

REQUEST FOR PROPOSALS
Advanced Primary Care Administrator
Purchaser Business Group on Health (PBGH)

Issued September 28, 2026

Proposals due October 23, 2026

1. RFP Overview

PBGH is seeking an administrative partner to operationalize a purchaser-designed Advanced Primary Care (APC) network. PBGH will establish the network strategy, partner with an administrative partner to identify and certify eligible clinics through the PBGH Care Excellence Program, define quality and service expectations, and enter into a master services agreement that outlines key terms for both the work of the administrative partner as well as key terms expected to be included in any contract between the administrative partner and advanced primary care clinic partners. Participating employers will sign a joinder and take on terms in the MSA in their contract with the administrative partner. The selected respondent will administer this structure consistently across employers and markets.

This procurement is not for a respondent-owned clinical model or a conventional claims-processing arrangement. The commercial structure is expected to use a per user per month (PUPM), otherwise also known as per engaged member per month, fee. Responses should therefore focus on eligibility, PUPM billing and reconciliation, provider payment administration, data exchange, reporting, contracting support, member and employer service, and accountable execution.

1.1 Objectives

Create a scalable, multi-market administrative platform for a customized network of in-person clinics that meet Care Excellence Program standards, along with virtual solutions to help expand access in the clinics and nationally.

Administer employer and practice eligibility, PUPM billing, payment, reconciliation, and performance guarantees (including any clawbacks) accurately at employer, market, clinic, and member levels.

Provide timely, usable data to employers, PBGH, the Care Excellence Program, practices, and designated partners.

Embed PBGH quality measures, standards of service, and performance guarantees as enforceable contractual obligations.

Maintain transparent pricing and disclose all direct and indirect revenue associated with the arrangement.

1.2 Proposed Contracting Structure

The anticipated structure includes:

A PBGH master services agreement with the selected administrative partner.

Employer-level participation agreements or joinders using a common set of terms.

PBGH-defined Care Excellence standards, quality measures, performance guarantees, pricing methodology, and other provisions incorporated into the master agreement.

Clinic and vendor agreements administered or supported by the administrative partner, using contracting requirements established by PBGH.

The ability to add employers, clinics, virtual partners, supporting vendors, and markets without renegotiating the core employer contract.

2. Procurement Instructions

2.1 Response Principles

Answer every question in sequence and repeat the question before the response.

Distinguish capabilities that are currently in production from configurable capabilities and future development.

Identify every assumption, dependency, limitation, required bundled service, subcontractor, and incremental fee.

Use “not available” where a capability cannot be provided. Roadmaps should not be presented as current capability.

Provide supporting examples, sample reports, file layouts, contract language, and client references where requested.

2.2 Capability Status

Status	Definition	Implementation effort	Incremental fee
Live	In production for current clients	None or standard configuration	State amount
Configurable	Available using existing functionality	Describe configuration and timing	State amount
Development required	Not currently available	Describe development, dependencies, and timing	State amount

Status	Definition	Implementation effort	Incremental fee
Not available	Respondent cannot support	Not applicable	Not applicable

3. Baseline Requirements (Pass / Fail)

Confirm each requirement and explain any qualification. A qualified response may be treated as a “No.”

ID	Requirement	Yes / No	Qualification or reference
B1	Accept the overall contracting structure, including a PBGH master services agreement and employer-level participation agreements or joinders.		
B2	Administer PBGH-defined Care Excellence certification and contracting criteria without imposing a conflicting APC standard.		
B3	Administer a PUPM eligibility, billing, provider payment, reconciliation, and performance guarantees at employer and market levels.		
B4	Support contracts with independent in-		

ID	Requirement	Yes / No	Qualification or reference
	person APC practices, virtual solutions, and other designated third-party partners.		
B5	Provide employer, PBGH, Care Excellence Program, and practice reporting in agreed formats and on agreed schedules.		
B6	Disclose all direct and indirect compensation and permit meaningful audit rights.		
B7	Place an agreed portion of administrative fees at risk against implementation, service, data, and operational guarantees.		
B8	Meet applicable licensing, privacy, security, financial, and regulatory requirements in every service market.		
B9	Permit PBGH to add employers, markets, contracted clinics, and virtual primary care solutions under		

ID	Requirement	Yes / No	Qualification or reference
	the master structure without executing a new core agreement for each expansion.		
B10	Acknowledge that the employer owns its eligibility, utilization, payment, and related plan data and may direct delivery to PBGH and designated partners.		

