to develop a customization of the model separately for the Iași, Cluj and Craiova REHs. The software used for the modelling task should be first discussed with EIB PASSA for agreement and verification of the licensing rules for easy future utilization by the final beneficiaries.

The conceptual model must include at least the following sections:

1. The objective of the financing modelling
2. Identification of the inputs
3. Identification of the outputs
4. Identification of the profit centres and the functional sub-units based on the detailed REHs structure¹
5. Healthcare system boundaries and projection period
6. Type of data needed for the simulation project and their sources
7. Proposed method for the simulation. The Service Provider may opt for any of the typical simulation methods but must clearly describe the advantages and drawbacks of the method chosen and how fitted is for the REHs financial simulation
8. Detailed description of the elements of the simulation model and their interaction
9. Processes networks, change states and its attributes and the representation of the interaction between entities
10. List of variables of the model.

The conceptual model should be aligned and validated in a workshop with the technical working groups (see task 6). The observations and conclusions of the workshop will be integrated in the conceptual model. Following this integration, the Service Provider will start the modelling activities as listed below.

The financing model for the three REHs must include, besides the typical elements of the hospital financial simulation project developed by the Service Provider, the following elements:

- Modelling of the REHs' revenues, developed at the level of each profit centre at least for each of the following:
 - Revenue streams: DRG based payments for acute inpatient cases, state budget subsidies for healthcare professionals and staff wages, MoH state budget or NHIH funds for emergency care services, National health programs funds, payments earmarked for chronic care, payments for ambulatory care, payments for day-care and day-surgery, direct co-payments from patients and other types of out-of-pocket payments made by patients, revenues collected from clinical studies/research activities, revenues collected from add-on payments pilot programs, revenues collected from space rentals or other type of commercial activities, revenues from other type of sources (e.g. EU projects, etc).

¹ As provided by the Iași, Cluj and Craiova REH Technical Projects.

- Modelling of REHs' costs, including direct costs, fixed costs, variable costs, staff costs, operating and administrative costs, developed at least at the level of each cost centre
- Forecasting patient volume and demand
- Tariffs strategy
- Risks assessment (changes in patient volume, etc).
- List of assumptions made when building the model
- List of variables and ranges on which the sensitivity analysis is run
- Verification and validation section describing the process used by the Service Provider to verify and validate the model with experts from the three regional emergency county hospitals in Iasi, Cluj and Craiova
- Customization of the model for the specific of NE, NW and SW regions
- Detailed sensitivity analysis.

The Service Provider will have to provide the model in its detailed version. The Service Provider bears full responsibility for the acquisition and/or right of use of the modelling software.

The Service Provider will deliver the fully customised financing model separately for Iasi REH, Cluj REH and Craiova REH alongside a detailed narrative of the hospital financial simulation project, with specific sections describing the results and interpretation of the sensitivity.

Due date of submission of the deliverable: No later than 26 weeks after the start of the Implementation Period.

Deliverable 5.3 The budgeting model for the 3 REHs

The budgeting model for REH should facilitate the estimation of revenues and expenses, in alignment with the strategic organizational goals. The budgeting model will serve the REHs leaders to deliver top-quality care to patients while preserving financial viability, as resources are limited and demand for services will be high. To meet this challenge and effectively allocate these resources, the financing model and the budget must be flexible (i.e. adjusting automatically to activity levels), regularly analysed and updated as new medical standards and public health needs arise.

This budgeting model should allow REHs clinical centres organisation around accounting centres. The Service Provider shall propose an accounting system structure to fit the new model of the REHs. The existing methodologies on cost and centre of costs should be considered. The accounting system structure will be designed considering the following:

- The REHs will be organised into cost centres to support multi-specialty/multi-disciplinary accountability and management model, distinguishing between the following:
 - Direct clinical cost centres
 - Clinical support cost centres
 - Non-clinical support cost centres
 - Administrative cost centres
 - Revenue centres aligned with payers' contracts structure

- Each cost centre will be financial accountable and will hold a certain degree of independence in its budget administration,
- Internal cross-charging of services within the REH must be possible.

The current coding structure used for the hospital accounting and ledger system must be reviewed by the Service Provider and the modification should be agreed during the workshop with the technical working group (see Task 6).

The Service Provider must propose an overall new budget structure for the REHs based on the outputs developed during previous tasks and the OPEX analysis presented by the Iasi, Cluj and Craiova feasibility studies. The REHs overall budget structure should be detailed specifically for each clinical centre and other cost centres should be identified to ensure multi-specialty accountability.

The Service Provider will develop a detailed guideline for the budget development process of the REHs so that multi-annual budgeting could be possible. This detailed guideline should also include specific sections on the following topics:

- a. Transaction accounting designed for the specific profile of REHs, including patient ledger and general ledger
- b. Financial accounting designed for the specific profile of REHs, including best practices when elaborating balance sheets, profit and loss statements, statements of uses of funds and of changes in fund balances, transparency recommendations, etc.
- c. Managerial accounting designed for the specific profile of REHs, including the internal chart of accounting centres, reporting on quantities and costs of resources consumed per unit, assigned transfer of funds between accounting units, etc.

At the end of each component described above, the Service Provider will develop a detailed table listing all the legal documents which need to be updated, each article which needs to be updated and a proposal for the way the article should be updated.

Specific requirements for the REHs budgeting model

A. Detailed cost centre taxonomy and chart of accounts

The Service Provider shall deliver a complete cost centre taxonomy for each REH, structured hierarchically to enable aggregation and disaggregation of cost data at multiple levels. The taxonomy shall align with the clinical centres structure defined in the REHs Technical Projects and shall include all clinical support, non-clinical support, and administrative cost centres. Each cost centre shall be assigned a unique alphanumeric code compatible with the Romanian public accounting chart of accounts and shall be mapped to the NHIH contract revenue lines. The proposed chart of accounts shall be presented in dual format: the statutory one compliant with the Romanian accounting regulations and the managerial account format designed for internal management decision-making, enabling cost tracking per clinical centre and cost category.

B. Costing Model with overhead stepdown allocation

The Service Provider shall implement a model that allocates all hospital costs, including overheads, to final clinical cost centres. The allocation shall use a sequential methodology (stepdown allocation) with clearly defined allocation bases for each intermediate cost centre. A detailed allocation matrix showing the allocation bases and allocation percentages from each support cost centre to each clinical cost centre should be provided, as well as sensitivity analysis showing how changes in allocation bases affect the fully absorbed cost per clinical centre. Where activity-based costing (ABC) elements are introduced for high-cost clinical support services the Service Provider shall define the activity drivers, cost pools, and cost driver rates.

C. Multi-Annual Budgeting Framework

The Service Provider shall design a multi-annual budgeting framework covering a minimum of three fiscal years, consistent with a Medium-Term Expenditure Framework approach. The framework shall include:

- annual budget preparation calendar with key milestones
- rolling forecast methodology that updates projections quarterly based on actual performance data
- budget adjustment rules
- capital budgeting component covering medical equipment replacement planning, IT infrastructure investment, and facility maintenance
- cash flow budgeting component providing monthly cash flow projections.

The framework should comply with Romania's annual budgetary cycle while enabling the REH management to plan and commit resources over a longer time horizon.

D. Integration with Governance Model

The budgeting model must explicitly describe how it integrates with the governance structures defined under Task 3. The following matters should be clearly defined:

- which governance body approves the overall REH annual budget and multi-annual financial plan
- which governance body approves the budget allocation to individual clinical centres
- what budget authority is delegated to clinical centre managers and what reporting obligations do they have
- what role each of REHs governance bodies play in the budget process
- how budget performance links to the performance evaluation of managers at all levels.

The budgeting model shall include a framework for budget monitoring and performance reporting, specifying the frequency, content, and recipients of budget execution reports aligned with the REH governance structure and with the hospital performance indicators established under Romanian legislation. Thus, the Service Provider should ensure that the final model is designed as a living management tool.

Note: After the due date of the submission of the deliverables but within the timeframe of its contract, the Service Provider will have to support ANDIS for following up on the feedback from MoH and from the other

authorities involved on the proposed legislation changes and for aligning and integrating this feedback in the proposed package of legislative changes.

Due date of submission of the deliverable: No later than 32 weeks after the start of the Implementation Period.

Deliverable 5.4 Study on recommendations for new payment methods

Based on the previous deliverables results, the Service Provider shall study the preliminary results of the baseline simulation exercise (see deliverables 5.2 and 5.3) and shall identify the magnitude of the gap between REHs revenues and expenses at macro level and granular level. The Service Provider shall perform a preliminary analysis of how this gap can be compensated for by proposing a set of recommendations for introducing new payment methods.

The Service Provider shall study and propose detailed recommendations, including the quantitative details and calculations needed for integration into the financing modelling, on at least the following elements:

A. The Romanian public authorities are in the process of preparing the upgrading of the present regulations on the hospital classification system. The REHs are classified at the highest level of competencies given the architectural model, construction condition, level of equipment and staff. There are currently several MoH orders in force that regulate the level of competence of hospitals and their roles in emergency medical care.

B. An updated methodology introducing the concept of hospital pay-for-performance model. The services provider will perform an analysis of the literature and best practices examples regarding the methods and solutions in EU countries in introducing new models of hospital payments to improve the quality and efficiency of the services. The objective is to identify good practices and formulate practical options for their adaptation to the Romanian context and make them feasible so that the REHs financing sustainability will be strengthen. Examples from other EU member states can be used when exploring the potential practical solution, like add-on payments for quality in use in France, which may act as "pay-for-performance" (P4P) schemes where hospitals receive extra payments for achieving quality targets (e.g. "Expérimentations de nouveaux modes de rémunération" (ENMR) for multidisciplinary coordination, hospital payment of ICU services).

C. Recommendations to update the payment mechanism for ambulatory care, day surgery and day care. The Service Provider shall consult the Technical Annex details (attached to this AtoR) and identify those topics for which proposals for new payment methods can be explored, based on the following criteria: highest positive impact on each REHs revenue/expenses, intensity of resources required for implementation, magnitude of required regulatory changes needed and time to complete implementation.

