NOVEMBER 14, 2017

ADVANCED AGENDA MATERIALS FOR RFP #17-084 WORKERS' COMPENSATION AND ANCILLARY SERVICES

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TAB 1

Inter Office Memo

DEPARTMENT OF
HUMAN RESOURCES

DATE: November 8, 2017

TO: Board of Supervisors

FROM: Paul Nerland, Director of Human Resources

SUBJECT: Supplemental Agenda Materials – Appeal of RFP 17-084 Workers' Compensation Third Party Administrator and Ancillary Services

Item number 8 on the regular Board agenda for Tuesday, November 14, 2017 recommends award of the contract for the Workers' Compensation Third Party Administrator and Ancillary Services Provider. The first recommended action hears and considers an appeal from Risico, our current vendor, who was not recommended by the committee. This item is a follow-up to the previous agenda item on October 31, 2017.

This supplemental packet includes an executive summary of the process and reasons the RFP selection committee unanimously recommended awarding the contract to AIMS (Tab 2). I have reviewed the committee's recommendation, conferred with Purchasing on the process and reassessed the recommendation. After reviewing the committee's unanimous recommendation and the process, the original recommendation stands. Risico also submitted a follow-up letter to the Board that is included in Tab 4 for your consideration.

Although Risico's appeal primarily focused on their current performance (reduced caseload, program liabilities and reduced program costs), the results do not take into account a change in philosophy at the County as it relates to open claims. For a number of years, the County left claims that required any possible future medical treatment or activity open to ensure that the County had future medical exposure for long-term claims considered. However, beginning in 2014, at the direction of the County, Risico was given authorization from County staff to close claims that had been settled with open future medical awards that were not being utilized. Industry standard indicates that if an injured worker has not used their awarded future medical care in two to three years, it is acceptable to administratively close the file to be re-opened only if and when the injured worker returns for treatment. This accounted for a significant reduction in claims being listed as "open" and allowed the County to reduce reserves by millions of dollars at the direction of County staff. Furthermore, during the recession, the County saw a reduction in its workforce. Along with the reduction came a reduction in work related injuries. This allowed to Risico, over a period of time, to close more claims than were being opened, leading to an additional reduction in expenses and a reduction in over-all reserves.

Although staff agrees that the statistics provided by Risico in their appeal are fairly accurate, it is clear that Risico benefited from not only a change in philosophy by County staff but also a reduction in new claims. This is something that would have been expected with any Third-Party Administrator that the County of Fresno would have been utilizing.

In addition, the statistics do not account for the work of Risk Management and Department staff including the creation of an enhanced "Return to Work Program" to minimize the effects of the employee's disability and aid in the speedy recovery of the occupationally injured/ill employee, to reduce costs associated with the employee's lost time, and to work toward permanent resolution of injured/ill employees' claim status.

It is also important to note that the stability of the County's Workers' Compensation program is extremely important. This is especially true given the size of the County's workforce, the long history of being self-insured, and the claims generated on a yearly basis. While staff recognizes the importance of using locally based firms when possible, Risico only has one other large self-insured client. It is of concern that should Risico no longer be contracted with that client, it could place the County's program in serious jeopardy. Although AIMS is headquartered in Sacramento, they have had a local office that has served other large public entity clients for many years. That said, this provides insurance that the County's program will remain stable and the benefits employees receive will remain unaffected regardless of any other changes AIMS might incur from any of their other clients.

Should you have any questions, please contact me at 600-1800.

TAB 2

Executive Summary

RFP 17-084 Workers' Compensation & Ancillary Services

The County of Fresno released an RFP for Workers' Compensation and Ancillary Services on June 9, 2017. The County's Workers' Compensation program is self-insured up to a retention level of $500,000 and excess coverage is provided by the CSAC Excess Insurance Authority.

RFP Review Committee

The RFP Review Committee consisted of five members. Three committee members were from the County of Fresno, Risk Management. Two committee members were from CSAC-Excess Insurance Authority (EIA); one is a Workers' Compensation Claims Manager, and one is a Senior Workers' Compensation Specialist.

Selection Criteria

Pursuant to the RFP, the committee reviewed and ranked proposals based on the following criteria:

- Overall responsiveness to the RFP
- Comprehensiveness of the bidder's submitted proposal
- Related technical capabilities
- Performance capabilities
- Capability of the bidder to complete the scope of work
- The bidder's acceptance of the terms and conditions of the RFP
- The cost of services in relation to the scope of work

RFP Review Committee Rankings

The proposals were ranked by each committee member based on its strength relative to the other bids and the provisions set forth in the RFP. The table below identifies the consensus of the respective Review Committee's evaluation of the proposals in ranked order from highest to lowest.

Ranking	Bidder
1	**AIMS**
2	**TRI-Star**
3	**Risico**
4	**Intelligent Medical Solutions**

The committee ranked the proposals based on the RFP criteria and ranked AIMS and TRI-Star as the top two proposals (three members favored AIMS, two members favored Tri-Star). No committee member ranked Risico as number 1 or recommended they be a finalist. The committee determined that finalist interviews to ask clarifying questions and an onsite visit to give the finalists the opportunity to demonstrate their claims system data support and reporting capabilities would be necessary.

AIMS and Tri-Star were sent questions from the committee, specific capabilities that required demonstration, and a request to view the workspace of the designated staff (*Attachment A* includes the questions and finalist responses). On August 31, 2017, the committee, along with Purchasing staff, met with AIMS and Tri-Star and received the requested information and demonstration. After review of the initial proposals, the clarifying questions, and site visits, the Review Committee met and *unanimously* recommended awarding the contract for services to AIMS.

All five evaluators recommended AIMS to act as the County of Fresno's new Third Party Administrator (TPA) and to provide ancillary services for the County's self-insured Workers' Compensation program.

Summary of RFP Review Committee Recommendation of AIMS

Although the committee considered that both AIMS and Tri-Star were costlier than Risico, all five members *unanimously* ranked AIMS as the best *overall* proposal and Risico was *unanimously* ranked third based on the criteria of the RFP. Although not exhaustive, a summary of the reasons for the committee's recommendation are as follows:

- Comparable Experience (Client Reference Lists Attached – *Attachment B*)
    - Comparing clients of similar size and background, AIMS demonstrated both experience with large public sector clients and stability. AIMS has over 100 Clients and 80% are Public Entities.
    - In contrast, Risico had one comparable public sector client and others for which they only perform some of the services in the RFP scope of work.
- Efficiency & Speed
    - AIMS' proposal demonstrated the ability to provide claims reporting by submitting injuries through their claims reporting system or through "Call Connect" that would allow injury reporting through nurse triage allowing for immediate medical intervention.
    - AIMS' sister company, Allied Managed Care (AMC), offers Utilization Review, Bill Review and medical provider networks that can help assure that only necessary

medical care is authorized, mitigating claims expenditures. Their integrated vendor referral system allows fast and easy referrals to all vendors of the County's choosing. In addition, the services provided by AMC provide for proper medical control and ensure that cost containment measures are in place.

As part of their medical cost containment they also use Utilization Review triggers with a customized menu of medical services that would allow their experienced claims examiners to authorize at their level instead of delaying authorization by submitting them through Utilization Review.

AIMS is also the only bidder *guaranteeing* the County a 24-hour turnaround three-point contact with injured employees after the receipt of the first notice of loss. AIMS proposal indicated that Claims Examiners are required to contact an injured worker every 2-weeks if they are receiving temporary disability benefits. If modified duty exceeds 30-days they are also required to make *continuous contact* every 30-days until they have returned to full duty and/or have identified permanent work restrictions. In contrast, Risico's proposal follows a three-point contact within three business days (72 hours) for employees losing time from work. The Risico claims adjuster will contact the injured workers no less than every 45 days while they are unable to return to work and more frequently based on the circumstances of the claim, the needs of the injured worker and the status of the medical treatment.

- <u>Staffing (Size, Stability, Capability & Training)</u>
    - Staffing Experience and Turnover
        - AIMS has demonstrated a long-term commitment to the Fresno area by having a local office since 1987. They serve several public sector clients of similar size to the County of Fresno throughout the State of California. AIMS is well staffed both at the local and corporate level. In addition to their claims handling capabilities, they offer a great deal of technical and training support to both their employees and their clients. AIMS' proposal confirmed that over a period of five years they demonstrated less than 4% turnover. Additionally, AIMS' proposal indicated that, before any offers of employment are made, they will only hire local staff that are desirable to the County and the County may participate in the interview process. In contrast, Risico has experienced high turnover over the last five years.
        - AIMS proposal summarized not only the experience but detailed job descriptions and organizational charts indicating the depth of resources available.

- Technology and Claims Reporting Capabilities
    - The demonstration AIMS provided of their claims system showed the ability to not only assist Claims Examiners in keeping the claims moving in an efficient manner, but the system also allows the County to access information, run reports and submit claims efficiently and electronically.
    - The Vice President of Technology for AIMS attended the meeting and was able to present on a "Test Client" the user-friendly intake reporting system and cost containment products for maximum efficiency and centralization of data.
    - AIMS was the *only* bidder with a claims management system that is fully integrated with their paperless mail system. They also have an effective Dashboard with a notification system to report late diaries, inactive files, and claims that require attention to keep the claims moving and in compliance with regulations.
- Thoroughness of the Proposal
    - AIMS proposal answered all questions thoroughly and included detailed descriptions of *how* they would accomplish what they proposed and provided samples where appropriate.
    - Risico's proposal often indicated that they were currently performing every task but did not explain in detail *how* they would perform the scope of work. This was noted by every reviewer on the RFP Review Committee.
- Additional Value-Added Services
    - Legislative Advocacy - AIMS also retains a legislative advocate on staff that will speak on the County's behalf and provide necessary information regarding upcoming legislation changes and other developments that could affect the County. For example, AIMS has spent several months preparing for a pending legislative change in the pharmaceutical area of Workers' Compensation so current clients are well prepared in advance of the effective date of the new legislation.
    - Liability Expertise – AIMS proposal also provides liability expertise to assist in the management of the Workers' Compensation claims as an additional benefit when injury to an employee is caused by a third party and/or damages to County property are incurred.
    - Enhanced Pharmacy Benefit Program – This cost control program would allow appropriate narcotic intervention before distribution of pharmaceuticals.

- Quality Control Program – AIMS' proposal includes an independent Quality Assurance and Audit Unit at their corporate headquarters that would allow upper management to consistently monitor, measure and review performance to ensure quality results and identify cost savings.

It was the committee's unanimous opinion that these additional resources will lead to cost savings that will offset the difference in the cost proposal. The committee submitted their unanimous recommendation to the Director of Human Resources who, after reviewing thoroughly, supported it (see *Attachment C* - Memo to Purchasing – September 12, 2017).

The County's Workers' Compensation program expended over $10 million dollars last fiscal year. This does not include the County's cost of partial wage placement for employees that are unable to work and the overtime incurred when other employees must cover for absences. The objectives of the successful bidder, pursuant to the RFP, include effective and efficient management of all County Workers' Compensation claims in such a manner as to minimize the County's costs. Additionally, pursuant to the RFP objectives, the successful bidder would provide information with which the County can evaluate the current condition of the Workers' Compensation program including injuries by department, type of injury, number of days lost on the claim, facility where the injured worker was treated, costs of claims including indemnity, medical and legal, diary reviews, and plans of action. AIMS proposal best demonstrated the ability to achieve these goals and ideally lower the costs of the Workers' Compensation program.

ATTACHMENT A

COVER LETTER – ELECTRONIC SUBMITTAL

August 25, 2017

Shannon W. Kirby
County of Fresno - Purchasing
4525 E. Hamilton Avenue, 2nd Floor
Fresno, CA 93702

Re: REQUEST FOR PROPOSAL NUMBER: 17-084 WORKER'S COMPENSATION AND ANCILLARY SERVICES – VISITATION AND QUESTIONS OF CLARIFICATION

Dear Mr. Kirby,

In response to County of Fresno ("County") request for Visitation and Questions of Clarification, TPA Candidates Questions and General Questions ("Questions"), **Acclamation Insurance Management Services, Inc. (AIMS)** is submitting the attached completed answers. Our senior operating management team has reviewed the County's Questions and has provided the appropriate responses, in blue font. Should the County need additional information or require clarification on any of answers please do not hesitate to contact us.

AIMS is a California corporation with over **44 years of successful service.** AIMS has extensive experience managing public agency programs similar to County's program having **over 100 Clients of which 80% are public entities. AIMS Clients** range in size from 10 open claims to over 3,000. With 80% of our Clients located here we have achieved the highest level of expertise in this State. AIMS has been providing the requested services for two-thirds of our Clients for greater than 10 years with one of our Central Valley Clients greater than 26 years. This is testament to the high quality of the services we provide and to the satisfaction of our Clients as well as our commitment to remaining in the Central Valley for years to come. AIMS established a Fresno office, our proposed claims office for the County, over 30 years ago and we have successfully continually services our valuable Clients in the Central Valley from this office with over 30 professional claims employees.

Our designated contact for the Visitation and Questions Clarification is:

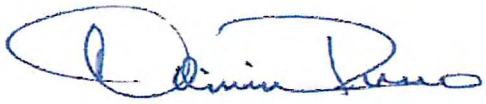
Larry Hunt, Senior Vice President
10445 Old Placerville Road, Sacramento, CA 95827
Direct: (916) 563-1900 or Mobile (916) 715-8461
Email: lhunt@aims4claims.com

The County can be assured it will have my full support and commitment that **AIMS** can and will deliver as promised. I will always be available not only to respond to any problems or concerns but to share my insight on our solutions and offerings. We will take our role as your Third Party Administrator of Workers' Compensation Claims seriously and, if selected, we will

strive to achieve a mutually beneficial partnership with the County, as we all work together toward the common goal of achieving the best possible program.

AIMS would be delighted to have the opportunity to answer any questions you may have regarding our RFP response or the Questions of Clarification and to further explore how we can customize a solution to enhance the overall success of the County's program.

Sincerely,



Dominic L. Russo
President & CEO AIMS/AMC, (Authorized bind the corporation)

TPA Candidates Questions:

An ongoing issue is the availability of experienced claims handlers. How do you propose to ensure that you will be able to sufficiently staff the designated unit with experienced claims handlers? What is your contingency plan for claims handlers in the event of absences?

AIMS is well aware of the pressures associated with recruiting and retaining qualified Claims Examiners and are confident in our ability to staff the County of Fresno program. The long-term dedication of our employees has been critical to our success in the industry. In the last five years the Company (AIMS / AMC) has seen less than a 4% turnover amongst our professional staff. This stable staff is invaluable in recruiting new candidates.

We offer our Claims Examiners flexible work hours, work-from-home options if certain criteria are met and systems that are easy to use and are efficient. We understand the day-to-day demands of the job and provide working solutions that give Claims Examiners back hours in their day. This allows for them to easily accomplish their daily tasks and focus on servicing their Client. That is what dedicated, experienced claims handlers want from an organization they work for – and we provide it.

