THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
ACTION AGENDA SUMMARY

DEPT: CEO-Risk Management Division BOARD AGENDA # III.

Urgent ☐ Routine ☐ AGENDA DATE 05/10/2013

CEO Concurs with Recommendation YES ☑ NO ☐ 4/5 Vote Required YES ☐ NO ☑
(Information Attached)

SUBJECT:

Consider a Letter of Appeal Submitted by JT2 Integrated Resources for Third Party Administration for Workers' Compensation Program and all Associated Actions of Approval and Authorization Related to Request for Proposal 12-58 MP

STAFF RECOMMENDATIONS:

1. Consider the letter of appeal submitted by JT2 Integrated Resources.
2. Uphold the Purchasing Agent's decision to deny the protest submitted by JT2 Integrated Resources.
3. Approve agreement with York Risk Services Group, Inc. for Workers' Compensation Third Party Administrator Services for the period of July 1, 2013 through June 30, 2016.
4. Authorize the Purchasing Agent to sign the Agreement and any future amendments or extensions to the Agreement based on changes in the volume of claims or legislative changes impacting caseload standards.

FISCAL IMPACT:

This agenda item is to consider an appeal submitted by JT2 Integrated Resources (JT2) of the Purchasing Agent's decision to award a contract for Workers' Compensation Third Party Administrator (TPA) services to York Risk Services Group, Inc. (York). The proposed contract period is July 1, 2013 through June 30, 2016.

(Continued on Page 2)

BOARD ACTION AS FOLLOWS:

No. 2013-228

On motion of Supervisor O'Brien , **Seconded by Supervisor** Monteith
and approved by the following vote,
Ayes: Supervisors: O'Brien, Withrow, Monteith, De Martini and Chairman Chiesa
Noes: Supervisors: None
Excused or Absent: Supervisors: None
Abstaining: Supervisor: None

1) X **Approved as recommended**
2) _____ **Denied**
3) _____ **Approved as amended**
4) _____ **Other:**

MOTION:

Christine Ferraro

ATTEST: CHRISTINE FERRARO TALLMAN, Clerk **File No.**

FISCAL IMPACT: (Continued)

The County currently contracts with Acclamation Insurance Management Services (AIMS) to provide Workers' Compensation claims administration services at a base rate of $50,196 per month (or $602,352 per year). The recommended agreement with York will provide a total base administrative cost of $1,488,395 over the three-year period, which represents a reduction of $318,661 or 18% in base administrative costs over this period of time.

In addition to the contracted rates for claims administration, the proposed agreement with York includes pricing for various care management programs designed to improve the efficiency and effectiveness of the Workers' Compensation program, and for administrative costs related to maintenance of the County's Medical Provider (MPN) network. All program costs are outlined in the Agreement for Professional Services attached to this agenda item.

The managed care program is a critical component in controlling Workers' Compensation claims and includes bill review, utilization review and nurse case management for appropriate cases. The proposed cost of bill review services with York contemplates a base rate of $7.50 per bill and the opportunity for York to keep 24% of any additional cost savings they generate through the use of their discounted Preferred Provider Organization (PPO) network contracts. Utilization review fees are charged on an hourly basis and referrals are made on an as-needed basis. Fees for these services are charged directly to individual claim files when deemed necessary and with the approval of the County. The total cost of the managed care program will vary dependent upon the number and complexity of claims filed, with costs projected to be approximately $55,000 per year billed to the individual claim files under the pricing structure of the new agreement.

The Workers' Compensation program is funded through contributions from departments based on each department's risk exposure and prior claims history. The projected costs of the proposed administrative agreement and managed care program have been included in the distribution of annual department Workers' Compensation charges for FY 2013-2014. Total cost of the Workers' Compensation program in FY 2013-2014 is projected to be $6 million, which includes administration, excess insurance premiums and claim payments.

DISCUSSION:

In early 2012, the General Services Agency Purchasing Division (GSA) issued a request for proposal (#12-06 MP) for a Third Party Administrator for Workers' Compensation Claims and on May 22, 2012 the resultant contract was presented to the Board for approval. The Board did not approve the contract, but directed staff to return to the RFP process (see Resolution 2012-257). Thereafter, GSA and the Risk Management Division of the Chief Executive Office (Risk) collaborated to develop a new request for proposal containing a refined evaluation process and scoring criteria as recommended by the Board. On December 11, 2012 staff returned to the Board for approval to initiate a Request for Proposal 12-58 MP Third Party Administrator for Workers' Compensation Claims (RFP) (see Resolution 2012-594). The following is a summary of the RFP and evaluation scoring criteria used for each of the five phases of the revised RFP process:

PHASE I – FINANCIAL REPORT	MAXIMUM POINTS
Review and Evaluate Proposal Submission and Financial Report	PASS/FAIL
Notify Vendors Proceeding onto Phase II	

PHASE II – EVALUATION OF QUALIFICATION PROPOSAL	MAXIMUM POINTS
A. Claims Management Services	75
B. Managed Care Services	25
Maximum Available Points – Phase II	100
Notify Proposers Proceeding to Phase III (min. score of 75 required)	

PHASE III – EVALUATION OF PRICING PROPOSAL	MAXIMUM POINTS
Proposed cost	100
Notify Proposers Proceeding to Phase IV (top 5 highest scores)	

PHASE IV – REFERENCE CHECKS & AUDIT RESULTS	MAXIMUM POINTS
Total available points	50
Notify Proposers Proceeding to Phase V (min. score of 25 required)	

PHASE V – PRESENTATION & INTERVIEW	MAXIMUM POINTS
Total available points	50

OVERALL MAXIMUM AVAILABLE POINTS:	300

The Board approved the RFP and GSA released it on December 11, 2012. Upon release, the RFP was sent electronically to 374 vendors, of which 34 downloaded the RFP. On December 20, 2012, a mandatory pre-conference was held with 15 vendors in attendance. On January 22, 2013, the RFP closed and GSA received complete proposals from the following 8 vendors:

- American All-Risk Loss Administrators, Inc. of Fresno, CA;
- CorVel Enterprise Comp, Inc., of Stockton, CA;
- Intercare Holdings Insurance Services, Inc., of Rocklin, CA;
- JT2 Integrated Resources, of Lathrop, CA;
- Keenan & Associates, of Torrence, CA;
- Pegasus Risk Management, Inc., of Modesto, CA;
- TriStar Risk Management of Concord, CA; and
- York Risk Services, Inc., of Orange, CA.

One proposer was disqualified during the financial review in Phase I of the evaluation process, and GSA sent a written notice of non-award to this proposer on January 29, 2013. No letter of protest was received during the five-day protest period of the RFP process. The remaining seven proposers were passed on to Phase II of the evaluation process, which was conducted by the Evaluation Committee.

The Evaluation Committee consisted of individuals with direct experience and knowledge of the contracting issues associated with selecting a Third Party Administrator for workers' compensation programs. The team included participants from Risk and three outside panel members working in public sector risk management programs. GSA conducted Phase I, and the Evaluation Committee was responsible for Phases II – V of the evaluation process.

Phase II consisted of a review and evaluation of each proposer's response, qualification and general understanding of the project. Proposers were scored in two categories, claims management and managed care, with a total of 100 points possible. Only those proposers receiving 75 of the 100 available points passed on to Phase III. Three proposers were disqualified during this phase, and GSA sent written notices of non-award to each on February 14, 2013. No letters of protest were received during the five-day protest period of the RFP process.

In Phase III, the pricing proposals submitted by each of the four remaining proposers were evaluated. As part of the RFP development, Risk prepared a specific form for proposers to use in submitting their pricing proposals in an effort to ensure an "apples to apples" analysis of the true cost for each vendor. The RFP pricing proposal template was a requirement for each proposer. The form included the following language:

> Proposers must submit pricing using this form, which shall be used as the basis for Phase III of the Evaluation Process. Proposers may submit an alternate pricing proposal separately in addition to this required Pricing Proposal. Such alternate pricing will not be considered as part of the evaluation process, but may be incorporated into the final agreement.
>
> The County will not pay for any services during the term of any future agreement that are not identified on your pricing proposal submitted during the RFP process, unless otherwise agreed to by the County during the term of the agreement.

Evaluation of pricing proposals was based upon a weighted average, with the lowest price assigned 100% of the 100 points possible. Since the RFP required the top five highest proposers to proceed to the next phase of the evaluation process, Phases III through V were run concurrently for all four remaining proposers. This provided an opportunity for the Evaluation Committee to question audit results as well as to clarify pricing and qualification proposals as needed during the Phase V Interviews. This also allowed time for Risk to develop a pricing model based upon historical data which would provide a fair comparison of all four pricing proposals.

Phase IV of the evaluation process consisted of reference checks and a review of audit results, with a total of 50 points available. Only those proposers receiving 25 of the 50 points available passed on to Phase V, the final phase of the evaluation process. All four proposers passed on to the final phase of the evaluation process. Interviews and oral presentations from each of the four finalists were conducted in Phase V of the evaluation process, with a total of 50 points available.

The Evaluation Committee then added the scores from Phases II and V for each of the four finalists to establish final scores for each. A summary of the scoring for all five phases of the evaluation process is provided as Attachment I. The final scores are as follows:

Proposer	Final Score
York	272.6
JT2	272.4
Pegasus	254.6
Intercare	247.4

As shown above, York received the highest score of 272.6 of a possible 300 points. The award of the contract was made to the proposer whose proposal best met the criteria set forth in the RFP and provides the best value to the County, with price and all other factors considered.

On March 11, 2013, GSA sent written notice of intent to award to York and notices of non-award to the other three remaining proposers. On that same day, GSA was contacted by JT2 inquiring about the scoring methodology and seeking an understanding of the pricing analysis. JT2 also submitted a request for a full copy of the qualification and pricing proposals submitted by York.

On March 13, 2013 the Purchasing Agent, GSA staff and Risk staff met with JT2. GSA provided the requested copies of York's proposal. Risk explained the pricing model and methodology used for scoring pricing proposals in detail, and answered all questions asked.

Within the prescribed five-day protest period, JT2 submitted a letter of protest (Protest Letter) to the Purchasing Agent which was received by GSA on March 13, 2013. In the Protest Letter, JT2 alleged "calculation errors" with respect to both Medicare reporting and the medical provider network calculation.

Upon receipt of the Protest Letter, GSA and Risk reviewed JT2's concerns as well as the entire pricing analysis. With regard to Medicare reporting, JT2 indicated there should have been no charge calculated in its pricing analysis since the County currently has this service available at no charge through a third party vendor, Gould and Lamb. JT2's pricing proposal, however, clearly shows a price of $20.00 per report. In reviewing JT2's pricing proposal, the Evaluation Committee needed clarification to understand how often this fee was charged. JT2 representatives provided this needed clarification during the Phase V presentation and interview, confirming JT2's proposed billing practices as to how this fee would be charged. The Evaluation Committee then estimated 10 files that would require 4 reports each year, for a total of $800.00 per year, or $2,400.00 over the three-year proposed contract term. The Evaluation Committee made no "material errors" in solving this simple mathematical equation.
In regard to the medical provider network, the Protest Letter states that "JT2's pricing proposal ... did not include any charges for administration of the County's current medical provider network." The Protest Letter also describes how JT2 anticipates a fee to apply only to 5% of the bills it would process each year, along with a very unique and complicated process for determining which medical providers would trigger this additional cost. This is new information, as JT2 did not provide it in its pricing proposal or in its qualification proposal, nor was it discussed during the Phase V presentation and interview. In fact, JT2's pricing proposal clearly and simply stated "$3.00 Per Bill" under the medical provider network category. To determine the total cost of this category, the Evaluation Committee took the actual average number of bills paid annually (6,223), multiplied this number by the $3.00 per bill fee listed on JT2's pricing proposal to equal an annual cost of $18,669, or a total cost over a three-year contract of $56,007. Again, the Evaluation Committee made no "material errors" in solving this simple mathematical equation.

The RFP closed on January 22, 2013, at which time all relevant information was to be submitted. The Phase V presentation and interview on February 22, 2013 provided an opportunity for proposers to clarify any ambiguities in their responding proposals. In its Protest Letter, JT2 attempted to submit new information to be added to its previously submitted pricing proposal, which is not permitted. JT2 has alleged "material errors in the pricing evaluation calculations" because the Evaluation Committee did not use the new information it its calculations. JT2's basis for protest was without merit and was, therefore, denied.

