SOLICITATION AMENDMENT #2		
YH19-0001 AHCCCS Complete Care	Solicitation Due Date: **January 25, 2018** **3:00 pm Arizona Time**	Chief Procurement Officer: Meggan Harley Email: ICRFPYH19_Questions@azahcccs.gov

A signed copy of this amendment must be submitted with your solicitation response.

This Solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

OFFEROR HEREBY ACKNOWLEDGES RECEIPT AND UNDERSTANDING OF THIS SOLICITATION AMENDMENT.	**THIS SOLICITATION AMENDMENT IS HEREBY EXECUTED ON THIS DAY, IN PHOENIX, AZ.**
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE: **SIGNATURE ON FILE**
TYPED NAME:	TYPED NAME: Meggan Harley, CPPO, MSW
TITLE:	TITLE: Chief Procurement Officer
DATE:	DATE:

AHCCCS COMPLETE CARE CONTRACTOR RFP YH19-0001 CLARIFICATIONS

1. RFP Section I, Exhibit A: Offeror's Checklist has been revised as shown below. The revised Exhibit has been posted to the RFP Bidders' Library.

OFFEROR'S CHECKLIST

Submission Requirement	RFP Section	Indicate Offeror's Bid Page Number(s)
Capitation Non-Benefit Costs Bid Submission		
Signed Agreement accepting capitation rates	RFP Section H, Instructions to Offerors	
Non-Benefit Costs Bid Submission workbook	RFP Section H, Instructions to Offerors	
Actuarial Certification(s) of ~~Administrative Rates~~ the non-benefit costs (administrative and UW gain bids)	RFP Section H, Instructions to Offerors	

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	DATE SUBMITTED	**RFP SECTION**	**PARAGRAPH No.**	**PAGE No.**	**OFFEROR'S QUESTION**	**AHCCCS RESPONSE**
1.	12/8/2017	H	12 - Award of Contract	285	This section indicates that AHCCCS anticipates awarding a Pima County-only contract to the third place Offeror in the South GSA. Please describe how the South GSA capitation rates will be adjusted for the Pima County-only contract. For example, will the actuaries adjust base period medical costs, trends, program changes, etc. to reflect the experience of Pima County-only?	Per the Rate Development Documentation in the Bidder's Library Data Supplement Section F: "The capitation rates will be developed by rate cell by GSA and thus will represent the average of all Contractors in that GSA and rate cell. The non-diagnostic based population risk adjustment factors will then be applied to the average capitation rates to get each Contractor's specific capitation rates." The factor for the Pima County-only Contractor will be based on the Pima County population.
2.	12/8/2017	H	12 - Award of Contract	285	Since Offerors are instructed to bid on the entire South GSA, will the Pima County-only awardee's administrative bid PMPMs be adjusted to reflect the specific membership mix (i.e., distribution of members by risk group) of Pima County-only if this mix is different than the South GSA membership mix?	Yes, the administrative bid PMPM will be adjusted to reflect the specific membership mix in Pima County.

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3.	12/8/2017	Data Supplement	D – Data Book Service Matrix, Integrated Contractor Service Matrix	2	Please confirm that injectable drugs administered in an outpatient hospital or physician office setting are grouped into the "Pharmacy" service matrix category in the databook.	This cannot be confirmed. The "Pharmacy Encounters" category covers services billed on a Form Type = C. For Form Type = O (Outpatient), select as follows: If the Encounter Form Type 'O' contains ONLY the following Revenue Codes – 0250-0259, 0630- 0633, 0636 it is considered a Pharmacy service encounter. If injectable drugs administered are billed with the above they will be grouped here. If injectable drugs administered in a physician's office are billed on a Form Type A (i.e. Physician office setting) they will usually be grouped in the "Physician Other" category or the "Misc. and Other Professional Services" category. If the administration of the injectable drugs is billed in any other manner, there could be other categories they are mapped to.

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4.	12/8/2017	Data Supplement	F – Rate Development Info, Non-Benefit Costs Bid Requirements	2	For the purpose of certifying the administrative cost PMPMs in the Offeror's bid, can AHCCCS please describe how they will use or rely on the specific administrative expense components in the Detail Admin Break Out section?	Per the RFP, "The capitation rates developed by the AHCCCS actuaries will be actuarially sound according to the applicable provisions of 42 CFR Part 438 and applicable Actuarial Standards of Practice, and will follow generally accepted actuarial principles and practices." The Detailed Administrative Break Outs will be used to inform the actuaries' work and maintain compliance with the Medicaid Managed Care Rules and ASOPs. See Amendment #1 pages 6 and 7 questions 1 and 2 for further guidance.