The conclusions shall be presented by the Service Provider during a technical workshop (see Task 6) with participants at least from EIB PASSA and ANDIS with the objective of identifying the main proposals for new payment methods which will be further detailed. Following this workshop, the Service Provider shall propose

at least three detailed recommendations for new payment methods, provide the detailed methodology and formulas, perform the required calculations, as well as forecasted financial and budgetary impact from REHs perspective, and integrate the results within the financing and budgetary model and run the alternative simulation scenario (see Deliverable 5.5).

For example, if five new day surgery procedures will be identified by the Service Provider as candidates to be added to the NHIH-FC Annex 22, and this recommendation will be agreed upon and approved during the technical workshops, as a following step the Service Provider will proceed to the calculation of the tariffs for the day surgery procedures, based on an a methodology agreed with the PASSA HPE, and integrate the results in the REHs financing model.

Therefore, to successfully complete this task and the required deliverable, the Service Provider shall complete the following phases:

1. Understand and perform the required calculations so that the new hospital classification system (mentioned above at point A) can be accounted for and integrated in the REHs financing/budgeting model alternative scenario.
2. Complete the study of a pay-for-performance methodology (see above point B) and of the topics included in Technical Annex details (attached to this AtoR) (and identify other topics if necessary). Based on the conclusions of the study, formulate proposals for possible new payment methods with the objective of optimizing REHs revenues/expenses model.
3. Present the study results during the technical workshop alongside the recommendations to select at least three new payment methods for further development and integration in the REHs financing/budgeting model. The selection recommendations shall be based on the criteria mentioned above.
4. Facilitate the technical discussions during the workshop so that the participants will reach an agreement.
5. Detail the methodology and perform the calculations needed for the three new payment methods, as agreed during the previous step.
6. Finalize and present the study on recommendations for new payment methods and facilitate stakeholders' agreement.
7. Following study approval, integrate the results in the REHs financing/budgeting model and run the alternative scenario (under Deliverable 5.5).

Due date of submission of the deliverable: No later than 48 weeks after the start of the Implementation Period.

Deliverable 5.5: Results of the advanced financing simulation for the 3 REHs

The Service Provider will develop a detailed document presenting the results of the financial and budgeting modelling, running simulations for a time horizon of 1 – 3 – 6 – 10 years from the start of the operation of the future REHs.

Some of the important requirements of the simulation exercise are described below.

The inputs should be based on the historical budget data (past budgets, expenditures) and projections, revenue sources, the cost structures, operational data, patient volume in all types of services, costs per department, staffing level, equipment maintenance, funding sources, reimbursement rate, inflation rate and other economic factors, other costs.

The expected outputs should be the budget projections, the projected revenue (total anticipated revenue based on patient volume, reimbursement rates, fees for services and transfers from the public budgets), the projected expenditures (total expected costs, including operational and capital expenditures).

The sensitivity analysis shall show the impact of changes in key assumptions (e.g. a 10% increase in costs).

The performance metrics such as cost per patient, the profit margins (breakdown of revenues versus expenses for different service lines) shall be clearly presented.

The visualization of outputs (budget trends, revenue sources, and expense categories) by graphs and charts, as well as dashboards for summary views of financial health for quick decision-making shall be delivered.

The report and recommendations shall include strategic insights like suggested budget adjustments or resource reallocations based on simulation results.

When running the simulation, at least two types of models shall be used based on the previous deliverables, as follows:

- A. The baseline model shall use the financial inputs according to the current regulations, according to the framework contract of the NHIH and MOH legislation in force and all the other financing inputs from all the sources allowed by the current legislation. The different types and level of services, staff level, organization and administration costs should be estimated according to the new forecasts provided for each REHs. After running the model, the gap between revenues and expenses shall be identified for each REH at macro level and granular level (per each clinical and non-clinical center) to identify the main drivers of costs and the most sustainable sources of revenues.
- B. The alternative model shall be based on a scenario which shall integrate the recommendations resulting from the Deliverable 5.4 and use in the model quantified variables according to these recommendations. The alternative scenario shall explore and demonstrate the potential impact of each recommendation provided under Deliverable 5.4 on each REH revenues and expenses flows.

The Service Provider shall deliver the fully customised financing models separately for Iasi REH, Cluj REH and Craiova REH alongside a detailed narrative of the hospital financial simulation project, with specific sections describing the results and interpretation of the sensitivity analysis and the conclusions and recommendations based on the simulations for each of the three REHs. The recommendations provided under Deliverable 5.4 used for the alternative model shall be ranked by the Service Provider based on their

implementation feasibility, resources requirements for full implementation and time horizon until full implementation.

Due date of submission of the deliverable: No later than 54 weeks after the start of the Implementation Period.

Deliverable 5.6: Transition plan from the current financing model of SJUs towards the financing model for the REHs

The Service Provider will have to develop a project charter for ensuring the transition and implementation towards the financing model of the REHs until the date of each REHs operationalization. The aim is to shift gradually from the current Financing model of the SJUs towards the Financing model of the REHs and should consider the results obtained under this task and the previous tasks.

This project charter will have to be aligned at each stage with the EIB PAS Team and ANDIS. The project charter will need to propose a decision mechanism for the main decisions to be taken related to the new REHs governance and financing model.

The Service Provider will have to map the key institutions and identify the key functions (including from the present county hospitals) to be consulted during the development and approval of the Project Charter. All the proposals shall be discussed and reviewed with the REHs technical working groups and technical representatives from NHIH. The final options will be included in the project charter following ANDIS and/or MoH decisions.

The Service Provider will present the final results to the stakeholders during three technical workshops (one per each REH region), as follows:

- The results of the advanced financing simulation (customized for each REHs) of the REHs Financing and Budgeting model (Deliverable 5.5)
- The transition plan, customized for each REH, from the current SJU financing to the new REH financing and budgeting model (Deliverable 5.6)

Due date of submission of the deliverable: No later than 60 weeks after the start of the Implementation Period.

Task 6: Ensuring continuous engagement of and strengthening ownership of the main stakeholders

The main stakeholders for developing the Governance and Financing models should be engaged based on the existing stakeholders' coordination committees and technical working groups at each region level.

The deliverables and outputs from tasks 2 to 5 should be presented during these workshops. The main objective of these workshops is to obtain alignment of the stakeholders on the key topics before ANDIS validation of the deliverables resulting from this Assignment.

The Service Provider should organise common national workshops and regional workshops, according to the plan outlined in Table 3 (see section 4.3 below), for presenting the REHs proposed governance model,

financing and budgeting model and recommendations of new payment models. The Service Provider shall follow the next steps when organizing these workshops:

- a. **Workshop Plan:** The Service Provider shall prepare the workshop plan covering the agenda, aims and outcomes, plan for the logistical arrangements, time plan, resources planning.
- b. **Workshop Materials and Targets:** The Service Provider shall prepare the workshop materials including the informative package for the participants and submit it to ANDIS after having addressed all EIB's comments. Two weeks prior to each workshop, the Service Provider must send invitations to the participants including informative packages aligned with the EIB PAS Team and ANDIS requests.
- c. **Workshop presentations:** The Service Provider shall be engaged in all the technical presentations on the subject matter of this Assignment which will be delivered by its key and/or non-key experts, following agreement obtained from the EIB PASSA TL.
- d. **Post Workshop Report:** After the workshops have been delivered, the Service Provider shall prepare one post workshop report covering at least the summary of discussions, main topics addressed, the presented deliverables, the main actions/action plan resulted. The following documents should be attached to the report as evidence in accordance with the General Data Protection Clause of this contract: list of participants, agenda, workshop materials used and questionnaires. This report will be sent to all the participants after the approval of the post workshop report by ANDIS.

The Service Provider shall use its expert judgment when selecting the professional background and/or clinical specialties of the invited participants in such a way that overlaps should be avoided and the diversity of backgrounds and specialties of the clinicians invited will be maximized.

All the costs associated with the organisation and delivery of the workshops under this Task (as listed in Table 2) shall be deemed as included in the Service Provider's fixed price.

Before the workshops, the Service Provider shall present to the EIB PASSA TL for approval the organizational coordinates for each technical workshop, following the next coordinates: workshop topic, estimated number of participants, duration as well as the catering services and the venue ensured by the Service Provider. The Service Provider shall include the costs of the meetings listed in Table 2 under the corresponding tasks and deliverable, including catering and venue costs.

The Service Provider shall not cover travel or accommodation costs for the participants.

Table 2. List of workshops to be delivered under Task 6

Workshop number	Related task/deliverable	Coverage	Date of submission
1	Del. 3.2 Governance model	Common for the 3 regions	No later than 20 weeks after the start of the Implementation Period.
2	Del. 4.2 The concept of the REH operating model	Iasi	No later than 36 weeks after the start of the Implementation Period.
3	Del. 4.2 The concept of the REH operating model	Cluj	No later than 36 weeks after the start of the Implementation Period.
4	Del. 4.2 The concept of the REH operating model	Craiova	No later than 36 weeks after the start of the Implementation Period.
5	Del 5.2 & 5.3 Financing & budgeting model	Common for the 3 regions	No later than 32 weeks after the start of the Implementation Period.
6	Del 5.4 Study on recommendations for new payment methods	Common for the 3 regions	No later than 48 weeks after the start of the Implementation Period.
7	Del 5.5 Results of the advanced financing simulation Del 5.6 Transition Plan	Iasi	No later than 60 weeks after the start of the Implementation Period.
8	Del 5.5 Results of the advanced financing simulation Del 5.6 Transition Plan	Cluj	No later than 60 weeks after the start of the Implementation Period.
9	Del 5.5 Results of the advanced financing simulation Del 5.6 Transition Plan	Craiova	No later than 60 weeks after the start of the Implementation Period.

Besides the workshops listed in Table 2, the effective implementation of technical tasks during the entire timeline of this Assignment should be ensured, mainly via organizing additional working meetings (whenever needed or requested by EIB-PASSA TL) and providing secretariat activities. These technical meetings shall be organized in online, physical or hybrid forms. If required by the EIB PASSA TL, for the organisation of the Stakeholders Coordination Committees at regional level on REH governance and financing model, the Service Provider should support ANDIS and the EIB PAS Team for the required secretariat activities. The Service Provider shall include the costs of such meetings under the corresponding tasks and deliverable and it is not expected to provide logistics (neither the meeting venue nor catering services and similar) for such technical meetings required in addition of the list of workshops in Table 2.