On March 26, 2013 the Purchasing Agent issued a written denial of the Protest Letter stating the facts and analysis set forth above. Within the prescribed ten-day appeal period, JT2 submitted a letter of appeal (Appeal) to the Board of Supervisors, with a copy to the Purchasing Agent. While the Appeal was delivered properly and timely, much of its substance is improper. Both the RFP (Section 3.14.4) and GSA Purchasing Policies and Procedures (page 25) state that the "Board of Supervisors shall review and decide the appeal based on the grounds and documentation set forth in the original protest to the Purchasing Agent." In its Appeal, however, JT2 raises several issues not set forth in the Protest Letter.

One such example is in the fourth paragraph of the Appeal, as JT2 discusses the "history of the contract" and makes the allegation that York "is the successor company of Claims Management, Inc.," the County's previous third party administrator for Workers' Compensation. This issue was not mentioned in the Protest Letter, is irrelevant to the RFP process and inaccurate. York has never been the County's third party administrator, nor did York purchase Claims Management, Inc. (CMI). When CMI closed its business York assumed CMI's existing client contracts. The County, however, was not a client of CMI at the time that CMI went out of business.

Another example is found in the fifth paragraph of the Appeal. JT2 states "[t]he Purchasing Department is recommending the poorest performer based on cost alone" and later in the same paragraph, "[t]he hard and soft costs of selecting the poorest quality candidate have not been considered or applied." In both of these statements, JT2 is questioning the scoring methodology of the RPF. This issue was not raised in the Protest Letter. Aside from the fact that the Board approved the scoring methodology used in the RFP on December 11, 2012, issues related to scoring methodology are not proper grounds for protest as set forth in Section 3.14.3 of the RPF. This section states that all protests must:

> Contain a concise statement of the grounds for protest; provided, however, RFP processes and procedures, including evaluation criteria, shall not be proper grounds for protest. Concerns related to such issues should be raised and addressed, if at all, prior to the bid or proposal opening date to allow adjustments before evaluation of bids or proposals.

Specifically, this means that should proposers have questions regarding the scoring criteria or methodoloy such questions should be addressed prior to the RFP closing date so that adjustments, if necessary, can be made. The process cannot be adjusted after the RFP has closed, and certainly not after scoring is complete.

The actual basis for JT2's appeal is only mentioned briefly in the fifth paragraph (page 2) of the Appeal, when JT2 refers to Attachment A to the Protest Letter. JT2 reiterates the allegations of "material errors in the pricing evaluation calculation." As JT2's Protest Letter was denied for lack of merit, so too should the ensuing Appeal be denied for lack of merit.

A copy of the Appeal from JT2 to the Board of Supervisors is attached to this agenda item.

If the Appeal is denied and the proposed agreement with York is approved, York is prepared to begin providing service by July 1, 2013. Managed care (bill review and network management), managed care review and utilization review will be provided through Wellcomp Managed Care Services, Inc. York's claims examiners will have a certification from self insured plans and will maintain a caseload of no more than 150 open indemnity claims at any time, consistent with the current contract standard.

York Risk Services Group, Inc. has been in business as a third party administrator for nearly 52 years. York has over 26 years of experience providing claims administration services for California public agencies. York has 17 offices in 8 States, providing service to private and public organizations. York provides contracted workers' compensation services to 572 public sector clients in California, including 28 Counties, 185 cities and 57 special districts, 300 school districts and 2 transit districts. York offers a state-of-the-art computer system, integrated managed care programs, as well as a quality assurance department with training programs. York operates in a paperless environment with instant communication and workflow processes designed to communicate claim updates to the County in a real-time electronic environment. The County will transition to paperless workers' compensation files upon implementation of the York system. Utilizing this system will reduce the County's current staff time dedicated to opening, distributing and filing mail.

A copy of the proposed agreement with York has been attached to this agenda item.

POLICY ISSUE:

Denial of the pending appeal and the approval of the proposed agreement will improve administration of the County's workers' compensation program and will support the Board of Supervisors' priorities of Efficient Delivery of Public Services and Effective Partnerships.

STAFFING IMPACT:

York will be responsible for the transition from the County's existing third party administrator. There will be training required for County staff, but it is anticipated that no new positions will be needed to implement this change. County Risk staff will continue to assure that all claims are processed timely and appropriately in conjunction with York and, as necessary, defense counsel.

CONTACT:

Keith D. Boggs, GSA Director/Purchasing Agent: 209-652-1514
Jody Hayes, Deputy Executive Officer: 209-525-5714

JT2 INTEGRATED RESOURCES

April 4, 2013

BOARD OF SUPERVISORS

2013 APR -5 A 9:43

County of Stanislaus
Board of Supervisors
William O'Brien
Vito Chiesa, Chairman
Terry Withrow
Dick Monteith
Jim DeMartini, Vice-Chairman
1010 10th Street
Suite 6700
Modesto CA 95354
Attn: Christine Ferraro Tallman, Board Clerk

RE: RFP 12-58 MP Third Party Administrator for Workers Compensation

Dear Ms. Tallman:

JT2 is in receipt of the Purchasing Agents correspondence dated and received on March 26, 2013, regarding our protest of the proposed award of services outlined in RFP 12-58 MP Third Party Administrator for Workers Compensation (the "RFP").

In accordance with Section 3.14.4 Protest Review, JT2 Integrated Resources is appealing to the Board of Supervisors the decision of the Purchasing Agent, as it relates to the above referenced RFP.

JT2 Integrated Resources disagrees with the Purchasing Agents decision.

The history of this contract is also relevant to the current proposed selection of York Risk Services. In July of 2008, the County released an RFP for Workers Compensation Claims Administration after receiving administration services by Claims Management, Inc. since August of 1993. York Risk Services, the current recommended candidate, is the successor company of Claims Management, Inc. Due to a variety of factors, including cost and quality, the County released the RFP as outlined in the Board Agenda dated November 4, 2008 number B-11. In 2008, the County replaced York Risk Services and contracted with Acclamation Insurance Management Services (AIMS) for your Workers Compensation Program. At the completion of the contract (June 30, 2012), the County again released a request for proposal in search of a provider who would provide the County with the best service for the counties employees. Due to vendor protest, in December 2012, the County re-released a request for proposal (RFP 12-58). JT2 participated in this RFP process and submitted a response to this request for proposal. On March 11, 2013, JT2 was notified that our firm was not selected. The purchasing department recommended that the County return to its previously terminated administrator, York Risk Services. Attached to the correspondence was a final evaluation summary prepared by the GSA – Purchasing Division of the County.

The analysis of this summary revels some important and significant facts for your consideration. If you compare the four vendors prior to applying the pricing proposal, JT2 was ranked number one by your purchasing department. The JT2 proposal ranked number one with 174.9 points. This exceeded the selected vendor by 2.3 overall points. The selected candidate ranked poorest in audits, references and quality. It is only after the pricing component is added to the analysis, that the selected candidate exceeds JT2's point total. The Purchasing Department is recommending the poorest performer based on cost alone. This selection exposes the County to increased claims penalties, unnecessary

and excessive claims costs and above all, potentially poor service to its valued employees. This exposure arises by ignoring the facts as stated in your own final evaluation summary. If you review our Attachment A to our protest, you will find that the Purchasing Department concluded that the difference between JT2 and York was valued at $44,623.08 over a 3 year contract period. For a mere $15,000 a year, the well being and satisfaction of the employees of County are being sacrificed. Additional costs associated with the selection of the poorest performer are not part of the evaluation of cost. Therefore, it is our position that after clarification, JT2 actually is the lowest price vendor. If the Board were to review and agree with JT2's assessment that the purchasing division erred in its assumptions, JT2 would be awarded the full 100 points in the pricing category thus revising the final summary matrix to reflect that JT2 be awarded 274.9 points and York be awarded 271.9 points. Even if the JT2 cost clarification were to be rejected by the Board, the analysis is flawed. The hard and soft costs of selecting the poorest quality candidate have not been considered or applied. The net effect is that the County will incur unknown and material additional costs associated with poor service and risk the goodwill of its employees for a matrix difference of $15k a year on a program that has contract costs in excess of $500k annually. Is that a responsible decision, given the facts? The answer to that question is central to the selection of the lowest cost "responsible" bidder. JT2 believes it is clearly the best available candidate as evidenced by your own evaluation documents and is the lowest "responsible" bidder, if the actual and demonstrated costs are accurately considered.

JT2 is available to meet with you and discuss our proposal at your request.

JT2 believes that our proposal best meets the criteria of this RFP and offers the best value to the County. We hope we have the chance to serve the County as its Workers' Compensation Claims Administrator.

Corporate Offices
JT2 Integrated Resources
5820 Stoneridge Mall Road
Suite 350
Pleasanton, CA 94588
Phone: 800-582-4671
Contact: Michael Ramser, Chief Marketing Officer (310) 775-1494 Direct
Tabatha Bettencourt, Sr. Vice President (209) 610-4569 Direct

Sincerely,

Jeff Sandford
CEO

Michael Ramser
Chief Marketing Officer

Cc: Keith Boggs, Purchasing Agent

Enclosures
November 4, 2008 Board Agenda item B-11
March 11, 2013 Stanislaus County correspondence
March 13, 2013 JT2 formal protest correspondence
March 26, 2013 Stanislaus County correspondence

Stanislaus County
Striving to be the Best

GENERAL SERVICES AGENCY

Keith D. Boggs
Assistant Executive Officer
GSA Director/Purchasing Agent

1010 10th Street, Suite 5400, Modesto, CA 95354

Phone: (209) 525-6319
Fax: (209) 525-7787

March 26, 2013

JT2 Integrated Resources
Attn: Michael Ramser, Chief Marketing Officer
5820 Stoneridge Mall Road, Suite 350
Pleasanton, CA 95488

via e-mail: mramser@jt2.com

RE: RFP 12-58 MP Third Party Administrator for Workers Compensation

Dear Mr. Ramser:

I am in receipt of your correspondence dated and received by my office on March 13, 2013 (the "Protest Letter") regarding RFP 12-58 MP Third Party Administrator for Workers Compensation (the "RFP").

The Protest Letter refers to correspondence from this office dated March 11, 2013 advising that JT2 Integrated Resources ("JT2") was not selected for award of the contract. The grounds provided in the Protest letter consist of allegations of "material errors in the pricing evalaution calculation," with respect to both Medicare reporting and the medical provider network (MPN).

With regard to Medicare reporting, the Protest Letter indicates there should have been no charge, as the County currently has this service available for free through a third party vendor, Gould and Lamb. JT2's pricing proposal, however, clearly shows a price of $20.00 per report (see attached Exhibit A). In reviewing JT2's pricing proposal, the Evaluation Committee (EC) needed clarification to understand how often this fee was charged. JT2 representatives provided this needed clarification during the Phase V presentation and interview, confirming JT2's proposed billing practices as to how this fee would be charged. The EC then estimated 10 files that would require 4 reports each year, for a total of $800.00 per year, or $2,400.00 over the three-year proposed contract term. The EC made no "material errors" in solving this simple mathematical equation.

In regard to the MPN, the Protest Letter states that "JT2's pricing proposal ... did not include any charges for administration of the County's current MPN." The Protest Letter also describes how JT2 anticipates a fee to apply only to 5% of the bills it would process each year, along with a very unique and complicated process for determining which medical providers would trigger this additional cost. This is new information, as JT2 did not provide it in its pricing proposal or in its qualification proposal, nor was it discussed during the Phase V presentation and interview. In fact, JT2'S pricing proposal clearly and simply stated "$3.00 Per Bill" under the MPN category. To determine the total cost of this category, the EC took the actual average number of bills paid annually (6,223), multiplied this number by the $3.00 per bill fee listed on JT2's pricing proposal to equal an annual cost of $18,669, or a total cost over a three-year contract of $56, 007. Again, the EC made no "material errors" in solving this simple mathematical equation.

The RFP closed on January 22, 2013, at which time all relevant information was to be submitted. The Phase V presentation and interview on February 22, 2013 provided an opportunity for proposers to clarify any ambiguities in their responding proposals. In its Protest Letter, JT2 is submitting new information to be added to its previously submitted pricing proposal, which is not permitted. JT2 has alleged "material errors in the pricing evaluation calculations" because the EC did not use the new information it its calculations. JT2's proposal is without merit and is, therefore, denied.

As you noted in your Protest Letter, Section 3.14.3 outlines the protest procedure. Specifically, subsection "c" establishes that each protest must:

> Contain a concise statement of the grounds for protest; provided, however, RFP processes and procedures, including evaluation criteria, shall not be proper grounds for protest. Concerns related to such issues should be raised and addressed, if at all, prior to the bid or proposal opening date to allow adjustments before evaluation of bids or proposals.

Please note that neither RFP processes nor procedure – which would include evaluation and scoring – are proper grounds for protest. Any questions or concerns regarding these issues should have been addressed either verbally at the pre-conference or in writing prior to the question deadline.

Stanislaus County appreciates your interest in serving our County.