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5.	12/8/2017	Data Supplement	Section J – Reinsurance Information		The historical reinsurance payments and offsets included in this section are based on the current deductibles and limits. Can AHCCCS provide an overall impact on the level of payments and offsets if the regular reinsurance deductible is increased to $50,000 (or $35,000) and the per member limit is lowered to $650,000? Alternatively, can AHCCCS provide a distribution of historical reinsurance claims so that Offerors can assess the impact?	AHCCCS estimates the overall statewide impact on the level of payments as follows, based on historical data (not including trends): • If the deductible is raised to $35,000, the overall impact to reinsurance payments is an approximate reduction of $7.2 million with a commensurate increase to capitation rates as well as an estimated reduction of 770 reinsurance cases. • If the deductible is raised to $50,000, the overall impact to reinsurance payments is an approximate reduction of $53.8 million with a commensurate increase to capitation rates as well as an estimated reduction of 3,300 reinsurance cases. Both of the above scenarios include the increase in the stop loss limit from the current $650,000 to $1,000,000. At this time, AHCCCS has only computed the aggregate payment estimates on a statewide basis.

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6.	12/8/2017	Solicitation Amendment #1	Q&A Response 10	10	In response to this question, AHCCCS amended the Non-Benefit Costs Bid Submission workbook to include multi-GSA tabs. It is our understanding this was done to spread fixed costs over multiple GSAs (if multiple GSAs are awarded). How will the variable PMPMs be handled if multiple GSAs are awarded? For example, if an Offeror is awarded the North and Central GSAs, will both the fixed and variable PMPMs from the North-Central tab be used for both the North and Central GSAs? Or will AHCCCS only use the same fixed PMPM for both GSAs, and use the GSA-specific variable PMPMs from each respective GSA's tab?	If an Offeror is awarded more than one GSA, the fixed and variable PMPMs from the GSA combination tab submitted by the Offeror will be used for both the awarded GSAs.

AHCCCS COMPLETE CARE CONTRACTOR RFP YH19-0001 QUESTIONS AND RESPONSES TEMPLATE

<table>
<tr><th></th><th>DATE SUBMITTED</th><th>RFP SECTION</th><th>PARAGRAPH No.</th><th>PAGE No.</th><th>OFFEROR'S QUESTION</th><th>AHCCCS RESPONSE</th></tr>
<tr><td>7.</td><td>12/8/2017</td><td>Solicitation Amendment #1</td><td>Q&A Response 11</td><td>11</td><td>This response describes the process for distributing the adjusted administrative PMPM to the risk groups. The following example is our understanding of the calculation. Is this understanding correct?

<table>
<tr><td>Bid PMPMs after Adjustment:</td><td></td></tr>
<tr><td>Total Admin PMPM:</td><td>$100.00</td></tr>
<tr><td>Fixed PMPM:</td><td>$40.00</td></tr>
<tr><td>Variable PMPM:</td><td>$60.00</td></tr>
</table>