All of our teams have a "buddy-system" where each member is assigned another member to support while they are on leave. This provides depth and knowledge of the department, division and Client from a singular individual to a broad range of staff who can provide additional support if necessary. In the event that the leave is of a longer duration, temporary staff will be brought in to support the team.

Assuming AIMS will be notified of successfully obtaining the County's account within 30 days prior to inception of the contract; we would then be able to provide the personnel assigned, necessary resumes/licenses and be fully staffed. Also, AIMS is open to receiving Claims Examiner recommendations from the County. If required, and before any offers are made, candidates may be interviewed by the County's personnel to reinforce our thoughts on who would best fit the program.

Our hiring process includes a written exam, face-to-face interview and background and reference checks. Because our office is located near several freeway systems, we are able to attract talented claims professionals from many directions. We are usually able to connect with interviewees through the efforts of our human resources department. When necessary, we have preferred recruiting firms who will assist us to find good candidates. Our overall salary and benefit compensation is in line with market conditions and we also have a variety of internal incentive programs.

Claims can be adversely affected by a lack of aggressive handling resulting in inflated pendings and, possibly, more costly resolutions. What do you have in place to ensure aggressive, proactive claims handling on all files by all your staff? What flags trigger the claims handler to become more aggressive in moving claims to closure?

The key component for aggressive, proactive claims handling is having the appropriate time to complete the tasks required. Being aggressive and proactive equals being current or on-top of the

activity on a file and affecting the next steps/actions that need to happen to achieve the desired outcome. In order to do this, the Claims Examiner must have the time to review reports, think about where the file needs to go, strategize with the Client and round-table difficult situations with other industry experts. This can only happen if the Claims Examiner has enough time in the day to complete the day-to-day tasks and still have time for reflection.

AIMS is able to provide this extra time due to all the efficiencies we have created within the "processing tasks" of a claim. The Claims Examiner should review the file at intervals not to exceed 45 calendar days. It is expected that the Claims Examiner have a current Plan of Action Update in the claim notes every 90-days with clear steps to resolve the outstanding issues to resolve the file. These steps focus the Claims Examiner on the next tasks to complete and the timelines associated with those tasks. Supervisor oversight concentrate on the Action Plans set forth in the file notes and if there are any quicker or better solutions to accomplish these tasks.

AIMS created a Claims Examiner Productivity Dashboard which quickly identifies files out of compliance with their Plan of Action Updates and/or last diary reviews. These files are targeted by the Supervisory staff to review and quickly get back on track. These Dashboards are run in real-time and provides a wealth of information to the Supervisors on which files are lagging and/or need attention.

The key to closing claims is to maintain a tight diary system to ensure that each claim progresses toward resolution without delays. In addition to diaries maintained by the Claims Examiner and Supervisor, our claims management system generates automatic diaries for each claim. Claims Examiner diary reports not only provide lists of claims on diary, but lists of those claims without future diary dates. Dual diaries by the Supervisors ensure that claims continue to be managed in an expedient manner.

What qualities do you look for when interviewing and selecting examiners? What sort of testing do you do as part of the interview process?

Generally, the qualities AIMS looks for in selecting Claims Examiners include the following:

- Excellent Client management and professional communication skills.
- "High Energy" individual with a desire to reach successful accomplishments.
- Good written communication skills.
- Strong interpersonal skills.
- Ability to investigate and analyze information and to draw conclusions.
- Must be able to exercise excellent independent judgment.
- Good at facilitating problem solving with Clients, customers and colleagues.
- Adept at managing commitments to Clients, customers and colleagues.
- Ability to work well under pressure with heavy project volume.
- Must be able to work in a team environment and be flexible to learn new things.
- Attention to detail and accuracy, well organized, ability to work with minimal supervision.

As part of our interview process AIMS will have candidates complete a written test. The written test has over 28 questions dealing with situations encountered by a Claims Examiner on a day-to-day basis and is intended to test the basic knowledge of the candidate regarding claims handling. The written test asks general and specific questions regarding new regulations, new disability rates, etc. to determine the applicants overall competency.

While written testing is helpful, it is not the only criteria we assess during an interview. In general, AIMS will conduct the interview by asking about situations the candidate has experienced. This allows for them to explain how they handled a problem, resolved a dispute, escalated an issue or concern and what claims handling resolution they are most proud of. All of these responses help define and complete the picture of how the candidate will perform once hired.

Our staffing plan will ensure effective recruiting, hiring, and training of all claims personnel dedicated to the County. AIMS is committed to continuously interviewing claims professionals at all levels on an ongoing basis. This proactive approach identifies qualified talent and ensures we always have resources available for additional staffing. Our hiring process includes a face-to-face interview with two Claims Managers or Claims Supervisors, a written technical claims test, and background and reference checks. We are usually able to connect with interviewees through the efforts of our human resources department. When necessary, we have preferred recruiting firms who will assist us to find candidates. Our overall salary and benefit compensation is in line with market conditions and we also have a variety of internal incentive programs.

AIMS will make every effort to hire personnel that is desirable to the County, including the County's current claims handlers. Before any offers are made, candidates may be interviewed by the County's key personnel to reinforce our thoughts on who would best fit the County's program. Upon successfully hiring new staff for the County's program, AIMS will utilize our training and mentorship programs to ensure the new staff are quickly brought up to speed on the AIMS protocols and best practices as well as the County's Best Practices and Performance Standards.

Can you discuss plans for transition if you are selected to handle our claims? Please discuss timeframes and measures to be taken to ensure an efficient transition from old administrator to new. Are there any fees for data conversion?

Upon notification of award of contract, a series of implementation/transition meetings are scheduled immediately with all key Client personnel and AIMS' Assistant Vice-President of Operations who serves as our Transition Coordinator. Orientation meetings are also conducted with new Clients to introduce our staff and provide all parties with the opportunity to become acquainted with us. AIMS creates a schedule of meeting dates, with no less frequently than weekly during the implementation phase and through the first 90-days of take-over. Thereafter, monthly meetings with the Claims Manager/Supervisor for the first six months and quarterly meetings thereafter to review claims status, identify where improvements can be made, and provide on-going support of the workers' compensation program.

As part of the implementation process, AIMS will create a document that is specific to the County's claims handling processes and procedures that support the County's workers' compensation program goals. The result of these meetings will be the development of customized *Special Account*

Instructions for the County. These standards will outline the customized approach to claims administration, which will include specific procedures for claims management and communication with the County.

Implementation meeting discussion topics will include but are not limited to:

- Discuss employees and the current/preferred staffing plan
- Confirm banking procedures, exchange financial information
- Determine claims systems specifics, etc.
- Determine vendor panel
- Discuss work flow
- Establish goals for program
- Review and determine reports required, to whom and the frequency to be provided
- Determine schedule for annual evaluation, Client training and claim reviews
- Any other issues that are critical to a smooth implementation

AIMS takes a proactive approach to ensure seamless transition of the physical files by securing agreed upon action plans with the retiring TPA (i.e. identifying priority claims – hearings, delays, ongoing payments etc. and delivery date of the files). We engage in a thorough "File Triage" that includes early identification of case closures, reserve adequacy, "hot file issues" requiring immediate pro-active attention and establishment of the initial case diary.

AIMS has extensive experience in the transitioning of large programs from other third party administrators and/or carriers. We adhere to estimated industry guidelines for transfer of claims administration. We normally recommend 30 to 60 days for a smooth transition of existing claim files. This includes a complete, detailed, conversion of all your claims and financial data from your prior administrator.

Our Clients experience seamless claims handling transitions where injured employees receive timely benefits with no disruption; all claims received are triaged by senior technical staff who identify key facts, issues and develop proactive action plans to move claims towards closure. Reserves are reviewed and allocated for probable ultimate cost and through this formal process we are able to achieve significant and immediate cost reductions and file closures.

AIMS will work with the County to develop a customized mutually agreed upon formal plan and schedule. The formal transition plan addresses the following critical areas: staff introductions to the County, program orientation, data conversion, physical file transfer and banking program procedures. The plan also includes step-by-step instructions for the transition of all claims and financial data from the prior administrator. This plan has emerged from years of hands-on practical experience in facilitating the transition of programs from other claim administrator. Our plan minimizes the risks, delays, and issues that are often associated with the movement of an existing workers' compensation program. The conversion process also allows the ideal opportunity for the County to review and make changes to their current claim coding and location structures.

There is a one time, direct pass through, fee for data conversion costs. Fee will not exceed $15,000.00 per source entity. Actual fee may be lower.

Please describe in detail your paperless intake process. What is done to avoid a bottleneck at the examiner level? Are documents stored by date of entry, date of document, or both? What is the turnaround time for system entry? Who is responsible for responding to documents? How is this monitored?

AIMS has partnered with a global leader in IT solutions, to provide a paperless solution that includes document-based business process management (BPM) with ease of usage and accessibility. The paperless system is separate and distinct from the claim system. In other words, the two systems are bifurcated. The AIMS paperless solution is built on a separate database and storage platform that is virtualized for redundancy and high availability. All documents are accessible through a separate interface from AIMS' claim system and can be opened simultaneously with the claim management system and viewed on a dual monitor.

Documents are scanned/uploaded the day they are received (and date stamped as such) and delivered to the Claims Examiners as "new mail" throughout the day via a Work Flow Queue. Documents are indexed by the mail team to assign the correct claim number, document types, document date, provider name, amount of bill, etc. These index fields were established to permit the most extensive search capabilities system wide for stored documents. Each Claims Examiner/user can set up their search queue in any way they prefer and sorting any way they prefer. So a user can view all documents attached to a claim file by various sort/filters and/or date filters (oldest to newest) etc. The document viewing is 100% customized to the user.

Mail queues are reviewed daily by the Supervisory/Management Team to insure that backlog and bottlenecking does not occur. If this event does occur, a correction plan is immediately put into place to resolve the issue. In addition to monitoring the amount of work pending in a Claims Examiner's mail queue, the Supervisor also can quickly view documents that have exceeded the AIMS Best Practices timelines for responding. As part of Work Flow design, each document type has been assigned a maximum days to complete. Supervisors can readily view those documents that are out of compliance and direct the Claims Examiner activity to resolve that mail.

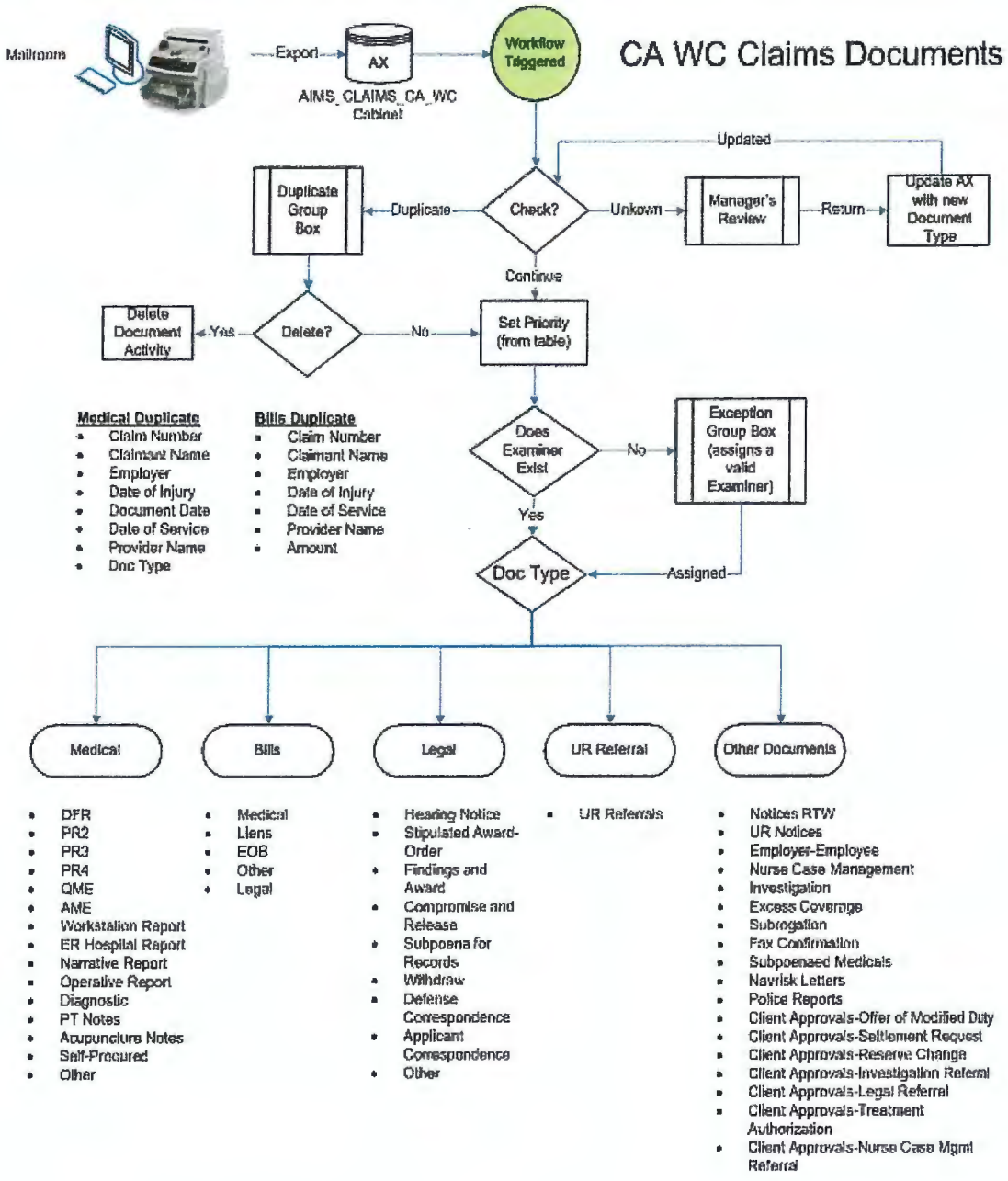
At any time, Supervisors can view all incoming mail for their team and insure that legal issues are handled, award payments are processed and MMI Reports are addressed appropriately to ease the file to resolution.

The AIMS paperless system (AX) is directly integrated with the claims system. AIMS Clients have appropriate access to the paperless documents through the claim system. When a claim is open in the claims system the County staff would select a hotkey that opens all associated files for that claim. Our paperless environment also has the ability to provide documents to the County by searching by date, physician name and/or medical report type, pulling the data across all claims and mail received. This eliminates the need to access each individual claim file to review reports.

All claims related documents are centrally captured, indexed, and stored in the paperless system. The paperless system has customized key index values to simplify file organization and search ability. A customized global workflow process has been created to eliminate the possible loss of documents, the duplication of documents, and the accuracy of filing. Customized business workflow processes are

attached to each document type (medical, legal, bills, etc.) to streamline activities required by Claims Examiners during the claims process. Documents requiring time sensitive processing have built-in triggers and management oversight flagging to ensure expedited handling of those documents.

