RFP/2021/018 – FOR THE ESTABLISHMENT OF
FRAME AGREEMENT(S)
FOR THE PROVISION OF

# Third Part Administrator (TPA) Service for secondary and tertiary Health Care to refugees in Lebanon

## Annex A: Terms of Reference (TOR)

Lebanon
May 2021

# Contents

List of abbreviations

| | |
|---|---|
| MoPH | Ministry of Public Health |
| NICU | Neonatal Intensive Care Unit |
| SGBV | Sexual and gender-based violence |
| PO | Purchase Order |
| POC | Persons of Concern to UNHCR |
| RFP | Request for Proposal |
| SOP | Standard Operating Procedures |
| SR | Registered Syrian Refugees |
| ToR | Terms of Reference |
| TPA | Third Party Administrator |

# 1. Background

## 1.1. Demographics of Refugees in Lebanon

As of March 2021, Lebanon remains the country in the world hosting the largest number of refugees per capita, having 855,172 Syrian Refugees (SR) or 191,512 Households (HH) registered with the UNHCR. About 23% of SR are residing in Beirut & Mt Lebanon, 27% in North, 39% in Bekaa and nearly 11% in South Governorates.1 More than half of the Refugees (54%) are below 18 years of age. Senior age population (60 years and above) forms 2% of the total registered SR. The share of women is 52%. The average household (HH) size made up 4.5 members in the registration database.

There are also 14,819 non-Syrian refugees registered with UNHCR. They are mainly from Iraq, Iran, Algeria, Bangladesh, Ethiopia, India, Jordan, Libya, Pakistan, Philippines, Sudan, Turkey, and Yemen. Most of them reside in Beirut-Mount Lebanon.

There are also a sizeable number of individuals residing in Lebanon theoretically eligible for UNHCR support but not (yet) known to UNHCR. Estimates on the size of this population is in the range of a few hundred thousands.

## 1.2. Health situation of Refugees in Lebanon

According to the 2020 Vulnerability Assessment of Syrian Refugees (VASyR)[2] 57% of households needed primary health care services during the 6 months preceding the Survey and 16% needed hospital care services during the same period.

The UNHCR referral care programme[3] supported during 2020 60,193 episodes of hospital care to in total 56,464 beneficiaries. The main reasons for care were pregnancy and childbirth (61.7%) and perinatal conditions (7.5%). Other important reasons include gastrointestinal and respiratory infections, injuries and conditions of the gastrointestinal system.

The programme supported 36,199 hospital deliveries whereof 32% needed cesarean section. According to the annual Health Access and Utilization Survey (HAUS)[4] 2020, 86% of delivered women had received antenatal care. 61% had had 4 visits or more.

Also, according to HAUS, 10% of the registered refugees had at least one chronic disorder and 41% of households had at least one member with a chronic disorder, the most

[1] Available from: https://data2.unhcr.org/en/situations/syria/location/71.
[2] Available from: https://data2.unhcr.org/en/documents/details/85002
[3] Available from: https://data2.unhcr.org/en/documents/details/86340
[4] Available from: https://data2.unhcr.org/en/documents/details/86346

common conditions being: Hypertension, diabetes, asthma/pulmonary disorders and heart-disease.

## 2. UNHCR Referral Care Programme

UNHCR is the main actor supporting hospital care for refugees in Lebanon. It does so through its referral care programme that has been running since the beginning of the Syrian crisis.

The programme covers anyone residing in Lebanon who is recognized by UNHCR as a Person of Concern (PoC) and needs hospital care for the following reasons:

- Deliveries
- Urgent potentially life-threatening conditions
- Urgent conditions that might lead to severe permanent disability

Health care provided to a PoC within a network of UNHCR-selected governmental and private hospitals (currently 35 in total) is supported through a cost-sharing scheme in which UNHCR cover 75% of costs exceeding 100 USD and 100% of costs exceeding 2900 USD (when the patient share has reached 800 USD). Deliveries are covered according to fixed rates, USD 150-175 for natural births and USD 225-250 for C-sections, depending on the MOPH classification of the hospital. A ceiling is set at 15,000 USD for neonatal and burns intensive care and 10,000 for other types of care. Costs above this amount are not covered by the programme.

In 2019 and 2020, the UNHCR expenses for hospital care were 35 million USD per year, it is projected that the cost will be approximately 30 millions in 2021.

## 3. Role of the Third-Party Administrator

### 3.1. Summary

The role of the Third-Party Administrator (TPA) is to ensure that UNHCR persons of concern are benefitting from the referral care programme in accordance with the UNHCR Guidelines for Referral Health Care in Lebanon, Standard Operating Procedures[5]. In doing so, UNHCR is expecting that the TPA does not only consider itself as a deliverer of a service but as a partner to UNHCR, sharing its objectives of protecting and assisting the persons of concern who are the ultimate clients.

