Request for Proposal
from Medicaid PHPs
for a
Preferred Payor Arrangement
Issued by
Carolina Medical Home Network
April 16, 2025

Overview

The Carolina Medical Home Network (CMHN) seeks to contract on behalf of as many as 43 federally qualified health center (FQHC) members through a Preferred Payor Arrangement (PPA) with one or more Medicaid prepaid health plans (PHPs). This Request for Proposal (RFP) is being sent to all current Medicaid PHPs for the purpose of affording the PHPs an opportunity to submit a responsive proposal to CMHN no later than June 13, 2025.

The current variation in PHP contracting requirements and processes has required these safety net providers to expend their limited resources on administrative activities that do not add value to actual patient care. The burden of these inconsistencies is so high that CMHN is prepared to contract only with PHPs that are responsive to the terms of this RFP. Such a Preferred Payor panel would allow CMHN and its members to better allocate resources to directly benefit patients and increase their providers' capacity to serve them and their communities.

CMHN will evaluate proposals and select a panel of preferred Medicaid PHPs on or about August 15, 2025. CMHN expects to negotiate a definitive PPA payor contract with the selected Medicaid PHP(s) for a minimum of five years, to commence on January 1, 2026. It is CMHN's intent for substantially all Medicaid patients of its members to be served by the selected Medicaid PHP(s). The terms of the negotiated PPA payor contracts shall apply to enrolled Medicaid patients assigned to CMHN practices beginning on January 1, 2026, and continue for the earlier of the full term of the PPA payor contract or when the selected Medicaid PHP is no longer recognized by NC Medicaid as a participating PHP.

Background

The North Carolina Community Health Center Association (NCCHCA) represents 43 FQHCs across the state, 26 of which currently contract through CMHN. CMHN currently serves Medicaid-covered individuals statewide by providing critical primary, dental and behavioral health care. Many of these patients have significant medical and social risks. CMHN supports the Healthy Opportunities Pilots to address health related social needs as well, and as community-based providers, all 43 members of NCCHCA routinely provide a wide range of supports to people in their communities. These include enrollment in Medicaid and other social programs and coordination with other community-based organizations.

North Carolina's Medicaid program, serving approximately 3.1 million residents in November 2024 grew by more than 600,000 members following Medicaid expansion in December 2023. Such a tremendous investment of taxpayer dollars in the health of North Carolina's citizens deserves both efficient and well-coordinated execution and clear evidence that the investment is delivering value

in the form of high quality and lower cost. At the conclusion of the third full year of Medicaid Managed care and the first full year of Medicaid Expansion, the promise of better health through Medicaid coverage is still nascent. Gaining access to coverage is critical but insufficient in meeting the state's goals of better care, healthier people and communities and smarter spending.

The kind of value expected in any of these three key performance areas becomes evident over years, not months, but we must act on lessons learned along the way to deliver the value we all seek through this bold investment. As the only clinically integrated network owned and led by FQHCs, CMHN is committed to equitable care for all North Carolinians, regardless of their ability to pay. Medicaid Managed Care benefits directly from CMHN's model of caring for enrollees in their communities, with clinicians and staff who collaborate closely with the other organizations that serve our patients. Our integrated, community-based model of care fosters trust in marginalized communities and has proven effective in achieving value-based contract goals under Medicaid Managed care.

Specifically, the divergent requirements of each PHP payor contract result in low-value activities to reconcile disparate accountabilities and reporting formats. We seek to replace these low-value activities with high-value efforts to increase the direct benefits of Medicaid coverage for Medicaid beneficiaries through increased access and improved quality of care, as well as CMHN's capacity to care for more patients under value-based agreements. While these issues impact all Medicaid providers, not just FQHCs, FQHCs are already under-resourced, with limited options for revenue streams to help support administrative burdens such as this one. Ultimately, these issues result in wasted resources and diminish the likelihood that safety net providers will be successful under value-based agreements. These challenges have been acknowledged by the NC Medicaid program in its recent publications requesting comment about implementing AMH Tier 3 Incentive Programs and paper released on April 7, 2025 describing the upcoming Standard Plan re-procurement entitled, "Improving Member Health Through Managed Care Program Enhancements."