4. Proposal Questionnaire

The questionnaire is organized into seven response domains. Respondents must address each question and the accompanying response guidance.

Domain 1: Network and Contracting Capability

1.1 Describe your acceptance of the proposed PBGH contracting structure and identify any required changes to the master services agreement, participation agreement, clinic agreement, or joinder approach.

Response guidance: *Provide a marked list of required provisions and distinguish legal requirements from business preferences.*

1.2 Describe your current ability to contract with and administer independent in-person APC practices, virtual practices, and supporting other third party solutions selected by PBGH.

Response guidance: *Include examples, markets, contract types, and whether PBGH may prescribe material contracting terms.*

1.3 Describe how clinic PUPM rates and service requirements would be established, amended, and communicated.

Response guidance: *Address market-specific, clinic-specific, and risk-tiered rates.*

1.4 Identify any proprietary network, exclusivity, all-products, anti-tiering, anti-steering, most-favored-nation, or other restrictions that could interfere with the PBGH network.

Response guidance: *Respond by target market and contract type.*

1.5 Describe credentialing, contracting, loading, and directory, workflows for clinics certified by the PBGH Care Excellence Program.

Response guidance: State whether you will accept PBGH certification as the APC qualification gate and identify any legally required additional checks.

1.6 Describe how you would administer referrals or connections from APC clinics to employer-required partners (such as point solutions and Centers of Excellence programs) without displacing the longitudinal primary care relationship.

Response guidance: Include closed-loop information exchange where available.

1.7 Disclose all subcontractors, network partners, or affiliates that would perform a material part of contracting or network administration.

Response guidance: Describe function, fees, data access, oversight, and replacement rights.

Domain 2: Eligibility, Billing and Payment Operations

2.1 Describe your end-to-end eligibility intake process for each employer.

Response guidance: Include file standards, cadence, validation, error handling, retroactivity, dependent status, effective dates, and employer reporting.

2.2 Describe how you will determine the billable eligible population for PUPM charges.

Response guidance: Address partial months, retroactive additions and terminations, duplicate coverage, leaves, COBRA, newborns, and eligibility corrections.

2.3 Describe PUPM invoicing at employer, market, clinic, and membership-segment levels.

Response guidance: Provide a sample invoice and explain supporting detail and controls.

2.4 Describe provider payment operations for PUPM payments.

Response guidance: Include payment schedule, remittance detail, banking controls, failed payments, tax reporting, and payment-status visibility.

2.5 Describe reconciliation and true-up processes between eligibility, employer invoices, and clinic payments.

Response guidance: Specify frequency, lookback period, thresholds, tolerances, dispute windows, and aging reports.

2.6 Describe your ability to administer clawbacks and credits.

Response guidance: Address retroactive eligibility changes, overpayments, underpayments, clinic termination, disenrollment criteria, nonperformance, duplicate payment, and contractual offsets.

2.7 Explain how you prevent an individual from generating duplicate PUPM payments across clinics, employers, or overlapping APC arrangements.

Response guidance: Describe match logic, exception workflows, and audit reporting.

2.8 Describe how you would administer member choice, member migration between clinic options, clinic selection, and assignment for payment purposes.

Response guidance: Include default assignment, opt-in or opt-out models, changes during a month, and effective dating.

2.9 Describe financial controls, segregation of duties, payment authorization, fraud monitoring, and audit trails supporting PUPM administration.

Response guidance: Include relevant assurance reports and control testing.

2.10 Provide current performance results for eligibility accuracy, invoice accuracy, provider payment accuracy, reconciliation timeliness, and issue resolution.

Response guidance: Define numerator, denominator, measurement period, and whether results are audited.

2.11 Describe all fees triggered by eligibility changes, invoice adjustments, payment transactions, reconciliations, payment corrections, or custom configurations.

Response guidance: Cross-reference the pricing exhibit.

2.12 How do you currently deal with employers who have a High Deductible Health Plan and administering the PUPM fee in this context?

Response guidance: Describe how you track first dollar coverage.