Sincerely,

Keith D. Boggs
Assistant Executive Officer
GSA Director/Purchasing Agent

Enclosure – Exhibit A (JT2 Pricing)

EXHIBIT A TO LETTER DATED 3/26/2013

TO MICHAEL RAMSER AT JT2 INTEGRATED RESOURCES

JT2

APPENDIX D
PRICING PROPOSAL

Proposers must submit pricing using this form, which shall be used as the basis for Phase III of the Evaluation Process. Proposers may submit an alternate pricing proposal separately in addition to this required Pricing Proposal. Such alternate pricing will not be considered as part of the evaluation process but may be incorporated into the final agreement.

The Pricing Proposal format is intended to identify ALL potential fees/costs that may be incurred during the term of the agreement. Additional space has been provided for "Other Charges" to document any potential costs not already identified within the pricing categories provided within the form.

For purposes of developing your claims administration pricing proposal, you should assume 2.5 full-time Claims Examiners and a minimum of 1.5 technical support staff. The County may modify the final staffing profile of the program prior to final contract award, however all proposers must submit their pricing proposal with the same base staff for Claims Examiners and support staff.

It is up to each individual Proposer to add all other applicable costs into the proposed Claims Administration Flat Fee (management, overhead, supplies, printing, etc.). Your administrative charges must include all other projected costs/fees not already identified on an individual basis within your Pricing Proposal. The County will not pay for any services during the term of any future agreement that are not identified on your pricing proposal submitted during the RFP process, unless otherwise agreed to by the County during the term of the agreement.

For each item, please include the specific dollar or percentage "Rate" (dollar or percentage amount) as well as the "Frequency" of the charge (annual, monthly, weekly, per claim, per bill, etc.). If no fee is contemplated for a specific category, please respond with "No Charge."

Category	Rate	Frequency
Claims Administration		
Claims Administration Annual "Flat" Fee Year One	$ 498,500	Annual
Claims Administration Annual "Flat" Fee Year Two	$ 508,470	Annual
Claims Administration Annual "Flat" Fee Year Three	$ 523,725	Annual
Other Administrative Costs		
Data Conversion	$ 0.00	
Access to Database/Misc IT Charges	$ 0.00	
Bank Reconciliation	$ 0.00	
Subrogation	$ 0.00	
Indexing *(may be done at no charge through CSAC-EIA)*	$ 0.00	CSAC
Claim file storage including closed inventory	$ 0.00	
Claim file storage including closed inventory	$ 0.00	
Medicare Reporting	$ 20.00	Per Report
Ad hoc report programming per hour	$ 0.00	
Medical Provider Network Administration	$ 3.00	Per Bill

PRICING PROPOSAL – CONTINUED

Category	Rate	Frequency
Bill Review		
Fee per Bill to reduce to fee schedule	$ 8.00	Per Bill
% of Savings for PPO Savings below fee schedule	% 20	
% of Savings for Hospital Inpatient	% 15	
% of Savings for Hospital Outpatient	% 15	
% of savings Negotiated Bill Review	% 25	
Utilization Review		
Nurse Review - per hour	$ 85	XXXXX Flat
Doctor Review - per hour	$ 210	XXXXX Flat
Peer Review - per hour	$ 210	XXXXX Flat
Pre-Certification (hospital or surgery) - fee per case	$ 85	Per Case
Concurrent Review - fee per case	$ 85	Per Case
Nurse Case Management		
Telephonic Case Management - per hour	$ 105	Hourly
Field Case Management - per hour	$ 110	Hourly
Travel and wait time - per hour	$ 110	Hourly
Mileage charges for travel	$ .55	
Catastrophic Case Management	$ 115	Hourly
Other Charges		
Hearing Representative	$95	Hourly

March 13, 2013

County of Stanislaus
Keith Boggs
Assistant Executive Officer
Chief Executive Office
1010 10th Street Suite #6800
Modesto, CA 95354

Re: Formal Protest of RFP #12-58MP closing date January 22, 2013
JT2 Integrated Resources
5820 Stoneridge Mall Road, Suite 350
Pleasanton, CA 94588
(800) 582-4671

Dear Mr. Boggs:

Respectfully submitted, this document will serve as formal notification of JT2 Integrated Resources' Protest to the County of Stanislaus ' RFP #12-58MP for "Third Party Administrator for Workers' Compensation" in accordance with Section 3.14.3.

JT2 received the County's Non-award notification on March 11, 2013 via e-mail. In conformity with the County's protest process provided in the RFP#12-58MP, Section 3.14.3, this protest is being forwarded to the Purchasing Agent via courier on March 13, 2013.

Corporate Offices
JT2 Integrated Resources
5820 Stoneridge Mall Road, Suite 350
Pleasanton, CA 94588
Phone 800-582-4671
FAX 925-701-8165
Contacts: Michael Ramser, Chief Marketing Officer (310)775-1494 Direct
Tabatha Bettencourt, Sr. Vice President (209)610-4569 Direct

Grounds For Protest

JT2 has found material errors in the pricing evaluation calculations that determined the winner for Phase III "Pricing". On March 13, 2013 in a meeting between JT2 Executives and The County Risk Management and Purchasing Staff, JT2 was provided the County's pricing evaluation spreadsheet that compared JT2 and York projected fees. A copy is included as Attachment A for your review.

JT2 has reviewed the County's pricing evaluation and has noted the following calculation errors and an explanation of why they are erroneous.

1) Medicare Reporting – The cost sheet identifies a $2,400 expense for JT2 Medicare Reporting. This projected cost is not correct. There is no charge based on the statement outlined in Addendum No. 2 which stated that an existing interface with County of Stanislaus and Gould and Lamb is in place. York had no dollar expense for this same proposed process.

This projected cost of $2,400 has been eliminated in our revised spreadsheet highlighted in blue on Attachment B.

2) Medical Provider Network Administration – The County's cost assessment for this category was incorrect. JT2 charges for MPN services only apply to non MPN and PPO providers. The County assessed JT2 an annual expense of $18,669 per year for a contract total of $56,007 dollars over a three year period.

JT2's pricing proposal under pricing section for MPN administration did not include any charges for administration of the County's existing MPN. Addendum No. 2, reflected that the County's existing MPN was transferable and did not require a re-filing until May of 2014. Therefore, there is no charge for MPN administration in year one. Based on the RFP, JT2 assumed a volume of 6,000 bills annually. Additionally, with our MPN experience, we assumed a maximum of 5% new providers to the MPN or PPO. This generates a maximum fee of $900 for years two and three for administration of the County's MPN. Attachment B, highlighted in green, has been changed to reflect the actual estimated contract maximum for a total of $1,800 dollars over a three year period. The County erroneously deduced that the fee of $3.00 per bill was to be applied to all medical bills as opposed to providers that are not currently in the MPN or PPO. JT2 anticipates that only 3-5% of medical providers will be outside of the MPN or PPO.

We appreciate the effort, diligence and professionalism that the County Staff has demonstrated. JT2 has refined and corrected the estimated costs over the three year contract period to more accurately reflect the County's ultimate probable cost through a relationship with JT2.

We are confident in our figures and would be willing to incorporate its estimates into any final agreement as per appendix D paragraph.

It is not JT2's intent to provide this data as alternate pricing but to accurately reflect our proposal response in the same light as other vendors.

Based upon the final evaluation summary provided to JT2 , exclusive of the Phase III pricing evaluation, JT2 ranked number one with 174.9 total points compared to the second place vendor, York at 172.6. With the accurate and corrected figures identified in attachment B, JT2's three year program costs are $1,748,899.70 versus York's cost of $1,760,883.62. Based on the County's evaluation criteria and scoring, JT2 would receive 100 points for the pricing section. This would revise the total score for JT2 from 272.4 to 274.9. York would have a revised score from 272.6 to 271.9. When those differences are recast as points to the matrix JT2 has a final evaluation score of 274.9 and York final score is 271.9. Based on this adjusted and more accurate final scoring for the pricing phase of the evaluation, JT2 believes that in accordance with RFP section 6.4, JT2 is the proposer whose proposal best meets the criteria set forth and provides the best value to the County, with price and all other factors considered.

JT2 looks forward to the Purchasing Agents written response to each material issue raised in our protest.

Sincerely,

Jeff Sandford
CEO

Michael Ramser
Chief Marketing Officer

Attachment A

Claims Administration	Simon	Intercare	York	JT2	
Claims Administration Annual "Flat" Fee Year One			$483,933.00	$498,500.00	
Claims Administration Annual "Flat" Fee Year Two			$496,031.00	$508,470.00	
Claims Administration Annual "Flat" Fee Year Three			$508,431.00	$523,726.00	
Other Administrative Costs					
Data Conversion			$0.00	$0.00	
Access to Database/Misc IT Charges			$0.00	$0.00	
Bank Reconciliation			$0.00	$0.00	
Subrogation			$0.00	$0.00	
Indexing *(may be done at no charge through CSAC-EIA)*			$0.00	$0.00	
Claim file storage including closed inventory			$0.00	$0.00	
Claim file storage including closed inventory			$0.00	$0.00	
Medicare Reporting			$0.00	$2,400.00	
Medicare Reporting 1st year			$0.00		
Medicare Reporting 2nd year					Year 2
Medicare Reporting 3rd year					Year 3
Ad hoc report programming per hour					
Medical Provider Network Administration			$52,050.00	$18,669.00	Year 1 & set-up
				18,669.00	Year 2
				18,669.00	Year 3
Three Year Claims Admin Fees			$1,540,445.00	$1,589,102.00	
Bill Review					
Fee per Bill to reduce to fee schedule			$46,672.50	$49,784.00	
% of Savings for PPO Savings below fee schedule year 1			$8,217.12	$5,135.70	
Fee per Bill to reduce to fee schedule			$46,672.50	$49,784.00	Year 2
% of Savings for PPO Savings below fee schedule year 2			$8,217.00	$5,136.00	Year 2
Fee per Bill to reduce to fee schedule			$46,672.50	$49,784.00	Year 3
% of Savings for PPO Savings below fee schedule year 3			$8,217.00	$5,136.00	Year 3
% of Savings for Hospital Inpatient				15%	
% of Savings for Hospital Outpatient				15%	
% of savings Negotiated Bill Review				25%	
Three Year Bill Review Fees			$164,668.62	$164,759.70	

Utilization Review				
Nurse Review - per hour			$3,515.00	$3,145.00
Doctor Review - per hour			$15,075.00	$14,070.00
Peer Review - per hour				
Pre-Certification (hospital or surgery) - fee per case				
Concurrent Review - fee per case				
UR Fees Year 1			18,590.00	17,215.00
UR Fees Year 2			18,590.00	17,215.00
UR Fees Year 3			18,590.00	17,215.00
Thee Year UR Fees			$55,770.00	$51,645.00
Nurse Case Management				
Telephonic Case Management - per hour				$105.00
Field Case Management - per hour				[illegible]
Travel and wait time - per hour				[illegible]
Mileage charges for travel				[illegible]
Catastrophic Case Management				[illegible]
Hearing Rep				[illegible]

Overall Program 3 Year Projection			$1,760,883.62	$1,805,506.70

Local Vendor Reduction

Total 3-Year Projection	$1,760,883.62	$1,805,506.70

Amount Over Lowest Bidder	$0.00	$44,623.08
% Over Lowest Bidder	0.0%	2.5%
% of Points Awarded	100.0%	97.5%
Points Awarded for Pricing	100.0	97.5