Due date of submission of the minutes of the meetings: No later than 5 working days after each meeting.

Task 7: Daily ad-hoc support in implementation of the assignment

Under Task 7, the Service Provider will provide support for the implementation of this Assignment (for the development of the Governance and Financing models), answering to specific request for services.

The time input of the Service Provider's key and/or non-key experts in delivering Task 7 is estimated at 115 working-days.

As an example, the following types of tasks might be requested to be provided by key or non-key experts under Task 7:

- Technical analyses, reports, reports, ToRs, studies
- Literature / legislation review
- Presentations
- Support for organizing meetings/trainings

The targeted objective of this Task is that the Service Provider supports in managing the development of the governance and financing models through providing technical advisory services on a demand basis.

The services provided under Task 7, if needed, will be additional to the other tasks performed under this assignment.

Working Methodology for Task 7

The EIB PAS Team will issue a Request for Services (RfS) for any service to be requested by ANDIS.

The detailed results to be achieved shall be defined for each RfS. Under each RfS, the Service Provider shall draw up one or more specific deliverables, as required and agreed with ANDIS and as stipulated in the RfS.

The RfS shall include the following details:

- Recipient and contact persons from ANDIS and PAS Team.
- Scope of the specific services and expected result (report, opinion, etc).
- Profile and category of experts to be mobilised.
- Language into which the deliverable(s) shall be submitted.
- Start of the services.
- Estimated duration and input.
- Location of services.

Within 5 working days from receiving the RfS from the EIB PAS Team Leader, the Service Provider will submit an answer to the RfS, consisting in the CVs of the team of experts proposed to deliver the requested task, a proposal for the input per expert (i.e. number of working days) and an estimate of overall duration.

The CVs of the non-key experts, proposal for experts' input and estimated duration will be checked against the general requirements of this ToRs and the specific requirement of the RfS prior to commencement of the services.

Should the EIB PAS Team Leader reject the answer, the Service Provider might be requested to submit a new answer.

Should the EIB PAS Team Leader accept the answer, a confirmation of his acceptance shall be issued, and the Service Provider shall ensure on-time mobilization of the team.

Deliverables: As requested, and agreed by ANDIS and to be stipulated in each RfS

4.2. Results to be achieved by the Service Provider

The main results that should be achieved by the Service Provider are:

- The Governance Model, a structured framework outlining hospital leadership, decision-making processes, and operational autonomy.
- The Financial Model, a comprehensive financial framework defining reimbursement mechanisms, budget allocations, and expenditure tracking.
- Granular results of the REHs financing simulation and recommendations for aligning the REHs with Romanian and EU health sector financial sustainability requirements.
- Legal changes proposal package to support the implementation of the new Governance and Financing model to enable effective operating of the new REH.
- Organization of consultation workshops with government bodies, regional authorities, hospital administrators, and healthcare professionals.

4.3. Technical deliverables to be produced

Table 3. Summary of deliverables, timeline related to the workshops and approvals required

TASK	DELIVERABLE	TIMELINE (from start of the Implementation Period)	RELATED WORKSHOPS	APPROVALS
1. Development of the assignment work plan	1.1 Assignment work plan	2 weeks	during kick-off meeting	EIB-PASSA ANDIS
2. Perform the assessment of the current situation and update the forecast of health services need	2.1 Assessment 'As is' Report	8 weeks	-	EIB-PASSA
3. Develop the Governance model	3.1 Methodology for developing the Governance model	10 weeks	-	EIB-PASSA
	3.2 Governance model	20 weeks	Workshop 1 (common)	EIB-PASSA ANDIS
	3.3 Transition plan from the current SJU framework to the new model for REH governance	24 weeks	-	EIB-PASSA ANDIS
4. Draft the REHs operating model concept proposal	4.1 Methodology for developing an updated operating model for the REHs	28 weeks	-	EIB-PASSA
	4.2 The concept of the REH operating model	36 weeks	3 regional workshops (one/region)	EIB-PASSA ANDIS

5. Develop the REHs financing and budgeting model	5.1 Methodology for the development of the financing and budgeting model	16 weeks	-	EIB-PASSA
	5.2 Financing model for the 3 REHs	26 weeks	Workshop 2 (common)	EIB-PASSA ANDIS
	5.3 Budgeting model for the 3 REHs	32 weeks		EIB-PASSA ANDIS
	5.4 Recommendations for new payment methods	48 weeks	Workshop 3 (common)	EIB-PASSA
	5.5 Results of the advanced financing simulation for the 3 REHs	54 weeks	3 regional workshops (one/region)	EIB-PASSA ANDIS
	5.6 Transition Plan from current SJU financing to the new financing model	60 weeks		EIB-PASSA ANDIS
6. Ensuring continuous engagement of and strengthening ownership of the main stakeholders	6. Workshops materials, minutes and reports	<i>According to the related workshops column</i>	As above	EIB-PASSA
7. Daily support in implementation	Based on Request for Services	Across the contract duration	-	EIB-PASSA ANDIS

5. Start date, period of implementation, location and logistic

5.1. Start date and period of implementation

The Contract shall enter into force on the day of signature of the Contract by the last Party (the “Effective Date”).

The intended start date is September 2026 and the services shall be provided for a period of 16 months from this date (the “**Period of Implementation**”). All tasks to be performed under the Contract will have to be completed within the Period of Implementation of the Assignment. All technical deliverables and administrative reports to be produced under the Contract will have to be submitted by the Service Provider and approved by the EIB within period of implementation of the Assignment.

The Services shall be provided from the “**Start Date**” until the earliest of:

- the written approval by the Bank of the Completion Report/Final Report or of the final deliverable (if a Completion/Final Report is not foreseen) as the latter is described in section 8.1 below or section 4.1 respectively, which shall not be unreasonably withheld by the Bank, or
- the expiry of 20 months from the Start Date (the “**End Date**”), save where the Service Contract is terminated in accordance with Appendix C of the Service Contract/Framework Agreement. The performance of the Services shall not commence before the Start Date.

Note 1: The Implementation Period (and not the End Date) may be prolonged due to delays attributable to the materialisation of risks associated with the assignment or the third parties. Prolongation shall not cover

contract management deficiencies attributable to the service provider. Any prolongation of the implementation period shall be decided and initiated by the EIB and will be communicated in writing to the Service Provider. In the event of a prolongation the EIB in discussion with the Service Provider will also amend the time schedule for the submission of the outstanding deliverables.

Note 2: This tender procedure, and the consecutive service contract, are launched with a “suspension clause”. This entails that the foreseen Period of Implementation (of 16 months) is subject to the signature of an addendum to the PASSA with ANDIS (“PASSA ANDIS”). The current closure date of the PASSA with ANDIS is 31/12/2027. The addendum to the PASSA ANDIS is foreseen to be signed within the coming months.

The tenderers by participating in this procurement procedure acknowledge that in the event an addendum to the PASSA ANDIS is not signed, the Contracting Authority shall not be liable for any damages whatsoever including, without limitation, damages for loss of profits/costs incurred due to a premature closure of the service contract (before the end of the foreseen Implementation Period), even if the Contracting Authority has been informed of the possibility of such damages.

5.2. Location

The operational base of the project is Bucharest. Travels are anticipated to the project sites in Iasi, Cluj and Craiova (at least 2 per each region). The Key Experts of the Service Provider shall be physically present in Bucharest enough time to ensure a good and timely performance of the Assignment tasks. EIB PASSA TL can specifically request the key experts to be present physically in Bucharest or at the project sites for specific needs as required by the Assignment. Non-key experts should participate in monthly monitoring meetings (online or in-person) and to any other ad-hoc meetings. During workshops organized in Bucharest or in the three regions, the key experts shall be present in person when their presence is requested by the EIB PAS Team Leader.

Target groups

- ANDIS
- The National Technical Working Groups
- The regional Stakeholders Coordination Committee
- Ministry of Health and other public health agencies

5.3. Logistics (Facilities to be provided to the Service Provider’s experts)

5.3.1. Facilities to be provided by the Service Provider

In principle, the costs of the facilities should be included in the tenderer's financial proposal. The Service Provider must ensure that experts are adequately supported and equipped. It must ensure that there is sufficient administrative, secretarial, translation and interpreting provision to enable experts to concentrate on their primary responsibilities. It must also transfer funds as necessary to support their work under the contract and to ensure that its employees are paid regularly and in a timely fashion.

5.3.2. Equipment

No equipment is to be purchased on behalf of the Contracting Authority / Beneficiary / Promoter / partner country as part of this service contract or transferred to the Contracting Authority / Beneficiary / Promoter /

partner country at the end of this contract. Any equipment related to this contract that is to be acquired by the Promoter must be purchased by means of a separate supply tender procedure.

5.3.3. Support to be provided by the Contracting Authority and/or other parties

The Contracting Authority (the EIB)

The Contracting Authority will provide the Service Provider, upon request, with all information relevant to the Assignment which is available to it and not covered by any confidentiality agreements and will fully cooperate with the Service Provider in order to achieve the best results.

The Beneficiary/Promoter/client

The Beneficiary/Promoter/Client undertakes to ensure that its employees co-operate at all times with the Bank and the Service Provider in relation to the provision of the Assignment and shall promptly provide the Service Provider with such information and documents at its disposal which may be relevant and necessary. Such documents shall be returned to the Promoter on completion of the Assignment.

The EIB benefits from VAT exemption on its purchases in Member States of the European Union.

The Service Provider might be exempt from direct and indirect taxes in Romania as a result of this project financed through EC funds. The Service Provider should verify that this tax exemption applies to their activities with the Government of Romania. The Promoter may be able to support the Service Provider regarding the administrative requirements upon his establishment in Romania. The EIB has no influence in this matter.

6. Contract management

6.1 Responsible bodies and management structure

The Contracting Authority

The European Investment Bank, through the Operations Resource Management (ORM) Division within the Operations Directorate (OPS), will act as Contracting Authority.