Domain 3: Data and Reporting

3.1 Confirm employer ownership and portability of eligibility, utilization, payment, clinic, performance, and member-service data.

Response guidance: Identify any data element, derived field, or report you consider proprietary.

3.2 Provide a data inventory and proposed data-flow diagram for employers, PBGH, the Care Excellence Program, APC clinics, and designated partners.

Response guidance: Include description of system use and access controls, source, recipient, format, cadence, lag, transmission method, and accountable owner.

3.3 Describe standard eligibility, payment, attribution, encounter, utilization, access, quality, and member-experience reporting.

Response guidance: Attach samples and data dictionaries.

3.4 Describe your ability to ingest encounter, clinical, access, quality, and patient-reported information from clinics and virtual APC partners.

Response guidance: Include supported standards, validation, identity matching, rejection handling, and data-use rules.

3.5 Describe reporting to the PBGH Care Excellence Program for certification monitoring and performance guarantees.

Response guidance: Include clinic-level and aggregate reporting, cadence, correction cycles, and historical restatement.

3.6 Describe employer-level and coalition-level dashboards and downloadable files.

Response guidance: Explain suppression, aggregation, benchmarking, role-based access, and drill-down capability.

3.7 State standard and maximum data lag for each material feed and report.

Response guidance: Provide current production performance and proposed service levels for employer requested reporting (like those listed in questions above) and whether they can be done real time or near time.

3.8 Describe privacy, security, business continuity, incident/breach response, retention, deletion, and subcontractor controls.

Response guidance: Attach relevant independent assurance reports and recent test summaries. Include confidentiality clauses and data use agreements in contracts for employers, APC clinic partners, and any other partners.

3.9 List every fee for standard reports, dashboards, extracts, APIs, custom files, historical restatements, third-party feeds, or data transmission.

Response guidance: Cross-reference the pricing exhibit.

3.10 Describe data-quality governance and escalation.

Response guidance: Include completeness checks, reconciliation controls, issue severity, root-cause analysis, correction timing, and notification obligations. Include any external data security certifications received (such as HITRUST)

Domain 4: Quality and Care Excellence Alignment

4.1 Confirm that PBGH Care Excellence certification will serve as the APC network qualification standard.

Response guidance: Identify only legally required or safety-related checks that would remain.

4.2 Describe how PBGH quality measures, access standards, and standards of service will be incorporated into clinic and administrative contracts.

Response guidance: Provide sample contractual language.

4.3 Describe your ability to administer clinic-level and aggregate performance guarantees.

Response guidance: Address measurement, baseline, monitoring progress towards targets, exclusions, data sources, validation, dispute resolution, payment or clawback, and reporting.

4.4 Describe your process for implementing annual changes to Care Excellence criteria or measure specifications.

Response guidance: Include configuration, contracting, testing, communication, and effective dates.

4.5 Explain how you will identify and manage clinics that do not meet certification, access, data, or service obligations.

Response guidance: Describe corrective action, probation, member continuity, termination, and replacement.

4.6 Describe how member experience, access, continuity, and care coordination will be measured for both APC clinic partners and your organization as the administrator.

Response guidance: Describe how you validate results (identify what is self-reported by the APC clinic vs validated using external sources or primary data collection. Include survey administration, response-rate management, reporting level, and action planning for results reflecting experience with the APC clinic as well as the administrative partner.

4.7 Describe how you would support PBGH or its designee in independent validation of performance.

Response guidance: Address source data, audit trails, methodology documentation, record retention, and reasonable access.

4.8 Identify any proprietary quality program, measure set, or accreditation requirement that would overlap with or conflict with PBGH standards.

Response guidance: Explain how conflicts would be resolved in favor of the PBGH contractual requirements.

4.9 Provide examples of contractual quality or service obligations you currently administer for non-owned provider organizations.

Response guidance: Include de-identified outcomes and lessons learned.

Domain 5: Scalability and Multi-Market Reach

5.1 Describe your current geographic reach and the markets in which you can administer independent APC arrangements.

Response guidance: Distinguish contracting, payment, member support, data, and licensing capability. Provide a map of current geographic footprint with APC clinic partners.

5.2 Describe how a new region would be added under the existing PBGH master structure.

Response guidance: Provide steps, dependencies, required amendments, configuration effort, and fees. How long does it take to implement a new region.