<table>
<tr><th></th><th>Membership</th><th>Risk-Adjusted Gross Benefit Costs (PMPM)</th><th>Total Admin PMPM</th></tr>
<tr><td>Rate Cell 1:</td><td>400</td><td>$1,000.00</td><td>$80.00</td></tr>
<tr><td>Rate Cell 2:</td><td>400</td><td>$1,500.00</td><td>$120.00</td></tr>
<tr><td>Combined:</td><td>800</td><td>$1,250.00</td><td>$100.00</td></tr>
</table>
</td><td>Yes, this is correct.</td></tr>
<tr><td>8.</td><td>12/8/2017</td><td>Solicitation Amendment #1</td><td>Q&A Response 12</td><td>12</td><td>Please explain what is meant by “Contractor specific relative cost ratios”. For example, does this refer to relative cost ratios by risk group after the application of the Contractor’s risk scores?</td><td>Yes, this refers to relative cost ratios by risk group after the application of the Contractor’s risk scores.</td></tr>
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9.	12/8/2017	Bidder's Library	ACOM 436	5	ACOM Policy 436 – Network Standards Draft effective 10/1/18. Dentist – Pediatric definition states "For purposes of this policy, Dentists are defined as a providers licensed to operate using the AHCCCS provider type 07 "Dentist" with the specialty code "804 – Dentist – Pediatric". There are many General Dentists (ST-800) that treat and/or are assigned children under the age of 21 that will not be accounted for in this standard. Can this please be reevaluated or may we have further discussion with AHCCCS before it's implemented?	AHCCCS will review suggestions for revisions in the policy definition and will work with Contractors for implementation of standards.
10.	12/8/2017	Bidder's Library	ACOM 436	7	ACOM Policy 436 – Network Standards Draft effective 10/1/18. We would expect the definition of OB/GYN to include ST-094 (RN Midwife), ST-181 (Surgery – Obstetrical), and ST-219 (Surgery – Gynecological). Can this please be reevaluated or may we have further discussion with AHCCCS before it's implemented?	AHCCCS will review suggestions for potential inclusion in the policy definition and will work with Contractors for implementation of standards.
11.	12/8/2017	Bidder's Library	ACOM 436	8	ACOM Policy 436 – Network Standards Draft effective 10/1/18. We would expect the definition of Primary Care Physician (PCP), Adult to include ST-084(RN Family Nurse Practitioner) and ST -097 (RN Adult Nurse Practitioner). Can this please be reevaluated or may we have further discussion with AHCCCS before it's implemented?	AHCCCS will review suggestions for potential inclusion in the policy definition and will work with Contractors for implementation of standards.

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12.	12/8/2017	Bidder's Library	ACOM 436	8	ACOM Policy 436 – Network Standards Draft effective 10/1/18. We would expect the definition of Primary Care Physician (PCP), Pediatric to include ST-798 (Physician's Assistant) and ST-176 (Adolescent Medicine). Can this please be reevaluated or may we have further discussion with AHCCCS before it's implemented?	AHCCCS will review suggestions for potential inclusion in the policy definition and will work with Contractors for implementation of standards.
13.	12/8/2017	Bidder's Library	ACOM 436	7	ACOM Policy 436 – Network Standards Draft effective 10/1/18. The OB/GYN definition does not include the population of members that providers should be measured against. Can AHCCCS define the age and gender to be used?	ACOM Policy 436 will be revised to reflect this standard should be measured for female members ages 15 to 45.
14.	12/8/2017	Section D	13	286	Will an SMI member of an unsuccessful contractor who previously opted out of the RBHA for physical health services who doesn't choose a contractor during the open enrollment period be passively enrolled with an ACC contractor? Or will they be passively enrolled with one of the eligible RBHA organizations identified on page 288?	AHCCCS will work one-on-one with members with SMI that are enrolled in unsuccessful incumbent plans for physical health only to determine the member's preference of Contractor for physical health services.

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15.	12/8/2017	Section D	50 – compensation	158	When will AHCCCS issue the new mapping matrix? It would be helpful to have this as part of our development of internal reports.	It is not clear what Matrix is being referred to as RFP Section D, Paragraph 50, Compensation, does not include a reference to a Matrix. As this does not appear to be necessary information for the Offeror's proposal, AHCCCS can discuss this with all successful offerors upon award of the RFP.
16.	12/8/17	D	Program Requirements 23. Medical Management.	120 of 311	*Does the following section correspond with the RBHA Contract Sections 18.12.11 and 8.12.12? If yes, are the groups for the monthly interdisciplinary team meeting involved, CMDP, DD/ALTCS and AIHP?* *"High Need/High Cost*: The Contractor shall identify, monitor and implement interventions for addressing the appropriate and timely to improve care provided to members with high needs and/or high costs who have physical and/or behavioral health needs. The Contractor shall conduct, at a minimum, monthly interdisciplinary team meetings to review and monitor the care provided to the members and to make recommendations for clinical interventions or alternative treatments. The Contractor shall report as specified in Section F, Attachment F3, Contractor Chart of Deliverables. AHCCCS shall provide further guidance on changes to the reporting requirements and the minimum number of members to be	AHCCCS is in the process of developing criteria and further guidance for expectations and requirements for High Need/High Cost (HN/HC) care management. AHCCCS understands that each Contractor may have their own method of identifying these members and in the future, requiring a minimum number of HN/HC members in care management may not be necessary in the event AHCCCS determines the Contractors are consistently working to identify and care manage these members. AHCCCS anticipates that the types of HN/HC members that are currently being collaboratively care managed by the Acute plans with other Contractors and the AIHP will be identified for this care management solely by the ACC Contractor. Although the ACC Contractor will be responsible for care management related to transitions, HN/HC care management requirements for DD/ALTCS (with exception of possibly targeted case management), CMDP, and AIHP members will not be in the ACC Contract as these members are not partially enrolled with the ACC Contractor.