Sample Paperless Workflow:



Please describe and compare what you deem to be the experience and knowledge levels of a Senior Examiner, a Junior Examiner and a Future Medical Examiner.

All Senior Claims Examiners and above will be certified by the Department of Self-Insurance Plans to administer self-insured workers' compensation claims, 4850 experience and possess the necessary certification as mandated by Insurance Code Section 11761. The Senior Claims Examiner will have public entity experience which will include administering 4850 benefits and five (5) years of technical claim adjusting experience.

Senior Claims Examiner Qualifications and Experience Required

- Self-Insurance Certificate.
- Minimum of 5 years' work experience in the insurance industry, specializing in workers' compensation handling active indemnity claims including litigation issues.

SKILLS AND ABILITIES

- Excellent client management and communication skills.
- "High Energy" individual with a desire to reach successful accomplishments.
- Good written communication skills.
- Strong interpersonal skills.
- Ability to investigate and analyze information and to draw conclusions.
- Must be able to exercise excellent independent judgment.
- Good at facilitating problem solving with customers/colleagues.
- Adept at managing commitments to customers and colleagues.
- Ability to work well under pressure with heavy project volume.
- Must be able to work in a team environment and be flexible to learn new things.
- Attention to detail and accuracy, well organized, ability to work with minimal supervision.

Claims Examiner Qualifications and Experience Required:

- Self-Insurance Certificate or successful passing within 18 months of hire date
- Minimum of 2 years' work experience in the insurance industry, specializing in workers' compensation handling indemnity claims.

SKILLS AND ABILITIES

- Excellent client management and professional communication skills.
- "High Energy" individual with a desire to reach successful accomplishments.
- Good written communication skills.
- Strong interpersonal skills.
- Ability to investigate and analyze information and to draw conclusions.
- Must be able to exercise excellent independent judgment.
- Good at facilitating problem solving with customers/colleagues.
- Adept at managing commitments to customers and colleagues.
- Ability to work well under pressure with heavy project volume.
- Must be able to work in a team environment and be flexible to learn new things.

- Attention to detail and accuracy, well organized, ability to work with minimal supervision.

Junior Claims Examiner & Future Medical Claims Examiner Qualifications and Experience Required:

- 2+ years of Workers' compensation experience handling medical only claims
- High school graduate
- 1-2 years previous experience as a Claims Assistant
- Has received or will receive workers' compensation training as specified by Ins. Code 11761

SKILLS AND ABILITIES

- Proficient computer skills
- Good communication and organization skills
- Ability to multi-task and prioritize duties
- Smoothly adapt to quick changes in priorities
- Portrays a professional company image to vendors, partners and fellow employees
- Ability to work independently and in a team environment
- Good typing and keyboard skills

Please describe your proposed staffing model.

The proposed staffing for County of Fresno will be as follows:

- 1 Manager (oversight)
- 1 Supervisor
- 6 Senior Claims Examiners
- 1 Future Medical Claims Examiner
- 2 Claims Assistants
- 1 Clerical Support

For caseload control, the AIMS general staffing model is one (1) Manager to a maximum of three (3) Supervisors; one (1) Supervisor to a maximum of six (6) Claims Examiners (depending on the maximum caseload requirement); two (2) Claim Assistants for every six (6) Claims Examiners and one and one-half (1.5) Clerical for every six (6) Claims Examiners. Of course, this staffing model is used as a guideline and adjusted according to the claim volume and complexity of the claims. AIMS generally allocates Claims Assistants and Clerical time based on the claims volume and work demands for a particular Client. Our Claims Examiners generally average between 125 to 150 indemnity claims depending on our Client's requirement. Our average indemnity claim inventory includes future medical claims and a blend of high to low severity claims.

The AIMS Managers/Supervisors do not carry a caseload. This enables them to provide technical oversight of the individual claims and the employers' workers' compensation programs. It also helps ensure the best possible quality, service, results, compliance with regulatory and Client-specific program performance standards are met.

AIMS has determined that the maximum number of claim files that a Supervisor can reasonably oversee and be responsible for is 1,050. The number of Claims Examiners that are allocated to 1,050 files is dependent on the maximum caseload count, which is generally 150. This would equal seven (7) Claims Examiners. At a maximum caseload of 125 claims per Claims Examiner the number of Claims Examiners to supervisor ratio would be approximately 8:1. Managers are generally responsible for up to three (3) teams or 3,100 open files.

In situations where caseloads include future medical and medical only claims, these claims will be counted as 2:1 in the caseload limit.

While "companion files" can be "ad-ons" to litigated and/or end of career claims, they still require the Claims Examiner time and attention and therefore are counted as an indemnity file on a 1:1 ratio.

What are your policies for staying current with changes to the fee schedule and updates to bill review software programs?

AMC's bill review software is ACS CompIQ, which was founded in 1997 and is a premier national provider of bill review software and services to the workers' compensation, group health, and liability insurance industries. CompIQ developed the first paperless workflow for bill review, incorporating an innovative web-based tool that enables claims professionals to view medical bills and re-pricing information from their desktop without exiting their claim management software. AMC's relationship with CompIQ dates back over 20 years of providing a high quality product for our Clients.

This bill review software is state-of-the-art Windows based software that is updated on a regular basis to reflect current fee schedules and PPO networks. AMC is compliant with E-bill regulations and state reporting as well. This bill review software system is used to detect a broad range of questionable billing practices, excessive and duplicate charges, over-utilization, and unnecessary services. AMC's qualified trained staff reviews each bill to determine appropriateness of treatment and to ensure provider compliance with fee schedule ground rules.

General Questions

Will you please clarify the staffing model you propose for the county? How many managers, supervisors, adjusters, assistants and clerical staff? How many of the adjusters will be seniors? Will the team be dedicated?

The proposed staffing for County of Fresno will be as follows:

- 1 Manager - Oversight
- 1 Dedicated Supervisor
- 6 Dedicated Senior Claims Examiners
- 1 Future Medical Claims Examiner
- 2 Claims Assistants
- 1 Clerical Support

For caseload control, the AIMS general staffing model is one (1) Manager to a maximum of three (3) Supervisors; one (1) Supervisor to a maximum of six (6) Claims Examiners (depending on the maximum caseload requirement); two (2) Claim Assistants for every six (6) Claims Examiners and one and one-half (1.5) Clerical for every six (6) Claims Examiners. Of course, this staffing model is used as a guideline and adjusted according to the claim volume and complexity of the claims. AIMS generally allocates Claims Assistants and Clerical time based on the claims volume and work demands for a particular Client. Our Claims Examiners generally average between 125 to 150 indemnity claims depending on our Client's requirement. Our average indemnity claim inventory includes future medical claims and a blend of high to low severity claims.

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In situations where caseloads include future medical and medical only claims, these claims will be counted as 2:1 in the caseload limit.

While "companion files" can be "add-ons" to litigated and/or end of career claims, they still require the Claims Examiner time and attention and therefore are counted as an indemnity file on a 1:1 ratio.

AIMS has allocated a staffing model that will be responsive to the requirements of the County's Workers' Compensation Program. If awarded the contract, AIMS will provide the required staffing to meet the needs of the program and the County's requirements. If claims frequency and Client request warrant, the account will be assigned on a *fully dedicated basis*. This will include either dedicated or designated Claims Examiner/Adjusters along with the necessary management/supervision and support staff, who will be in full compliance with regulatory and Client-specific program performance standards.

Please elaborate on your plan to staff the account; how many of your current examiners would be assigned to the account and how many would you hire from the outside? Would you be willing to hire examiners/supervisors that are currently working on the account if the County recommends them?

AIMS prefers to promote from within whenever possible and adding this account to the Fresno Office would provide for some promotional opportunities for our existing staff. So it is difficult to say if internally we will have Senior Claims Examiners applying for the Supervisor position, but we would expect that to be the case. So, there could be existing staff who will transition over to this new account

(if it is a promotional opportunity). Following any internal promotions we would be recruiting from the outside for the remaining staff.

We would encourage the County to recommend existing staff for AIMS to recruit and secure before the termination of the contract with their current TPA. This would insure that the current claims administration work-product does not lag during the transition period.

Our staffing plan will ensure effective recruiting, hiring, and training of all claims personnel dedicated to the County. AIMS is committed to continuously interviewing claims professionals at all levels on an ongoing basis. This proactive approach identifies qualified talent and ensures we always have resources available for additional staffing. Our hiring process includes a face-to-face interview with two (2) Claims Managers or Supervisors, a written technical claims test, and background and reference checks. We are usually able to connect with interviewees through the efforts of our human resources department. When necessary, we have preferred recruiting firms who will assist us in finding candidates. Our overall salary and benefit compensation is in line with market conditions and we also have a variety of internal incentive programs.

AIMS will make every effort to hire personnel that is desirable to the County, including the County's current claims handlers. Before any offers are made, candidates may be interviewed by the County's key personnel to reinforce our thoughts on who would best fit the County's program. Upon successfully hiring new staff for the County's program, AIMS will utilize our training and mentorship programs to ensure the new staff are quickly brought up to speed on the AIMS protocols and best practices as well as the County's Best Practices and Performance Standards.

Does your current office location have enough room to house the proposed new staff?

Yes, the Fresno Claims office has enough room to house the proposed new staff for the County of Fresno program.

AIMS office in Fresno located at 4450 North Brawley #125C Fresno, California 93722.

AIMS opened its Fresno office in 1987.

Square feet:

11,086 office space

4,456 warehouse for claim file storage for CA offices

15,542 Grand total square feet

- Reception Area
- Keycard/Fob Entrance
- Kitchen/Break Room plus Kitchenette
- Large Conference Room
- Small Conference Room
- Training Room/Meeting

Current Employee Totals:

28 Workers' comp employees

03 Liability employees

31 Total employees

Will you please clarify how you intend to make claim assignments to the examiners? You indicate losses are assigned based on examiner expertise and experience. Do claims get re-assigned as they get more complex?

As part of the implementation process AIMS will discuss with the County how they would prefer their claims be divided among the Claims Team. In our experience departments/divisions within an organization prefer to be assigned one Claims Examiner, if possible, rather than an alphabet split. This will all depend on the volume of claims in each department/division and again, what the preference is for the County. Claims would then be assigned based on this division and according to claim type. All indemnity claims are assigned to Senior Claims Examiners for handling. Medical Only files would be handled by the Future Medical Claims Examiner and transferred to a Senior Claims Examiner if there is an expectation of lost time or permanent disability benefits being paid.

Supervisor's responsibility to review all new reported losses and make assignments based upon the Claims Examiner's expertise and experience. Supervisor's responsibility to review all new reported losses and make assignments based upon the Claims Examiner's expertise and experience.

Your proposal mentions a "Lead Litigation Examiner" who handles all files with upcoming legal issues. Will you please explain this person's role? Does a claim get transferred to this person when it becomes litigated? Does this person handle only certain aspects of litigation? Is there an additional cost for this person?

As California public claim specialists, we bring special insights as well as unique contacts (our seasoned staff has garnered many relationships over the years with judges, attorneys, carriers etc.) cultivated over many years handling claims for many statewide California public agencies. We have full knowledge of the geographic area and court system throughout the State and AIMS' have extensive experience in many of the immunities that are shared by public entities, and the litigation management experience necessary to keep the claim cost to a minimum. Our Claims Examiners have proven to be a critical partner with our Clients in structuring settlements that are consistent with their desired outcome. We provide greater efficiency in the handling of claims and obtain bottom line cost reductions, which include: a customized proactive claims management program ensuring expedient handling and closure of claims, continuous communication with the Client, efficient staffing plans, best practices performance standards and our state-of-the-art technological resources.

In support of claim resolution, we will work closely with the County Defense Attorney on all litigated matters. It will be our goal to create an excellent working relationship with the in-house attorneys handling the workers' compensation litigation. To accomplish this we recommend monthly meeting

with the legal team from the County to discuss any upcoming WCAB hearings, trials and/or Conferences. The AIMS team will be responsible for assisting the legal team in preparing necessary documents, copying records and supporting the overall legal strategies to resolve the claim. A Lead Litigation Claims Examiner is one or more of the team Claims Examiners who has extensive experience in litigated claims. This title is only to identify the resource or resources available to other Claims Examiners in the handling of litigated claims. The litigated claims do not get transferred to the Litigation Claims Examiner but stays with the original Claims Examiner for continuity of handling. Again, this position is only a resource for others based on their extensive litigation experience. There is no additional cost for this person as they are part of the County's Claims Team.

It appears you have some robust reporting capabilities. As we all know, reports are only as good as the data that is used to compile them. What do you do to ensure staff is coding claims timely and accurately?

AIMS has taken painstaking time in cleaning up our coding tables to remove ambiguous descriptions and miscellaneous coding types. This helps direct the staff in selecting correct codes when entering claims into the system. To insure this process is accurate we recommend a monthly report with all new claims entered be provided to the County and Supervisor for review. As the team matures and becomes more familiar with the program, these coding issues should resolve and the monthly report will become a quick check/balance of our data entry process.

AIMS takes a proactive approach to Claims Examiner caseload management. Caseload levels are managed based on client specific requirements. On a monthly basis, we review the Claims Examiner activity reports that capture all new claims and closing ratios. The Supervisors consistently manage the Claims Examiner caseloads to ensure caseload levels are managed based on Client specific requirements. We do not allow our Supervisors and managers to carry caseloads as they are focused on providing continuous oversight of the claims and programs to ensure accurate reporting.

The Supervisor, as a part of his/her performance evaluation, has to review a select percentage (minimum 10%) of files under their supervisor on a monthly basis. This review is conducted to ascertain that the Claims Examiner is performing up to our standard as well as the agreed upon standards of the Client. For sensitive or high exposure cases, the Supervisor utilizes a personal oversight diary, identifying those cases that warrant periodic management review. The Supervisor Review is clearly noted in the notepad. All claims have a diary follow-up date set automatically by the computer for an initial 28-day review by the Claims Examiner and a 42-day review by the Supervisor.

The Supervisor subsequently reviews claims at regularly timed intervals (not less than every 90 days) or when specific events occur such as surgery or litigation, when the claim meets reserving or payment thresholds, and in the course of continuous random audits. The Supervisor reviews delayed claims every 30 days until a decision is rendered. Higher value claims or claims with complex issues are also reviewed by the Claims Manager and Vice President of Workers' Compensation. Management group reviews are also conducted.

In addition to the standard supervisory audit, our own Internal Audit Unit, headed by the Vice President of Workers' Compensation, conducts audits against our best practice standards as well as the Client's Special Handling Instructions. The Audit Unit's process involves notification that an audit is to be conducted in the Branch or local office. The Manager shall make available all requested information, claim files, logs, contracts, etc. In addition, the Manager shall participate in the actual audit itself. All files with deficiencies and/or recommendations are immediately returned to the Claims Examiner for corrective action. The Claims Managers review the file for compliance at each diary date. The Supervisors carry independent diaries for this purpose. Audit scores are incorporated into Performance Evaluations conducted annually for each employee. The audit conducted by our internal audit unit is comprehensive and takes into consideration all facets of claim file handling, including appropriate and necessary coding.