5.3 Describe how a new employer would join mid-term.

Response guidance: Address implementation, eligibility, pricing band, data access, guarantees, governance, and employer-specific requirements. How long does it take to implement a new employer.

5.4 Describe how new APC clinics, virtual partners, and supporting vendors would be added or removed.

Response guidance: Include volume capacity, batch onboarding, effective dating, and member continuity. How long does it take to implement a new APC clinic partner.

5.5 State minimum enrollment, revenue, clinic count, or market size requirements.

Response guidance: Identify any condition that could prevent launch or expansion.

5.6 Describe platform and operational capacity for growth over three years.

Response guidance: Provide relevant current volumes, tested capacities, staffing assumptions, and material constraints.

5.7 Explain how you will maintain common terms and service levels while supporting reasonable employer and market variation.

Response guidance: Identify which elements must be standardized and which may be configured.

5.8 Describe national virtual APC administration and how virtual and local in-person practices would coexist in the same network.

Response guidance: Address member choice, payment overlap, data sharing, and continuity.

5.9 Describe any change in pricing, staffing, service level, or contracting approach as scale increases.

Response guidance: Cross-reference all tiering and volume assumptions in the pricing exhibit.

Domain 6: Implementation and Service Model

6.1 Provide a detailed implementation plan for the anticipated July 1, 2027 effective date.

Response guidance: Include workstreams, milestones, dependencies, critical path, decision gates, testing, training, communications, and contingency plans.

6.2 Identify the proposed executive sponsor, implementation lead, account lead, operations lead, data lead, contracting lead, and customer-service lead.

Response guidance: Provide role, location, allocation, relevant experience, and named backup.

6.3 Describe the account management structure and expectations for an employer and PBGH.

Response guidance: Include service channels, response standards, account reviews, reporting support, and escalation.

6.4 Describe the member support model.

Response guidance: Address eligibility questions, clinic selection, directory help, complaints, continuity needs, accessibility, language support, and handoffs to employers or clinics.

6.5 Provide your implementation risk register for this arrangement.

Response guidance: For each major risk, state likelihood, impact, mitigation, owner, trigger, and contingency.

6.6 Describe testing and readiness criteria before launch.

Response guidance: Include eligibility, invoice, payment, file exchange, reporting, member materials, support workflows, security, and disaster recovery.

6.7 Propose administrative performance guarantees and fees at risk.

Response guidance: At minimum address implementation, eligibility accuracy, invoice accuracy, provider payment, reconciliation, data delivery, service responsiveness, and issue remediation.

6.8 Provide two relevant client references.

Response guidance: Prioritize self-funded employers, coalitions, multi-employer arrangements, independent provider contracting, prospective payment, or comparable data interfaces.

6.9 Describe financial condition, insurance coverage, business continuity, and any material litigation or regulatory action relevant to performance.

Response guidance: Provide audited financial statements for the most recent three completed fiscal years.

6.10 Describe your current employment model including number of employees by role.

Response guidance: Define how many employees in each function.

6.11 Do you currently use artificial intelligence, machine learning or big data to help improve patient care experience, quality of care, and/or administrative workflows? If so, please describe.

Response guidance: Describe how AI is being used in your organization currently or intentionally by any subcontractors.

6.12 Do you have immediate plans in the next 2 years to expand use, beyond current use described above, of artificial intelligence, machine learning, or big data to help improve patient care experience, quality of care, and/or administrative workflows? If so, please describe.

Response guidance: Only include projects that are on the roadmap and already budgeted for in terms of investment of capital and human resources.

6.13 Describe any additional services offered through your model that brings additional value to employers or enhances the Care Excellence Program.

Response guidance: Cross reference the pricing exhibit. Additional services could include integrated behavioral health, specialty centers of excellence programs, and quality based specialty referrals (be sure to name your quality source).

Domain 7: Cost and Pricing Transparency

7.1 Complete the pricing exhibit using a PUPM administrative fee as the primary pricing unit.

Response guidance: Provide fees by enrollment band, employer, market, and contract year where they differ. This should only be for administrative functions. If other pricing structure is needed, please indicate what pricing structure and rationale for not doing a PUPM structure.