[5] https://data2.unhcr.org/fr/documents/details/79080

## 3.2. List of Services and Deliverables

This list is supposed to be read together with the UNHCR Guidelines for Referral Health Care in Lebanon. The TPA might need to perform services not listed below if needed for the guidelines to be followed.

## 3.3. Representation

3.3.1. The TPA should appoint a dedicated manager to ensure timely communication and coordination between UNHCR and the TPA.

3.3.2. Ensure medical delegate presence in all hospitals included in the network, according to hospital admission load. There should be at least 1 full-time (Mon-Fri 8.00-16:00, Sat 8:00-12:00) delegate per facility with an average of 200 monthly admissions. For hospitals with less than 200 admissions/month delegates should be physically present at least half time, the following number of days per week depending on number of admissions:

- 100-200 admissions per month = every working day of the week;
- 50-99 admissions per month = at least 3 days per week;
- 20-49 admissions per month = at least 2 days per week;
- <20 admissions per month = at least 1 day per week

Assuming an average of 5000 admissions per month in the present hospital network, a safe estimate for number of needed full-time delegates is around 25.

3.3.3. The admission rates in the network hospitals should be analyzed on quarterly basis and the delegate's distribution to be adjusted accordingly. The TPA should share the delegate's schedule with UNHCR on a monthly basis with contact details for all the delegates. In addition, the TPA should establish an internal monitoring system to ensure that delegates are present in the hospitals according to the schedule outlined above.

3.3.4. Ensure a call center available 24/7 to answer calls from UNHCR, partners and PoCs. The call center should be able to guide PoCs to suitable health care providers and provide approvals to health care providers whenever a delegate is not physically present in a hospital. Call center key performance indicators should be monitored according to the monitoring and evaluation framework in the Guidelines for Referral Health Care in Lebanon.

3.3.5. Ensure strong supervision and support system of delegates including key medical specialists contactable for support in decision making (to include at

least pediatrician/neonatologist, obstetrician, general physician, general surgeon).

3.3.6. Establish a complaints mechanism where refugee's complaints related to TPA staff behavior and performance can be received in a confidential manner and dealt with. UNHCR should be kept informed of complaints received. Complaints about the programme itself (coverage levels etc) or hospital performance should be referred to appropriate mechanisms.

3.3.7. Establish a mechanism for investigation of allegations of fraud, conflict of interest or inappropriate behavior of TPA staff in relation to the UNHCR programme. The TPA to share reports of such investigations with findings and mitigating actions.

3.3.8. A mechanism for investigation of allegations of fraud, mistreatment of beneficiaries or medical negligence by contracted health care providers. The TPA to share reports of such investigations with findings and mitigating actions taken.

3.3.9. Co-convene (with UNHCR) quarterly meetings centrally and in each region with partners to exchange information on challenges, outcomes and any changes in the process that affect referral from PHCs or care in hospitals.

3.3.10. The TPA should provide UNHCR with all necessary documents about its staff (job descriptions), hierarchical structure (organigrams) and processes (SOPs) for the different departments and units involved in the UNHCR programme.

## 3.4. Health Care Providers

3.4.1. The TPA to make contact with health care providers selected by UNHCR (this is mostly hospitals but occasionally other providers such as forensic doctors, labs) and offer them a contract when applicable.

3.4.2. Amend the contracts with the health care providers to include coverage of UNHCR PoCs. Negotiate to amend rates based on the Ministry of Public Health flat rates. UNHCR has the final decision to any amendments made to the contracts.

3.4.3. To actively liaise and work with health care providers and UNHCR to find solutions to issues resulting from any devaluation of the currency in the market.

3.4.4. To maintain a dialogue with contracted health care providers and continuously answer to queries regarding contract issues and payment of

claims. The TPA should always be the main interlocutor with the contracted providers, only exceptionally should the TPA refer to UNHCR to answer the providers' queries.

3.4.5. To inform UNHCR of medical quality concerns in any contracted hospital and provide, if appropriate, recommendations to the hospital. Assist UNHCR in conducting investigations of suspected cases of medical negligence or mistreatment of beneficiaries. In case of conflict between a hospital and a beneficiary (e.g. about payment), to act as a mediator and assist UNHCR field office staff to find solutions.

3.4.6. If agreed upon with UNHCR, issue official warnings and take appropriate measures against poorly performing hospitals (found to be overcharging patients and not following the contracted rates, detaining patients illegally, turning patients away despite having the capacity to admit, mismanagement of cases, etc.). Suspension of contract with such hospitals may be considered.