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					reported." *If no, does this section correspond to the members being care managed at the Contractor level and so will AHCCCS be determining the minimum number of members in the new Contractor's care management program, similar to how it is in the integrated RBHA contract as per this statement "AHCCCS shall provide further guidance on changes to the reporting requirements and the minimum number of members to be reported."?* **<u>Reference to Current HCIC Contract</u>** Section 8.12.11 – Implement the High : 8.12.11 Implement the High Need/High Cost Program. 8.12.12 Identify High Need/High Cost members for each Acute Care Contractor in each RBHA Geographic Service Area in accordance with the standardized criteria developed by the AHCCCS/Contractor workgroup: 8.12.12.1 Plan interventions for addressing appropriate and timely care for these identified members. 8.12.12.2 Report outcome summaries to AHCCCS utilizing the standardized template developed by the AHCCCS/Contractor workgroup as specified in Exhibit-9, Deliverables. Through collaboration between the two Contractors, the Contractor responsible	

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					for physical health services may opt to provide the reporting of high need/high cost members on behalf of both parties. 8.12.12.3 Short-and long-term strategies for improving care coordination using the physical and behavioral health care data available for members with behavioral health needs. 8.12.12.4 Documentation of collaboration and meetings with AIHP and AHCCCS Health Plans in their assigned GSA at least semi-monthly to identify and jointly manage shared members that would benefit from intervention and care coordination to improve health outcomes. 8.12.12.5 Documentation of the High Need/High Cost Report to AHCCCS every six months regarding criteria to identify members, count of members and outcomes. 8.12.12.6 Proposed interventions to improve health care outcomes, such as developing care management strategies to work with acute care providers to coordinate care. 8.12.12.7 Identification of a minimum of one measurable short and long term goal designed to determine the impact of applied interventions such as reduced emergency room visits (all cause, inpatient admissions (all cause), and readmission rates (all cause). 8.12.12.8 Identify and track members	

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					who utilize Emergency Department (ED) services inappropriately four or more times within a six month period. Interventions must be implemented to educate the member on the appropriate use of the ED and divert members to the right care in the appropriate place of service. 8.12.12.9 The Contractor shall submit a semi-annual report as specified in AMPM Policy 1020 and Exhibit-9, Deliverables.	
17.	12/08/2017	Section H: Instructions to Offerors	3	293	RFP states "all responses shall be in Calibri 11 point font or larger..." Please confirm that these font requirements do not apply to graphics, tables and callout boxes.	These font requirements do not apply to graphics or tables. However, do apply to callout boxes.
18.	12/08/2017	Exhibit C: Narrative Submission Requirements	Question 10	304	Does this question pertain only to in-patient or should the offeror also include residential as part of their response?	The Offeror should respond as they feel is most appropriate for this topic.
19.	12/08/2017	Section H: Instructions to Offerors	19. Submission Requirements	294	Can the state confirm that completed Exhibits A, B, D, E, and F, as well as the completed RFP page and addenda should be loaded to the Subfolder: Proposal (excluding Section G)?	It is unclear what is meant by 'RFP page' and 'addenda'. However everything on the Offeror's Checklist is required as part of the proposal and should loaded to the SFTP Subfolder: Proposal (excluding Section G).