Additionally, the Medicaid program faces financial challenges, with costs rising faster than state budget allocations and creating a funding gap that threatens the stability and effectiveness of Medicaid services and the overall success of the state's investment in Medicaid Managed Care.

NCCHCA strongly supports North Carolina's shift to Medicaid Managed Care and believes that value-based agreements are key to FQHCs' sustainability as safety net providers. For many in their communities, an FQHC is the only point of access for health care other than an emergency room, making their success under value-based contracts critical to lowering Medicaid costs for taxpayers. Our shared success will require focusing limited resources on delivering high-value care under current value-based agreements, while reinvesting increased revenues earned under value-based agreements to expand access to care and build capacity for increasingly sophisticated value-based agreements, including down-side risk. This virtuous cycle will correct many problematic dynamics in the current state of Medicaid healthcare financing that present multiple barriers to the feasibility of serving the unique populations served by FQHCs under value-based agreements. This RFP seeks to address those challenges.

In anticipation of this RFP, more than 40 of NCCHCA's FQHC members have executed Letters of Intent declaring their desire to participate in CMHN's PPA as an alternative to their current Medicaid

provider contracts. Their desire for change is grounded in the administrative burden mentioned above and their desire to participate fully in the success of North Carolina's Medicaid Managed Care program. This RFP provides a unique opportunity for PHPs to strengthen their standing in future procurement cycles by aligning with a network of FQHCs that provide care to nearly 8% of North Carolina's Medicaid population. By partnering with FQHCs, who successfully engage some of their most difficult to reach members, PHPs can also improve quality performance. In return, CMHN seeks their fair share of savings generated by this unique provider network.

Objectives

The primary objectives of the PPA are:

1. **Simplify Contracting and Reduce Administrative Burden**: Reduce the administrative burden on FQHCs of participation in the NC Medicaid program by contracting with preferred PHP(s) willing to align contract terms to the unique needs of patients served by FQHCs.
2. **Align Incentives:** Create value-based agreements that align financial incentives with health improvement and access, clinical integration and management of costs in high-cost, high-need populations.
3. **Ensure Network Adequacy and Patient Access**: Strengthen primary care options for NC Medicaid enrollees by bolstering PHP network adequacy through a state-wide network of community-based providers.
4. **Enhance Sustainability of FQHCs:** Equip FQHCs to be full participants in the shift to value-based payment while building the infrastructure and workforce necessary for success.
5. **Expand Access to Integrated, Community-Based Care**: Improve access to high-quality, community-based, integrated care for historically marginalized people and address social determinants of health in a trusted community environment.
6. **Reduce Medicaid Costs and Improve Outcomes:** Scale CMHN's early success in lowering state and federal spending for a population with disproportionately high number of high-risk patients from historically marginalized populations.

North Carolina's Division of Health Benefits (NC DHB) and PHPs choosing to partner with CMHN will benefit by optimizing a targeted system of care for this medically needy population that is rooted in the high levels of provider-patient trust developed in the FQHC environment.

Payor Contract Domains

The selected PHP(s) will collaborate with CMHN to develop a provider-led, five-year contract that is aligned with principles of effective value-based care adoption including:

- Improved and more equitable health outcomes across different segments of the population
- Comprehensive, coordinated care delivery designed to address the specific needs of CMHN's Medicaid population
- Payment aligned with the risk-adjusted cost of CMHN's Medicaid patients' care needs
- Clear and specific performance requirements with near real-time data analytics and reporting
- Access to complete and accurate performance data

Each PPA payor contract domain is accompanied by specific requirements to be addressed in your response to the RFP. Generalized or non-specific responses will not be considered.