Attachment B

Claims Administration	Simon	Intercare	York	JT2		Revised JT2	
Claims Administration Annual "Flat" Fee Year One			$483,933.00	$498,500.00		$498,500.00	*No Change
Claims Administration Annual "Flat" Fee Year Two			$496,031.00	$508,470.00		$508,470.00	*No Change
Claims Administration Annual "Flat" Fee Year Three			$508,431.00	$523,725.00		$523,725.00	*No Change
Other Administrative Costs							
Data Conversion			$0.00	$0.00		$0.00	*No Change
Access to Database/Misc IT Charges			$0.00	$0.00		$0.00	*No Change
Bank Reconciliation			$0.00	$0.00		$0.00	*No Change
Subrogation			$0.00	$0.00		$0.00	*No Change
Indexing *(may be done at no charge through CSAC-EIA)*			$0.00	$0.00		$0.00	*No Change
Claim file storage including closed inventory			$0.00	$0.00		$0.00	*No Change
Claim file storage including closed inventory			$0.00	$0.00		$0.00	*No Change
Medicare Reporting			*$0.00*	*$2,400.00*		*$0.00*	***Per RFP 12-58MP Addendum No. 1, County has existing interface with Gould & Lamb for medicare reporting. JT2 pricing was for alternate pricing assuming a change in vendors by County.***
Medicare Reporting 1st year							
Medicare Reporting 2nd year							
Medicare Reporting 3rd year							
Ad hoc report programming per hour			$0.00	$0.00		$0.00	*No Change
Medical Provider Network Administration			*$52,050.00*	*$18,669.00*	*Year 1 & Set Up*	*$0.00*	***County calculation misinterpretted JT2's proposal response. *Per RFP 12-58MP Addendum No. 1, County's current MPN may be transferred to the new TPA. TPA must reapply and receive approval for MPN prior to May 27, 2014.***
				$18,669.00	*Year 2*	*$900.00*	***MPN fee of $3.00 per bill is for providers outside of MPN only***
				$18,669.00	*Year 3*	*$900.00*	***MPN fee of $3.00 per bill is for providers outside of MPN only***
Three Year Claims Admin Fees			*$1,540,445.00*	*$1,589,102.00*		*$1,532,495.00*	
Bill Review							
Fee per Bill to reduce to fee schedule			$46,672.50	$49,784.00		$49,784.00	*No change
% of Savings for PPO savings below fee schedule year 1			$8,217.12	$5,135.70		$5,135.70	*No change
Fee per Bill to reduce to fee schedule			$46,672.50	$49,784.00	Year 2	$49,784.00	*No change
% of Savings for PPO savings below fee schedule year 2			$8,217.00	$5,136.00	Year 2	$5,136.00	*No change
Fee per Bill to reduce to fee schedule			$46,672.50	$49,784.00	Year 3	$49,784.00	*No change
% of savings for PPO savings below fee schedule year 3			$8,217.00	$5,136.00	Year 3	$5,136.00	*No change
Three Year Bill Review Fees			**$164,668.62**	**$164,759.70**		**$164,759.70**	*No change

Attachment B

Utilization Review							
Nurse Review - per hour			$3,515.00	$3,145.00		$3,145.00	*No change
Doctor Review - per hour			$15,075.00	$14,070.00		$14,070.00	*No change
Peer Review - per hour							
Pre-Certification (hospital or surgery) - fee per case							
Concurrent Review - fee per case							
UR Fees Year 1			$18,590.00	$17,215.00		$17,215.00	*No Change
UR Fees Year 2			$18,590.00	$17,215.00		$17,215.00	*No Change
UR Fees Year 3			$18,590.00	$17,215.00		$17,215.00	*No Change
Three Year UR Fees			**$55,770.00**	**$51,645.00**		**$51,645.00**	*No Change
Nurse Case Management							
Telephonic case management - per hour			$98.00	$105.00		$105.00	*No change
Field Case Management - per hour			$98.00	$110.00		$110.00	*No change
Travel and wait time - per hour			$98.00	$110.00		$110.00	*No change
Mileage charges for travel			Current IRS Rate	$0.55		$0.55	*No change
Catastrophic Case Management			$98.00	$115.00		$115.00	*No change
Hearing Rep				$95.00		$95.00	*No change
Overall Program 3 year Projection			**$1,760,883.62**	**$1,805,506.70**		**$1,748,899.70**	
Local Vendor Reduction							
Total 3-year Projection			$1,760,883.62	$1,805,506.70		$1,748,899.70	
Amount Over Lowest Bidder			$0.00	$44,623.08	*Based on COS		
% Over Lowest Bidder			0.0%	2.5%			
% of Points Awarded			100.0%	97.5%			
Points Awarded for Pricing			100.0	97.5			
Amount Over Lowest Bidder			$11,983.90	$0.00	*Based on Revised pricing of JT2		
% Over Lowest Bidder			0.7%	0.0%			
% of Points Awarded			99.3%	100.0%			
Points Awarded for Pricing			99.3	100.0			

GENERAL SERVICES AGENCY
PURCHASING DIVISION

Keith D. Boggs
Deputy Executive Officer
GSA Director/Purchasing Agent

1010 10th Street, Suite 5400, Modesto, CA 95354

Phone: (209) 525-6319
Fax: (209) 525-7787

March 11, 2013

JT2 Integrated Resources
Attn: Michael Ramser, Chief Marketing Officer
1700 Murphy Parkway
Lathrop, CA 95350

via e-mail: mramser@jt2.com

RE: RFP 12-58 MP Third Party Administrator for Workers Compensation

Dear Michael:

Thank you for your interest in the recent Request for Proposal (RFP) for Third Party Administrator for Workers Compensation. We have completed the evaluation process, and enclosed for your records is a copy of the final scores. Although your firm was not selected for the award of a contract resultant from this RFP, Stanislaus County shall retain your firm on the County's vendor list for future projects.

This contract requires the approval of the County's Board of Supervisors ("Board"). The County anticipates submitting the contract for such approval within the next 60 days. The tentative date for presentation is March 26, 2013; however, the exact date is dependent upon on the Board's calendar. The Agenda for each Board meeting can be viewed on the County's website located at http://www.co.stanislaus.ca.us/board/index.shtm. Agreements are not binding unless approved by the Board of Supervisors and/or an executed contract is in place.

Thank you for your interest in providing service to Stanislaus County. Should you have any questions, you may contact me at (209) 567-4958.

Sincerely,

Melinda Pallotta

Melinda Pallotta, C.P.P.O.
Purchasing Supervisor/Contract Administrator

cc: RFP File

STANISLAUS COUNTY
GENERAL SERVICES AGENCY - PURCHASING DIVISION
FINAL EVALUATION SUMMARY
FOR RFP 12-58 MP (See RFP § 6.3)

		TOTAL AVAILABLE	INTERCARE	JT2	SIMON	YORK
Phase I	Financial	N/A (PASS/FAIL)	PASS	PASS	PASS	**PASS**
Phase II	Proposal	100	78.8	84.0	77.0	**84.8**
Phase III	Pricing	100	83.9	97.5	93.5	**100.0**
Phase IV	References/Audits	50	44.9	46.3	48.1	**42.8**
Phase V	Interview	50	39.8	44.6	36.0	**45.0**
TOTAL SCORE:		300.0	247.4	272.4	254.6	**272.6**

RFP § 6.4 Award will be made to the proposer whose proposal best meets the criteria set forth herein and provides the best value to the County, with price and all other factors considered.

THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
ACTION AGENDA SUMMARY

DEPT: CEO-Risk Management Division BOARD AGENDA # B-11

Urgent ☐ Routine ☒ AGENDA DATE November 4, 2008

CEO Concurs with Recommendation YES ☒ NO ☒ 4/5 Vote Required YES ☐ NO ☒
(Information Attached)

SUBJECT:

Approval of Agreement between the County of Stanislaus and Acclamation Insurance Management Services, Inc (AIMS) for the Workers' Compensation Program

STAFF RECOMMENDATIONS:

1. Approve agreement between the County of Stanislaus and Acclamation Insurance Management Services, Inc for the Workers' Compensation Claims Management Program from January 1, 2009 through June 30, 2012.

2. Authorize the Chair of the Board to sign the Agreement.

3. Authorize the Chief Executive Officer or his designee to sign future amendment/extensions to the agreement based on material changes in the examiner's case-load or legislative changes in the law.

FISCAL IMPACT:

The proposed cost of Workers' Compensation Third Party Administration with AIMS, for a period of three and one-half years, from January 1, 2009 through June 30, 2012 is $1,891,209. An additional $301,875 will be expended from July 1, 2008 through December 31, 2008 for the current agreement with the County's existing vendor. This brings the total cost of Workers' Compensation Third Party Administration for four (4) fiscal years beginning on July 1, 2008 through June 30, 2012 to $2,193,084.

(continued on page 2)

BOARD ACTION AS FOLLOWS:

FISCAL IMPACT (continued)

The total cost for the current fiscal year will be $558,552 which includes the costs for two Third Party Administrators, Claims Management Services, Inc. ($301,875) and Acclamation Insurance Management Services Inc. ($256,677). For the remaining fiscal years, the cost will include an approximate four percent annual price escalator as follows: Fiscal year 2009-2010 - $523,620; Fiscal year 2010-2011 - $544,565; and Fiscal year 2011-2012 - $566,347. Funds for claims management services are included in the Workers' Compensation Self-Insurance Fund for fiscal year 2008-2009. The cost of this agreement is included in the distribution of annual department Workers' Compensation charges.

DISCUSSION:

Background:
Claims Management, Inc. has been the County's Workers' Compensation claims administrator since August 1993. Since that time the CEO-Risk Management Division has released six requests for proposal to determine competitiveness in the market and to assure the County receives the best service for its money. The most recent request for proposals for Workers' Compensation claims administration was released in July 2008.

Request for Proposal (RFP) Process and timelines:

Project posted and mailed	July 15, 2008
Mandatory Pre-Conference	July 28, 2008
Addendum #1 Issued	July 31, 2008
Addendum #2 Issued	August 5, 2008
RFP Closing Date	August 19, 2008
Phase I: Pre-Screening & Financials – Pass/Fail score	August 20, 2008
Phase II: Reference Check – Minimum 80% score required	September 8, 2008
Phase II: Proposal Qualifications – Minimum 80% score required	September 15, 2008
Phase II: Proposal Interviews – Minimum 80% score required	September 24, 2008
Phase III: Pricing – Lowest cost proposer	September 26, 2008

There were nine (9) proposals received for the Workers' Compensation Claims Management Program.

Process Summary

Phase I consisted of the prequalification screening and review of financials. This was a pass/fail score. The team assigned represented the Chief Executive Office, the CEO-Risk Management Division and the General Services Agency. After completion of this phase, it was determined that all nine (9) proposers were qualified for Phase II of the process.

Phase II consisted of three components – Reference checks, Proposal qualifications and Interviews.

There were two separate evaluation committees: First, the reference checking team and, second, a team reviewing proposal qualifications as well as serving on the interview panel. Members of the reference checking team consisted of County Departmental representatives who work closely with the CEO-Risk Management Division and were familiar with claims administration services.

Members of the evaluation team consisted of representatives or experts in Workers' Compensation. This team included two high level staff from the California State Association of Counties-Excess Insurance Authority, Stanislaus County's Disability Manager in the CEO-Risk Management Division, a County Risk Manager, a risk management consultant who has 30 plus years in the field, and a manager in the Chief Executive Office. The Assistant County Counsel attended the interviews but did not evaluate and the Deputy Executive Officer in the CEO-Risk Management Division moderated the interview process but also did not evaluate.

At the conclusion of Phase II, three proposers did not receive the minimum score of 80% and were eliminated from the process.

Phase III analyzed the six qualifying proposers pricing submission. This analysis consisted of creating uniform pricing sheets to assure that proposers submissions could be compared. The lowest cost proposer of all qualified firms would be selected the County's Workers' Compensation Third Party Administrator.

Workers' Compensation Third Party Administrator

Acclamation Insurance Management Services, Inc. (AIMS) submitted the lowest cost for third party administration services to the County.

Overall AIMS scored 91.9 percent on all phases of the process. AIMS was founded in 1973 by Leonard Russo and in 1990 underwent a name change to Acclamation Insurance Management Services to better reflect its diverse nature of product offerings. AIMS has the reputation of being one of the premier loss portfolio managers in California with special exposure in public entity (70 public entities) claims administration.

The philosophy of AIMS is to bring Stanislaus County an approach that will return employees back to work as soon as medically feasible. A priority of AIMS is constant communication with the County and the injured workers. Their dedicated and experienced staff, team approach and constant communication is consistent with the CEO-Risk Management Division Disability Management Unit.

AIMS has a web-based claims management tool that allows County staff to maintain full access to each claim. They also have the ability to generate reports to mitigate losses in the future.

AIMS can also provide a medical management service through its sister company, Allied Managed Care. This includes Bill review, Utilization reviews and Nurse Case Management services. However, the cost of these services are not included in the claims administration fees and are billed directly to the claimants. These services and the experience and qualifications of the AIMS staff is consistent with the philosophy of the CEO-Risk Management Division which has been a customary process over the years.

AIMS included as references in the RFP public agencies for which they provide third party administration services. These included the City of Bakersfield, a portion of the County of Los Angeles, the Central San Joaquin Valley Risk Management Authority, a 53 member city group, and the County of Madera. AIMS also provides overflow and conflict claim support for the Counties of Kern and Sacramento, both of which are self–administered.

New Agreement

1). Claims administration fees for the following three and one-half years are as follows:

January 1, 2009 – June 30, 2009		$256,677
July 1, 2009 – June 30, 2010		$523,620
July 1, 2010 – June 30, 2011		$544,565
June 30, 2011 – June 30, 2012		$566,347
	Total	$1,891,209

2). Each examiner will have a caseload of no more than 150 open indemnity claims at any one time. It is preferred that a one-to-one ratio be maintained between technical assistance and claims examiners. Claims Examiners will have the certification from Self Insured Plans.