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20.	12/08/2017	Exhibit A: Offeror's Checklist	N/A	300	Exhibit A: Offeror's Checklist would indicate that individual completed exhibits are required to be part of the sequential page numbering for "all pages of the Offeror's Proposal (RFP page 293); is this correct? If so, would page numbering for the entire proposal begin with page 1 of the completed Bid Choice form since that is the first item on Exhibit A?	Yes, individual completed exhibits are required to be part of the sequential page numbering of the Offeror's Proposal. Per RFP Section I, Exhibit A, Offeror's Checklist, the completed Offeror's Checklist shall be the initial pages of the Proposal.
21.	12/08/2017	Section H	6 (Member Choice of RBHA Organization)	288	Please provide examples of member choice under the three different RBHA statuses that have been outlined in this section.	(1) If the RBHA is awarded an ACC Contract through the YH19-0001 solicitation, members enrolled in an Unsuccessful Incumbent Contractor and RBHA utilizing members will have a choice of all ACC Contractors after passive assignment, as described in the RFP, Section H, Instructions to Offerors. For enrollment effective on and after October 1, 2018, member choice will also be available upon initial enrollment, for annual enrollment choice, and upon member re-enrollment when the 90 day re-enrollment period has passed. (2) If the RBHA is an Affiliated Organization to a Successful Offeror in the same GSA served by the RBHA (Affiliated RBHA Organization), members will have a choice of the Affiliated Organization ACC Contractor consistent with #1 above. (3) If the RBHA successfully elects to become an AHCCCS Complete Care Contractor

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						(RBHA-ACC), AHCCCS will not passively enroll members to the RBHA-ACC for enrollment effective October 1, 2018 and members will not be auto-assigned to a RBHA-ACC. However, AHCCCS will offer the RBHA-ACC (if available) as a choice among all other AHCCCS Complete Care Contractors for members enrolled in an Unsuccessful Incumbent Contractor. RBHA utilizers in Successful Incumbent Contractors will also have a choice of the RBHA-ACC as described in the RFP, Section H, Instructions to Offerors. For enrollment effective on and after October 1, 2018, member choice will also be available upon initial enrollment, for annual enrollment choice, and upon member re-enrollment when the 90 day re-enrollment period has passed.
22.	12/08/2017	Section H	CRS Member Assignment	288	For CRS members who will transition to ACC, how many or what percentage will fall under the family continuity enrollment rules and have a family member with a current incumbent Acute Health Plan?	We have not yet assessed the potential alignment of CRS members through the member movement processes.

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23.	12/08/2017	Section D 50 Compensation/72 Value-Based Purchasing	Various	160/201	Various sections reference ACOM Policy 306 and 307, which in Addendum 1 AHCCCS stated would be released in mid-December. Would AHCCCS consider allowing an additional Q&A period related to these Policy documents once released?	The policies referenced are currently available for Public Comment https://comments.azahcccs.gov/ahcccs-contractors-operation-manual-acom-tribal-consultation-notificationpublic-comment/ Additionally, any CYE19 changes to these policies will also be available for public comment at a later date when the policy is amended. AHCCCS will not add a Q&A period for the RFP.
24.	12/08/2017	Section D 50 Compensation	Whole page	160	Through the Quality Measure Performance, do contractors have the opportunity to earn a portion or all of the 1% withhold as well as earn an additional incentive? Please describe how these two separately written items may interrelate or are they independent from one another?	There is a 1% withhold applied to all Contractors. Contractors can earn up to 1% of the withhold based on performance on specific quality metrics. The difference between the total earned withhold across all Contractors and the total amount withheld becomes the incentive pool. Through the Quality Measure Performance Incentive Payment, some Contractors will have the opportunity to earn a portion of the Quality Measure Performance Incentive Pool. See ACOM policy 306 for additional information on the Withhold and Quality Measure Performance Incentive. https://comments.azahcccs.gov/ahcccs-contractors-operation-manual-acom-tribal-consultation-notificationpublic-comment/
25.	12/08/2017	Data Supplement Section F non-benefit cost bid requirements	4	1	Please define start-up expenses	Start-up expenses are administrative expenses incurred prior to October 1, 2018.