If the County needed a custom report built for them, would this be an additional fee? If so, how much?

Most **ad-hoc report** requests can be completed by our Data Delivery Services (DDS) team without any additional charge to the Client. Should the County have a highly specialized report that requires special programming of the system then DDS will secure and provide an estimate of the fees to complete the request and seek approval from the County before proceeding. All specialized report fees are on a "pass-through" basis. Generally, the fees for customization reports run approximately $200.00.00 per hour. Again, the fees for this service is on a "pass-through" basis with no markup.

Some of your claims practices appear to be inconsistent with the EIA Claims Handling Guidelines – are you willing to adjust your practices to be in compliance?

We will comply with all of the CSAC-EIA guidelines.

AIMS has over one-hundred (100) Clients of which approximately 80% are public entities in the State of California. Numerous AIMS Clients are contracted with CSAC-EIA. AIMS has worked with CSAC-EIA for many, many years and AIMS is familiar with their guidelines. AIMS' own protocols mirror those of CSAC-EIA, with Client-driven exceptions, and AIMS will apply the CSAC-EIA guidelines to the management of the County's claims unless the County directs us otherwise.

You indicate you have liability staff in Fresno to consult with on subrogation cases – what does this involve? Does your liability staff handle the subrogation aspect of a claim?

The TPA shall immediately provide information to the County concerning all claims with subrogation potential. AIMS believes in aggressively seeking subrogation reimbursement and recovering damages from a third-party that is determined to be legally liable for the damages sustained by our Client. In conjunction with the Client's approved attorney, AIMS will proceed against responsible person, agencies, and/or their agents in an effort to recover losses suffered by our Client when approved by our Client.

AIMS Claims Examiners understand they have the responsibility to review each claim for possible subrogation potential. Any file which indicates the possibility of subrogation is forwarded to a Claims Supervisor for review to determine if further investigation is required. When authorized by our Client,

consultation with AIMS liability specialists to evaluate the strengths and weaknesses of the subrogation will take place.

AIMS value added: AIMS Fresno office has a liability claims administration department. Having liability specialists within the same office as the workers' compensation claims administration enables our workers' compensation claims team to have access to experts, as resources, on subrogation potential, every day. AIMS provides this expertise at no additional charge to our Clients. Again, the liability claims administration department is a resource only and the Claims Examiner retains control of the claim.

AIMS will review and identify the cause of the accident for each new claim received and AIMS assigned Claims Examiner will serve as the main subrogation "adjuster". Notice of third party credit recovery is sent out once the relevant party is identified. A notice letter is also sent out to the injured worker.

On P. 43 of your proposal when talking about MPNs, you indicate you are a "Network Service Entity" and offer less customization. What is a "Network Service Entity" and how does this benefit the county?

Senate Bill 863 (SB 863) became effective January 1, 2014. Prior to SB 863, self-insured employers or workers' compensation insurers may have an MPN. Each employer or insurer had to file their own MPN. Under SB 863, an entity providing physicians network services can also have and MPN.

AMC's Service Entity MPN: On March 11, 2015 AMC received the AMC Network Service Entity MPN approval (#2360) from the Department of Industrial Relations, Division of Workers' Compensation Medical Unit. The approval is for a period of four (4) years. AMC's network is filed as a "Network Service Entity" which means that we can add the County without having to refile with the State, saving many months of implementation.

As part of the process, AMC Network Service Entity customized the network of providers, including physicians, created to provide medical treatment for work injuries of employees in California. Each employer that utilizes the AMC Network Services Entity has the ability to further customize the MPN based on their own needs and the needs of the injured employees.

As a "Network Service Entity" AMC can offer the County:

- Only one filing
- Customization to suit the County
- Only one website
- Only one audit
- Better control of Network

The workers' compensation specific networks incorporate the medical providers with extensive, specialized experience in dealing with injuries incurred at the work place or job site. AMC does not own the contracts inside the PPO Network it utilizes for its MPN Product – therefore they can provide an objective analysis as to what physicians are best suited for the County. An additional benefit is the MPN Network is a product of AMC and not created by the County, therefore disputes over removal will rest with AMC and not the County.

In your proposal you indicated there would be a 5% increase in the flat fee for catastrophic events. Please describe what you consider to be catastrophic events.

This provision is intended to cover unexpected situations that would require the AIMS to permanently increase claims staff to ensure the proper handling of the County's program. A catastrophic event is one that is destructive in nature and causes massive damage. A catastrophic event, such as a major earthquake or fire that destroys a County facility, may result in a significant increase in reported claims that may require the ultimate adjustment of permanent staffing.

The fees proposed cover claims administration for all new and existing claims set forth in this RFP. This fee is premised on, and in reliance on, the claim volumes as set forth in the RFP or related information provided (815 open indemnity claims, 412 open future medical claims (maintenance or stipulated indemnity claims) and the 61 medical only claims). Should AIMS receive more claims than anticipated from the current claim administrator at the time of transfer and/or if there is a 5% increase/decrease during the initial transfer or during any period of the contract due to significant change in the number of employees, and/or as a result of a catastrophic event, then both AIMS and the County will negotiate, in good faith, a reasonable fee increase/decrease fee adjustment based on any revised required staffing.

Is the 5% increase for catastrophic events negotiable?

Yes, this provision is rarely utilized but, in the event it is, the resolution is negotiable.

What is the average case load for your claims examiners?

AIMS' recommended Senior Claims Examiner average caseload is 150 active indemnity claims. Future Medical Claims Examiner average caseload is 250 non-discounted future medical claims. Medical Only Claims Examiner average caseload is 150 to 200 active medical only claims. We do not blend caseloads, if possible, but will blend caseloads if it makes sense to the structure of the Unit.

TRISTAR

August 30, 2017

Shannon W. Kirby
Purchasing Analyst
County of Fresno
4525 E. Hamilton Ave.
Fresno, CA 93702

RE: Questions of Clarification, RFP 17-084 Workers' Compensation and Ancillary Services

Dear Mr. Kirby,

Thank you for the opportunity to participate in the visitation and clarification process related to the County's workers' compensation program. We have addressed your questions below, and look forward to the County's visit to TRISTAR's offices on August 31.

1. **An ongoing issue is the availability of experienced claims handlers. How do you propose to ensure that you will be able to sufficiently staff the designated unit with experienced claims handlers? What is your contingency plan for claims handlers in the event of absences?**

TRISTAR's Human Resources includes an in-house recruitment department, which is responsible for recruiting efforts across the company. We also on occasion work with staffing and recruiting agencies specializing in servicing the needs of the insurance industry to assure that we identify the highest quality candidates for each open temporary or permanent position. TRISTAR welcomes in-house referrals from existing staff with a monetary bonus program for placed candidates. Some of the best recruiting we find is by our existing staff which serves a good indication of whether a candidate will assimilate in the TRISTAR corporate culture and needs of our clients.

TRISTAR will maintain the necessary staffing levels to meet the County's staffing requirements during the life of the contract. Our operational plans are prepared to assure continuity of service in instance of short-term absences, long-term absence, and, when necessary, staff turnover. We develop our detailed client service instructions, automated workflow prompts, and triggers on specific client-handling directives to assure transparency of the protocols and procedures for each client. This environment nurtures and encourages a constant exchange of ideas regarding all claims issues.

For short-term absences, claims or tasks may be assigned within the County's dedicated unit; which as proposed includes a dedicated supervisor, seven (7) senior level examiners and three (3) medical only examiners/claim assistants. For long-term absences, TRISTAR may utilize a temporary employee, or temporarily reassign an existing employee, to service the County's claims programs. In addition to additional employees located in our Fresno office, TRISTAR has seven offices and hundreds of

employees specializing in California workers' compensation.

2. **Claims can be adversely affected by a lack of aggressive handling resulting in inflated pendings and, possibly, more costly resolutions. What do you have in place to ensure aggressive, proactive claims handling on all files by all your staff? What flags trigger the claims handler to become more aggressive in moving claims to closure?**

TRISTAR agrees that prompt, aggressive claims administration is critical to the overall health of the County's workers' compensation claim program.

The success of the TRISTAR program relies heavily on early intervention; those initial moments directly following the injury/incident can have a dramatic effect on the County's claims costs. TRISTAR highly suggests the use of our 24/7 Nurse Triage program as the County's injury/incident intake process. Supplemented by detailed best practices, close oversight at the individual claim level, and analysis of broad program trends allows TRISTAR to assure the County that claims are managed promptly and aggressively to the best possible outcome.

24/7 NURSE TRIAGE – Across TRISTAR's significant public entity book of business, the most common injuries are Sprains & Strains, Bruises and Contusion, Pain and Soreness and Minor cuts and Lacerations. For many of these types of injuries, there is not much that can be done at the clinical level above basic homecare such as rest, ice, ibuprofen, etc. By having a Registered Nurse evaluate the immediate medical needs at the time of injury and using a medical algorithm to guide care TRISTAR has developed a more effective approach for the injured worker and also more cost effective for our clients. Conservatively, TRISTAR has seen a 30% reduction in reportable claims through the use of our 24/7 Nurse Triage program as well as a reduction in litigation.

EVALUATION, NEGOTIATION & SETTLEMENT - TRISTAR attempts to evaluate and settle claims at the earliest possible date. The longer claims are open, the more expensive they become. We adhere to all client requirements regarding settlement approval authority levels and authorization protocols.

Contrary to the conventional approach, TRISTAR has had great success utilizing Compromise & Release (C&R) for legitimate claims while employees are still employed with our public agency clients. When an injured employee leaves the employment of our client, we also attempt to settle their claim with a Compromise and Release (C&R). If we denied the injured employee's claim and they contest the denial, we evaluate the cost effectiveness of taking the case to trial versus settling with a C&R. We consult with our client prior to settling any denied claims. If it is determined to be beneficial to our client to settle a denied claim; we attempt to settle the case with a Thomas Waiver.

Structured settlements can be a benefit to both the injured employee and the client. Besides the cost savings, structured settlements can also resolve the claim in its entirety and define our client's total exposure.

The settlement of a workers' compensation claim often involves many different parties;

TRISTAR, the County, excess carriers, Medicare, defense and claimant attorneys and various lien claimants. Communication between all parties is essential to assure the examiner addresses and resolves all issues. Once the examiner receives settlement authorization from the County, settlement negotiations may proceed as authorized by the County.

RED FLAGS - Over the last 30 years in business TRISTAR developed a list of red flags that trigger more aggressive claims handling from our examiners in moving claims towards closure, such as:

1. Claimant Personality/Disposition: report of frequent requests to prolong treatment or disability by attending physician or aggressive behavior with medical staff in a perceived attempt to intimidate.

2. Frequent Specialist Referrals: primary treating physician makes frequent referrals to additional medical providers

3. Problem Employees: very few employees set out to be a problem for their employers and those that do usually reveal themselves quickly. They tend to be disgruntled, suspicious, and apathetic employees who generally have chronic attendance issues, performance issues, and disciplinary issues.

3. What qualities do you look for when interviewing and selecting examiners? What sort of testing do you do as part of the interview process?

TRISTAR recruits experienced service representatives. The recruitment process includes, but is not limited to an extensive background check, e-verification, and credit and reference checks. Additionally, the candidates must pass an integrity test and an in-house claims test administered to determine claims adjusting skills, knowledge, speed and expertise pertaining to the specific jurisdiction for the open position. All newly hired employees participate in training programs conducted by our quality assurance department and management team that includes sessions regarding TRISTAR best practices and customer claim handling guidelines.

TRISTAR believes the multi-level interview process in place significantly improves the examiners we place. The multi-level interview process requires two senior level management staff to conduct separate interviews for each candidate after they have successfully completed the required internal testing. This ensures that we have two distinct opinions on a particular candidate. The primary qualities TRISTAR considers when selecting examiners are: customer service, quick-thinking, and the ability to formulate a cohesive plan of action on complex claim scenarios.

4. **Can you discuss plans for transition if you are selected to handle our claims? Please discuss timeframes and measures to be taken to ensure an efficient transition from old administrator to new. Are there any fees for data conversion?**

TRISTAR prefers at least 90 days from award of contract to inception date; however, we have successfully transitioned numerous large client programs in far shorter timeframes when necessary.

As part of the transition plan for the County, TRISTAR's office management and adjusting team will help transition and triage open claims at the time of transfer. We will begin accepting new claims on the commencement date determined by the County. We will provide an Implementation and Transition Plan showing our extensive, detailed process, with tentative timelines and accountability to ensure a successful implementation. Our experience and credentials demonstrate our ability to meet milestones and efficiently and effectively transition large accounts. We will develop Customized Servicing Instructions that describe the County's unique servicing requirements.

TRISTAR's detailed implementation program begins at award of contract and extensive transition plan is provided for review with all parties. Daily and weekly calls are facilitated to assure that all parties stay apprised of the on-going progress. The dates of each implementation activity are established upon award and the timeframe provided for the transition. A high-level overview of activities include:

- Planning
  - Internal TRISTAR meeting
  - Identification of TRISTAR and the County teams
  - Contract execution, provision of required documentation
  - Establish regular conference calls with the County
  - Establish transition roles & responsibilities: TRISTAR & the County
  - Customize transition & project plan
  - Secure the County's excess policy information
- Customized Handling Instructions, including but not limited to:
  - First Notice of Loss process, including emergency escalation
  - Catastrophic loss procedure
  - Authority levels
  - Reporting/communication policy
  - Medical management
  - Litigation management
  - Return to work
  - Labor agreements
  - Review standard forms/letters: submission, employee notifications, denials, etc.
- Staff Recruitment and Development:
  - Recruit service staff as needed to fulfill contract requirements
  - Interview candidates and agree on candidate hires
  - Conduct background checks, integrity & knowledge tests

- Issue offer letters
- Conduct orientation: employee manuals, benefit selection
- Conduct training: Best Practices, Client Procedures, Claim System

- Facilities:
  - Determine space requirements for County's dedicated unit
  - Establish office space /workstations
  - Furnish with furniture and equipment
  - Confirm facility readiness
- Pending Inventory (Open Claims):
  - The County to secure approval from carrier for transfer of open/pending claims to TRISTAR
  - Notify incumbent & provide transfer items/agenda
  - Provide detail file transfer instructions
    - Advance indemnity payments
    - Medical bill processing/cut off
    - Mail handling: current/future
    - Phone calls: current/future
    - File notes, financial records
    - Boxing & labelling instructions
  - Notify providers regarding bill submission
  - Notify claimants
  - Transfer physical files
  - Complete data conversion
- Information technology & risk management information systems
  - Review any special claim types
  - Review any special data capture/hierarchies
  - Review automatic triggers
  - Review forms
  - Obtain test data, imaged files for mapping, begin mapping
  - Obtain table/layout file
  - Discuss CMS report files, current bill review vendor
  - Obtain prior 2 Years bill review data
  - First Notice of Loss script, automated pool/member/branch notification
  - Outline first report of injury process
  - Create log-ins & conduct training for the County users
- Banking & Accounting
  - Review the County banking process
  - Establish Loss Fund & replenishment process
  - Establish approved signatures, complete bank card
  - Establish desired financial reports
  - Test check issuance
  - Add the County preferred vendors
  - Invoice timing & format
- Compensation and Audits:
- Launch
  - Visit the County to distribute claim manuals and discuss program with key the County staff

- Accept new losses
- Implementation analysis/the County's satisfaction
- Establish future claim reviews & stewardship schedule

5. **Please describe in detail your paperless intake process. What is done to avoid a bottleneck at the examiner level? Are documents stored by date of entry, date of document, or both? What is the turnaround time for system entry? Who is responsible for responding to documents? How is this monitored?**

TRISTAR's paperless claims management environment delivers superior service and results for our clients by using state of the art technology.