3). AIMS pricing includes the following elements in the cost control programs:
- Loss portfolio management
- Claims management
- Return to work
- Medical management
- Litigation management
- Rehabilitation management
- Excess reporting
- Online access to claims system
- Trust account management
- Administration of the County Medical Provider Network (MPN)

- Occupational Safety and Health Act (OSHA), actuary and Self Insurance Plans (SIP) reports

SUMMARY :

The change to a new third party administrator will require much communication, meetings and form changes with the new vendor. The CEO-Risk Management Division is prepared to make this change based on the comprehensive request for proposal process. The County's philosophy of aggressive claims handling and effective loss control techniques also appear to be goals which are consistent with AIMS.

Policy Issues

The Board of Supervisors should determine if the recommended actions to enter into an agreement with Acclamation Insurance Management Services, Inc as third party administrator for the County's Workers' Compensation Program are in the best interest of the County, are cost effective and meets the Board's goal of Efficient delivery of public services.

Staffing Impact

There will be some staffing impact as the transition from the current third party administrator to AIMS takes place. However, it is anticipated that no new positions or support staff will be required as AIMS will be responsible to implement the transition. There will be training required for County staff but this will also be provided by AIMS. The position of Disability Manager, under the direction of the Deputy Executive Officer, will continue to assure that all claims are processed timely and filed, in conjunction with County Counsel, AIMS and the defense attorneys.

AGREEMENT
FOR
PROFESSIONAL SERVICES

This Agreement for Professional Services is made and entered into by and between the County of Stanislaus ("County") and YORK RiskServices Group, a California corporation ("Consultant"), as of July 1, 2013 (the "Agreement").

Introduction

WHEREAS, the County has a need for services involving Workers' Compensation claims administration and medical management; and

WHEREAS, the Consultant is specially trained, experienced and competent to perform and has agreed to provide such services;

NOW, THEREFORE, in consideration of the mutual promises, covenants, terms and conditions hereinafter contained, the parties hereby agree as follows:

Terms and Conditions

1. Scope of Work

1.1 The Consultant shall furnish to the County upon execution of this Agreement or receipt of the County's written authorization to proceed, those services and work set forth in **Exhibit A**, which is attached hereto and, by this reference, made a part hereof.

1.2 All documents, drawings and written work product prepared or produced by the Consultant under this Agreement, including without limitation electronic data files, are the property of the Consultant; provided, however, the County shall have the right to reproduce, publish and use all such work, or any part thereof, in any manner and for any purposes whatsoever and to authorize others to do so. If any such work is copyrightable, the Consultant may copyright the same, except that, as to any work which is copyrighted by the Consultant, the County reserves a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, and use such work, or any part thereof, and to authorize others to do so. The County shall defend, indemnify and hold harmless the Consultant and its officers, employees, agents, representatives, subcontractors and consultants from and against all claims, damages, losses, judgments, liabilities, expenses and other costs, arising out of or resulting from the County's reuse of the documents and drawings prepared by the Consultant under this Agreement.

1.3 Services and work provided by the Consultant under this Agreement will be performed in a timely manner in accordance with a schedule of work set forth in Exhibit A. If there is no schedule, the hours and times for completion of said services

and work are to be set by the Consultant; provided, however, that such schedule is subject to review by and concurrence of the County.

1.4 The Consultant shall provide services and work under this Agreement consistent with the requirements and standards established by applicable federal, state and County laws, ordinances, regulations and resolutions. The Consultant represents and warrants that it will perform its work in accordance with generally accepted industry standards and practices for the profession or professions that are used in performance of this Agreement and that are in effect at the time of performance of this Agreement. Except for that representation and any representations made or contained in any proposal submitted by the Consultant and any reports or opinions prepared or issued as part of the work performed by the Consultant under this Agreement, Consultant makes no other warranties, either express or implied, as part of this Agreement.

1.5 If the Consultant deems it appropriate to employ a consultant, expert or investigator in connection with the performance of the services under this Agreement, the Consultant will so advise the County and seek the County's prior approval of such employment. Any consultant, expert or investigator employed by the Consultant will be the agent of the Consultant not the County.

2. Consideration

2.1 The Consultant shall be compensated on either a time and materials basis or a lump sum basis, as provided in Exhibit A attached hereto.

2.2 Except as expressly provided in this Agreement, Consultant shall not be entitled to nor receive from County any additional consideration, compensation, salary, wages or other type of remuneration for services rendered under this Agreement, including, but not limited to, meals, lodging, transportation, drawings, renderings or mockups. Specifically, Consultant shall not be entitled by virtue of this Agreement to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays or other paid leaves of absence of any type or kind whatsoever.

2.3 The Consultant shall provide the County with a monthly or a quarterly statement, as services warrant, of fees earned and costs incurred for services provided during the billing period, which the County shall pay in full within 30 days of the date each invoice is approved by the County. The statement will generally describe the services performed, the applicable rate or rates, the basis for the calculation of fees, and a reasonable itemization of costs. All invoices for services provided shall be forwarded in the same manner and to the same person and address that is provided for service of notices herein.

2.4 County will not withhold any Federal or State income taxes or Social Security tax from any payments made by County to Consultant under the terms and conditions of this Agreement. Payment of all taxes and other assessments on such sums is the sole responsibility of Consultant. County has no responsibility or liability for

payment of Consultant's taxes or assessments.

3. Term

3.1 The term of this Agreement shall be from July 1, 2013 through June 30, 2016 unless sooner terminated as provided below or unless some other method or time of termination is listed in Exhibit A.

3.2 Should either party default in the performance of this Agreement or materially breach any of its provisions, the other party, at that party's option, may terminate this Agreement by giving written notification to the other party.

3.3 The County may terminate this agreement upon 30 days prior written notice. Termination of this Agreement shall not affect the County's obligation to pay for all fees earned and reasonable costs necessarily incurred by the Consultant as provided in Paragraph 2 herein, subject to any applicable setoffs.

3.4 This Agreement shall terminate automatically on the occurrence of (a) bankruptcy or insolvency of either party, or (b) sale of Consultant's business.

4. Required Licenses, Certificates and Permits

Any licenses, certificates or permits required by the federal, state, county or municipal governments for Consultant to provide the services and work described in Exhibit A must be procured by Consultant and be valid at the time Consultant enters into this Agreement. Further, during the term of this Agreement, Consultant must maintain such licenses, certificates and permits in full force and effect. Licenses, certificates and permits may include but are not limited to driver's licenses, professional licenses or certificates and business licenses. Such licenses, certificates and permits will be procured and maintained in force by Consultant at no expense to the County.

5. Office Space, Supplies, Equipment, Etc.

Unless otherwise provided in this Agreement, Consultant shall provide such office space, supplies, equipment, vehicles, reference materials and telephone service as is necessary for Consultant to provide the services under this Agreement. The Consultant--not the County--has the sole responsibility for payment of the costs and expenses incurred by Consultant in providing and maintaining such items.

6. Insurance

6.1 Consultant shall take out, and maintain during the life of this Agreement, insurance policies with coverage at least as broad as follows:

6.1.1 General Liability. Commercial general liability insurance covering bodily injury, personal injury, property damage, products and completed operations with limits of no less than One Million Dollars

($1,000,000) per incident or occurrence. If Commercial General Liability Insurance or other form with a general aggregate limit is used, either the general aggregate limit shall apply separately to any act or omission by Consultant under this Agreement or the general aggregate limit shall be twice the required occurrence limit.

6.1.2 Professional Liability Insurance. Professional errors and omissions (malpractice) liability insurance with limits of no less than One Million Dollars ($1,000,000) aggregate. Such professional liability insurance shall be continued for a period of no less than one year following completion of the Consultant's work under this Agreement.

6.1.3 Automobile Liability Insurance. If the Consultant or the Consultant's officers, employees, agents or representatives utilize a motor vehicle in performing any of the work or services under this Agreement, owned/non-owned automobile liability insurance providing combined single limits covering bodily injury and property damage liability with limits of no less than One Million Dollars ($1,000,000) per incident or occurrence.

6.1.4 Workers' Compensation Insurance. Workers' Compensation insurance as required by the California Labor Code. In signing this contract, the Consultant certifies under section 1861 of the Labor Code that the Consultant is aware of the provisions of section 3700 of the Labor Code which requires every employer to be insured against liability for workmen's compensation or to undertake self-insurance in accordance with the provisions of that code, and that the Consultant will comply with such provisions before commencing the performance of the work of this Agreement.

6.2 Any deductibles, self-insured retentions or named insureds must be declared in writing and approved by County. At the option of the County, either: (a) the insurer shall reduce or eliminate such deductibles, self-insured retentions or named insureds, or (b) the Consultant shall provide a bond, cash, letter of credit, guaranty or other security satisfactory to the County guaranteeing payment of the self-insured retention or deductible and payment of any and all costs, losses, related investigations, claim administration and defense expenses. The County, in its sole discretion, may waive the requirement to reduce or eliminate deductibles or self-insured retentions, in which case, the Consultant agrees that it will be responsible for and pay any self-insured retention or deductible and will pay any and all costs, losses, related investigations, claim administration and defense expenses related to or arising out of the Consultant's defense and indemnification obligations as set forth in this Agreement.

6.3 The Consultant shall obtain a specific endorsement to all required insurance policies, except Workers' Compensation insurance and Professional Liability insurance, naming the County and its officers, officials and employees as additional insureds regarding: (a) liability arising from or in connection with the performance or

omission to perform any term or condition of this Agreement by or on behalf of the Consultant, including the insured's general supervision of its subcontractors; (b) services, products and completed operations of the Consultant; (c) premises owned, occupied or used by the Consultant; and (d) automobiles owned, leased, hired or borrowed by the Consultant. For Workers' Compensation insurance, the insurance carrier shall agree to waive all rights of subrogation against the County its officers, officials and employees for losses arising from the performance of or the omission to perform any term or condition of this Agreement by the Consultant.

6.4 The Consultant's insurance coverage shall be primary insurance regarding the County and County's officers, officials and employees. Any insurance or self-insurance maintained by the County or County's officers, officials and employees shall be excess of the Consultant's insurance and shall not contribute with Consultant's insurance.

6.5 Any failure to comply with reporting provisions of the policies shall not affect coverage provided to the County or its officers, officials and employees.

6.6 The Consultant's insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the insurer's liability.

6.7 Each insurance policy required by this section shall be endorsed to state that coverage shall not be suspended, voided, canceled by either party except after thirty (30) days' prior written notice has been given to County. The Consultant shall promptly notify, or cause the insurance carrier to promptly notify, the County of any change in the insurance policy or policies required under this Agreement, including, without limitation, any reduction in coverage or in limits of the required policy or policies.

6.8 Insurance shall be placed with California admitted insurers (licensed to do business in California) with a current rating by Best's Key Rating Guide of no less than A-:VII; provided, however, that if no California admitted insurance company provides the required insurance, it is acceptable to provide the required insurance through a United States domiciled carrier that meets the required Best's rating and that is listed on the current List of Eligible Surplus Line Insurers maintained by the California Department of Insurance.

6.9 Consultant shall require that all of its subcontractors are subject to the insurance and indemnity requirements stated herein, or shall include all subcontractors as additional insureds under its insurance policies.

6.10 At least ten (10) days prior to the date the Contractor begins performance of its obligations under this Agreement, Contractor shall furnish County with certificates of insurance, and with original endorsements, showing coverage required by this Agreement, including, without limitation, those that verify coverage for subcontractors of the Contractor. The certificates and endorsements for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf. All

certificates and endorsements shall be received and, in County's sole and absolute discretion, approved by County. County reserves the right to require complete copies of all required insurance policies and endorsements, at any time.

6.11 The limits of insurance described herein shall not limit the liability of the Consultant and Consultant's officers, employees, agents, representatives or subcontractors.

7. Defense and Indemnification

7.1 To the fullest extent permitted by law, Consultant shall indemnify, hold harmless and defend the County and its agents, officers and employees from and against all claims, damages, losses, judgments, liabilities, expenses and other costs, including litigation costs and attorneys' fees, arising out of, resulting from, or in connection with the performance of this Agreement by the Consultant or Consultant's officers, employees, agents, representatives or subcontractors and resulting in or attributable to personal injury, death, or damage or destruction to tangible or intangible property, including the loss of use. Notwithstanding the foregoing, Consultant's obligation to indemnify the County and its agents, officers and employees for any judgment, decree or arbitration award shall extend only to the percentage of negligence or responsibility of the Consultant in contributing to such claim, damage, loss and expense.