1. Shared Savings Model

We seek a five-year shared savings contract with down-side risk beginning no sooner than year 3 of the contract. A feasible glide path toward down-side risk would include 50/50 split of cost savings for the first two years, from which CMHN will place 5-10% of earnings in escrow to build financial readiness for down-side risk. Downside risk could begin as early as year 3 with anticipated upside increase to 75% and no more than 25% downside. Year four could continue with 75% upside and 25% downside, with CMHN's network assuming full risk with a fully capitated rate in year 5.

Quality and Total Cost of Care (TCOC) are equally important for achieving the goals of value-based care. To ensure that both high-quality care and cost containment are incentivized, each should be rewarded independently of the other. We expect an agreement that benchmarks CMHN's medical loss ratio (MLR) to the current state-wide market average, rather than past CMHN performance or the performance of the PHP's provider panel. Calculation of CMHN shared savings earnings should be based solely on TCOC methodology and should be awarded irrespective of meeting quality performance gates, which will be addressed through a separate Quality Incentive Program. TCOC will include most Medicaid covered services but will exclude high-cost/low-prevalence claims (e.g., high-cost drugs).

By partnering with CMHN on a glidepath toward down-side risk, PHPs can both optimize their opportunity to advance value-based payment throughout their network and show success in doing so in safety net populations, making them more competitive during the upcoming re-procurement cycle.

Response should address:

a. How would you structure a TCOC shared savings model that addresses these criteria? How would you calculate shared savings earnings?
b. What high cost/low prevalence claims would you exclude from the TCOC calculation?
c. What safeguards will be in place to ensure that CMHN is not disproportionately impacted by any future downside risk, given that FQHCs accept all patients regardless of coverage or ability to pay?

2. Risk Adjustment

The TCOC benchmark and other benchmarks used to impact payment should be risk adjusted using an industry standard model that incorporates adjustments for social determinants of health, geography and health variation in outcomes in the patient population. The model used should be made transparent to CMHN so that it can perform its own mirrored calculations, and a clearly defined validation and appeals process should be incorporated into contract terms. Standardized and transparent risk adjustment methodology with clear appeals processes serve both payors and providers well by reducing complexity and enabling clearer, less burdensome communications. It will also help increase trust.

Response should address:

a. Describe your risk adjustment model, including the specifications. Specifically describe how social determinants of health and health variation in outcomes are incorporated into the risk model and/or accountabilities under value-based agreements.
b. How do you plan to provide risk scores at the CMHN (CIN), practice and patient levels?
c. How do you propose to address fluctuations in risk and significant variation between health plan risk calculations and CMHN calculations?
d. How do you typically handle appeals, and what is the standard resolution timeframe?

3. Quality Incentive Program

The Quality Incentive Program is designed to reward PHPs for achieving high quality care and meaningful improvements in patient health outcomes and access. It is a critical component of CMHN's glide path to down-side risk - and ultimately a fully capitated rate - while delivering value to PHPs through increased preventative care uptake, more effective, holistic management of chronic conditions, including behavioral health and reductions in preventable utilization of hospital admissions and emergency room visits.

Shared savings and quality incentives should reinforce each other as networks build the infrastructure and expertise necessary for sustainable achievement of better care at lower cost under fully capitated rates. Therefore, we seek a standalone network performance incentive that is separate from, but carefully aligned with, total cost of care to ensure that high-quality care is not disincentivized. This aligns with NC DHB's goals of improving patient experience and addressing inequities in care delivery.

By decoupling quality incentives from shared savings, CMHN aims to support the business and financial capacity building necessary for successful adoption of value-based care. For example, effective and sustainable financial models that adequately support management of populations with complex medical, behavioral and social needs must be developed for providers that do not have the same opportunities for additional revenues to offset high-cost, high-need patients as large health systems and practices. FQHCs bring the value of an integrated approach to physical, behavioral and social health that can increase the effectiveness of all three, if properly resourced in a trusted, community-based environment.