3.4.7. If agreed upon with UNHCR, issue official warnings and take appropriate measures against poorly performing individual physicians (found to charge beneficiaries extra fees, provide false information to the TPA about beneficiaries' condition to influence decision on coverage or to be medically negligent). Refusal to cover cases treated by such a physician might be considered.

3.4.8. The TPA must disclose to UNHCR or to its designated third party auditing firm, in a fully transparent way, all financial arrangements and agreements between the health care providers and the TPA that are directly or indirectly related to the UNHCR programme. No transactions, discounts or remuneration related to the UNHCR programme should take place between the TPA and the health care provider without UNHCR's knowledge.

## 3.5. Training

3.5.1. In collaboration with UNHCR, ensure that TPA newly recruited staff for the programme are provided with sufficient training prior to work assignment. Staff should receive periodic training on UNHCR code of conduct (CoC) and sign CoC. They should also be trained on UNHCR guidelines and SOPs developed.

3.5.2. In collaboration with UNHCR ensure that TPA staff receive periodic training on counselling for medical delegate staff to improve ability to communicate

complex medical rejection criteria and deal with frustrations and negative reactions to rejection of coverage.

## 3.6. Guidance for beneficiaries in need of treatment

3.6.1. The TPA to guide beneficiaries in need of treatment to an appropriate health care provider (that provides the required services and has available beds).

3.6.2. If not in need of hospital care, to inform beneficiary of available primary health care services.

3.6.3. Refer cases to UNHCR who might have difficulties with payment of deposits or who need other assistance outside of TPA responsibility.

## 3.7. Validate entitlement

3.7.1. Ascertain whether a person who seeks support from the programme is entitled to such support (i.e. UNHCR person of concern) as per UNHCR referral care guidelines.

## 3.8. Pre-treatment approval

3.8.1. Pre-approve treatment and medical procedures before commencement of treatment according to UNHCR referral care guidelines. When a medical delegate is physically present in a hospital, pre-approval is done by him/her, but in the delegate's absence it should be done by the call-center.

3.8.2. For cases that do not require UNHCR notification, the time should not exceed 2 hours between the TPA receiving the request for coverage from the hospital and approval/rejection decision is taken and shared. The TPA should establish a system to reliably measure turnaround time for those cases. Pre-approval should be carried out at all hours, all days of the week. For cases do require UNHCR notification, the time should not exceed 48 hours between the TPA receiving the request for coverage from hospital and approval/rejection decision.

3.8.3. To notify UNHCR if the total cost of the treatment (beneficiary and payer's share together) is expected to reach $2,900 or more for one case, or when otherwise indicated in the guidelines.

3.8.4. In case of denied coverage, delegates should deliver the decision in a sensitive way to minimize distress. When necessary to provide basic counselling to the beneficiary.

3.8.5. To timely notify UNHCR when cases are denied coverage at delegate level

## 3.9. Hospital admission

3.9.1. For cases where bed space or service is not available in one hospital, facilitate admission to nearest suitable alternative contracted hospital. This includes identifying where there are available beds and assisting in finding transport (LRC ambulance).

3.9.2. Follow-up on patients during admission through regular visits, approve/reject if new interventions or extended hospital stay is proposed by the hospital and seek UNHCR pre-approval when indicated.

3.9.3. Document patient visits through brief notes attached to the medical file.

3.9.4. Ensure treating physicians adhere to approved treatment protocols and UNHCR SOPs; choose conservative, least expensive, evidence based and effective treatment procedures.

3.9.5. The TPA to inform UNHCR of notifiable diseases, nosocomial infections and other hospital caused complications and maternal deaths among the admitted refugee population.

## 3.10. Exceptional care committee (ECC)

3.10.1. Refer exceptional cases as per UNHCR SOPs in writing to UNHCR. This includes both cases to be considered for treatment within the programme as well as cases to be considered for resettlement on medical grounds

3.10.2. Send a medical doctor and the relevant senior medical delegate to each ECC meeting to discuss medical cases

3.10.3. Assist in communicating with treating physicians if unclarities in relation to diagnoses and requested interventions

3.10.4. Assist in identifying health care providers where interventions and investigations can be carried out for this complicated patient group

3.10.5. Provide regular updates to UNHCR on ECC approved cases (extension of stay or discharge documents including estimated costs).

## 3.11. Vulnerable groups

3.11.1. To be particularly vigilant regarding vulnerable groups and notify UNHCR whenever it can be suspected that a beneficiary is a survivor of SGBV, torture or other mistreatment. Also, to notify cases of severe malnutrition and mental disorders.

## 3.12. Audit of hospital bills

3.12.1. Audit medical bills and ensure accurate billing of medical procedures, consultation, supplies, and that consumables are properly itemized and charged.