- Central scanning center receives all documents for assignment to branch and examiner
- Automated Workflows with 750+ incoming and outbound documents accounted for and mapped to necessary activities, diaries and supervisory reviews.
- Categories include claimant correspondence, legal and State filings, medical reports, claimant or claimant correspondence, legal documents and more
- Filing in folders is standardized; items cannot be misfiled
- Document types and keywords automatically trigger important workflows and required actions
- Automated reminders assure appropriate review by technical and management staff
- Workflows and potential backlogs are monitored by supervisors, branch management and quality assurance staff.

TRISTAR's paperless system is more than a document image repository. Benefits include:

1.) **Productivity & Accuracy** - Our electronic document routing system enables users to process work more efficiently, quickly, and accurately than traditional paper processing. TRISTAR's workflows streamline collaboration and accelerate the completion of critical business tasks. The integration of the document imaging, workflows, and claims management systems create efficiencies along with checks and balances to increase productivity and accuracy.

2.) **Compliance** - Mail is received and scanned at a central location and is delivered to the examiner's electronic in-box on a daily basis. The examiner reads and identifies incoming documents. By assigning a document type or keyword, there may be one or more workflows or diaries initiated within the paperless system. These workflows are designed to ensure compliance with regulatory due dates and requirements as well as TRISTAR policies and procedures.

3.) **Management Visibility** - One of the most powerful components of our paperless system is its management capability. The supervisor and manager have the ability to view where every piece of mail is, where it has been, what the examiner or staff have done with it. Managers and supervisors can identify areas where claims activities may be creating a backlog and make adjustments via processes or resources to keep claims moving towards resolution.

6. **Please describe and compare what you deem to be the experience and knowledge levels of a Senior Examiner, a Junior Examiner and a Future Medical Examiner.**

Senior Examiner: BA/BS preferred. Five to seven years California workers' compensation claims management experience, SIP Certificate and ICA (or comparable) Certificate. Experience administering public entity claims preferred. Extensive knowledge of statutory and regulatory requirements, exceptional interpersonal skills including verbal and written communication, including ability to convey technical details to claimants, clients and staff, strong investigation and reserve analysis skills, strong prioritization and organizational skills, ability to effectively coordinate with multiple parties, ability to independently and effectively manage complex and high exposure claims.

Junior Examiner: BA/BS preferred. Minimum one to three years workers' compensation claims management experience, state certifications and/or licensures as required. Knowledge of statutory regulations and medical terminology, analytical skills. excellent written and verbal communication skills, including ability to convey technical details to claimants, clients and staff, ability to interact with persons at all levels in the business environment, proficient in Microsoft Office suite, certification and/or or license as required by State regulation.

Future Medical Examiner: BA/BS preferred. Three to five years California workers' compensation claims management experience, SIP Certificate and ICA (or comparable) Certificate. Technical knowledge of statutory regulations and medical terminology, strong analytical skills, excellent written and verbal communication skills, including ability to convey technical details to claimants, clients and staff, ability to interact with persons at all levels in the business environment, ability to independently and effectively manage complex and high exposure claims.

7. **Please describe your proposed staffing model.**

The County's unit will include the following key team members:

- Adrian Garcia, Director of Sales & Client Solutions
- Curt Crockett, Vice President, Claim Operations
- Pamela Guiles, Vice President, Managed Care Operations
- Sharon Castillo, Branch Manager
- Brandon Wheeler, Director, Client Services
- 1.0 Dedicated Claims Manager/Supervisor
- 7.0 Dedicated Senior Workers' Compensation Examiner
- 1.0 Dedicated Nurse Advocate
- 3.0 Claims Assistant/Medical Only/Support Staff

8. **What are your policies for staying current with changes to the fee schedule and updates to bill review software programs?**

TRISTAR's bill review system is delivered as an Application Service Provider (ASP) model. This means clients receive updates to the state fee schedule, clinical guidelines and application changes as soon as it is loaded into the system. A relevant adjustment to

any Fee Schedule occurs on a bi-weekly timeframe. Average delivery time for incremental changes and adjustments, from release by the state to introduction into the production environment, occurs in approximately 30 days. Reasonable and customary rates are captured from actual provider charges and stored and updated within the system.

General Questions

9. **You indicated that manager/supervisor span of control is 4+. Can you please explain that in more detail – what is the average span of control for your managers? Your supervisors? What would be the upper limit you would allow?**

The average span of control for TRISTAR Claims Supervisors is 5 Examiner. For the County of Fresno dedicated unit, TRISTAR proposes one dedicated Claims Manager to oversee the unit, which includes 7.0 senior examiners and 3.0 medical only/claim assistant staff. Because the unit is solely dedicated to the County, TRISTAR feels confident that one highly seasoned Claims Manager will provide necessary oversight of all staff, while appropriately balancing cost to the County. The County's Claims Manager will still have oversight locally by the Fresno Branch Manager.

More broadly, TRISTAR's claim operations are organized as follows: TRISTAR has four regional property and casualty claims vice presidents overseeing defined geographic territories, as well as vice presidents overseeing national managed care, medical cost containment, leave of absence administration, and group health benefits administration services. We provide our services through 30 "brick and mortar" offices and several remote-staff locations throughout the United States. Branch level managers report into regional vice presidents, and oversee claims supervisors. Claims supervisors typically manage teams of four to seven examiners, and associated support staff. Seven Examiners and associated support staff represents the upper limit TRISTAR would allow.

TRISTAR offices range in size from 10 to 70 employees. The average office has 23 employees, and includes a branch manager, 2-3 supervisors, supervising units of 6-10 employees (including examiners and support staff).

For our largest offices, TRISTAR may assign Unit Manager positions to oversee several claims units (supervisor level and below) as an additional layer between the Branch Manager and Supervisor personnel.

10. **Please elaborate on your plan to staff the account; how many of your current examiners would be assigned to the account and how many would you hire from the outside? Would you be willing to hire examiners/supervisors that are currently working on the account if the County recommends them?**

At the County's request, TRISTAR will certainly attempt to recruit and hire the County's

existing team members, assuming that all candidates meet TRISTAR's standards. TRISTAR would recruit internally and externally to staff the account. With close to 1,000 employees across the nation, intra-company transfer is a common staffing mechanism.

11. Does your current office location have enough room to house the proposed new staff?

TRISTAR's Fresno office has the capacity to staff the County's proposed dedicated unit.

12. Your proposal indicates that you "understand the County's employees have a militant training and approach to their unique job duties, and in fact are associated with national militant organizations". What does this mean and where did you get that understanding?

Our intention in this language is to state that we understand that County employees in specific departments, such as law enforcement or fire departments, have training comparable to military service members, and often employ veterans, reservists, and National Guard soldiers. Such departments employ a culture and protocols that closely approximate those of the armed forces: concepts like the chain of command, organizational hierarchies, military order and discipline, and others are ideas that are present in all law-enforcement organizations. Such departments may also partner with other local, regional or federal first responder/military units for training, task forces, special projects, etc. Individuals or agencies may also belong to associations and organizations that are exclusive to individuals with military or law enforcement experience.

TRISTAR is skilled and experienced at administering claims for public safety/first responder employees, including various labor agreements, and attuned to the unique complexities, needs and sensitivity that can be associated with claims for injured employees in such departments.

13. You talk about Home Office referrals on cases meeting certain criteria – what is that criteria and what is the purpose of the Home Office referral? How does the county benefit from this oversight?

TRISTAR has various authority levels based upon staff position. TRISTAR Branch Manager's incurred authority level threshold is $500,000. Claims breaching the authority threshold must be reviewed and approved by the Regional Vice President in Home Office.

In addition to dollar value, claims with specific sensitivities or complexities are also reviewed with Executive Staff, which, in addition to the Regional Vice President, may also include various subject matter experts such as our Vice President of Claims Operations, General Counsel; Vice President of Managed Care; or our Home Office Fraud Referral Group (a Director and two managers from our Quality Assurance department).

The County benefits from the knowledge and expertise that TRISTAR's executive

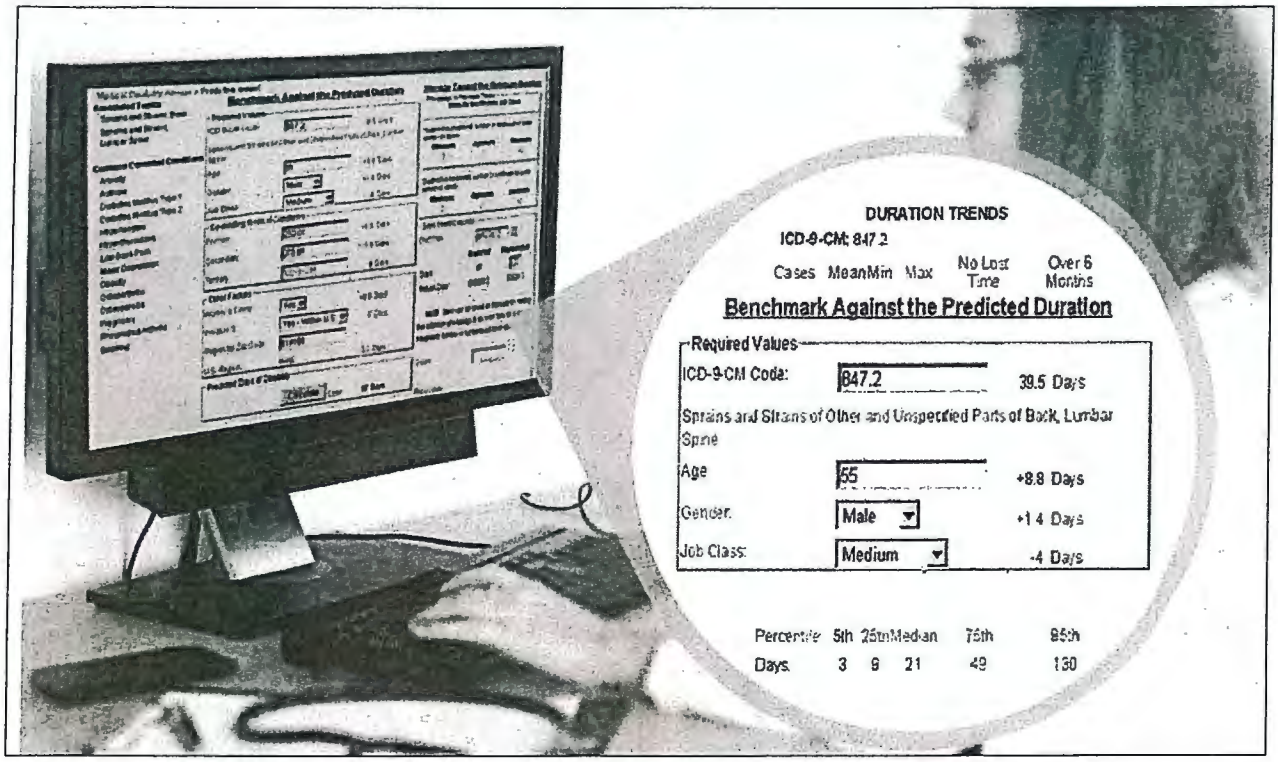
team/home office team brings to high value or complex claims. As a company that was founded in California and maintains eight offices dedicated to workers' compensation in the state, we provide great depth of technical knowledge of the California workers' compensation system among our leadership team.

14. You mention that the county can have access to "Medical Disability Adjuster – Predictive Model" – what is that? Is there an additional cost for this? What would be the benefit to the county in accessing this?

TRISTAR uses various tools to determine disability duration and return to work time including the Medical Disability Advisor (MDGuidelines©) and the Return to Work on-line access tools. Utilizing evidenced based medicine, MDGuidelines has many goals for this site: to infuse occupational medicine into the mainstream of physician education and practice; to provide innovative tools for case managers to better understand clinical and statistical considerations in achieving optimum return to work durations; to enable employers to minimize costs and maximize productivity in the workplace; and, most importantly, to help people return as quickly as possible to their productive endeavors.

We store all crucial data points such as key demographic information, diagnoses codes including co-morbidities, temporary disability duration rate, and return-to-work status. We track the provider's and Tax ID#'s to further evaluate providers and their statistics for RTW work by diagnosis against guideline protocols. Case managers can seamlessly integrate the most recently updated versions of disability durations, predictive recommendations, and referential content into their workflow. Below is a screenshot of the Predictive Return to Work modeling tool available to our staff and our customers. If desired, TRISTAR will provide access to these tools for authorized County users.

There is no cost to the County to utilize this tool.



15. It appears you have some robust reporting capabilities. As we all know, reports are only as good as the data that is used to compile them. What do you do to ensure staff is coding claims timely and accurately?

The system is designed to assure that the loss information collected is sufficient to adequately describe the loss and to support analysis for future business planning. Extensive and immediate edits for content and logical cross-checks are performed as the data enters the system. Automatic examiner and supervisor diary features and mandatory fields ensure the timeliness and completeness of entries. The real time nature of the Risk Management System makes a claim available to all users as soon as it is entered to the system at any location.

The system has built-in controls based on Policy, Contract and Service Information. Contract/Policy information, as well as excess limits, are maintained in the system and are the driving force behind acceptance of a claim. Extensive editing takes place when a claim is first entered to the system to make sure that the information is accurate and complete, and that it represents an appropriate claim for the client.

Data is edited electronically as it is entered into the system to ensure accuracy. Verification includes:

- Field Content edits – numeric and alphabetic edits of the information entered to the field
- Cross-Checks – comparison of information in related fields to ensure logical relationships

- Contract/Policy edits – verification of valid coverage, dates, etc.
- Required Field edits – to ensure the data entered represents a complete claim.

16. If the County needed a custom report built for them, would this be an additional fee? If so, how much?

Custom reporting fees are extremely rare at TRISTAR. If the data point is something captured in TRISTAR's proprietary system generating a report with this content is not considered a custom report. In the unlikely event that TRISTAR does not capture the data the County is requesting a fee of $150 per development hour would be applicable.