We seek a Quality Incentive Program that includes no more than nine measures, all of which should be aligned with stated NC Medicaid's Division of Health Benefits' priorities and CMHN clinical priorities that address the unique needs of the populations and communities they serve. Under their Federal contracts, FQHCs are held accountable by HRSA for specific measures that are currently only partially aligned with state-specific Medicaid goals. This misalignment between state and Federal priorities presents further complexity for CMHN providers that dilutes resources and distracts attention from the true needs of patients and their communities. PHPs can capitalize on existing alignment around chronic disease outcomes, prevention and behavioral health by building these measures into a focused quality incentive program that is aligned across payment sources. Individual practice gap closure incentives are also important for driving individual provider engagement in key areas in need of improvement.

The ideal quality incentive program should be funded at a level that is 2% of the premium received by the health plan from the state and will not be included as an expense in CMHN's MLR calculation. State benchmarks for performance will be used for Level 1 payout thresholds, but CMHN would be open to a tiered approach that incorporates higher, yet still attainable, thresholds relative to CMHN's past year's performance. Given the historically underserved populations served by FQHCs, CMHN would also be open to an approach that incentivizes targets for specific population segments to both advance access and further demonstrate the value we deliver to patients, communities, NC DHB and payors.

In addition to quality incentives, we seek partial credit and compensation for improvement equivalent to at least a 25% relative closure of the gap between the previous year's performance and the benchmark, if benchmarks are not met. Not only does this support continued building and maintenance of network infrastructure but also provides incentives to focus on critical measures that have been historically resistant to threshold-level improvement (Combo 10 vaccines and child and adolescent well-child visits, for example). Performance rates should be calculated both including and excluding the Medicaid expansion population for at least the first year of the contract, and determination of incentive payment should be based on the higher of the two rates.

The following measures are CMHN's priority clinical measures, which are aligned with both federal and state priorities:

- Cervical Cancer Screening (CCS/CCS-E)
- Child and Adolescent Well-Care Visits (WCV)
- Colorectal Cancer Screening (COL-E)
- Controlling High Blood Pressure (CBP)
- Glycemic Status Assessment for Patients with Diabetes (GSD)
- Well-Child Visits in the First 30 Months of Life (W30)
- Prenatal and Postpartum Care (PPC)
- Depression Screening and Follow-Up (DSF-E)
- Childhood Immunization Status Combo 10 (Combo 10)

Response should address:

a. Describe your proposed Quality Incentive Program and the specific metrics you would use.
b. If you propose different metrics than those outlined above, please provide a rationale for each measure not included in the list above.
c. Would CMHN earn quality incentives as a network if MLR targets are not reached?
d. Would individual practices be incentivized for quality performance in addition to network level performance? If so, what measures do you anticipate using for care gap closure incentives directly to practices?

4. Reporting and Accountability

Full data transparency is essential, including easy accessibility of data and reports, clearly defined and transparent methodologies, near real-time reporting and a process for CMHN review and appeal with reasonable timeframes for response and resolution. CMHN seeks the following:

For negotiating and contracting:

- Two years of CMHN's historical TCOC performance data, with associated claims and assignment data. Rates should be reported with Medicaid expansion population included and segmented.
- Health plan network-wide TCOC and MLR performance data for comparison.
- Risk adjustment information, including specifications and historical member, practice and network-level risk scores
- Proposed MLR target and TCOC benchmark, with explanation of how these were derived.
- Current performance data on all proposed quality measures for CMHN's network providers at the provider level and network level and at least one year of past performance.

For contract execution:

- All content reflected in Appendix A must be provided. Please describe in detail how you plan to provide the content listed, including:
    - Method(s) by which the data will be made available and frequency with which it will be refreshed.
    - Specific reports to be used by the health plan to monitor progress, descriptions of their content and frequency with which they will be produced
    - Process for notifying PHP of errors and timeframe for resolution
- For any content you do not plan to make available, please provide a rationale and propose an alternative.
- Reporting should clearly indicate which metrics are linked to shared savings and incentives
- Performance and utilization data should be available for the total Medicaid population and segmented by expansion population.