3.12.2. Implement the agreed upon flat rates on the TPA auditing system, including surgical codes.

3.12.3. In addition to UNHCR internal controls, UNHCR may assign third party auditing firms to audit TPA Programme and the prospective TPA shall provide the necessary cooperation and assistance in completion of such exercise.

## 3.13. Further processing of hospital bills

3.13.1. TPA should offer flexible financial transactions with hospitals and other service providers, using either USD or LL (local currency) exchangeable to maximize benefits for UNHCR and service providers. The TPA should have agreements with banks and other financial institutions to facilitate this provision.

3.13.2. Each week the TPA will submit to UNHCR a dossier of bills that have been processed during the preceding 7 days. No more than 45 days should pass between the bill has been received by the TPA until it is delivered to UNHCR, unless the bills miss supporting documentation.

3.13.3. The TPA will act as a remitting agent to transfer the due payments to its contracted hospitals for the hospitalization cost of the refugees. The TPA agrees to act as UNHCR remitting agents to transfer the money to its contracted hospitals without any extra cost to UNHCR or hospitals. The remittance from the TPA to its contracted hospitals should not exceed 3 working days upon receipt of funds from UNHCR.

3.13.4. To provide proof of transfer to hospitals and receipt of the same on a regular basis. The TPA is to submit proof of payment to hospitals for each and every invoice submitted to and paid by UNHCR.

3.13.5. The TPA to ensure that hospitals do not overcharge the patient (if found otherwise, the TPA is to obtain reimbursement for the patient or deduct from UNHCR contribution to hospital). The TPA should also ensure that hospital provision of treatments, interventions and investigations not approved for coverage by UNHCR is done fairly and with the beneficiary's consent. The TPA should ensure that a copy of the receipt of the refugee contribution to both covered and non-covered services is attached with the supporting documentation for each claim presented to UNHCR

3.13.6. Ensure that specialized consultants (such as forensic doctors in cases of sexual and gender-based violence) are paid by the hospital and bills are settled via the TPA.

3.13.7. Present invoices disaggregated by hospital, by month and by year. Presentation of original claims to UNHCR along the same disaggregation

3.13.8. The TPA should encourage hospitals to submit bills within one month after client discharge, send reminders when applicable, and inform hospitals that delayed submitted bills are subject to payment rejection.

## 3.14. Monitoring and reporting

3.14.1. To maintain an overview on available bed capacity at key hospitals and ensure that TPA delegates are aware of where to orient patients

3.14.2. Monitor and update UNHCR on services available in each hospital as the situation changes

3.14.3. To maintain a live updated database that captures the essential information to monitor the programme according to the monitoring and evaluation framework in the Guidelines for Referral Health Care in Lebanon. TPA database should respect strict confidentiality of PoC data with no third party access

3.14.4. Provide UNHCR continuous access to the above database

3.14.5. Provide quarterly reports summarizing findings from the TPA's monitoring of health care providers and actions taken.

3.14.6. Provide detailed Monthly, biannual; and annual referral care report as per sample provided by UNHCR.

3.14.7. The TPA expected to report individual neonatal mortalities to activate on timely manner the mortality audit

# 4. Role of UNHCR

## 4.1. General

4.1.1. To create and update essential strategy and procedural documents such as the Guidelines for Referral Health Care in Lebanon and share these with the TPA as updates and amendments are done.

4.1.2. To provide timely updates to the TPA on changing situation in terms of fluctuations in the refugee population, epidemic developments etc

## 4.2. Health care providers

4.2.1. To select hospitals to be included in the hospital network in which PoCs can receive care.

4.2.2. To monitor hospital performance through exit interviews with beneficiaries and visits and share the results with the TPA

4.2.3. To review and adjust the hospital network at least twice a year depending on the development of the situation, PoC needs and hospital performance

## 4.3. Training

4.3.1. To assist the TPA in training of their staff so that the content of strategy and processes is well understood.

## 4.4. Guidance of beneficiaries/pre-approval/admission procedures

4.4.1. To communicate with and inform PoCs about the existence of the referral care programme, to update them about changes in the hospital network and provide information how to reach the TPA

4.4.2. To guide PoCs to other supporting mechanisms available through UNHCR or partners such as cash-assistance, etc.

4.4.3. To provide timely response when PoCs are referred from the TPA for confirmation of eligibility for support.

4.4.4. To provide timely response when PoCs are referred from the TPA for confirmation of whether requested interventions/investigations/extension of length of stay should be covered by the programme or not.

4.4.5. To compile cases for the bi-monthly ECC meeting, to chair the meetings and present the cases

## 4.5. Processing of hospital bills

UNHCR will transfer to the TPA the amount due to the respective hospitals within 45 days from the submission of the audited bills by the TPA. UNHCR's payments to the TPA shall be made only for the hospital bills audited by the TPA.