17. Will you please explain your UR "pre-clinical" review in more detail? Is there an additional cost for this?

TRISTAR is rolling out a customizable, automated service to reduce ancillary Utilization Review fees while expediting access to appropriate care. Our pre-clinical review program provides an automated decision tool which bounces provider treatment or prescription requests against applicable state guidelines, American College of Occupational and Environmental Medicine Guidelines ("ACOEM"), Official Disability Guidelines ("ODG"), and other nationally recognized guidelines for appropriateness. If a request is determined to be appropriate, it is quickly approved and appropriate documentation is issued to providers. If not, it is returned back to the examiner who may submit for Utilization Review or Peer Review in accord with client requirements.

In accordance with the County's request for flat annual fees there is no additional fee for Pre-Clinical Utilization Review.

18. You mention you have a 24/7/365 First Notice of Loss (FNOL) Nurse Triage call center. How does this work? Is there an additional cost for this?

TRISTAR's operations include a 24-hour, in-house, US-base call center for operator service, telephonic claim intake, and optionally, referral to our in-house telephonic nurse triage service. The injured employee, or the employee's supervisor, calls the telephonic intake center to report the incident, and our telephonic triage nurse assesses the situation utilizing our treatment protocols to determine the appropriate level of care to ensure the best health outcome. Examples of guidance that the nurse may provide include but are not limited to: call 911, seek immediate care, visit an occupational health clinic within 24 hours, visit an occupational health clinic within 4 hours, or treat with self-care (over-the-counter pain medicine, ice pack application, etc.).

Fees for telephonic intake are $20 per call; which is waived if the call progresses to nurse triage. Nurse triage fees are $120 per call and includes FNOL completion and up

to 4 conversations with the Registered Nurse.

Features	Benefits
24/7/365 toll-free telephonic intake includes customized script, customized escalation protocols, and voice recording of the call	• Accommodates all shifts at all locations • Easy set up and training
Nurse Triage is an effective tool to assess the severity of the injury and determine best course of action to ensure prompt necessary treatment is provided. Treatment guidance to network facilities with provider notification.	• Streamlines Injury Reporting • RN's available within moments of injury • Remove shift supervisors and managers from making difficult medical care decisions
Flexibility to accommodate client processes and workflows. The immediate notification allows all parties to efficiently manage the claim.	• Preferred provider direction within network • Avoidance of unnecessary medical treatment
Easily partnered with early intervention, the employee knows the employer cares and a nurse is there to assist throughout their recovery	• Red flags quickly identified • Reduces number of claims and medical costs associated with workplace injuries • Improves employee satisfaction by providing trusted nurse support to injured employee at point of intake, cultivating a positive relationship and minimizing potential for distrust.

19. Your proposal mentions a "Transitional Work Coordinator" who works with the county to assist in the interactive process. Is this a Tristar employee? What is the extent of their involvement? Is there a cost for this?

TRISATAR uses the term Transitional Work Coordinator and Nurse Advocate interchangeably. This individual will function in, assisting the examiner, injured worker, and County Risk Management with medical question, coordinating resources to facilitate quality individualized treatment goals and return-to-work placement.

20. Some of your claims practices appear to be inconsistent with the EIA Claims Handling Guidelines – are you willing to adjust your practices to be in compliance?

Yes.

21. What is "black box auditing"?

An outside auditor must review a technical process, in which the auditor may not be an expert, and may not be familiar with the technical processes carried out by the staff. For instance, a data security auditor may not be an expert in workers' compensation claims handling, but must audit procedures to ensure that overall processes in terms of:

- Are the inputs and outputs adequately checked?
- Is the process itself adequately documented consistent with the expected skill level of the staff involved?
- What happens when there is an error?
- Are records adequate to demonstrate that work has been processed correctly?
- Has the staff been adequately trained to carry out the process?

22. From your proposal, we did not get a feel for your relationships with medical providers in the Fresno area. Will you please briefly talk about that?

TRISTAR has significant experience with providers in the Fresno area and the entire Central Valley. Several of our clients have tailored or custom Medical Provider Networks which include only specific providers in Fresno County. We invite the County to review our extensive contracted provider database at http://www.tristarmanagedcare.com/#

23. What is the average case load for your claims examiners?

Lost time examiners average 125-150 open cases; medical only examiners average 250 open cases.

ATTACHMENT B

REFERENCE LIST

VENDOR MUST COMPLETE AND RETURN WITH REQUEST FOR PROPOSAL

Firm: Acclamation Insurance Management Services (AIMS)

Provide a list of at least five (5) customers for whom you have recently provided similar services. Be sure to include all requested information.

Reference Name: City of Los Angeles Contact: Dawn Alvarado
Address: 700 E. Temple St. RM 210
City: Los Angeles State: CA Zip: 90012
Phone No.: (213) 473-3339 Project Date: 2011 - Ongoing
Service Provided: Third Party Administration

Reference Name: City of Huntington Beach Contact: Patti Williams
Address: P.O Box 906
City: Huntington Beach State: CA Zip: 92648
Phone No.: (714) 536-5290 Project Date: 2010 - Ongoing
Service Provided: Third Party Administration

Reference Name: City of Clovis Contact: Lori Shively
Address: 1033 5th St.
City: Clovis State: CA Zip: 93612
Phone No.: (559) 324-2726 Project Date: 2007 - Ongoing
Service Provided: Third Party Administration

Reference Name: Monterey County Local Agencies Contact: Steve Negro
Address: 19900 Portola Dr.
City: Salinas State: CA Zip: 93905
Phone No.: (831) 594-7934 Project Date: 2005 - Ongoing
Service Provided: Third Party Administration

Reference Name: Central San Joaquin Valley Risk Management Authority Contact: Kevin Werner
Address: 1750 Creekside Oaks Dr. Ste. 200
City: Sacramento State: CA Zip: 95833
Phone No.: (209) 599-2108 Project Date: 1995 - Ongoing
Service Provided: Third Party Administration

Failure to provide a list of at least five (5) customers may be cause for rejection of this RFP.

VII. REFERENCES:

REFERENCE LIST

VENDOR MUST COMPLETE AND RETURN WITH REQUEST FOR PROPOSAL

Firm: **RISICO CLAIMS MANAGEMENT, INC.**

Provide a list of at least five (5) customers for whom you have recently provided similar services. Be sure to include all requested information.

Reference Name: **CITY OF FRESNO** Contact: **Jeffrey Cardell, Personnel Director**
Address: **2600 Fresno St** **Jeffrey.Cardell@fresno.gov**
City: **Fresno** State: **CA** Zip: **93721**
Phone No.: (**559**) **621-6964** Date: **3/1/2004 - Present**
Service Provided: **Claims Administration, Bill Review, MPN/PPO Management, Telephonic Case Management, Field Case Management, Early Intervention, Utilization Review.**

Reference Name: **GOLDEN EMPIRE TRANSIT** Contact: **Jeanie Hill, HR Manager**
Address: **1830 Golden State Ave** **jhill@@getbus.org**
City: **Bakersfield** State: **CA** Zip: **93301-1012**
Phone No.: (**661**) **324-9874** Date: **7/1/2007 - Present**
Service Provided: **Claims Administration, Bill Review, MPN/PPO Management, Telephonic Case Management, Early Intervention, Utilization Review.**

Reference Name: **SELF-INSURED SCHOOLS OF CA** Contact: **Gabriel Rodriguez, Director of WC**
Address: **2000 K St** **garodriguez@kern.org**
City: **Bakersfield** State: **CA** Zip: **93301**
Phone No.: (**661**) **636-4422** Date: **9/20/2004 - Present**
Service Provided: **Utilization Review**

Reference Name: **AMTRUST NORTH AMERICA** Contact: **Richard McKenna, WC Director**
Address: **400 Executive Blvd South, 4th Floor** **mckenna@amtrustgroup.com**
City: **Southington** State: **CT** Zip: **06489**
Phone No.: (**860**) **571-2113** Date: **1/1/2011 - Present**
Service Provided: **Claims Administration, Telephonic Case Management, Utilization Review**

Reference Name: **LION RAISINS, INC.** Contact: **Eric Vollmer**
Address: **9500 S De Wolf Ave** **evollmer@lionraisins.com**
City: **Selma** State: **CA** Zip: **93662**
Phone No.: (**559**) **834-6677** Date: **8/1/2014 - Present**
Service Provided: **Bill Review, MPN/PPO Management, Utilization Review**

Failure to provide a list of at least five (5) customers may be cause for rejection of this RFP.

ATTACHMENT C

County of Fresno

DEPARTMENT OF HUMAN RESOURCES
PAUL NERLAND
DIRECTOR

DATE: September 12, 2017

TO: Gary Cornuelle, Purchasing Manager

FROM: Paul Nerland, Human Resources Director

SUBJECT: Evaluation Summary and Recommendation for Request for Proposal No. 17-084 for Workers' Compensation and Ancillary Services

The intent of this memorandum is to forward the recommendations and findings of the evaluation panel regarding the subject Request for Proposal (RFP), as set forth in the attached summary of process and findings. I concur with the panel's recommendation that Acclamation Insurance Management Services receives the award from this RFP and be permitted to act as the provider of workers' compensation administration and ancillary services in support of the County's self-insured workers' compensation program. The summary of the RFP process and formulation of the recommendation is attached. If you are in agreement with this recommendation, please issue the appropriate award letters at your earliest convenience in order to facilitate our ability to begin the contract and Board Agenda processes. Once the award letters are issued, please notify our department by emailing Berta Mims, Human Resources Manager.

The department appreciates your expedient review of this item. If you have any questions or comments regarding this matter, please contact Berta Mims at (559) 600-1850.

SUMMARY OF EVALUATION
Request for Proposal (RFP) # 17-084
Workers' Compensation and
Ancillary Services

TIMELINE

RFP RELEASE DATE	June 9, 2017
VENDOR CONFERENCE	June 15, 2017
ADDENDUM RESPONSE	June 26, 2017
RFP CLOSING DATE	July 11, 2017
RFP COMMITTEE REVIEW	August 10, 2017
FINALIST INTERVIEWS	August 31, 2017
TENTATIVE BOARD DATE FOR AGREEMENT	September 26, 2017

SUMMARY OF REQUESTED SERVICES

The Request for Proposal (RFP) sought qualified firms to provide workers' compensation Third Party Administrative (TPA) services locally to the County of Fresno. The RFP also included a provision for workers' compensation and ancillary services to be provided as a part of the TPA contract or as an individual ancillary service. The State of California mandates employers provide workers' compensation benefits for employees who become injured or incur an illness as the result of their employment. The County of Fresno is permissibly self-insured and has historically contracted with a TPA to administer these benefits.

PROPOSALS RECEIVED

Although there are many TPA firms throughout the state, given that the County of Fresno requested responses from only those with local offices; only four (4) proposals were received by Purchasing and were reviewed by the RFP Review Committee. Proposals were received from the following organizations:

A. Risico
B. Tri-Star
C. Acclamation Insurance Management Services (AIMS)
D. Intelligent Medical Solutions (IMS)

RFP REVIEW COMMITTEE MEMBERS

The RFP Review Committee consisted of five members. Three committee members were from the County of Fresno, including one Human Resources Manager, one Senior Human Resources Analyst, and one Human Resources Analyst. Additionally, one member was a CSAC-EIA (CSAC-Excess Insurance Agency) Workers' Compensation Claims Manager, and one member was a CSAC-EIA Senior Workers' Compensation Specialist.

Bid review guidelines were provided to each committee member prior to bid review. The Review Committee members individually reviewed each proposal. Members convened on August 10, 2017 to discuss each proposal and the proposed services. Each evaluator was able to provide qualitative explanations for their recommendation along with commentary on the content of each proposal.

REVIEW COMMITTEE RANKINGS

At the conclusion of the RFP committee review meeting, the members were split (3) three votes to (2) two in favor of AIMS over TRI-Star. The committee members agreed it was in the best interest of the County to conduct on-site interviews with the two top viable Workers' Compensation Third Party Administrator bidders to ask additional clarifying questions and give the finalists the opportunity to demonstrate their data support and reporting capabilities of the proposed claims system. The recommendations to continue with the oral interviews relied heavily on compliance with the RFP.

The top two bidders, AIMS and TRI-Star, were sent a list of questions from the committee, specific areas the committee wanted to see as a part of the site visit including workspace and staff, and a demonstration of the claims system.

On August 31, 2017, the committee reconvened with the assistance of Purchasing and met with AIMS and TRI-Star at their local office location. The committee toured each office, met with representatives, and were given a demonstration of the proposed computer system each company planned to use.

After review of the initial proposals, the clarifying questions, and site visits, the Review Committee unanimously recommended awarding the contract for services to AIMS.

The proposals were ranked by each committee member based on its strength relative to the other bids and the provisions set forth in the RFP. The table below identifies the consensus of the Review Committee's evaluation of the proposals in ranked order from highest to lowest.

Ranking	Bidder
1	AIMS
2	TRI-Star
3	Risico
4	IMS

All five evaluators recommended AIMS to act as the County of Fresno's new Third Party Administrator (TPA) and to provide ancillary services for the County's self-insured workers' compensation program. Based on both the response to the RFP and the on-site visit, AIMS provided the best over-all proposal and was unanimously ranked first by the Review Committee. AIMS has demonstrated a long-term commitment to the Fresno area by having a local office since 1987. They serve several public sector clients of similar size to the County of Fresno throughout the State of California. AIMS is well staffed both at the local and corporate level. In addition to their claims handling capabilities, they offer a great deal of technical and training support to both their employees and their clients.

From the tour of their offices, it is apparent that AIMS has room for employee expansion to meet the County's needs, space to store the paper files in their onsite warehouse, and the technology to scan our paper files as they are reviewed and transferred into their claims management system for County accessibility.

Training and retention of the TPA staff is currently a concern for the County. AIMS explained that they strive to provide consistent and up-to-date training and the tools necessary to create job satisfaction and minimize staff turnover.

AIMS also retains a legislative advocate on staff that will act on the County's behalf and provide necessary information regarding upcoming legislation changes and other developments that could affect the County. For example, AIMS has spent several months preparing for a pending legislative change in the pharmaceutical area of Workers' Compensation so their current clients are well prepared in advance of the effective date of the new legislation.

The demonstration AIMS provided of their claims system showed the ability to not only assist claims examiners in keeping the claims moving in an efficient manner, but also allows the County to access information, run reports and submit claims efficiently and electronically. The Vice President of Technology for AIMS attended the meeting and was able to present on a "Test Client," the user friendly intake reporting system. AIMS was the only bidder with a claims management system that is fully integrated with their paperless mail system. They also have an effective Dashboard with a notification system to report late diaries, inactive files, and claims that require attention to keep the claims moving and in compliance with regulations. AIMS is also the only bidder guaranteeing the County a 24-hour turnaround three-point

contact after the receipt of the first notice of loss. They were also able to demonstrate their ad hoc reporting capabilities and 30-60 day claims conversion. Each of these capabilities further support the committee's recommendation to award the bid to AIMS.