Response should address:

a. How do you intend to provide real-time or near real-time data to CMHN and its member practices (e.g.: website, static report, combination of both, etc.)?
b. How will your organization ensure that data is shared on time and that it is complete? What safeguards are in place to prevent delays or inaccuracies?
c. How far in advance of Joint Operating Committee meetings or other collaborative review meetings do you anticipate providing data to be discussed?
d. How would you handle delays in sharing data and reconciliation of data errors? What process would you use for communication with and escalation of issues to your corporate leaders? To CMHN?

5. Delegated Care Management

Requirement: The PHP must delegate all care management responsibilities to CMHN. This delegation must include a pass-through without deductions by the PHP of the PMPM financial resources allocated by NC DHB to provide workforce and operational support. Any adjustments by

NC DHB to PMPM rates will also be passed through, enabling CMHN to carry out care coordination activities autonomously.

CMHN's FQHC network of Tier 3 advanced medical homes working collaboratively with CMHN's Care Management Team has proven to be highly effective in managing patient care in the community. Based on exemplary past performance, audits should occur no more than twice per year, unless performance issues arise. This would save both the health plan and CMHN significant administrative burden.

Response should address:

a. Explain your approach to delegating care management responsibilities to CMHN.
b. How would you evaluate the quality and performance of CMHN's care management program? What measures of success would you use? How frequently would you conduct audits and what would that process look like?
c. How do you plan to coordinate health plan population health interventions (such as mailings, automated outreach, deployment of resources to practices) with CMHN's ongoing network care management and population health processes?
d. Describe your process for compensating CMHN for providing delegated care management services. What data and reports would be made available to CMHN for purposes of accounting, validation and PHP accountability to CMHN?

6. Healthy Opportunities Program: As primary care providers rooted in underserved communities, CMHN has always been well-positioned to support the success of the Healthy Opportunities Pilots. With the possible state-wide program expansion after recent CMS approval of North Carolina's 1115 waiver, CMHN is already planning how best to continue our support for this critical and nationally acclaimed program, assuming its continued funding by the NC General Assembly.

Requirement: CMHN will continue providing support to beneficiaries with connections to services that address their identified health-related social needs under the HOP program. PHPs aiming to partner with CMHN will be expected to pass through all PMPM payments for eligibility screening and referrals, along with a clear accounting of those dollars separate from care management PMPM funds**.** This will not only enable clearer, more accurate accounting to CMHN's member practices and to state auditors but will also provide critical data for use by both CMHN and the health plan in addressing access issues and evaluating impact.

By using social needs data alongside clinical and utilization data, CMHN can better understand the specific drivers of health outcomes and costs for its patients, as well as the interventions that most effectively impact them for different segments of the population. Such data driven approaches to quality, cost and social needs will enhance members' quality of life and experience of care, both of which are priorities of NC DHB.

Response should address:

a. Should the opportunity arise for plans to engage in stakeholder input on the Healthy Opportunities Program, how will you engage CMHN and FQHCs to provide input?
b. How would you approach the integration of this program into your health plans execution of Medicaid Managed Care?
c. What is your plan for allocation of HOP funds, and how do you plan to account for the funds in communications and reporting to CMHN?
d. Will you provide patient-level HOPs data to CMHN? If so, what data points would you include?

7. Medicaid Enrollment, Assignment and Attribution: The proper accounting for Medicaid beneficiaries from initial enrollment to assignment to primary care providers to the attribution of patients to FQHCs is a foundational feature of value-based care. For these processes to be performed accurately, consistently and on a timely basis requires a fully aligned and collaborative approach among all parties.

Requirement: A program through which Medicaid beneficiaries served by FQHCs are accurately accounted for under CMHN's value-based contracts is critical to achieving continuity of care, alignment of incentives and financial efficiencies for both CMHN and the selected health plans. Since member alignment directly affects shared savings, quality measures, and overall performance metrics, it will be important for selected PHPs to collaborate with CMHN on enrollment, assignment and attribution activities.

Response should address:

a. How does your organization plan to support the accurate assignment and attribution of existing and new FQHC patients enrolled in your PHP?
b. What specific strategies will you employ to ensure that errors in patient assignment and attribution are efficiently resolved?
c. How will you collaborate with FQHCs to address errors in patient assignments and attribution?