At the EIB, the Project Advisory Support Unit (PASU), from within the Projects Directorate (PJ) – Housing, Cities and Regions Department (HCR) – Regional Development Division (REGDEV) is responsible for the management and technical follow up of the contract. The activity of the Service Provider will be supervised by the EIB Team Leader who shall act as the Assignment Manager responsible for implementation of the Contract. During the day-to-day implementation of this assignment, the EIB Team Leader will be assisted by the Health Policy Expert Consultant (HPE) for sectorial content related matters and by the EU Projects and Project Administration Expert (PE) for administrative matters. The contact details of the EIB Assignment Manager, HPE and PE and of the responsible counterparts at ANDIS will be communicated to the Service Provider following signature of the Contract.

Beneficiary

The beneficiary is ANDIS. The other important stakeholders are: MoH and other relevant national level administration institutions, 3 regional hospitals administration and personnel, local authorities.

The Service Provider

The Service Provider should nominate an operation director from its head office with sufficient authority to commit the necessary resources, and to take overall responsibility for the performance of the consultancy team. The operation director should have a minimum of 5 years of professional experience at a level of senior responsibility and be fully fluent in English (**CV to be submitted**).

7. Resource requirements

7.1 Staff

The Service Provider shall provide the adequate staff (in terms of expertise and time allocation) to complete efficiently all the activities required under the scope of the Assignment and to achieve the specific and the overall objectives of this contract in terms of time, costs and quality.

Note that civil servants and other staff of the public administration of the partner country or of international/regional organisations based in the partner country cannot be recruited as experts, unless prior written approval has been obtained from the Contracting Authority, on a case-by-case basis.

The justification should be submitted with the tender and shall include information on the added value the expert will bring as well as proof that the expert is seconded or on personal leave.

7.1.1. Key experts

Key experts have a crucial role in implementing the contract. These Terms of Reference contain the required key experts' profiles. The tenderer shall submit CVs and Statements of Exclusivity and Availability for the key experts mentioned below in their Technical Proposal.

- One of the key experts will also be the Team Leader of the Service Provider and will act as primary focal point to the EIB. The Service Provider shall clearly identify the Team Leader in its proposal. The Team Leader shall lead the overall assignment, coordinate the preparation of all the deliverables, ensure that activities performed by non-key experts are timely, ensure a high quality level of the deliverables, follow the progress of the tasks to ensure that the timelines of the Assignment are rigorously respected and present the deliverables to EIB PASSA and, if requested, to ANDIS. The Team Leader shall also coordinate and monitor the prompt delivery of the activities performed by the other key experts and non-key experts and oversee quality control over the technical deliverables.

Key Expert 1: Senior Health Management Expert

Key Expert 1 shall be the main expert for the governance part of the assignment. Key Expert 1 shall also coordinate and monitor the delivery of the activities related to the governance part of the assignment performed by the other key and non-key experts and oversee quality control over the deliverables related to the governance tasks.

Qualifications & Skills	<ul style="list-style-type: none"> • At least at bachelor's degree level or academic equivalent in one of the following fields: Medicine, Public Health, Health Policy, Health Management, Economics, Public Administration. • Post graduate degree (Master or PhD) in Public Health or Health Management shall be considered as a strong asset. • Graduate training courses internationally recognized on health management shall be considered an asset.
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	<ul style="list-style-type: none"> • Very good command of English (CEFR C1) and good command of Romanian (CEFR B2). • Communication skills needed for moderating meetings/workshops, as demonstrated by participation in similar activities in previous projects, shall be considered an asset. • Leadership skills, demonstrated by previous experience in leading similar projects, shall be considered an asset.
General professional experience	<ul style="list-style-type: none"> • At least 10 years of relevant professional experience in health sector. • Project management experience and international working experience in hospital management and services improvement shall be considered as an important asset.
Specific professional experience	<ul style="list-style-type: none"> • Minimum 5 years of specific experience in providing guidance to national / regional / local authorities or managers of healthcare providers in one or more of the following fields: <ul style="list-style-type: none"> ○ Hospital management or organization ○ Hospital financing ○ Governance of healthcare providers. • At least 2 projects addressing one or more of the following areas: hospital management or organization, hospital clinical management or organization, quality of care improvement, services improvement methods, hospital financing, health systems strengthening, public administration reform. • Experience in conducting a hospital transformation / operationalisation / health quality improvement project shall be considered as an important asset. • Experience in at least one public health/health systems strengthening project at international level implemented by an international financing institutions (e.g. EIB, EBRD, WB, ADB) or international organisations (e.g. EC, WHO) shall be considered as an important asset. • Experience in moderating technical working groups and/or coordination of healthcare stakeholders will be considered an asset.

Key Expert 2: Senior Health Economics Expert

Key Expert 2 shall be the main expert for the financing part of the assignment. Key Expert 2 shall also coordinate and monitor the delivery of the activities performed by Key Expert 3 and non-key experts and oversee quality control over the deliverables related to financing.

Qualifications & Skills	<ul style="list-style-type: none"> • At least bachelor's degree level or academic equivalent in one of the following fields: Medicine, Economics, Public Administration, Health Economics, Public Health, Health Policy, Health Management.
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	<ul style="list-style-type: none"> • Post graduate degree (Master or PhD) in Health Economics, Health Policy or Health Management shall be considered as a strong asset. • Very good command of English (CEFR C1). • Communication skills needed for moderating meetings/workshops, as demonstrated by participation in similar activities in previous projects, shall be considered an asset. • Leadership skills, demonstrated by previous experience in leading similar projects, shall be considered an asset.
General professional experience	<ul style="list-style-type: none"> • At least 10 years of relevant professional experience in health economics and in the healthcare sector or international development. • Project management experience and international working experience shall be considered as an important asset. • Participation in WHO training courses or other internationally recognized courses on health management and health economics/health financing shall be considered an asset.
Specific professional experience	<ul style="list-style-type: none"> • Minimum 5 years of specific experience in providing guidance to national/regional/local authorities or managers of healthcare providers in the following fields: <ul style="list-style-type: none"> ○ Hospital Financing ○ Hospital Accounting ○ Health Economics. • Experience in at least 2 projects on health financing / budgeting / modelling projects. • Specific experience in health economics in one or more EU member states. • Experience in at least one public health/health systems strengthening project at international level implemented by an international financing institutions (e.g. EIB, EBRD, WB, ADB) or international organisations (e.g. EC, WHO) shall be considered as an important asset. • Experience in moderating technical working groups and/or coordination of healthcare stakeholders will be considered an asset.

Key Expert 3: Health Economics Expert

Key Expert 3 shall lead the REH stakeholder's engagement in the Project as regards financing.

Qualifications & Skills	<ul style="list-style-type: none"> • At least bachelor's degree level or academic equivalent in one of the following fields: Economics, Medicine, Public Health, Public Administration, Engineering, IT, Statistics. • Post graduate degree (Master or PhD) in Health Economics shall be considered as a strong asset. • Participation in internationally recognized training courses or nationally recognized courses on health economics and economic modelling shall be considered an asset. • Good command of English (CEFR B2) • Communication skills needed for moderating meetings/workshops, as demonstrated by participation in similar activities in previous projects, will be considered as an asset.
General professional experience	<ul style="list-style-type: none"> • At least 6 years of relevant professional experience in economics/financing and in the healthcare sector or the international development sector. • International working experience shall be considered as an important asset.
Specific professional experience	<ul style="list-style-type: none"> • Minimum 3 years of specific experience in the following fields: <ul style="list-style-type: none"> ○ Health Economics ○ Hospital Accounting • Experience in at least 1 project on health financing or economic modelling for healthcare providers. • Proven specific experience with development of at least 2 economic/financing models. • Practitioner experience in health economics or modelling for the healthcare system projects in one or more EU member states will be considered as an important asset.

7.1.2. Non-Key experts

The profile of the non-key experts for this contract as a minimum are as follows:

- Statistician (desirable with experience in health economics)
- Clinician (hospital doctor with experience in the Romanian hospital services organization)
- Expert in hospitals' facility management (engineer or other similar credentials, with experience in the Romanian healthcare system)
- Epidemiologist / public health expert (DRG coding experience is desirable)

- Legal expert (desirable with experience in Romanian hospitals' accounting systems).

The Service Provider shall submit for EIB's approval an Expert Mobilisation Plan (EMP) (excluding the experts to be engaged for Task 7) within their Inception Report. The non-key experts will have to be mobilised by the Service Provider within 1 week after the approval of the EMP by the EIB.

The EMP should cover all non-key experts that the Service Provider intend to employ in this contract. The Service Provider should as a minimum engage 1 non-key expert for each category listed above. The Service Provider must mobilise any additional expertise that might be required to implement the assignment successfully and prepare the deliverables. The CVs for each non-key expert should be submitted as annexes to the mobilisation plan. When reviewing the EMP, in addition to the minimum individual requirements for each non-key expert and the collective requirements for the pool of non-key experts, the EIB will also assess the following points:

- Balance between senior profiles (i.e. highly experienced experts who were previously employed in complex or sensitive assignments) and newer generation profiles (i.e. although relatively less experienced, they should have good knowledge of recent approaches, trends, methodologies, and technologies);
- Balance between international expertise and local expertise.

Minimum requirements for non-key experts

Each non-key expert must meet the following minimum profile and qualifications requirements as follows:

Qualifications:

- At least bachelor's degree in relevant fields to their proposed positions (or academic equivalent)

General professional experience:

- At least 5 years of general professional experience related to the positions they are proposed

Specific professional experience:

- Minimum 3 years of first-hand practitioner experience in their respective field of activity

Language skills:

- Good command of English.

Collective requirements for the pool of non-key experts

In addition to individual minimum requirements for each non-key expert, their competences should complement each other well. The pool of non-key experts must collectively meet the following minimum requirements:

- Experience in planning and providing healthcare services at the hospital level, including day care, ambulatory care.
- Experience in medical services costs and accounting methods for Romanian healthcare providers.
- Experience in DRG system coding specific for the Romanian context.
- Experience in costing and pricing of services and maintenance services specific for hospitals' facility management.
- In depth experience in providing advisory secretariat functions to policy making groups/commissions.