7.2 Consultant's obligation to defend, indemnify and hold the County and its agents, officers and employees harmless under the provisions of this paragraph is not limited to or restricted by any requirement in this Agreement for Consultant to procure and maintain a policy of insurance.

7.3 To the fullest extent permitted by law, the County shall indemnify, hold harmless and defend the Consultant and its officers, employees, agents, representatives or subcontractors from and against all claims, damages, losses, judgments, liabilities, expenses and other costs, including litigation costs and attorney's fees, arising out of or resulting from the negligence or wrongful acts of County and its officers or employees.

7.4 Subject to the limitations in 42 United States Code section 9607 (e), and unless otherwise provided in a Scope of Services approved by the parties:

(a) Consultant shall not be responsible for liability caused by the presence or release of hazardous substances or contaminants at the site, unless the release results from the negligence of Consultant or its subcontractors;

(b) No provision of this Agreement shall be interpreted to permit or obligate Consultant to assume the status of "generator," "owner," "operator," "arranger," or "transporter" under state or federal law; and

(c) At no time, shall title to hazardous substances, solid wastes,

petroleum contaminated soils or other regulated substances pass to Consultant.

8. Status of Consultant

8.1 All acts of Consultant and its officers, employees, agents, representatives, subcontractors and all others acting on behalf of Consultant relating to the performance of this Agreement, shall be performed as independent contractors and not as agents, officers or employees of County. Consultant, by virtue of this Agreement, has no authority to bind or incur any obligation on behalf of County. Except as expressly provided in Exhibit A, Consultant has no authority or responsibility to exercise any rights or power vested in the County. No agent, officer or employee of the County is to be considered an employee of Consultant. It is understood by both Consultant and County that this Agreement shall not be construed or considered under any circumstances to create an employer-employee relationship or a joint venture.

8.2 At all times during the term of this Agreement, the Consultant and its officers, employees, agents, representatives or subcontractors are, and shall represent and conduct themselves as, independent contractors and not employees of County.

8.3 Consultant shall determine the method, details and means of performing the work and services to be provided by Consultant under this Agreement. Consultant shall be responsible to County only for the requirements and results specified in this Agreement and, except as expressly provided in this Agreement, shall not be subjected to County's control with respect to the physical action or activities of Consultant in fulfillment of this Agreement. Consultant has control over the manner and means of performing the services under this Agreement. If necessary, Consultant has the responsibility for employing other persons or firms to assist Consultant in fulfilling the terms and obligations under this Agreement.

8.4 Consultant is permitted to provide services to others during the same period service is provided to County under this Agreement; provided, however, such services do not conflict directly or indirectly with the performance of the Consultant's obligations under this Agreement.

8.5 If in the performance of this Agreement any third persons are employed by Consultant, such persons shall be entirely and exclusively under the direction, supervision and control of Consultant. All terms of employment including hours, wages, working conditions, discipline, hiring and discharging or any other term of employment or requirements of law shall be determined by the Consultant.

8.6 It is understood and agreed that as an independent contractor and not an employee of County, the Consultant and the Consultant's officers, employees, agents, representatives or subcontractors do not have any entitlement as a County employee, and, except as expressly provided for in any Scope of Services made a part hereof, do not have the right to act on behalf of the County in any capacity whatsoever as an agent, or to bind the County to any obligation whatsoever.

8.7 It is further understood and agreed that Consultant must issue W-2 forms or other forms as required by law for income and employment tax purposes for all of Consultant's assigned personnel under the terms and conditions of this Agreement.

8.8 As an independent contractor, Consultant hereby indemnifies and holds County harmless from any and all claims that may be made against County based upon any contention by any third party that an employer-employee relationship exists by reason of this Agreement.

9. Records and Audit

9.1 Consultant shall prepare and maintain all writings, documents and records prepared or compiled in connection with the performance of this Agreement for a minimum of four (4) years from the termination or completion of this Agreement. This includes any handwriting, typewriting, printing, photostatic, photographing and every other means of recording upon any tangible thing, any form of communication or representation including letters, words, pictures, sounds or symbols or any combination thereof.

9.2 Any authorized representative of County shall have access to any writings as defined above for the purposes of making audit, evaluation, examination, excerpts and transcripts during the period such records are to be maintained by Consultant. Further, County has the right at all reasonable times to audit, inspect or otherwise evaluate the work performed or being performed under this Agreement.

10. Confidentiality

The Consultant agrees to keep confidential all information obtained or learned during the course of furnishing services under this Agreement and to not disclose or reveal such information for any purpose not directly connected with the matter for which services are provided.

11. Nondiscrimination

During the performance of this Agreement, Consultant and its officers, employees, agents, representatives or subcontractors shall not unlawfully discriminate in violation of any federal, state or local law, rule or regulation against any employee, applicant for employment or person receiving services under this Agreement because of race, religion, color, national origin, ancestry, physical or mental disability, medical condition (including genetic characteristics), marital status, age, political affiliation, sex or sexual orientation. Consultant and its officers, employees, agents, representatives or subcontractors shall comply with all applicable Federal, State and local laws and regulations related to non-discrimination and equal opportunity, including without limitation the County's nondiscrimination policy; the Fair Employment and Housing Act (Government Code sections 12900 et seq.); California Labor Code sections 1101, 1102 and 1102.1; the Federal Civil Rights Act of 1964 (P.L. 88-352), as amended; and all applicable regulations promulgated in the California Code of Regulations or the Code of

Federal Regulations.

12. Assignment

This is an agreement for the services of Consultant. County has relied upon the skills, knowledge, experience and training of Consultant and the Consultant's firm, associates and employees as an inducement to enter into this Agreement. Consultant shall not assign or subcontract this Agreement without the express written consent of County. Further, Consultant shall not assign any monies due or to become due under this Agreement without the prior written consent of County.

13. Waiver of Default

Waiver of any default by either party to this Agreement shall not be deemed to be waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach, and shall not be construed to be a modification of the terms of this Agreement unless this Agreement is modified as provided below.

14. Notice

Any notice, communication, amendment, addition or deletion to this Agreement, including change of address of either party during the term of this Agreement, which Consultant or County shall be required or may desire to make shall be in writing and may be personally served or, alternatively, sent by prepaid first class mail to the respective parties as follows:

To County:
County of Stanislaus
CEO-Risk Management Division
1010 10th Street, Suite 5900
Modesto Ca 95354

To Consultant:
YORK
750 The City Drive, Suite 350
Orange, CA 92868

15. Conflicts

Consultant agrees that it has no interest and shall not acquire any interest direct or indirect which would conflict in any manner or degree with the performance of the work and services under this Agreement.

16. Severability

If any portion of this Agreement or application thereof to any person or circumstance shall be declared invalid by a court of competent jurisdiction or if it is found in contravention of any federal, state or county statute, ordinance or regulation

the remaining provisions of this Agreement or the application thereof shall not be invalidated thereby and shall remain in full force and effect to the extent that the provisions of this Agreement are severable.

17. Amendment

This Agreement may be modified, amended, changed, added to or subtracted from by the mutual consent of the parties hereto if such amendment or change is in written form and executed with the same formalities as this Agreement and attached to the original Agreement to maintain continuity.

18. Entire Agreement

This Agreement supersedes any and all other agreements, either oral or in writing, between any of the parties herein with respect to the subject matter hereof and contains all the agreements between the parties with respect to such matter. Each party acknowledges that no representations, inducements, promises or agreements, oral or otherwise, have been made by any party, or anyone acting on behalf of any party, which are not embodied herein, and that no other agreement, statement or promise not contained in this Agreement shall be valid or binding.

19. Advice of Attorney

Each party warrants and represents that in executing this Agreement, it has received independent legal advice from its attorneys or the opportunity to seek such advice.

20. Construction

Headings or captions to the provisions of this Agreement are solely for the convenience of the parties, are not part of this Agreement, and shall not be used to interpret or determine the validity of this Agreement. Any ambiguity in this Agreement shall not be construed against the drafter, but rather the terms and provisions hereof shall be given a reasonable interpretation as if both parties had in fact drafted this Agreement.

21. Governing Law and Venue

This Agreement shall be deemed to be made under, and shall be governed by and construed in accordance with, the laws of the State of California. Any action brought to enforce the terms or provisions of this Agreement shall have venue in the County of Stanislaus, State of California.

22. Incorporation of Performance Standards

22.1 All claims administration services performed by TPA shall comply with those provisions set forth in the CSAC EIA Workers' Compensation Claims Administration Guidelines attached hereto as Exhibit A and incorporated herein as though fully set forth. Should the attached Standards be amended, during the term of the Agreement, such amendments shall be deemed to be incorporated herein.

22.2 TPA shall comply with the SCOPE of work as provided in the County's Request for Proposal including a maximum case load of 150 indemnity claims.

22.3 Additionally, the compensation for claims administration services may be adjusted according to the Performance Based Contract Provision, attached hereto as Exhibit B and incorporated herein as though fully set forth during the term of the Agreement, such amendments shall be deemed to be incorporated herein.

[SIGNATURES SET FORTH ON THE FOLLOWING PAGE]

IN WITNESS WHEREOF, the parties or their duly authorized representatives have executed this Agreement on the day and year first hereinabove written.

COUNTY OF STANISLAUS

By:_____

Keith D. Boggs, Deputy Executive Officer,
GSA Director/Purchasing Agent

"County"

BUSINESS NAME

By:_____

Jody Gray, President Public Entity
York

"Consultant"

APPROVED AS TO CONTENT:
Department of CEO-Risk Management Division

By:_____
Jody Hayes
Deputy Executive Officer

APPROVED AS TO FORM:
John P. Doering, County Counsel

By:_____
Jack P. Doering, County Counsel

EXHIBIT A

A. SCOPE OF WORK

The Consultant shall provide services under this Agreement for Professional Services between the County of Stanislaus and YORK ("Consultant"), as set forth in the Consultant's Proposal and Scope of Work dated January 22, 2013 (APPENDIX B), and CSAC-EIA's ADDENDUM A Workers' Compensation Claims Administration Guidelines (APPENDIX C) attached hereto and, by this reference, made a part hereof.

B. COMPENSATION

The Consultant shall be compensated for the services provided under this Agreement as follows:

1. Consultant will be compensated as noted in APPENDIX D and APPENDIX D-2 as set forth in the proposal and scope of work dated January 22, 2013, attached hereto and, by this reference, made a part hereof.

The parties hereto acknowledge the maximum amount to be paid by the County for claims administration services provided shall not exceed $1,488,395. including, without limitation, the cost of any subcontractors, consultants, experts or investigators retained by the Consultant to perform or to assist in the performance of its work under this Agreement.

Contractor will work with the County to identify medical providers within the County's existing Medical Provider Network (MPN) that will require new contracts with YORK (Medical provider Network option 1 on APPENDIX D). The compensation for this service is in addition to the administration fees noted above. The fee for this service as is anticipated to be less than $17,250 but in any event will not exceed $52,050. While new contracts are being obtained, the Contractor will allow the County access to its existing MPN at no additional cost to the County.

C. PERFORMANCE BASED CONTRACT PROVISIONS

The Consultant shall adhere to the Performance Based Contract provisions, as set forth in the Performance Based Contract provision - TPA (APPENDIX E), attached hereto and, by this reference, made a part hereof.

APPENDIX B
SCOPE OF WORK

(NOTE: PROPOSERS ARE TO PROVIDE ITEMS DESCRIBED IN RED TEXT)

1. SERVICES

Services to be provided MUST include, but not be limited to:

1.1 Claims Administration of new and existing claims. The County's past three year claim average has been 132 new indemnity claims and 127 medical only claims per fiscal year.

1.2 Online real time access to all claims data including but not limited to:

- Ability to access and input information for completion of the Form 5020 into an online system (NOTE: This system must generate a hardcopy of the form as well as populate the TPA's claim system database).
- Ability to view claim payments.
- Ability to view examiner's Plan of Action.
- Ability to view claims disposition (accepted, denied, settled).
- Ability to view list of authorized RX including date approved, dosage and applicable medical condition.
- Ability to view claims settlement type; Stipulated Award, Compromise & Release, Findings & Award, etc.
- Accurate tracking of lost time and associated payments (TTD, TPD, LC 4850).
- Ability of County to run standard and ad hoc reports (provide copies of reporting capability with RFP submission).
- Ability to produce claim status reports including paid to date amounts by reserve type and outstanding reserve balances (NOTE: provide copy of status report with RFP submission).
- Ability to view examiner notes.
- Ability to view examiner's Diary Status.
- Ability to view accepted and denied body parts.
- Ability to view the litigation status, along with applicant and defense attorney contact information.
- Ability to view staff of Contractor's assigned (i.e., Nurse Case Management, Investigators, etc.).
- Ability to produce accurate OSHA reports on a monthly and annual basis.