8. Infrastructure and Administrative Funding: FQHCs and networks that are relatively new to high-volume value-based care should receive upfront and ongoing financial support to meaningfully transform operations and care delivery models in exchange for progress toward downside risk.

Requirement: CMHN expects PHPs to provide up-front per-member-per-month (PMPM) infrastructure funding over the first two years of the five-year contract to fund value-based infrastructure development and activities. Additionally, CMHN expects ongoing PMPM administrative funding to support variable cost population health infrastructure to offset the inherent enrollment instability of a Medicaid population.

CMHN seeks to move rapidly toward taking on down-side risk arrangements. To do so, the CMHN network needs to build significant infrastructure and seeks contract terms that enable it to accrue

adequate resources to build this critical infrastructure as it delivers value to PHPs under early-stage value-based agreements. Examples of infrastructure and administrative funding needs include:

- Sophisticated network-wide population health data management platform
- Twenty-six EHR integrations
- Full-time network administrator and roster manager
- Full-time data informaticist
- Full-time Quality Director
- Two full-time Practice Transformation Specialists

Response should address:

a. What up-front infrastructure dollars would you propose to support CMHN in building its value-based care infrastructure?
b. How will your organization ensure ongoing administrative funding in the early years of the contract to maintain operations, care coordination, and risk management?
c. What mechanisms will you have in place to adjust funding as population health needs evolve over the contract term?

9. Collaboration and Accountability: CMHN has enjoyed a collegial and supportive relationship with local staff at each of the five PHPs, but has encountered significant barriers whenever corporate input, approval or action is required. Specific examples include delays in finalization of contracts, difficulty validating data and minimal access to management reports. These barriers undermine potential for success as CMHN deepens its engagement in value-based agreements, and therefore we look forward to more consistent and responsive collaboration from the corporate offices of PHPs selected to be part of the panel of preferred payers.

Requirement: The selected PHP(s) and CMHN must designate key management staff to form a Joint Operating Committee (JOC) that meets quarterly to oversee contract performance, resolve issues, and ensure alignment on care models, financial targets, and quality measures. In addition to the primary point of contact for operational needs, we also expect a single point of contact with the authority to make decisions regarding CMHN's contract.

The PHP must provide performance reports to CMHN at least two business days in advance of any JOC meeting to provide adequate time for CMHN staff to review and prepare for a productive discussion. Reports must reflect up-to-date performance metrics using recently refreshed (i.e., no more than five business days old) data, beneficiary assignments, and any corrections to discrepancies identified in previous meetings.

Response should address:

a. How will your organization support collaboration through the JOC? What specific roles and responsibilities will be defined for the PHP and CMHN in the committee?
b. What processes will you have in place to ensure timely and accurate performance reporting for JOC meetings?
c. How will your organization address and resolve discrepancies in performance data, operational or contractual issues raised during or in between JOC meetings?

10. Provider of Choice: CMHN and its members desire to be the providers of choice for all PHPs and request that CMHN be included on the provider panel of all product lines offered by health plan (including Medicaid Managed Care, Tailored Plans, and Medicare Advantage).

Requirement: PHPs should ensure CMHN's network of FQHCs are treated as core partners in any expansion into new populations or programs. This includes supporting CMHN's inclusion in dual-eligible strategies and future Medicare-aligned products. Given CMHN's reach and performance in managing high-need populations, we expect PHPs to treat CMHN as a strategic partner across all lines of business.

Response should address:

a. How will your organization ensure CMHN's inclusion as a preferred provider across all product lines?
b. What steps will be taken to support CMHN's participation in Medicare Advantage and future dual-related products?
c. How will your organization communicate provider choice options to members and encourage selection of CMHN-affiliated providers?
d. What contractual or procedural commitments can be made to reinforce CMHN's role as a key provider across your product portfolio?