CVs for non-key experts should not be submitted in the Proposal but the tenderer will have to demonstrate in their technical proposal that they have access to experts with the required professional profiles. The Technical Proposals shall include an indicative list of non-key expert candidates who the tenderers intend to propose within their mobilisation plan if they are awarded the contract. The tenderers are expected to include short profiles for the non-key expert candidates. No other supporting documents for non-key experts (including their CVs) should be submitted in the Proposal. In case a tenderer includes the CVs of non-key experts in its Proposal, these will not be evaluated.

The mobilisation of all non-key experts under the Assignment is subject to prior approval by the EIB. Before mobilising any non-key expert, the Service Provider will have to submit a formal request to the EIB Assignment Responsible by email. The request will have to include, not only the CV of the proposed non-key expert, but also information on his/her role under the assignment and clarity on the task(s) the expert will be assigned to. In no case shall a non-key expert be mobilised without a prior approval by the EIB Assignment Responsible.

Other aspects

In case of doubt on the professional profile received, the EIB may require evidence of the above skills.

If during the implementation of a Contract, the EIB judges the expert(s) unable to meet the level of quality required for preparing the written outputs such as reports, the Service Provider will provide, at no additional cost to the EIB, immediate additional support for these outputs to meet the appropriate standards. Should the EIB require the replacement of an expert for important reasons (i.e. for consistently failing to meet the requirements of the ToR), the Service Provider will take the necessary steps to propose a replacement solution to the EIB at the shortest term possible.

The Service Provider should provide the total number of working days and specify the number of experts having national or international experience.

CVs for non-key experts should not be submitted in the tender, but the tenderer will have to demonstrate, providing explanations on how these non-key experts can be selected and mobilised, in their offer that they have access to experts with the required profiles.

The Service Provider must select and hire other experts as required according to the profiles identified in the Organisation & Methodology and/or these Terms of Reference. It must clearly indicate the experts' profile so that the applicable daily fee rate in the budget breakdown is clear.

All experts must be independent and free from conflicts of interest in the responsibilities they take on.

The profile for each non-key expert (*i.e.* senior / junior) must be indicated clearly, so as to be able to establish which fee rate in the budget breakdown will apply. For the purposes of this contract, the classification of the experts as senior/junior is entirely the decision of the Service Provider but should nevertheless be communicated to the Contracting Authority when requesting the approval of the experts, for contract management purposes.

The selection procedures used by the Service Provider to select these other experts must be transparent, and must be based on pre-defined criteria, including professional qualifications, language skills and work experience. The findings of the selection panel must be recorded. The selected experts must be subject to approval by the Contracting Authority before the start of their implementation of tasks.

The Tenderers must indicate in their technical proposal the minimum indicative estimated input (to be expressed in terms of "number of working-days") that they propose for each expert for each task (apart from Task 7). It is the responsibility of the Service Provider to accurately estimate the input (*i.e.* number of expert days) to ensure implementation of the tasks and preparation of the deliverables as indicated in this ToR. **In any case, the Technical Proposals shall include at least an overall input, for all tasks (apart from Task 7), of 1650 expert-days.**

If needed, the Service Provider shall engage higher number of expert working days (than the minimum estimated input during the tendering and/or inception phase) during the implementation of the project. **In this case, the Service Provider shall not be paid any additional fee or reimbursed for his expenses.**

The table below presents the minimum required specific expertise for each Task.

Task	Required minimum specific expertise
Task 1 Development of the assignment work plan	Senior Health Management Expert (Key Expert 1), Senior Health Economics Expert (Key Expert 2), Health Economics Expert (Key Expert 3)
Task 2 Perform the assessment of the current situation and update the forecast of health services need	Senior Health Management Expert (Key Expert 1), Senior Health Economics Expert (Key Expert 2), Health Economics Expert (Key Expert 3), Legal Expert, Epidemiologist/Public Health expert, other non-key experts
Task 3 Develop the Governance model	Senior Health Management Expert (Key Expert 1), Legal Expert, Clinician, Epidemiologist/Public Health expert, other non-key experts
Task 4 Draft the REHs operating model concept proposal	Senior Health Management Expert (Key Expert 1), Epidemiologist/Public Health expert, Legal Expert, Clinician, other non-key experts
Task 5 Develop the REHs financing and budgeting model	Senior Health Economics Expert (Key Expert 2), Health Economics Expert (Key Expert 3), Senior Health management expert (Key expert 1) Legal Expert, Epidemiologist/Public Health expert, Clinician, Statistician, Expert in hospitals' facility management, other non-key experts
Task 6: Ensuring continuous engagement of and strengthening ownership of the main stakeholders	Senior Health Management Expert (Key Expert 1), Senior Health Economics Expert (Key Expert 2), Health Economics Expert (Key Expert 3), Clinician, Legal Expert, other non-key experts

7.1.3. Support staff and backstopping

The Consultant shall supply all support staff (administrators, secretaries, interpreters, and head office back-up, drivers etc.) as necessary for the proper fulfilment of his obligations. The costs of supporting staff must be included in the fee rates of the experts.

Backstopping costs for logistical and management support (including the activity of the TA operation director designated by the Consultant) of the team must be included in the fee rates of the experts.

The Consultant should identify and describe in his offer the arrangements for the provision of the support staff and backstopping facilities.

Note that the support/backstopping staff cannot be assigned as short or long-term experts while still maintaining their original assignment. The two responsibilities must be kept separate and double budgeting under the project shall be avoided.

7.1.4. Other aspects

If, during the implementation of a Contract, the EIB judges the expert(s) unable to meet the level of quality required for preparing the written outputs such as reports, the Service Provider will provide, at no additional cost to the EIB, immediate additional support for these outputs to meet the appropriate standards.

Should EIB require the replacement of an expert for important reasons (i.e. for consistently failing to meet the requirements of the AToR), the Service Provider will take the necessary steps to propose a replacement solution to the EIB at the shortest possible.

International (mobilization and demobilization) and local transport and associated costs (vehicles, incl. drivers if considered necessary, per diem, etc.) of Key and Non-Keys experts posted on site should be included in the fees.

Office accommodation

Office accommodation of a reasonable standard and of approximately 10 square meters for each expert working on the contract and reasonably accessible by phone, fax and e-mail over the duration of the assignment is to be provided by the Consultant.

The costs of the office accommodation are to be covered by fee rates.

8. Technical deliverables and administrative reports

8.1. Technical deliverables

See section 4 above. All technical deliverables are expected to be submitted electronically and in hard copy (1 copy) in Romanian and in English. The EIB might lift the requirement for submission of hard copy.

8.2. Administrative Reports

In addition to the technical deliverables identified above, the Service Provider shall provide the following administrative reports:

Name of report	Content	Due date for submission
Inception Report	See below	No later than 2 weeks after the start of implementation.
Monthly progress reports	See below	No later than the 5th working day of the following month.
Quarterly progress reports	See below	The quarterly progress reports shall be submitted within 10 working days of the following Quarter.
Draft Assignment Final Report	See below	No later than one month before the end of the period of implementation.
Final Report	See below.	Within 15 days after receipt of approval on the draft final report.

The reports mentioned are described as follow:

Inception Report shall confirm the aims of this technical assistance. In the report, the Service Provider shall describe e.g. initial findings, progress in collecting data, any difficulties encountered or expected in addition to the work programme proposed in the offer.

In the report, the Service Provider shall provide the Expert Mobilisation Plan (EMP) that shall include the input of both key and non-key experts and the Quality Control Plan (QCP).

If there are any proposed modifications to the original Terms of Reference due to changed circumstances after arrival on site, these are to be discussed and agreed in principle with the Contracting Authority and the Beneficiary before the submission of the Inception Report.

This Report will describe the Service Provider's proposed establishment, personnel, and where they will be based, as well as the Service Provider's proposed approach to the project, stakeholders' engagement plan, taking into consideration the situation at the starting date of the assignment. The expected achievement of the outputs listed in the Terms of Reference should be clearly identified, with any milestones, and the confirmation of the counterpart staff and other commitments to be made by the recipient counterparts. The inputs to support key activities for each beneficiary should be based on a thorough needs assessment taking account of individual circumstances.

The EMP shall include for each Task: list of proposed experts team, a narrative explanation where the tasks and responsibilities proposed for each key and non-key experts will be explained and the non-key experts' knowledge and specific experience (in relation to the proposed tasks and responsibilities) will be demonstrated, CVs of the non-key experts and minimum level efforts (in terms of expert days) per expert, as well as a timeline for stakeholders' involvement.

The QCP shall include project team members to be involved in preparation, revision, quality control, review and approval of the output and deliverables, internal quality control process with the timelines, process of addressing the EIB PAS Team's feedback/comments, communication and information flows, contact points, versioning, document management and similar). The QCP shall identify clearly the quality control person responsible for each task from the three key experts proposed.

Should the Inception Report point out the necessity to perform additional services which were not included in these Terms of Reference and which would have become necessary to the completion of the Assignment, the EIB reserves the right to amend the contract and to extend the scope of the services and/or the duration of the contract in accordance with the terms and conditions of the contract.

Monthly Progress Reports shall include the following:

A narrative section made of: A summary of the task performed in the frame of the Assignment in the reported period, including progress and key achievements (in the form of a table).

- Information on delays, bottlenecks and potential risks (if any) that may influence the outcome of the performance of the planned activities and the submission of technical deliverables, including interventions and specific actions to be taken during the next reporting period to ensure timely delivery of the project, if necessary.
- defining the milestones to be achieved in the next reporting period.

The Service Provider should include in the monthly reports a list of Technical Deliverables prepared related to the corresponding Task as well as chronology of the deliverable development and submission phase. The

chronology should include at least: the dates of submissions of draft and final versions, dates of comments received from ANDIS and/or EIB PAS Team, date of agreement by ANDIS and/or EIB PAS Team (if applicable), date of the submission of the hard copies to the EIB PAS Team (if applicable).

Monthly progress reports will contain at least the following information in the main body of the report:

- a. Summary of the progress
- b. Review of the activities (e.g. tasks performed, outputs produced/contributed, etc.)
- c. Changes in implementation arrangements and/or institutional set-up
- d. Challenges encountered
- e. Outstanding issues and challenges ahead
- f. Pressing matters (e.g. deadlines, etc.)
- g. Information on time input for all experts. Even for the tasks 1 – 5, under a lump sum regime, the actual inputs shall be indicated and should not show major deviations as against the requirements of the ToRs and the indications of the Technical Proposal.
- h. Plan for the following month
- i. Any other important matter

Monthly progress reports will contain the following annexes:

Annex 1: A list of deliverables produced during the reporting period.