7.2 Itemize all one-time implementation, contracting, configuration, integration, testing, communication, and training fees.

Response guidance: State what is included in the base PUPM fee.

7.3 Disclose all direct and indirect compensation associated with this arrangement.

Response guidance: Include affiliate revenue, subcontractor margins, network revenue, referral or placement fees, data-related revenue, interest or float, incentives, commissions, and rebates.

7.4 Identify any fee or revenue that varies with enrollment, clinic payment, utilization, savings, transaction count, vendor selection, or employer decision.

Response guidance: Explain the potential conflict and proposed mitigation.

7.5 Describe pricing changes when employers, markets, clinics, virtual partners, or data feeds are added or removed.

Response guidance: Include minimums, volume tiers, true-ups, and retroactive adjustments.

7.6 Provide a three-year pricing schedule and state every escalation factor.

Response guidance: Separate fixed, indexed, volume-driven, and discretionary changes.

7.7 State the percentage and dollar-equivalent portion of administrative fees you will place at risk.

Response guidance: Cross-reference the proposed performance guarantee schedule.

7.8 Describe invoicing detail, payment terms, credits, dispute rights, audit rights, and record retention for respondent fees.

Response guidance: Attach a sample administrative invoice.

7.9 Confirm that no fee applies unless disclosed in the final agreement or an authorized change order.

Response guidance: Describe your change-order approval and pricing process.

7.10 Provide a total-cost illustration for the specified enrollment scenarios in the pricing exhibit.

Response guidance: Show assumptions and separate base PUPM, one-time, pass-through, optional, and contingent charges.

7.11 Describe any proposed gainsharing, shared savings, or value-based administrative compensation.

Response guidance: If proposed, provide formula, data source, validation, exclusions, caps, and conflict safeguards.

5. Pricing Exhibit Requirements

Respondents should submit an editable pricing workbook. The workbook should include the following schedules and reconcile to the narrative proposal.

Base PUPM administrative fee by enrollment band and contract year (if any fees deviate from PUPM, please explicitly describe the pricing structure, services included, and rationale for deviation).

Employer, market, clinic, and virtual APC variations, if any.

One-time implementation and integration fees.

Recurring fees outside the base PUPM charge.

Clinic onboarding, contracting, payment, reconciliation, and termination fees.

Data-feed, API, report, dashboard, extract, and third-party transmission fees.

Subcontractor and pass-through amounts, including markups.

Performance-guarantee fees at risk and maximum credits.

Total-cost illustrations for PBGH-provided enrollment scenarios.

Full direct and indirect compensation disclosure.

Pricing should remain firm for 120 days after the proposal due date. Any assumption that could change price must be stated in the pricing workbook and the executive summary.

6. Required Attachments

1. Executive summary and statement of acceptance of the proposed structure
2. Completed baseline requirements table

3. Completed questionnaire
4. Implementation plan and risk register
5. Proposed governance and service model
6. Data inventory, data-flow diagram, file layouts, and sample reports
7. Sample employer invoice, clinic remittance, and reconciliation report
8. Sample clinic agreement or term sheet
9. Proposed performance guarantee schedule
10. Completed pricing and compensation disclosure workbooks
11. Security and business continuity materials
12. Subcontractor and affiliate disclosure
13. Client references
14. Exceptions and requested contract modifications

7. RFP Process and Administrative Terms

Respondents must follow the procurement calendar and submission instructions in this RFP. All communications regarding this RFP must be directed to the PBGH contact identified in the cover letter. Respondents must protect confidential information, disclose conflicts of interest, bear their own response costs, identify all requested contract exceptions, and keep proposals valid for 120 days after the proposal due date. PBGH reserves the right to amend or cancel this RFP, request clarifications, reject any or all proposals, and negotiate with one or more respondents.

7.1 Procurement Calendar

Milestone	Date
RFP issued	September 28, 2026
Intent to respond due	October 2, 2026
Written questions due	October 9, 2026
Responses to questions posted	October 16, 2026
Proposals due	October 23, 2026
Finalist notification	November 6, 2026
Finalist presentations	November 13-20, 2026
PBGH recommendation	December 4, 2026

Milestone	Date
Award decision	To be determined
MSA execution target	January 10, 2027
Anticipated effective date	July 1, 2027