11. Sustainability: CMHN seeks to negotiate a five-year payor contract with the selected PHP(s) to prepare its FQHC members for success in VBC and support PHP success in high-cost/high-need populations. We understand that PHP contracts will be subject to re-procurement in the next few years, most likely before the end of this contract term, but a minimum five-year contract is consistent with our desire to develop long-term relationships with selected PHP partners.

Requirement: The term of the payor contract will be conditioned upon the PHP's successful extension of its Medicaid PHP status with NC DHB during the PHP re-procurement process, which is expected at some point during the term of the contract. Responses should offer reasons why CMHN should anticipate PHP's successful re-procurement of the NC Medicaid Managed Care contract.

Response should address:

a. Please describe your current success in North Carolina's Medicaid managed care environment.
b. What makes you confident that you will be selected to continue?

General Contract Terms:

CMHN seeks a service level agreement (SLA) that addresses the following:

- Name and contact information for both the primary contact for contract decisions and the primary contact for ongoing operational issues.
- Response times for contracting questions, changes and communications, preferably within three business days.

- Advance notice of any contract or rate changes at least 30 business days in advance of the effective date of the change.
- Resolution of data platform access issues prior to finalization of contract.
- A list of specific deliverables due to CMHN and expected date(s) of delivery (e.g. monthly reports, payments, etc.).
- Timeline for sharing of TCOC, utilization, and quality performance data prior to JOC or other meetings in which data is to be reviewed, ideally no later than two business days in advance.
- Expectations surrounding data delays and other issue notification, including timing of resolution. Late or incomplete data without prior notice and resolution will be considered a breach of contract.
- A well-defined data validation process with a single point of contact for all validation issues.
- Appeals process for addressing performance reporting issues identified by CMHN and expectations regarding resolution time. CMHN expects resolutions not to exceed two months from the time PHP is made aware of the error, with a corrected report serving as confirmation of resolution.
- Specific consequences for PHP's breach of SLA requirements, including financial compensation for breach.

RFP Response Requirements

Interested PHPs must submit a responsive proposal to the RFP no later than June 13, 2025, that includes responses to each of the domains described above and in accordance with the following outline:

1. **Company Profile:** Overview of the PHP, including experience in Medicaid VBC contracting.
2. **Responses to Domain Requirements:** Provide detailed responses to each of the domains described in the RFP section entitled, "Payor Contract Domains."
3. **Approved Payor Contract:** Affirm that the selected PPA PHP(s) will be responsible for preparing the payor contract inclusive of agreed upon contract terms in compliance with the requirements of federal and state Medicaid rules and regulations.

The response shall be no longer than thirty (30) single-spaced pages with at least half-inch margins using New Times Roman, Arial, or Aptos font and a font size no smaller than 11. A page is defined as one side of a sheet, 8 ½" x 11". An unlimited number of pages of attachments are permitted, but attachments will not be weighed as heavily in the evaluation as the initial thirty (30) pages of the response.

Proposal Evaluations, Written Questions, Selection of Medicaid Preferred PHP(s) and Invitation to PPA Negotiations

Responses to the RFP will be competitively evaluated by CMHN. CMHN's evaluation team may include, but not be limited to, appropriate healthcare attorneys, VBC experts, actuaries, healthcare data analysts, healthcare financing experts and FQHC representatives. The scoring rubric presented in Appendix B – Scoring Rubric will be utilized to score proposals. PHP applicants may submit written questions regarding the RFP up to June 6, 2025, and CMHN will make best efforts to respond within two business days. Upon evaluation of all PHP responses and on or about August 15, 2025, CMHN will make Medicaid PHP selections for participation in CMHN's PPA program.

Contract negotiations will ensue with the goal of finalizing PPA payor contracting by October 31, 2025.

Submission Instructions
Please submit your written questions and completed response to the Request for Proposal electronically via email to the following email address: PPA-RFP-Questions@ncchca.org

Reservation of Rights
CMHN reserves the right to accept or reject any and all proposals submitted in response to this request for proposal.