In regards to the ancillary services, the sister company to AIMS, Allied Managed Care (AMC), offers Utilization Review, Bill Review and medical provider networks that can help assure that only necessary medical care is authorized, mitigating claims expenditures. In addition, the services provided by AMC provide for proper medical control and ensure that cost containment measures are in place.

Available, at no additional cost, is liability expertise to assist AIMS in the management of the workers' compensation claims as an additional benefit when injuries to an employee and/or damages to County property are caused by a third party.

TRI-Star, one of the top two bidders, were also considered to be capable of providing the quality of service the County requires from a TPA and Ancillary services provider. They too are a national TPA with a local office in Fresno. They have several public entity clients and emphasized their ability to service the County's growing workforce. TRI-Star was the last bidder given the opportunity to participate in the County's on-site visits. Of concern to the County in selecting a new TPA is the TPA having the ability to provide a user friendly claims management system along with IT support and the County having access to ad hoc reporting capabilities and on demand IT assistance as needed. TRI-Star was not able to demonstrate that they have a user friendly claims system. In fact, TRI-Star confirmed they have a bifurcated claims management system, keeping their claims notes and paperless mail system separate. TRI-Star was not able to demonstrate efficacy in their claims management system or the ability to provide on-demand reporting as they do not have access to a test environment to produce these types of entries and inquiries. A particular area of concern to the committee, is that the TRI-Star system does not have the ability to pause and go back to the "Employer First Report of Injury." County Staff would not have the ability to partially enter information and save it to later input additional or accurate information when additional information regarding an injury is acquired by County Departments or Human Resources. This is important as this information entered as the employer first report is what is reported to the State and the information is also used to set up new claims by the TPA.

Risico was ranked third over-all by the committee. Although they are the current incumbent and had the lowest cost proposal, it was by consensus of the committee that structurally, Risico would not be able to meet the needs of the County as compared to AIMS, the top contender. The committee agreed that in the areas of corporate support, staff stability, and client and staff education, that it is in the best interest of the County, given its size and claims volume, to go with a TPA that is more structurally sound and aligned with the needs of the County of Fresno. Although cost was certainly a factor, the financial difference in recommending AIMS is insignificant compared to the additional resources that will be available to both AIMS claims examiners and County staff. It is the committee's opinion that these additional resources will lead to cost savings that will offset the difference in the cost proposal.

Intelligent Medical Solutions (IMS) was the lowest ranked bidder. IMS does not have a local office as required in the provisions of the RFP and only submitted a proposal based on one piece of the entire workers' compensation program (Bill Review). It was the committee's opinion that it was not in the County's best interest to contract with IMS.

DEPARTMENT OF HUMAN RESOURCES RECOMMENDATION

The Department concurs with the Review Committee's vendor recommendation.

RFP 17-084 WORKER'S COMPENSATION AND ANCILLARY SERVICES TIMELINE

June 09, 2017	RFP #17-084 released on Public Purchase
June 15, 2017	Vendor Conference attended by: 1. Risico – Steven C. Wigh 2. AIMS – Larry Hunt, Janine Bowman 3. Sam Mann – Country of Fresno Risk Management 4. Shannon W. Kirby – County of Fresno Purchasing
June 22, 2017	Period for submitting questions for clarification expired at 10:00 AM
June 26, 2017	Addendum #1 issued
July 11, 2017	RFP closed with four (4) vendors responding 1. AIMS 2. Intelligent Medical 3. Risico 4. Tristar
August 10, 2017	Evaluation Team meeting held at Purchasing, responses were ranked from one to four with one being the best. Evaluation team voted to visit the two top ranked vendors, AIMS and Tristar for a look at their facilities and a demonstration of their IT systems.
August 31, 2017	Visited AIMS' facility in the morning and Tristar's in the afternoon. Reconvened at Purchasing to discuss the visitations and select a vendor for recommendation of award. The Evaluation team voted unanimously to recommend AIMS.
September 12, 2017	Received Letter of Recommendation from the HR Department Head recommending AIMS for the Award. The Purchasing Manager concurred.
September 12, 2017	Issued and posted Tentative Award Notice to Acclamation Insurance Management Services (AIMS).
September 13, 2017	Received written request for and E mailed copies of the review committee's rating sheets to Steven Wigh at Risico.
September 15, 2017	Received written request for any additional rating sheets or scorecards from Steven Wigh at Risico.
September 18, 2017	E mailed the final ranking sheets done after the site visitations on August 31, 2017.

RFP 17-084 Timeline, continued

September 21, 2017	Received Letter of Appeal from Steven Wigh at Risico.
September 26, 2017	Purchasing Manager sent response and denial of appeal to Steven Wigh at Risico.
October 31, 2017	Board Agenda Item 34 was moved to November 14, 2017 to allow the Board of Supervisors to review the RFP Committee Evaluation Worksheets.
November 7, 2017	Response from Risico Claims Management, Inc. Regarding RFP 17-084

TAB 3

Third Party Administrator COST COMPARISON

	AIMS Proposed	Risico Proposed**	Difference
Year 1	$ 2,308,065.00	$ 1,725,000.00	$ 583,065.00
Year 2	$ 2,333,202.00	$ 1,725,000.00	$ 608,202.00
Year 3	$ 2,374,544.00	$ 1,725,000.00	$ 649,544.00
Year 4	$ 2,417,125.00	$ 1,735,000.00	$ 682,125.00
Year 5	$ 2,460,981.00	$ 1,745,000.00	$ 715,981.00
Totals	**$ 11,893,917.00**	**$ 8,655,000.00**	**$ 3,238,917.00**

**does not include Medical Director Engagement

	AIMS Proposed	Risico Current	
Year 1	$ 2,308,065.00	$ 1,509,225.00	$ 798,840.00
Year 2	$ 2,333,202.00	$ 1,509,225.00	$ 823,977.00
Year 3	$ 2,374,544.00	$ 1,509,225.00	$ 865,319.00
Year 4	$ 2,417,125.00	$ 1,509,225.00	$ 907,900.00
Year 5	$ 2,460,981.00	$ 1,509,225.00	$ 951,756.00
	$ 11,893,917.00	**$ 7,546,125.00**	**$ 4,347,792.00**

Current Workers' Comp Program Administration Costs	
Risico	$1,300,000.00
NCM TS	$90,720.00
NCA TMC	$108,000.00
PPO Fee's*	$10,505.00
Total	**$1,509,225.00**

10/30/2017

*PPO Fee's average of 3 years

TAB 4

Response from Risico Claims Management, Inc.

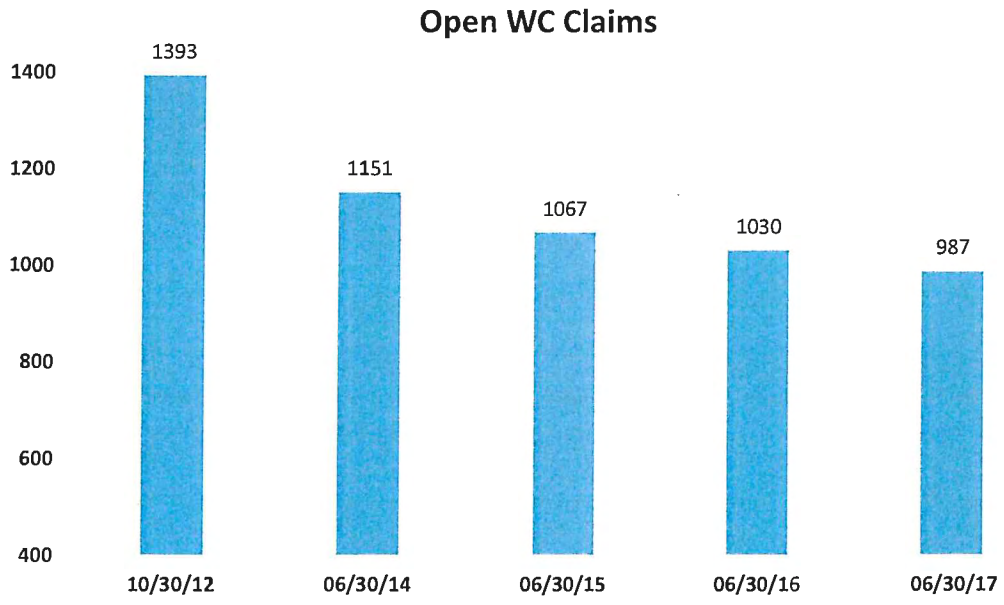
Regarding RFP 17-084

Chairman Pacheco and Members of the Fresno County Board of Supervisors. Thank you for the opportunity once again to address the issue of our appeal of the tentative award for RFP 17-084. My purpose in preparing this response is to illustrate our historic results, comment on past performance feedback, comment on the RFP Evaluations, present a cost analysis and finally provide you with some concluding remarks.

Risico Performance Achievements

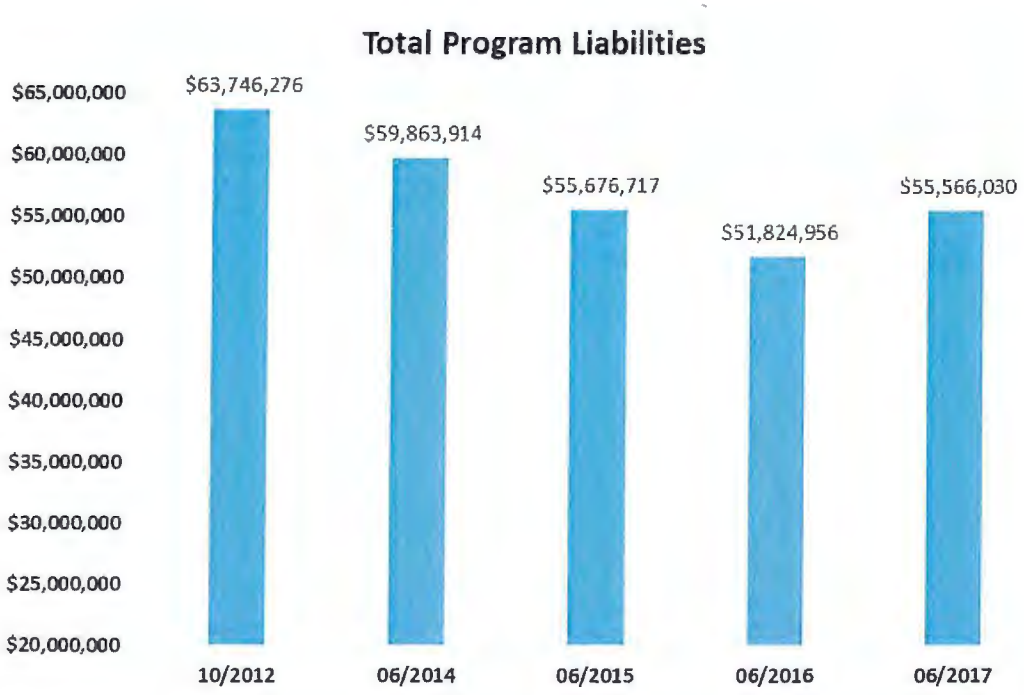
During my presentation on October 31, 2017 I identified three areas in which Risico delivered historically spectacular results.

First, Risico has successfully reduced the overall caseload from 1393 claims to 985 claims which equates to a reduction of 30% or 406 claims.

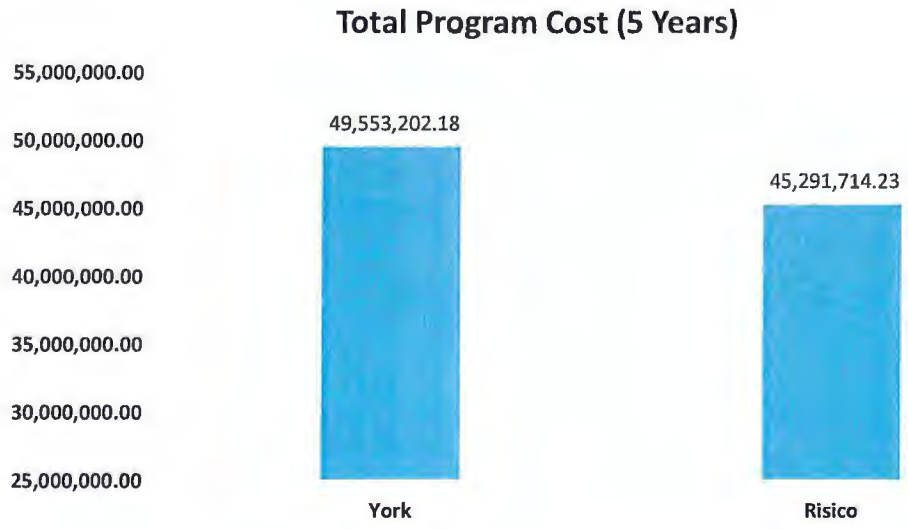


A reduction of this magnitude paves the way for lower program liabilities and costs.

Second, Risico has lowered the County's Total program liabilities by 13% or $8,180,246 over the past 5 years. It is important to note this figures include the catastrophic claims which significantly influenced the 06/2017 results.



Third, Risico has similarly reduced Total Program costs by $4,261,488 or 9.1% over a 5 year period when the results of the County's prior TPA are compared to Risico's results. Once again, making this result very significant is the fact these figures include payments for the County's recent catastrophic claims.



County Feedback on Risico Performance

During the last 5 years, Risico has met with the County Risk Management Staff on a quarterly basis to discuss the performance of the County's workers compensation program. These meetings are designed to have an open discussion on the financial and statistical results of the prior quarter or an annual stewardship report. We are proud to say, the feedback from County staff in all of these meetings has been positive.

From our perspective, our work with the County has been virtually free of documented negative issues. Only once has an issue risen to the level of the Director of Human Resources, and that issue was quickly and successfully resolved to his satisfaction.