1.3 Transition claims from current TPA provider, both electronic files and hard copy files. The Contractor must be able to begin claims administration on February 1, 2013 and must be able to avoid any late payments. The Contractor will identify time line for transition of all claim data, records and files.

1.4 Assist the County in submitting a revised Medical Provider Network. The County has an existing Medical Provider Network (Appendix F that the Contractor shall work with the County to mirror the existing providers and may make recommendations for additions or deletions to the existing network subject to the County's approval. The Contractor will be able to provide access to the current MPN providers through its existing PPO Networks. If there are any physicians on the existing network that the Contractor does not currently have access to, the Contractor will notify the County in the RFP submission. The Contractor may make recommended changes to the Network in the RFP submission.

2. CLAIM MANAGEMENT

2.1 Each Claims Examiner shall (a) have a minimum of three years active claims adjusting experience as a claims examiner, (b) have a Self-Insured Competency Certificate and (c) maintain a case load of 150 open indemnity claims or less at all times. The County requests to have Claims Examiners (Claims Trainee or Assistant will not suffice) assigned exclusively to the County's account *, with availability to County staff during core business hours of 8:00 am to 5:00 pm Monday through Friday. It is preferred that a 1.5-to-1 ratio be maintained between Technical Assistance and Claims Examiners. Claims Examiners and support staff shall have direct supervision from a licensed supervisor and/or manager. *Two examiners shall be full time and assigned to the County exclusively. One examiner may be part time or be shared with another client. The County currently utilizes a department assignment for examiners and will approve all examiner department assignments.

2.2 Claim files shall be reviewed and set up within twenty-four (24) hours of receipt from the County. All new claims will be indexed through CSAC-EIA's index system upon setup and annually thereafter. Questionable claims will be delayed and promptly investigated. The County will be notified of the disposition of all new claims within forty-eight (48) hours of receipt of the claims. A completed signed medical release shall be obtained on all claim files.

2.3 If a doctor's first report of work injury is received without a corresponding claim, the examiner will immediately contact the County to determine if a new claim has occurred.

2.4 The Contractor proposer shall establish monetary reserves adequate for the expected compensation and medical benefits on each injury/claim file made up. A claims diary system to review the status of each injury/claim every twenty (20) to thirty (30) days will be adhered to by all examiners.

2.5 Claims with severe injuries or extended lost time require phone or personal contact with claimants shall occur within twenty-four (24) hours of receipt of claim, except in cases where employees are represented by an attorney. All other indemnity claims shall have contact with claimants within three (3) business days or less.

2.6 All claim files shall be available to the County, in person and on line, for inspection, review, and/or claims audit with or without prior notice to the adjusting firm. It is understood and agreed that all files will remain the property of Stanislaus County at all times.

2.7 All Claims Administration staff must be pre-approved by the County. The Contractor will provide the County with current resumes and past work experience history for the County's review prior to assigning staff to the County's account.

2.8 All claim decisions (deny/accept) require prior consultation and consideration by County's Risk Management Division.

2.9 The County must first approve settlement authority for claims before presented or negotiated with injured workers or their attorneys. The Contractor shall submit a written analysis of the case, including settlement options and recommendations to County's Risk Management Division at least ten (10) working days prior to settlement offers or conferences. The County must approve all settlement offers in excess of $5,000. The County must be informed of all settlement offers below $5,000.

3. COMPENSATION AND MEDICAL BENEFITS

3.1 The Contractor shall provide all compensation and medical benefits that may be due, in a timely manner in compliance with the statutory requirements of the California Labor Code and County expectations. All treatment plans should be reviewed and approved in accordance with Utilization Review criteria to determine if treatment is reasonable, necessary and appropriate based on readily accepted scientific medical evidence such as ACOEM or other nationally recognized and peer- reviewed scientific medical evidence.

3.2 Temporary Disability and LC 4850 benefit payments shall coincide with the County's payroll schedule.

3.2.1 All required benefit and informational notices shall be sent to the injured employees in a timely manner.

3.2.2 Estimates of permanent disability shall be provided to the County and defense counsel on all claims where PD benifis are anticipated or may be due.

3.2.3 Medical evaluations will be arranged when needed, reasonable, and/or requested. Copies of all medical reports and legal correspondence will be provided to the County within 24 hours of receipt. Access to electronic documents may replace the need to send hard copies. Notification of new documents must be provided within 24 hours of documents being received by the claims examiner.

3.2.4 Promptly pay all medical and other bills on the claims within twenty (20) days or file a timely objection.

3.2.5 Reduce medical bills, other than medical legal expenses, to the Relative Value Schedule and recommended rates set by the Administrative Director, Division of Industrial Relations or based on PPO contracts that may apply.

3.3 Medical Control

3.3.1 Expedite obtaining signed medical release forms for all claims.

3.3.2 Administration of the County's existing Medical Provider Network (MPN), including monitoring medical treatment to allow changes through the MPN. Any changes to the MPN will require the County's final approval.

3.3.3 Monitor medical treatment for injured employees, including the review of all "Doctors First Report of Work Injury", to ensure that the treatment is related to a compensable injury or illness and complies with ACOEM and other nationally recognized and peer-reviewed scientific medical evidence guidelines.

3.3.4 Maintain close liaison with treating physicians to ensure that employees receive proper care, avoid over-treatment, and to assure physician compliance with Utilization Review standards.

3.3.5 The County has an aggressive Disability Management Program and will accommodate modified duty whenever possible. The Contractor must assist the County in facilitating injured employees in returning to work, including modified duty options and expediting evaluations to determine the physical capabilities of all injured workers.

3.3.6 Maintain close working relationship with County's Risk Management Division, Disability Management Unit which includes the Disability Manager, and the Disability Coordinators.

3.3.7 Provide medical reports in a timely manner including, but not limited to all reports of work restrictions, temporary or permanent from any and all physicians even if the report is not considered substantial evidence.

3.4 Employee Services

3.4.1 Provide information and guidance to the County's employees regarding workers' compensation benefits, inquiries on specific injuries and permanent disability ratings in accordance with the County's policies and the County's MPN.

3.4.2 Assist in resolving employee problems related to an industrial injury in non-litigated cases.

3.4.3 Recommend policies and procedures to ensure that the employee's ability to work is consistent with the findings of the Workers Compensation Appeals Board.

4. REHABILITATION, JOB DISPLACEMENT, LITIGATION & SUBROGATION

4.1 Job Displacement

4.1.1 Comply with labor code statutes and rules & regulations applicable to rehabilitation for workers' compensation injuries.

4.1.2 Provide injured employees Job Displacement vouchers in a timely manner and comply with the Labor Codes statutes and rules & regulations applicable to job displacement benefits for workers' compensation injuries.

4.1.3 Maintain adequate reserves on all claims where rehabilitation is an issue.

4.1.4 Prepare and submit the Division of Industrial Relations Rehabilitation forms as required by statute.

4.2 Litigation

4.2.1 Selection of defense counsel shall be approved by the County prior to an assignment being made. Investigations are to be coordinated with County staff.

4.2.2 Litigation effort shall be controlled and closely monitored by the administrator with regular communication with the County (copies, etc.)

4.2.3 Medical Control of litigated claims shall stay with the Administrator and shall not pass to defense counsel unless approved by the County.

4.2.4 The County staff must first approve settlement authority for claims before being presented or negotiated with injured workers and or their attorney(s). The Contractor shall submit a written analysis of the case, including settlement options and recommendations to County's Risk Management Division at least ten (10) working days prior to settlement offers or conferences. The County must approve all settlement offers in excess of $5,000. The County must be informed of all settlement offers below $5,000.

4.2.5 Claims examiners will make an effort to settle claims without assignment to defense counsel when ever possible.

4.3 Subrogation

4.3.1 The Contractor shall identify and pursue subrogation opportunities in consultation with County's Risk Management Division.

4.4 Investigation

4.4.1 The use of investigators must be approved by the County prior to an assignment being made.

4.4.2 The Contractor shall investigate every claim using three-point contact, and recorded statements when appropriate. Recorded statements require prior approval of County's Risk Management Division.

4.4.3 The Contractor shall take an aggressive stance against fraud by filing FB1/FB2 forms with the State Department of Insurance whenever warranted. The Contractor shall aggressively pursue fraud cases with the District Attorney's office when appropriate.

5. REPORTS AND REPORTING CAPABILITY

NOTE: Proposers should provide sample reports available with RFP submission.

Contractor shall provide a computerized loss analysis and summary reports each month covering activity on all newly reported, opened, and newly closed claims for the period. The report will be customized, as determined by the County, for County needs within the capability of the adjusting firm and, as a minimum, provide the following for claim year:

5.1 Excess Insurance Carrier Claims & Reports: The Contractor shall adhere to the County's excess insurance carrier claim reporting requirements (attached).

5.2 Actuary Reports: The Contractor shall provide reports and other requested data to actuarial firm at the County's request.

5.3 Weekly Reports: The Contractor shall provide at a minimum the following reports to County's Risk Management Division electronically on a weekly basis:

5.3.1 Status of all open claims with employees off on a disability or newly returned to work.

5.3.2 List of all employees being accommodated on modified duty including the current work restrictions.

5.3.3 Appearance, hearing, trial and important date calendar.

5.3.4 Claims in "delay" status or newly accepted or denied claims.

5.3.5 Check register in Excel format.

5.3.6 All claims open by claim type.

5.3.7 Bill Review activity and associated savings.

5.3.8 Utilization Review referrals and decisions.

5.4 Monthly Reports: The Contractor shall provide at a minimum the following reports to County's Risk Management Division electronically on a monthly basis before the 10th day of each month:

5.4.1 Detailed report of all open claims (regardless of date of injury), including name, claim number, location, description of claim, injury and mechanism of injury, amounts paid, reserved and incurred for medical expense and indemnity.

5.4.2 All new claims opened during the month by department and location stating the claim number, injured's name, cause and type of injury, body part, amount paid during the period to date and remaining reserves for medical, compensation, and any future allocated expense. Total amount incurred for each type of payment must also be shown.

5.4.3 All claims closed during the month by department and location stating the claim number, injured's name, cause and type of injury, body part, amount paid to date for medical, compensation, and any future allocated expense. Total amount incurred for each type of payment must also be shown.

5.4.4 Lag report listing all claims reported in the last month, by department and dates of knowledge and reporting dates.

5.4.5 Administrative reports containing number of claims, medical only, indemnity and first aid/incident; number of closed claims; number of active files assigned to each examiner; amount paid for medical, expense, and indemnity for each department, division or agency in: amount reserved for medial expense and indemnity for each agency; indemnity paid, 4850 benefits, Temporary Disability, Permanent Disability, Death Benefits, expenses paid for:, Nurse Case Management, Investigators, and attorneys; cases assigned to counsel, investigators, nurse case managers; amounts recovered in apportionment and subrogation; number of litigated cases; list of cases settled during the month, indicating the amount of the settlement and method of settlement (stipulations, C&R, dismissal, etc); penalties paid, including whether attributable to TPA or County; savings related to modified duty accommodations and ad hoc reports upon request.

5.4.6. Report claims accurately and timely including tracking for all claimants meeting mandatory Medicare reporting requirements per Medicare Secondary Payer and related statutes and provide associated data to the County.

5.4.7. Prepare and provide County's Risk Management Division with OSHA 300 report at the department and division levels to meet Cal-OSHA standards.

5.4.8. Prepare charts and graphs on a quarterly basis for statistical analysis of countywide claim frequency and severity as well as similar charts and graphs for the top five departments.

5.4.9 Provider summaries to include individual claims, number of visits, visit intervals and amounts paid.

5.4.10 Monthly check reconciliation reports.

5.4.11 Bill Review activity and associated savings.

5.4.12 Utilization Review referrals and decisions.

5.5 Quarterly Reports: The Contractor shall provide at a minimum the following reports to County's Risk Management Division electronically on a quarterly basis before the 10th day of the month ending the quarter:

5.5.1 Charts, graphs and supporting documents (include number of claims, paid to date and future reserves valued as of the end of the quarter) for Claims Filed by Year of Injury for past six (6) years (number of indemnity, medical only and first aid claims); Occupation most frequent, Cause of Loss Most Frequent, Paid Loss Days by Department, Modified Duty Savings by Department, Job Experience (number of years employed 1-5, 6-10, etc). Valuation for all charts and graphs that include prior years data are all valued as of the same date as the end of the quarter.

5.6 Annual Reports: The Contractor shall provide at a minimum the following reports to County's Risk Management Division on an annual basis by September 1st of each year;

5.6.1. Annual Self-Insured Report as required by the State of California.

5.6.2 Vendor report in spreadsheet format, listing amounts paid to each vendor.

5.6.3 1099 reports for each vendor.