Annex 2: List of meetings participated.

Quarterly Progress Reports will contain the following elements:

A narrative section made of: A summary of the task performed in the frame of the Assignment in the reported period, including progress and key achievements.

- a. Information on delays, bottlenecks and potential risks (if any) that may influence the outcome of the performance of the planned activities and the submission of technical deliverables, including interventions and specific actions to be taken during the next reporting period to ensure timely delivery of the project, if necessary.
- b. Defining the milestones to be achieved in the next reporting period.
- c. The narrative section will include as annexes a copy of all technical deliverables/reports/documents/material produced during the reporting period.

The Narrative Section of the Quarterly Interim Reports will contain at least the following information in the main body of the report:

- a. Summary of the progress
- b. Review of the activities
- c. Review of the outputs

- d. Changes in implementation arrangements and/or institutional set-up
- e. Challenges encountered
- f. Outstanding issues and challenges ahead
- g. Pressing matters (e.g. deadlines, etc.)
- h. Any other important matter

A financial section made of:

- For the period covered by the Report: A financial report including all information related to services provided on fees basis (Task 7), covering fees payable for the experts mobilised and itemised expenses eligible for reimbursement.
- Editable excel sheet with summary of timesheets by day/expert/price relevant to Task 7.
- A summary of the financial situation covering the entirety of the assignment since its start (fees payable for the experts mobilised and itemised expenses eligible for reimbursement).
- List of deliverables, showing their status of approval. For the approved deliverables, the value will be indicated as per the contract provisions.
- Annex A: Incidental Expenditure. For the period covered by the Report: annexes for all approved expenses and for all business trips undertaken by the Service Provider's expert, copies of all original invoices and airplane boarding passes (where applicable) as well as a copy of the ex-ante approval by the EIB of the authorisation for expenditure.
- Annex B: Timesheets. For the period covered by the Report: signed and completed timesheets for the experts. Timesheets will be established for each expert having been mobilised. Timesheets will report, for each month, the days worked, and the activities having been performed. The timesheets shall clearly identify each task which was undertaken. The smallest unit adopted for timesheets shall be ½ day. The timesheet shall be co-signed by the Service Provider's expert, and by the Service Provider's Team Leader

These interim reports should provide information on the state of progress of the project over the period, for ease of monitoring activities and outputs and should clearly distinguish between activities/outputs achieved and considered finished, and activities still in progress, so that the evaluation of the project is clear.

Draft Assignment Final Report

The Service Provider will submit to the EIB the Draft Assignment Completion Report, in English and Romanian which will contain the summary of the services performed during the Assignment with reference to the tasks/deliverables set out in the ToR, including, as the case may be, all changes to the tasks/deliverables incurred during the course of the Assignment.

It shall consist of a narrative section. It shall, inter alia, include:

- i. a summary of the services performed during the Assignment with reference to the tasks/deliverables set out in the Assignment Terms of Reference, including as the case may be all changes to the tasks/deliverables incurred during the course of the Assignment.

- ii. if any, a list of the points diverging from those fixed in the initial objectives/tasks together with a comment on the steps undertaken to remedy the situation and any suggestion to improve the process for any similar projects that may be implemented by ANDIS in the future.
- iii. if any, a statement summarizing the various difficulties encountered and an evaluation of the impact of the above-mentioned difficulties in terms of the project itself, total cost for the Assignment and deadlines.

Final Report will contain the following:

- a summary of the services performed during the Assignment with reference to the tasks/deliverables set out in the Assignment Terms of Reference
- a synthesis of all analysed projects presenting the main issues solved and the remaining aspects to be tackled
- lessons learned as regards the activities performed and recommendations for the MA and beneficiaries
- if any, a statement summarising the various difficulties encountered and an evaluation of the impact of the above-mentioned difficulties in terms of the project itself, total cost for the Assignment and deadlines
- with the same specifications as the draft Assignment Completion Report, incorporating any comments received from the parties on the draft report.
- The Completion Report shall also include as annex: A copy of all deliverables/reports /documents /material produced during the Assignment

All reports will be written in concise, clear and well-edited Standard English and will be translated into Romanian language. All reports shall be made available in electronic format. They will have to be provided in Microsoft Word compatible format, in a single file or with a series of files following a structure that makes it easy to print and generate hard copies, with all support files also attached. All produced spreadsheets have to be provided in Microsoft Excel compatible format, including all underlying formulas. Such formulas shall be unprotected and available to the EIB (this is valid also in the case of using other spreadsheets formats, with prior approval from the EIB PASSA TL).

File origins shall be clearly identifiable in a header or footer. A list of essential contact persons is to be included. The reports should have a title page, which should include project name, project code or reference, report title, date issued and period covered, the name of the Service Provider's experts authoring/co-authoring the report and the name and address of the Service Provider. The Contracting Authority shall provide the Service Provider, after the starting date of the assignment, with a recommended structure of the Reports. The Service Provider may propose changes to this structure, which must be agreed with the Contracting Authority in advance.

The draft technical deliverables and administrative reports required in the Assignment ToR will be made available in electronic format.

The EIB will have 15 working days to examine each report. Should the EIB request amendments, the Service Provider will be requested to re-submit the report within 5 working days following the request, completed and adequately amended.

All technical deliverables and outputs submitted to the EIB will be named in such a way as to easily identify the following elements:

- i. the AA reference number of the assignment,
- ii. type of the document submitted: Deliverable - DELIV.
- iii. the date and language of the document,
- iv. the version of the document: draft, version number of the draft, or final
- v. the Task Order (TO)/Request for Services (RFS) number, if applicable.

For example, *AA-012642 DELIV yyyy mm dd Name of document EN draft 3, or*

AA-012642 DELIV TO02 yyyy mm dd Name of document EN final

All administrative reports submitted to the EIB will be named in such a way as to easily identify the following elements:

- i. the AA reference number of the assignment,
- ii. type of the document submitted: Inception Report - TAINCEPREP, Progress Report - TAPROGREP, Final Report - TAFINREP.
- iii. the date and language of the document,
- iv. the version of the document: draft, version number of the draft, or final
- v. the Task Order (TO) number, if applicable.

For example, *AA-012642 TAINCEPREP yyyy mm dd Name of document EN draft 3*

AA-012642 TAFINREP yyyy mm dd Name of document EN final

Also, the "Subject" field of the e-mails by which the above-mentioned files are transmitted to the EIB shall contain the AA reference number of the assignment and the name of the concerned document as per the example below:

Subject: AA-012642 – Transmission of the... [report or deliverable explicit name].

Other requirements

Monthly management meetings will be held between the EIB PASSA Team and the Service Provider team for the purpose of the parties sharing information on the progress of activities and tackling various technical, methodological issues, discussing deliverables, working on specific tasks etc. At the discretion of the EIB these meetings may be held online or face-to face (on the premises of the EIB in Bucharest) and may be postponed or have another frequency depending on the Assignment needs.

For these meetings, **the Service Provider will prepare Power Point presentations** detailing aspects such as: contract / project overall status, progress for on-going activities, plans / methodologies for upcoming activities and deliverables, objectives / priorities on the short and medium term, risks to project activities / objectives and proposed prevention / mitigation measures to be taken by the Service Provider, status of progress reporting and payments, status of verification / approval of deliverables, deployment of experts on the short-term in connection to planned activities etc. The EIB may request additional type of information to be presented as needed for proper, in-depth monitoring and supervision of the contract and for supporting its decision-making processes on aspects relevant for the contract.

Unless otherwise agreed in advance by the EIB PAS Team Leader in exceptional circumstances, duly justified by the Service Provider, **the monthly meetings will be attended by the Service Provider's all key experts and approved non-key experts** (please see section 7 for details on required staff from the Service Provider). The meeting will be moderated by the Service Provider and each expert is expected to be visible and active during the meeting, presenting his/her own activities and recommendations in his/her area of competence.

Following each meeting, within 1 working day, the Service Provider will send via email summary notes of the meetings discussions and decisions to the EIB representatives. The Service Provider is expected to accurately reflect feedback, working instructions formulated by EIB representatives during the meeting.

Ad-hoc coordination meetings will be held with ANDIS team and EIB PAS Team (and/or REH teams where relevant), as agreed by the EIB and ANDIS. The purpose of these meetings will be for the parties to share information on the progress of activities, tackle various technical, methodological issues, discuss deliverables, agree on necessary work adjustments etc.

The Service Provider will suggest dates / timing and agenda. Format of the meeting (online or in person) will be agreed with the EIB and ANDIS.

As in the case of ad-hoc coordination meetings, **the Service Provider will prepare Power Point presentations** if so requested detailing relevant aspects for example: contract / project overall status, progress for on-going activities, plans / methodologies for upcoming activities and deliverables, objectives / priorities on the short and medium term, risks to project activities / objectives and proposed prevention / mitigation measures, list of decisions, actions proposed for ANDIS or risks to be addressed by ANDIS directly. The EIB / ANDIS may request additional type of information to be presented as needed for proper monitoring and supervision of the contract and for supporting their decision-making processes on aspects relevant for the contract.

Unless otherwise agreed in advance by the EIB PAS Team Leader in exceptional circumstances, duly justified by the Service Provider, **the ad-hoc coordination meetings will be attended at least by the Service Provider key experts** (please see section 7 for details on required staff from the Service Provider). The meeting will be moderated by the Service Provider and each expert is expected to be visible and active during the meeting, presenting his/her own activities and recommendations in his/her area of competence.

Following each meeting, within 1 working day, the Service Provider will send via email summary notes of the meetings discussions and decisions to the EIB representatives. The summary notes will be sent to ANDIS following the verification of the EIB and potential needed adjustments.

Note: draft Power Point Presentations will be sent for review in advance to the EIB at least 3 working days in advance of each meeting.