Appendix A: Data and Reporting

CMHN seeks significantly greater data transparency than has been available to date. We seek both a real-time (or near real-time) data feed that contains complete and accurate data, as well as regular reports showing health plan assessment of current quality, utilization and cost of care performance. Reports must include clear performance targets and methodology for tracking progress over time. Essential data and reports include:

A. Data feed to CMHN's data warehouse for claims, utilization rates, enrollment, assignment, attribution and detailed demographics, health status, and service utilization history at the member, TIN and individual provider level; drill-down capabilities that enable analysis at the patient, provider, and practice levels, with flexibility for CMHN to use the data in their internal systems. Data will be refreshed at least daily.
B. Assignment roster (at least monthly) by TIN - must include all members assigned to CMHN's participating health centers at the TIN level and individual provider level.
C. Member level attribution for quality measures included in Incentive program at least monthly.
D. Monthly CMHN utilization rates and PMPM costs, along with benchmarking data for each Medicaid product line type of service compared to how they are broken out by the Medicaid agency in the rate book.
E. Final annual accounting of performance, including attributed patients by TIN to CMHN no later than the end of April of the year following the contract year.

Appendix B: Scoring Rubric

A panel of evaluators will score each proposal submitted in response to the PPA's Request for Proposal according to the following Scoring Rubric.

Scoring Rubric

Responses will be evaluated using the thematic domains below, which reflect CMHN's values and goals for its Medicaid network. Rather than assigning points, reviewers will assess how well each submission addresses the intent of each domain. The goal is to reward thoughtful, responsive proposals—even if they offer alternative approaches—while identifying gaps in clarity or alignment.

Evaluation Tiers

- High**:** The response offers a clear, thoughtful, and well-structured approach that aligns with CMHN's goals and provides compelling justification.
- Moderate**:** The response addresses the area but may lack detail, clarity, or full alignment with CMHN's preferred model.
- Limited Alignment: The response is incomplete, vague, or does not reflect understanding of CMHN's preferred model.

Evaluation Doman	What We're Looking For	Reviewer Considerations
Organizational Fit	Demonstrated presence and infrastructure in NC Medicaid. Experience with value-based care for underserved groups.	How well does the response reflect capacity to partner with FQHCs and manage Medicaid work?
Shared Savings Model	Vision and structure for shared savings, including readiness for downside risk and equitable risk protections.	Does the model demonstrate fairness, feasibility, and sustainability?
Risk Adjustment & Social Risk	How risk is measured and adjusted including use of SDOH, transparency, and plans for reconciliation and appeals.	Are tools equitable and accessible? Is data shared in meaningful ways?
Quality Incentives Program	Approach to funding and distributing incentives. Alignment with meaningful, actionable quality measures.	Are incentives designed to drive care improvement? Are measures appropriate and clear?
Data Reporting, Accountability & Transparency	Commitment to data sharing, performance transparency, and timely reporting.	Will CMHN and FQHCs have actionable data and mechanisms to resolve data concerns?

Care Management Delegation	Approach to working with CMHN on care management, including funding pass-through and oversight.	Is the model rooted in trust and collaboration? Are processes efficient but flexible?
Health Opportunities Program	Integration of HOP funding and operations, including patient-level data exchange and pass-through of HOP funding.	How well does the PHP support HOP as a value-driving, data-supported component?
Medicaid Attribution & Enrollment	Processes for member attribution and corrections, especially in collaboration with FQHCs.	Are methods accurate and adaptable? Is CMHN included in resolving issues?
Infrastructure and Administrative Support	Upfront and ongoing financial and administrative support for VBC infrastructure at CMHN and FQHCs.	Does the plan support network readiness and sustainability?
Governance & Collaboration	Proposed operating structure, including joint governance and dispute resolution.	Is there meaningful CMHN participation in oversight and shared accountability?
Sustainability	Stability and readiness for a multi-year agreement aligned with NC Medicaid strategy.	Does the respondent show commitment to Medicaid space?
Contracting Readiness	Capacity to lead contracting processes and ensure regulatory compliance.	Will CMHN have a contract that reflects mutual agreement and Medicaid alignment?