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26.	12/08/2017	Section H	CRS Member Assignment	288	Does CRS passive assignment take precedence over auto-assignment for CRS members without family continuity?	The question is not clear. As described in Section H, following assignment of CRS members utilizing family continuity enrollment rules, AHCCCS will passively assign members proportionally to the Contractors estimated enrollment after completion of the conversion group assignment. Effective October 1, 2018, the auto-assignment process will be utilized consistently for all ACC members.
27.	12/8/17	General	N/A	N/A	Will AHCCC generate and provide a client information system (CIS) identifier for persons enrolled with an ACC contractor?	No, CIS identifiers (CIS ID's) are a product of the behavioral health services system and only those RBHA members processed through the CIS system will receive CIS ID's.
28.	12/8/17	SECTION D: PROGRAM REQUIREMENTS	6	119	What electronic files detailing membership with behavioral health coverage through other RBHA or ACC contractor will AHCCCS make available? Such a file would enable contractors to efficiently and systematically prevent creation of NT eligibility segments for members having existing BH coverage through another contractor.	A process to ensure appropriate access to needed information for the provision of crisis and state only services to all AHCCCS enrolled members is currently under evaluation.
29.	12/8/17	SECTION E: CONTRACT TERMS AND CONDITIONS	5	217	If awarded multiple GSAs, will a distinct contract be issued for each GSA?	Multiple contracts will not be issued for an individual ACC Contractor awarded more than one GSA under the YH19-0001 RFP.
30.	12/8/17	SECTION E: CONTRACT TERMS AND CONDITIONS	5	217	Will ACC contractors awarded more than one GSA be assigned distinct plan identifiers?	No, consistent with current processes, ACC Contractors will be assigned a single contractor/health plan ID.

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31.	12/8/17	ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES	All	231-273	If awarded multiple GSAs, are distinct deliverables required for each GSA?	Some deliverables may or may not require breakout by GSA as required in policy or other AHCCCS guidance.
32.	12/8/17	SECTION D: PROGRAM REQUIREMENTS	6	46	Have you considered for PPC making it all reside under the ACC entity. This will allow system and provider questions regarding routing of claims. If PPC is performed by ACC, provider will only need to submit claims to one entity vs separate entities for PPC and different process for Active coverage.	The PPC segment will only be different for members initially assigned to a RBHA for Non TXIX/TXXI services. This assignment will prevent claim recoupments from providers that have been paid by the RBHAs for Non TXIX/TXXI services.
33.	12/8/17	SECTION D: PROGRAM REQUIREMENTS	5	79	Are ACCs required to assign members not receiving behavioral health services a Behavioral Health Professional?	No. AHCCCS will provide further guidance on this assignment at a future date. Members not receiving behavioral health services do not need an assigned Behavioral Health Professional.
34.	12/8/17	SECTION D: PROGRAM REQUIREMENTS	6	102	Is the member's assigned Behavioral Health Professional detail required on Member Identification cards?	No.
35.	12/8/17	SECTION D: PROGRAM REQUIREMENTS	1	92	If an entity is awarded contracts in multiple GSAs, do the staff limits apply to the contractor or GSA?	Staff limits apply to the Contractor regardless of the number of GSAs awarded.

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36.	12/8/17	SECTION D: PROGRAM REQUIREMENTS	N/A	N/A	As the ACC will have one payer id, the cohorts of eligibility will be driven by contract type, will separate 834 files for the eligibility cohorts – Crisis, Acute, Non-Title (State-Only), Integrated, CMDP and DD.	Although this question does not pertain to the populations covered by the ACC RFP, the following answer is provided. AHCCCS intends to provide separate 834 files driven by contract type for Integrated ACC members; Non-TXIX (if applicable) members; SMI (if applicable) members; and RBHA only (if applicable) members. Crisis is not a separate contract type, and provision of member information for this service is currently being evaluated.
37.	12/8/17	SECTION D: PROGRAM REQUIREMENTS	N/A	N/A	For the DD population, will member enrollment/eligibility be provided in one 834 or will BH or PH be separate?	Although this question does not pertain to the populations covered by the ACC RFP the following answer is provided. DES/DDD subcontractor enrollment will continue to be provided by DES/DD. RBHA functions for DDD members will be a separate 834.
38.	12/8/17	SECTION D: PROGRAM REQUIREMENTS	1 and 17	41 and 101	The contractor is required to have a single phone number for physical and behavioral health services or issues; as an affiliated organization, will all telephone metrics be consolidated into one report for the ACC plan, or do the RBHA telephone performance measures need to be reported separately	AHCCCS will require RBHA telephone metrics to be reported separately from ACC metrics.

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39.	12/8/2017	Section H: Instructions to Offerors	18. Contents of Offeror's Proposal	292	In the Contents of Offeror's Proposal, it states the offeror shall submit 1. Capitation Submission: (1) Agreement accepting capitation rates. Does this agreement exist as a form to complete, or shall the offeror develop its own agreement document? Please advise.	Offerors will develop their own agreement document.