Other coordination / working meetings between the Service Provider and EIB may need to take place whenever necessary to cover for the needs of the Assignment. The Service Provider is expected to adjust flexibly its working schedule and the mobilisation of experts to meet promptly such implementation needs. The Service Provider should, as a general rule, always prepare minutes of meetings held, unless otherwise agreed with the EIB.

Communication in writing

In its communications in writing with ANDIS or other stakeholders of the Assignment, the Service Provider has the obligation to prior consult the EIB PAS HPE and always copy EIB Assignment representatives (as communicated by the EIB PAS Team Leader, including other third-party consultants that may be involved in the implementation of the Project, if so, decided by EIB). Also, the Service Provider is expected to promptly

forward to the EIB any communication received from ANDIS or other project stakeholders and systematically strive to maintain open, transparent, real-time communication channels with all Assignment parties. Also, emails should be sent by members of the Service Provider team and these members should be clearly identified (no generic email addresses are allowed or generic titles for the sender).

Also, the “Subject” field of the e-mails by which the above-mentioned files are transmitted shall contain the AA reference number of the assignment and the name of the concerned document as per the example below:

Subject: AA-012642-001 – Transmission of the... *[report or deliverable explicit name]*.

Communication via videoconferencing facilities

Part of the meetings within this Assignment will take place in online/hybrid format, via videoconferencing facilities, the Service Provider should make sure it is able to work with tools such as Webex or Microsoft Teams. Moreover, while online, the experts are required to be visible, with video facilities on.

Transfer of documents

As a general rule, documents will be transferred via emails, unless too large for email capacity in which case the Service Provider will use the EIB MS Teams system.

Records of activities run

The Service Provider will maintain accurate records of activities run such as meetings in terms of signed lists of presence in compliance with EU General Data Protection Regulation rules (or online records for virtual meetings).

Format of documents

All documents will be made available in electronic, editable format. They will have to be provided in Microsoft Office compatible format, in a single file or with a series of files following a structure that makes it easy to review, edit, print and generate hard copies, with all support files also attached. All produced spreadsheets must be provided in Microsoft Excel compatible format, including all underlying formulas. Such formulas shall be unprotected and available to the EIB.

Conflict of interest and confidentiality obligations

All experts and other team members involved by the Service Provider in the implementation of the Assignment (e.g. support staff, management staff, translators) must be independent and free from conflicts of interest in the responsibilities they take on, particularly with regards to their potential involvement in the process of preparation of applications for funding to be evaluated under the present assignment.

Furthermore, strict confidentiality protection rules should be applied by the Service Provider to prevent disclosure of information pertaining to this Assignment or to which it has access by the virtue of this Assignment to any third party without prior agreement from the EIB. This obligation should be observed also after finalisation of this Assignment.

The Service Provider may be requested by the EIB to provide proofs or other evidence for how it observes the rules on conflict of interest and confidentiality of data.

General performance management arrangements and expectations for the assignment

Apart from other performance requirements set throughout these AToR, the Service Provider is expected to observe the following general rules of delivery in the execution of this Assignment: flexibility, professionalism,

ethical behaviour and results-orientation. Nevertheless, the service provider should be preoccupied not only by the fulfilment of activities and preparation of deliverables, but also by the achievement of Assignment objectives, taking actions and calibrating its consultancy approach to flexibly address potential challenges in the Assignment implementation. For instance, as part of this requirement, the experts are required to build good working relations with ANDIS, and stakeholder, based on trust, regular visits, clarity, promptness of communication (including ad-hoc), and have a very good level of understanding of the general political and administrative background of it, as relevant for the successful implementation of the Assignment.

As the Services Provider acts under the authority of the EIB, it should always behave loyally towards the latter, by, for instance, informing it promptly of any issues affecting or potentially affecting the Assignment or not communicating with PASSA Recipients or other stakeholders without the knowledge of the EIB / its previous approval, as per the case. The Services Provider is expected to act with good judgement in such situations, observing strictly the authority of the EIB as Contracting Authority and observing requests from the EIB related to communication practices.

Visibility requirements

All deliverables and reports will observe visibility requirements set under the PASSA for which they are issued. Also, all deliverables and reports prepared under this agreement, shall contain elements of visibility regarding financing from Technical Assistance Program 2021-2027 as presented in the Manual for visual identity that can be found on the following site: <https://mfe.gov.ro/comunicare/strategie-de-comunicare/>.

The Consultant must also comply with the latest Communication and Visibility Manual for EU External Actions concerning acknowledgement of EU financing of the project. (https://ec.europa.eu/europeaid/communication-and-visibility-manual-eu-external-actions_en and with the EIB logo –user guide .

The EIB logo should appear on the cover page of reports/technical deliverables produced under the TA contract. THE EIB LOGO MAY NOT BE USED FOR ANY OTHER PURPOSE.

The following text should also be included in all documents produced: “The technical assistance is provided under EIB Project Advisory Support Service Agreement.”

The following disclaimer should also be included: “The authors take full responsibility for the contents of this report. The opinions expressed do not necessarily reflect the view of the European Union, nor the European Investment Bank”.

9. Type of Contract, Budget, Remuneration and Payment Schedule and Invoicing

9.1 Type of Contract

The services are to be provided based on a combination of a fixed price basis for Tasks 1 to 6 and of a time and material basis inclusive of expenses for the task 7.

9.2 Budget

The maximum budget for the present assignment is 1,350,000 EUR.

9.3 Remuneration

For the performance of the services to be undertaken under the Assignment, the Service Provider shall be remunerated as follows:

- For the performance of Tasks 1, 2, 3, 4, 5 and 6 the Service Provider shall be remunerated on the basis of fixed prices (lump sums)² inclusive of expenses and exclusive of VAT for all the deliverables formally approved under each task (with the exception of expenses eligible for reimbursement listed under section 9.3 above which related to business trip to be undertaken outside Bucharest by key and non-key experts to perform services).
- For the performance of Task 7 the Service Provider shall be remunerated on a time and material basis. The non-key experts' shall be remunerated based on a fixed daily rate price inclusive of expenses and exclusive of VAT for services performed from Bucharest.

Expenses eligible for reimbursement

The provision for incidental expenditure covers ancillary and exceptional eligible expenditure incurred under this contract. It cannot be used for costs that shall be covered by the Service Provider as part of its fee. In this regard and for the sake of clarity, the following categories of expenses will not be eligible for reimbursement by the EIB:

- travel expenses to / from the Service Provider home office to Bucharest,
- expenses related to missions within Romania undertaken for the purpose of Tasks 1 to 6.

The provision for incidental expenditure may cover costs related to:

- the purchase of documents (for example, reports, maps or statistical information) if they are strictly necessary for the experts to achieve the purpose of the assignment under the Contract.
- the logistical requirements and expenses related to additional events (i.e. those not anticipated in this ToR) including hiring of (equipped) training facilities, meeting rooms, catering and similar expenses for the organisation and delivery of the trainings/workshops/working meetings.
- expenses incurred during business trips necessary to be undertaken in Romania outside Bucharest for the purpose of Task 7 activities, subject to prior authorisation by the EIB Team Leader.

Before undertaking any business trip or undergoing any expense potentially eligible for reimbursement, the Service Provider shall address a request for expenses/travel authorization to the EIB Assignment Responsible in charge. Such request shall provide a detailed budget estimate See here-under for information the main categories of expenses eligible for reimbursement in this context:

- Air	- Economy Class. Business class shall be authorized only where the air travel includes three or more hours of actual flight
- Rail	- Day: first class Night: single sleeper
- Hotel expenses	- Only room and breakfast charges of hotel approved by the Assignment Responsible

² All inclusive lump-sum prices to be paid based on the approved deliverables only.

- Taxis	- Each journey to be itemized and supported by a receipt where possible (N.B. Reasonable use of taxis without prior agreement will be accepted).
- Other	- Eligibility of other expenses should be verified in advance.

No equipment shall be purchased via the incidental budget.

Expenses eligible for reimbursement incurred in other currencies than EUR will be converted to EUR using the monthly euro foreign exchange rate - the Inforeuro rate, published by the EC³ applicable for the month when the draft Progress Report is first submitted to the Bank for approval.

Expenses eligible for reimbursement will be reimbursed without VAT. VAT incurred for mission expenses will be reimbursed only when the Service Provider can demonstrate that such VAT is an actual cost, i.e. that it is actually (i) incurred by the Service Provider and (ii) not recoverable by the Service Provider under the VAT regulations applying to it.

The maximum amount payable to the Service Provider for expenses eligible for reimbursement is **EUR 25,000**.

9.4 Payment schedule and invoicing⁴

By derogation from the provisions of Article 8 of the General Terms and Conditions, the Contracting Authority will make payments to the Contractor in accordance with the following provisions:

- Interim payments after the receipt by the Contracting Authority of the corresponding invoice, subject to the receipt and approval by the Contracting Authority of the corresponding Quarterly Progress Report, and including the amounts related to:
 - Approved relevant deliverables (under Task 1, 2, 3, 4, 5 and 6) within the reporting period, and
 - Approved timesheets and proofs of expenses eligible for reimbursement (under Task 7) within the reporting period.
- Final payment after the receipt by the Contracting Authority of the corresponding invoice, subject to the receipt and approval by the Contracting Authority of the corresponding Final Report, and including the amounts related to:
 - Approved relevant deliverables (under Task 1, 2, 3, 4, 5 and 6) within the reporting period, and
 - Approved timesheets and proofs of expenses eligible for reimbursement (under Task 7) within the reporting period.

10. Monitoring and Evaluation

³ InforEuro exchange rate: https://ec.europa.eu/info/funding-tenders/procedures-guidelines-tenders/information-contractors-and-beneficiaries/exchange-rate-inforeuro_en

⁴ Payment is made, in principle **within a period of 30 days after the receipt of a correct invoice**. The invoice shall be submitted to: invoice@eib.org (with subject of the e-mail starting with the word: INVOICE) and to: cpcm-eu-disbursements@eib.org and the related Assignment Manager for validation and, after the validation, to: invoice@eib.org.

Definition of indicators

The EIB will monitor the performance of the Assignment as per requirements set in these Terms of Reference, including performance indicators in this chapter, and will keep records of the performance of the Services Provider and of its experts for its business use. EIB will also take note of potential feedback from PASSA Recipients on the performance of the team or of individual experts.