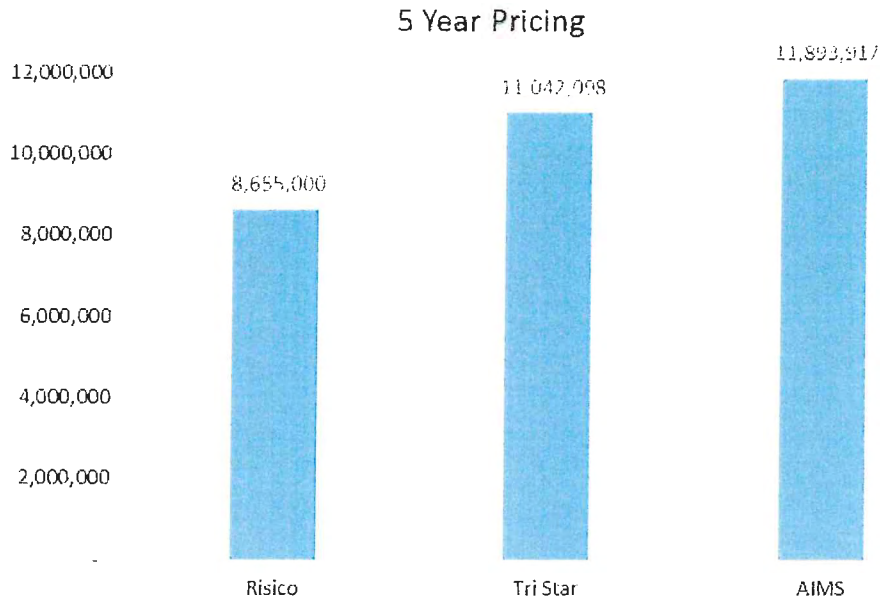
RFP Evaluations

We have reviewed the RFP Evaluations and would like to offer several comments for your consideration. First, several of the issues raised in the evaluations of RISICO would have been resolved by allowing Risico to participate in the onsite/oral interviews which was granted to our competitors. Several of the evaluator's conclusions were wrong but would have been corrected in an oral interview. The County had only 3 TPA's bid on all of the services proposed by this RFP. Risico should have been afforded the opportunity to participate in this process.

The RFP Evaluation process lacked a quantitative point system that would have provided the evaluators with a balanced scoring system. The Evaluations and TPA rankings were purely subjective and did not assign a percentage of importance or weight to any of the categories. This is most apparent in the area of cost evaluation where the significant price differential goes without comment or analysis. A point system, as used in the last RFP 5 years ago, and used regularly by other Public entities, would have provided the County with the ability to assign numerical importance to each area thus providing a more balanced, less subjective, approach.

Pricing Comparison

Presented on the next page is a graph showing the 5 Year pricing for this RFP.



The pricing identified above graph is derived from our RFP, County documents including the evaluations of the panel. We have not been given any official pricing analysis from the County.

The pricing proposed by Risico was $2,387,089 lower than Tri-Star and $3,238,917 lower than AIMS.

Concluding Remarks

We grateful for having the opportunity to submit this response for your review and consideration.

We are asking for a decision that considers our work product and competitive pricing. The results of our past performance show we have performed at a very high level having delivered an outstanding result. This result, combined with the fact we are the lowest bidder by a significant margin, sets us apart from the other two TPA's.

Our goal will be to continue this effort, if given the opportunity to do so by the Board.

Respectively,

Steven C. Wigh

President, Risico Claims Management

TAB 5

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September 21, 2017

Mr. Gary Cornuelle, Purchasing Manager
County of Fresno Purchasing
4525 E Hamilton Avenue, 2nd Floor
Fresno, CA 93702-4599

Re: Appeal of Notice of Award
Workers' Compensation and Ancillary Services RFP 17-084

Dear Mr. Cornuelle:

Risico Claims Management, Inc. is respectively appealing the decision to issue the Notice of Award for RFP 17-084 to Acclamation Insurance Services.

Our appeal is based on two issues. ***First,*** the Request for Proposal (RFP) evaluation panel scoresheet and evaluation panel, failed to question, consider and evaluate the results achieved by Risico over the last 5 years. Failing to incorporate a formal line of questioning and analysis regarding Risico's past performance into its RFP process has led the County to overlook Risico's achievements, creating an RFP process that is incomplete. ***Second,*** Risico was not afforded the opportunity to participate in the oral interviews or onsite visit, which gave our competitors an unfair competitive advantage.

The RFP document and evaluation form are completely void of any reference of past performance. In our response we tried to compensate for this by creating a "Performance Highlights" coversheet, however, after reviewing the evaluation panel scoresheets, it is apparent at least one panelist actually viewed this negatively and the others had no comment.

I will reiterate for the purpose of this appeal, Risico achieved results that were never realized by a previous County TPA dating back to 2004. **Using records provided by the County, Risico was able to reduce the County claims caseload by 30%. Specifically, the total open claim caseload was lowered from 1393 claims to 985 claims.** No prior TPA has ever come close to this result. I will add, such performance is extremely rare in the workers' compensation claims industry and I can assure you, would be a result enthusiastically welcomed by any self-insured entity. I will point out the last TPA, a large national company, was unable to achieve this result.

The reduction in caseload, combined with Risico's management oversight has favorably impacted the cost of the County's Workers' Compensation Program and significantly lowered the overall program liabilities.

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Mr. Gary Cornuelle, Purchasing Manager

At the end of FY 11/12 the County's annual workers' compensation program cost was $10.8m. Risico's contract started on October 1, 2012 and at the end of FY 12/13, we achieved a program cost of $9.6m. FY 13/ 14 the program cost was $8.7m, FY 14/15 was $8.3m and FY 15/16 was $8.6m. **This result shows Risico outperformed a large, national TPA by lowering the County's program cost by an average of $2 million per year.**

The County program liabilities (future estimated reserves/payments) have been significantly reduced as well. Omitting the catastrophic claims program liabilities, **overall program liabilities were reduced from $62.8m in FY 12/13 to $41m in FY 16-17, a reduction which benefited the County in the amount of $21.8 million.**

It is clear, Risico achieved an outstanding outcome for the County. Unfortunately, the County's RFP process failed to consider the importance of our prior performance by omitting such an evaluation from its RFP process.

Additionally, Risico was not allowed to participate in oral interviews or subject to an onsite visit, which was afforded to the other competing TPA's. Risico was identified as a RFP finalist by a County Purchasing Official. The Purchasing Official explained the Evaluation Panel was familiar with our operation and did not need an oral interview or onsite visit. We believe this decision gave our competitors an unfair advantage. We believe all finalists should be afforded an oral interview and onsite visit in order to maintain a sense of fairness between those organizations and uphold the creditability of an RFP process. It is clear from reading the panel's scoresheets that they had questions about our proposal that were left unanswered because of this decision.

We respectively ask for our appeal to be given your full consideration.

Sincerely,

Steven C. Wigh
President, Risico

SCW/ph

TAB 6

County of Fresno

INTERNAL SERVICES DEPARTMENT
ROBERT W. BASH, DIRECTOR – CIO

Facility Services • Fleet Services • Graphics
Information Technology • Purchasing
Security • Telecommunications

September 29, 2017

Mr. Steven C. Wigh, President
Risico Claims Management
PO Box 9783
Fresno, CA 93794

RE: Appeal to Decision of the County of Fresno, Request for Proposal Number (RFP) 17-084 Worker's Compensation and Ancillary Services.

Dear Mr. Wigh,

The following addresses your letter dated September 21, 2017 appealing the recommendation for tentative award for the above-mentioned RFP.

1. ***The Request for Proposal (RFP) evaluation panel scoresheet and evaluation panel failed to question, consider and evaluate the results achieved by Risico over the last 5 years.***

Response:
The evaluation committees for all County of Fresno RFPs base their tentative award on the proposals that are submitted for each RFP process. This is done to ensure all proposers have a fair and equal chance at a tentative award for the County. Past performance and references may factor into the tentative awarding of a contract. On this RFP, past performance was not a factor to evaluate.

2. ***Risico was not afforded the opportunity to participate in the oral interviews or onsite visit, which gave our competitors an unfair competitive advantage.***

Response:
After a thorough review and consideration of all the proposals for the RFP, the evaluation committee elected to interview the two top ranked vendors. Risico was not ranked high enough for consideration of a site visit. This determination was solely made by the evaluation panel and not the Purchasing Analyst who only oversees this process.

I have discussed the process for this RFP with the County Purchasing Analyst who presided over this RFP and I am confident that all procedures were properly followed and the process to tentatively award was fair and equable to all proposers.

Based on the review of your concerns addressed in your appeal letter, I find nothing in your letter that supports your appeal. As a result, your appeal has been denied. You have the option to continue the appeal process. To do so, a Letter of Appeal must be submitted in hardcopy form to the County Administrative Officer, Mr. Jean Rousseau, 2281 Tulare St., Room 304, Fresno, CA

93721. The letter must be received by Mr. Rousseau within seven (7) County business days, commencing on the date of this letter. Your letter must clearly state, in specific terms, the reason(s) for the appeal.

Sincerely,

Gary E. Cornuelle

Gary E. Cornuelle
Purchasing Manager

TAB 7

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claims management

October 4, 2017

Mr. Jean Rousseau, CPA
County Administrative Officer
County of Fresno
2281 Tulare St. Room 304
Fresno, CA 93721

Re: Appeal of Notice of Award
Workers' Compensation and Ancillary Services RFP 17-084

Dear Mr. Rousseau:

Risico Claims Management, Inc. is respectively appealing the decision of Mr. Gary Cornnuelle, Purchasing Manager, denying our appeal of the Notice of Award for RFP 17-084.

Our appeal was based on two issues. First, the Request for Proposal (RFP), evaluation panel scoresheet and evaluation panel to question, failed to consider and evaluate the results achieved by Risico over the last 5 years. Failing to incorporate a formal line of questioning and analysis regarding Risico's past performance into its RFP process has led the County to overlook Risico's achievements creating an RFP process that is incomplete. Second, Risico was not afforded the opportunity to participate in the oral interviews or onsite visit which gave our competitors and unfair competitive advantage and failed to recognize our statue as the County's TPA of Record.

The RFP document and evaluation form used by the County for RFP- 17-084 were completely void of any reference of past performance. In our response, we tried to compensate for this by creating a "Performance Highlights" coversheet, however, after reviewing the evaluation panel scoresheets, it is apparent at least one panelist actually viewed this negatively and the others had no comment. Additionally, in his letter denying our appeal, Mr Cornnuelle, stated "On this RFP past performance was not a factor to evaluate".

It is a matter of record, Risico achieved financial results never accomplished by a previous County TPA dating back to 2004. **During our tenure, Risico reduced the County claims caseload by 30%. Specifically, the total open claim caseload was lowered from 1393 claims to 985 claims.** No prior TPA has ever come close to this result including the County's prior TPA who was a large national vendor. I will respectfully add, such performance is extremely rare in the workers' compensation claims industry for an active program and I can assure you would be enthusiastically welcomed by any self-insured entity.

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The County's annual workers' compensation program cost for FY 11/12 was $10.8m. Risico's contract started on October 1, 2012 and at the end of FY 12/13, we achieved a program cost of $9.6 million. FY 13/ 14 the program cost was $8.7 million, FY 14/15 was $8.3 million and FY 15/16 was $8.6 million. **This result shows Risico outperformed a large, national TPA by lowering the County's program cost by an average of $2 million per year or $8 million over the 4 year period.**

The County program liabilities (future estimated reserves/payments) have been significantly reduced as well. Omitting the catastrophic claims program liabilities, **overall program liabilities were reduced from $62.8m in FY 12/13 to $41m in FY 16-17, a reduction which benefited the County in the amount of $21.8 million.**

It is clear, Risico achieved an outstanding outcome for the County. Unfortunately, the County's RFP process failed to consider the importance of our prior performance by omitting such an evaluation from its RFP process. Mr. Cornnuelle asserts this was done to "have a fair and equal chance at a tentative award". However, why would the County solely consider speculative statements and totally disregard proven performance? A fair approach would have been to include such a line of questioning into the RFP that allows the respondents to show results they have had on similar accounts and estimate what type of result they could achieve for the County.

The second issue addresses the fact Risico was not allowed to participate in oral interviews or subject to an onsite visit which was afforded to the other competing TPA's. Risico was identified as a RFP finalist by a County Purchasing Official. The Purchasing Official explained the Evaluation Panel was familiar with our operation and did not need an oral interview or onsite visit. We understand from Mr Cornnulle's letter, the decision not to include us in the oral interviews and onsite visits was made by the Evaluation Panel. In response, I again question the fairness of such an action. During our tenure as your TPA, the County enjoyed financial success and a near flawless record of customer service to the County's injured workers. Why wouldn't we be afforded the courtesy to participate in an oral interview and on site visit? We believe all finalists should be afforded an oral interview and onsite visit in order to maintain a sense of fairness between those organizations and uphold the creditability of an RFP process.

While we have not been allowed to formally evaluate the costs proposals submitted our competitors, we have been able to review the notes made by the Evaluation Panel. **From those notes, the claims administration cost of the AIMS proposal was $1,576,138 higher, and TriStar cost was $2,837,371 higher than the cost of our proposal.** It is clear this is a "significant" difference price that the Evaluation Panel failed to properly evaluate because of the issues mentioned above.

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I respectively request our appeal be granted thereby awarding the tentative award to Risico Claims Management.

Sincerely,

Steven C. Wigh
President

SCW/sw

TAB 8

County of Fresno
COUNTY ADMINISTRATIVE OFFICE
JEAN M. ROUSSEAU
COUNTY ADMINISTRATIVE OFFICER

October 4, 2017

Via U.S. Mail & Email To: swigh@risico.com

Mr. Steven C. Wigh, President
Risico Claims Management
P.O. Box 9783
Fresno, CA 93794-9783

RE: 2nd Appeal to Decision of the County of Fresno, Request for Proposal Number (RFP), 17-084; Worker's Compensation and Ancillary Services

Dear Mr. Wigh:

The County of Fresno is in receipt of your letter appealing the recommendation for tentative award for the above-mentioned RFP. Your letter identifies the basis for your appeal. The issues of your concerns are addressed below.

Your appeal is on the grounds that the evaluation panel failed to consider and evaluate the results of your firm for the past five years and that your firm was not afforded an interview as the other proposers were.

The County's RFP process is strictly based on the proposals that are submitted. It would not be a fair practice to bring in past performance, either positive or negative, as many things can change with a vendor from one contract period to the next. The language in the RFP regarding past performance and references may be used in the evaluation of the proposal is standard language in the RFP template that gives the opportunity to consider those two elements. In this RFP process, past performance was not considered. I do appreciate what your firm has done for the County over the past five years; however, the evaluators ranked two other proposals higher based on the overall quality of the proposals that were submitted. It is the responsibility of the evaluation panel to make recommendations in this process. It is Purchasing's responsibility to manage the process.

As for the recommendation by the evaluation panel to not recommend visiting your firm, that was strictly based on the overall ranking of the proposals and the evaluation panel's decision to visit the top two ranked proposers. You also mention cost in your letter. In

the RFP process, cost is only one factor in evaluating the proposals. The evaluation panel reviews the entire proposal and determines which proposal is best for the County overall with all factors taken into consideration.

Based on the reasons stated above, it is my conclusion that there is insufficient reason to change the tentative award recommendation. This denial of your appeal and our intent to recommend award of the contract to Acclamation Insurance Management Services (AIMS) may be further appealed to the Fresno County Board of Supervisors. If that will be your intent, please contact Gary Cornuelle, Purchasing Manager, by **Monday, October 9, 2017, 5 pm**, as the AIMS contract is scheduled to go before the Board of Supervisors on October 31, 2017.

Sincerely,

Debbie Padwell
for

Jean M. Rousseau
County Administrative Officer