Furthermore, the EIB, via PAS ANDIS Team, will assess periodically, in a quantitative and qualitative manner, its overall level of satisfaction with the performance of the Services Provider (including by reference to its individual experts), against, minimally, the following criteria:

Criterion	Definition
Quality	Deliverables, outputs prepared by the Service Provider demonstrate advanced knowledge and experience on the subject matter along with very good understanding of the stakeholders' environment and require little or no revision following feedback from EIB or other Assignment stakeholders. If the case for revision, the EIB expects that its requests or comments formulated as part of the quality review process over deliverables and reports are completely, accurately and correctly treated by the Services Provider in the next version. Failure to comply with this rule (i.e. having to submit several versions of the same deliverable or report before the EIB is able to assess that its initial requests or comments have been treated in an acceptable manner) may be considered by the EIB as poor performance of the Assignment and may trigger contractual remedy mechanisms as those described under letter e), letter f) or similar as foreseen in the contract.
Timing	Activities are always performed on time and deliverables are always presented as per the deadlines agreed, unless objective situations, outside of the control or influence of the Service Provider, justify delays.
Team mobilization	The Services Provider should make sure experts fulfil their role as per these Terms of References and are visibly active during the implementation in interactions with the PASSA Recipients (perform presentations, present solutions / deliverables), act as owners of their workstream and commit the necessary time to fulfil their responsibilities successfully. If during the implementation of the Assignment and/or Task Orders within this Assignment, the EIB considers that an expert is unable to meet the level of quality required for delivering his/her assigned activities, to fulfil his/her tasks or to demonstrate the competencies, skills, behavior required by the role, the Service Provider will provide, at no additional cost to the EIB, immediate additional support for the activities and deliverables to meet the appropriate standards (while this does not exclude an obligation to replace altogether the respective expert with another proposed one, if so instructed by the EIB) or take other management actions, if so agreed by the EIB. In such circumstances, following the notification from the EIB PASSA Team Leader, the Services Provider will submit in maximum 2-4 working days (depending on the urgency for the Assignment) a detailed, well justified, relevant proposal for a plan to address the performance of the expert, to rapidly remedy the quality of project implementation and to recover any delays generated by the expert suboptimal performance. The EIB will review the plan and provide feedback, as appropriately. This performance mechanism applies also in case several experts are considered by the EIB to be in the above-

Criterion	Definition
	described situation or the whole team as such. Should the EIB require the replacement of an expert, the Services Provider will take the necessary steps to propose a replacement solution to the EIB within maximum 10 working days – meanwhile, the Services Provider will take appropriate measures to ensure continuity of activities within the Assignment and/or the requests for services within this Assignment.
Backstopping	While backstopping staff will be designated by the Services Provider, the latter is expected to act at all times in a professional manner, producing accurate and complete outputs within the scope of the Assignment and serving diligently the objectives and general activities set-out in these Terms of References.
Reporting obligations	Reports describing the activities performed and the financial situation are delivered on time, are clear and accurate.

11. Technical Annex

This technical annex objective is to serve for the Service Provider as a technical guidance for the preparation of the technical workshop under Deliverable 5.4. The Service Provider shall perform its own detailed technical research and study on the below topics and present its findings and recommendations in the technical workshop.

The day care and day surgery care payment model

One of the key elements of the new REHs operational models is to shift the service profile from heavily relying on inpatient care to more day care and day surgery. Such shift is also one of the identified objectives of the National Health Strategy 2023-2030. The Service Provider will explore the Romanian legal definitions of ambulatory care, day care, day surgery and short-term care. Shifting care patterns from inpatient care to day care and/or ambulatory care and the development and integration of day care and ambulatory care into the regional healthcare networks are goals mentioned in other several MoH strategic documents, such as the Regional Health Services Master Plans 2021-2027 for NE, NW and SW regions, as well as in the feasibility studies of Iasi, Cluj and Craiova REHs.

Several regulatory acts⁵ present such definitions at least for hospital day care and ambulatory care, as well as the rules under which payments are made to healthcare providers under the National Health Insurance House Framework Contract⁶ (NHIH-FC). It must be noted that even if the current Romanian definition of hospital day care provides that this type of healthcare service has a “maximum length of 12 hours / visit (day)”, the actual rules which are set by the NHIH-FC allow for reimbursements to be made under the label of hospital day care even for services which should be included under outpatient care.

The Service Provider must identify inconsistencies and study how the current Romanian regulations can be aligned with internationally accepted definitions for the following concepts:

- ambulatory care,
- day care (including day care surgery, oncological care and dialysis services),
- extended recovery (or overnight stay),
- short stay (or short-term care)
- intermediary care / post acute care

⁵ For details, see Ministry of Health Order no. 914/2006, especially annex 3.

⁶ For details, see the Ministry of Health and National Health Insurance House Order no. 1068/627/2021 for the implementation of the Government Decision no. 696/2021, especially annex 22 and annex 23.

- recovery, respiratory care.

The international organisations which provide specialized publications on this topic are the World Health Organisation, the International Association for Ambulatory Surgery, the European Observatory on Health Systems and Policies and OECD, but the Service Provider should perform research also into similar documents elaborated by other internationally recognized organisations.

The Service Provider shall study the NHIH-FC list of procedures with tariffs for day care and day care surgery focusing on the following elements:

- Identify the strengths and weaknesses of the current system, as well as opportunities for improvement so that the following objectives will be promoted: incentivizing day care and ambulatory care, increasing the practical use of clinical pathways, accounting for new advanced technologies used for diagnosis and treatment in a complex emergency tertiary care hospital
- Identification of examples of day care surgery procedures and ICD-10/11 codes suited for day care reimbursement which could be added to the NHIH-FC (by referencing to specialized international or European documents like the British Association of Day Surgery Directory of Procedures 6th Edition or most recent systematic reviews published in an ISI indexed international medical scientific journal) with a positive impact on the REHs financing/budgeting model and in correlation with REHs staff availability and training plan.

The ambulatory payment model

Ambulatory care is provided as an integrated service by the healthcare providers and the contracting rules are regulated by the NHIH-FC. Currently, there are no specific DRGs for ambulatory care, the payment method being a point-based one with a cap on the maximum number of consultations which can be provided. The Service provider shall study if the current list of ambulatory services which can be reimbursed to a healthcare provider are appropriate for the REHs care profile and financing model. Currently, the list is organized in various categories, each with a fix allocated number of 'reimbursement points': diagnostic procedures of simple, medium, high or very high complexity, simple or complex therapeutic procedures/surgical interventions, therapeutic procedures/medical treatments of simple, average or high complexity, orthopaedic procedures, psychiatric therapies and medical genetics therapies. The Service Provider shall study potential solutions to improve the payment model for ambulatory care. Such solutions may include: expansion of the list of ambulatory services with new procedures; introduction of differentiated payment for repeat visits; opportunity of the introduction of DRG-like ambulatory care groups; transferrability of the methodologies used in other EU countries for calculating tariffs for ambulatory care; etc.

The DRG payment model

The future REHs will be the main providers of tertiary care at regional level with a significant focus on treating complex cases which usually require high-intensity care and use of advanced medical technologies. The Service Provider shall study if the current Romanian case-based payment mechanism for hospitals accounts for the REHs specific profile. If the case, the Service Provider shall study transition options to update the DRG model so that it will be appropriate for the REHs mix of healthcare services.

The future REHs will be at the top of the pyramid of healthcare services in each region, thus providing care for highly complex cases which are resource intensive and with an average length of stay difficult to forecast, especially during the first years of operationalisation. Evidence-based practice (EBP) is essential for ensuring high-quality patient care, operational efficiency, and optimal health outcomes. The incorporation of interdepartmental collaboration and promoting standardized practices – guidelines and clinical protocols for patient care will be used to improve patients' outcomes and ensure a standardization of practices. The Service Provider shall also study if the use of the 'k coefficient' (in Romanian, 'coeficientul K al cazurilor extreme'⁷) used to account for the financial impact of outlier cases in the NHIH-FC is appropriate for the future REHs payment model and, if considered necessary, may propose an updated integration of this coefficient in the payment model.

The Service Provider shall study if the current Romanian adjustment method used to stratify hospital payments according to their competence level is appropriate for the future REH financing model. Currently, the reference index ('p' value) for category I hospitals (the highest level of competence) is set at 0.85 which adjusts the final amount contracted by category I hospitals with the NHIH.

The current DRG-based hospital payment mechanism in Romania do not account for the introduction of technological innovation and may disincentivise the introduction of innovative technologies. The Service Provider should study the feasibility of "top-up" payments for innovation, teaching, and research, as used in France and other modern healthcare systems.

The base rate used in Romania for monetary conversion of the DRG relative weights is called "weighted case rate" (the acronym used in Romanian is "TCP – tarif pe caz ponderat"). The Service Provider should study if the current methodology⁸ used to calculate the "weighted case rate" is fitted for the future REH financing model and, if necessary, should propose recommendations for improvements.

It is important that REH benefits from a realistic reimbursement rate for the services it will provide, given that it is the most developed and complex provider of medical services in the region.

The service provider will follow up and update its proposal with the regulations adopted by the Ministry of Health and the National Health Insurance House.

⁷ See MoH Order 587 / 30 April 2013

⁸ Regulations referring to this are provided by the MoH Order 862/2011, MoH Order 423/2013 and the most recent version of NHIH-FC.

The ER payment model

The Hospital Emergency department (abbreviated in Romanian as 'UPU') will provide a significant segment of the future REHs activities. The current payment model for UPU in Romanian public hospitals involves two options: financing directly from the MoH budget or financing through the NHIH-FC. The two options are currently mutually exclusive. If the UPU is financed from the MoH budget, the amount of funds earmarked is based on 12 criteria, among which the hospital's level of competence, historic criteria related to the number of cases treated and the related quantities of pharmaceuticals and other medical equipment needed, and the salary level of UPU personnel. If the UPU is financed through the NHIH-FC, there is a maximum cap per patient which can be reimbursed, regardless of how complex and/or intense the required treatment was. A special tariff for high tech imagistic services is reimbursed. The Service Provider must study if the current system is appropriate for the REHs profile and provide potential recommendations for improvement.