5.6.4 OSHA 300 A report by department and division.

5.6.5 An annual report as of June 30th each fiscal year with loss trend analysis including charts, graphs and supporting reports.

5.6.6 Charts, graphs and supporting reports to assist Departments in the development of Departmental Action Plans.

5.6.7 Amounts paid for fiscal year valued as of year-end by Reserve Type. Amounts paid for prior five (5) fiscal years valued as of current year-end date by reserve type of year of injury.

5.6.8 Amounts paid during the fiscal year for all dates of injury valued as year-end by Department/Division/Unit.

6. OTHER SERVICES

6.1 At the sole discretion of the County, examiners attendance at Workers' Compensation Appeals Board Hearings, rehabilitation conferences, conferences with legal counsel (defense counsel), meeting with County staff, departments and employee groups shall be required.

6.2 Claims Management services shall include:

6.2.1 Special claims review of open claim files at the request of the County.

6.2.2 Regular quarterly review of all indemnity claims with reserves in excess of $50,000 and/or of problem & complex claims as deemed appropriate by the County.

6.2.3 Ensure that all required payments are made timely and that medical bills are paid within twenty (20) days or objection timely filed.

6.2.4 Indexing of all new claims and periodic reindexing of existing claims.

6.2.5 Quarterly department file reviews will be coordinated and attended by claims administration staff.

6.2.6 Semi-annual defense attorney file reviews will be coordinated and attended by claims administration staff.

6.3 Forms: Forms necessary for the County's processing and benefits or claims information are to be provided at the expense of the adjusting firm to include pre-printed DWC-1 forms, state mandated posting notices, workers' compensation facts brochures, MPN website, MPN brochures and MPN employee notification letters as necessary.

6.4 Managed Care: Managed Care services include medical bill review, utilization review, and nurse case management. The County may award these services separately from the awarded Third Party Administrator, or may award a single contract for all services to one (1) firm, which ever is determined to be in the County's best interest. The firms awarded Managed Care and Claims Administration shall cooperate fully with each other.

6.5 Bill Review Services: The Contractor shall perform bill review, which may include pharmacy review, and provide reports for such reviews to the TPA and the County. The selected Bill Review vendor will provide weekly and monthly reports.

6.6 Utilization Review Services: The Contractor shall be responsible for evaluating situations that may require and/or benefit from referral to the approved UR vendor. It is expected that the experienced examiner will make most first line UR decisions and defer to formal UR assessment when an appropriate medical expertise is needed or when required by the State. The Contractor shall employ utilization standards and guidelines to review treatment requests and outline all review fees to include physician reviews and any automatic per file referral fees. The Contractor's medical director shall be Board certified as required by law. The Contractor shall provide monthly reports.

6.7 Nurse Case Management: The use of Nurse Case Managers shall be pre approved by the County. The assigned nurse case manager shall be a licensed RN and must have direct experience working with medical providers in Stanislaus County.

6.8 Medical Provider Network (MPN): The County has an established MPN in place and wishes to continue to utilize the existing MPN. The Contractor will be expected to either administer the current MPN while working to improve it or to develop, establish and attain State approval of a new custom MPN that meets all the needs of the County. There must be a specific contact designated who will act as the representative responsible for administering the Medical Provider Network. The administrator will provide any necessary notice to the State, medical providers, claimants and/or their representatives. The County will have final approval of the physicians to be included in the MPN.

7. FINANCIAL ACCOUNTING

7.1 A trust fund shall be maintained for the purpose of paying benefits that may be due on the claims. The amount that will be maintained in the trust fund shall be determined by the parties and confirmed by written document or letter.

7.1.1 Payments from the trust fund will be those sums that should reasonably be paid on benefits mandated and/or required by the California Labor Code on those injuries where such benefits may be due.

7.2 TPA will reconcile bank statement monthly and will submit copies to the County's Risk Management Division for final verification.

7.3 The adjusting firm shall provide monthly check/vouchers register of all transactions made for the period. It shall list the checks/vouchers in numerical order, claim number, amount, payee, recoveries of all types and any other information considered necessary.

7.4 At the sole discretion of the County, there may be an annual/yearly financial audit of the trust account to ensure the integrity of the account. This account may also be subject to a Grand Jury audit at any time.

7.5 Request for special deposits and all requests for payments in excess of $5,000 must be requested prior to check being disbursed and reimbursement at month end for a trust transfer balance.

7.6 The Contractor shall employ measures to mitigate penalties and overpayments and ensure that the County does not incur expenses due to no fault of the County. Penalties that are incurred due to no-fault of the County shall be reimbursed to the County within thirty (30) days of payment of penalty. Overpayments that occur due to no fault of the County shall be reimbursed to the County within thirty (30) days of overpayment. Penalties and overpayments will be documented by monthly reports provided to the County by the Contractor.

7.7. The Contractor's employees designated as signors on the County's trust account must be pre approved. Prior to obtaining signing authority, the Contractor shall conduct a background investigation including but not limited to an individual credit check.

8. RECORDS, FILES, TRANSCRIPTS, TAPES, ETC.

All records, files, transcripts, computer tapes and any other materials on workers' compensation adjusting activities developed on the County of Stanislaus workers' compensation claims are the property of the County and must be relinquished in good order and condition upon termination of the contract with the adjusting firm without an additional cost.

9. DATA CONVERSION

All open and closed claims must be converted from current claims system to claims administrator's claims system. Conversion must be completed within two months of award.

10. IMPLEMENTATION TIME LINE

The Contractor must provide an implementation time line to illustrate how claims transition, data conversion, etc. will take place.

11. SUPPLEMENTAL SCOPE OF SERVICES

11.1 Audits

11.1.1 In the event of the State audit by OBAE (Office of Benefits Assistance and Enforcement), the Administrator selected shall be responsible for all associated legal costs, including those of the County.

11.1.2 The Administrator is required to cooperate with an independent outside auditor selected by the County. The County reserves the right to audit the administrator at any time and as frequently as the County may deem necessary.

11.2. Penalty assessments and payments

11.2.1 The parties hereto acknowledged that they are familiar with the various penalties that the California Workers Compensation Reform Act of 1989 (and subsequent laws) can impose on both employers and claim administrators. Penalties arising from a failure of the County to provide timely notice of claims or such other employer obligations shall be and remain the sole responsibility of the County and the County hereby agrees to indemnify, defend and hold the Administrator harmless from all claims arising from the imposition of such penalties. Administrative penalties arising solely from the failure of Administrator to comply in a timely and proper manner with its duties as a claims administrator shall be and remain the sole responsibility of the Administrator and the Administrator hereby agrees to indemnify, defend and hold the County harmless from all claims arising from the imposition of such administrative penalties.

11.2.2 More specifically, the parties acknowledge that the California Workers' Compensation Reform Act of 1989 requires first payment of Temporary Disability Indemnity within fourteen (14) days of the County's knowledge of the injury and generally imposes an automatic penalty of 10% of the amount delayed for late indemnity payments, which shall be payable directly to the injured employee without application. Furthermore, the parties agree that unless the Administrator is provided with notice of the claim within ten (10) days of the County's knowledge date of the injury, the above referenced automatic penalty of 10% shall be and remain the sole responsibility of the County. The Administrator will agree, however, to make good faith effort with due diligence to issue the first Temporary disability indemnity payment within the fourteen (14) day requirement, even in the event that the notice of claim is not received by the Administrator within ten (10) days of the County's knowledge of injury.

11.3 Meetings with the County: The County requires the Contractor to schedule, organize and conduct meetings with County representatives at least twelve (12) times per year. County representatives may include large departments' top management and/or outside defense counsel. The purpose of the meetings will be to review current cases; review the functioning of the workers' compensation program; develop coordinated plans for handling claims; coordinate plans for returning employees to work; and develop and implement appropriate rehabilitation plans. From time to time, the County may request Contractor to address specific issues as may arise during the course of the contract about which County desires additional information.

11.4 Cost Savings: Contractor shall maximize cost savings by efficient and timely provision of benefits to injured workers', utilization review, medical provider networks, recovery of

subrogation rights, co-defendant contributions, advantageous negotiated settlements, and early return to work as appropriate.

11.5. Training County Personnel: Contractor shall assist in the training of County staff as required. Design forms, procedures and techniques to improve the claim process. Contractor shall instruct County personnel as directed by the County's Risk Management Division about automated systems and reports. Contractor shall update County staff on current changes in workers' compensation law and case decisions.

11.6 Procedure Manual
Contractor shall assist in preparing and maintaining standards and procedure manual in compliance with state law and County needs with particular attention to a coordination of benefits between the Labor Code and the Government Code.

11.7 Accreditation of Administrator
Contractor shall maintain appropriate accreditation and/or license with five (5) years experience as a provider of workers' compensation services in the State of California (NOTE: Include a copy of the license with the RFP submission). Contractor must notify County immediately if accreditation is lost. The Contractor must have provided claims administration for public sector clients.

11.8 Toll Free Telephone Number: The County requests Contractor maintain a toll-free number for access to contractor's office by injured workers and other interested parties. The Contractor shall bear the cost of the toll-free telephone service.

11.9 Claims Examiner Education: All of Contractor's claims examiners assigned to provide service to the County of Stanislaus account will have a solid working knowledge of the Labor Code, including reforms as provided in SB 227, SB 228, SB 899, and any other workers compensation reform currently or hereafter in effect.

11.10 Claims Staff: Contractor shall conduct background checks on all personnel assigned to work on the County's account.

12. SYNOPSIS OF MAJOR SERVICES

The following is a synopsis of the major services requested of the proposer awarded the Claims Management Agreement:

12.1. Initial Services:

12.1.1 Preparation of the basic claims management agreement.

12.1.2 Written Utilization Review procedure to be filed with the State.

12.1.3 Development of the claims payment procedure (subject to County approval).

12.1.4 Design and printing of employer reports, medical referrals, notice to injured employees and any other forms necessary or required.

12.1.5 Establish banking arrangements and/or claims replenishment/reimbursement procedures.

12.1.6 Assume claims management of open files for prior policy years.

12.1.7 Establish all database-coding requirements.

12.2 Ongoing Services:

12.2.1 Issue payments of temporary disability synchronized with the County bi-weekly payroll period.

12.2.2 Issue 4850 payments with vouchers synchronized with the County bi-weekly payroll period.

12.2.3 Review and process all industrial cases in accordance with the requirements of the Department of Industrial Relations and the Workers' Compensation Appeals Board.

12.2.4 Maintain a physical claim record or file on each reported industrial injury.

12.2.5 Maintain, administer and monitor use of County's Medical Provider Network.

12.2.6 Assure medical treatment is in accordance with agreed upon Utilization Review policy and procedure and is based on readily accepted scientific medicine.

12.2.7 Bill Review reducing fees to RVS or PPO contracts as appropriate.

12.2.8 Maintain on a case-by-case basis current estimates of future claims cost.

12.2.9 Prepare all necessary reports to the various state agencies (annual report to self- insurance plans, OSHA and others as required by law).

12.2.10 Coordination of claims activities required due to legal, investigation or subrogation concerns.

12.2.11 Advise the County on each subrogation/excess insurance reimbursable/recovery case and provide recommendations. Recovery checks on excess cases to be sent to County for deposit at the end of each quarter.

12.2.12 Provide monthly, quarterly, and annual loss reports as needed and or as deemed appropriate by the County's Risk Management Division.

12.2.13 Assist the County's Risk Management Division in returning injured employees to work as soon as medically possible.

12.2.14 Work with County's Disability Management Unit on all problematic claims including, but not limited to:

12.2.14.1 Modified Duty Assignments beyond 30 (thirty) days. Evaluate every thirty (30) days for signs of improvement.

12.2.14.2 Total Temporary Disability in excess of 30 (thirty) days. Evaluate every thirty (30) days, develop and monitor action plans.

12.2.14.3 All claims where hospitalization is necessary.

12.3 The CSAC-Excess Insurance Authority Addendum "A" (attached) Worker's Compensation Claims Administration Guidelines are to be used in addition to the requirements set forth in this Request for Proposal.

Adopted:	December 6, 1985
Amended:	March 4, 1988
Amended:	October 7, 1988
Amended:	October 6, 1995
Amended:	October 1, 1999
Amended:	June 6, 2003
Amended:	March 2, 2007
Amended:	July 1, 2009
Amended:	July 1, 2011
Amended:	March 2, 2012

ADDENDUM A
WORKERS' COMPENSATION
CLAIMS ADMINISTRATION GUIDELINES

The following Guidelines have been adopted by the CSAC Excess Insurance Authority (hereinafter The Authority or the EIA) in accordance with Article 18(b) of the CSAC Excess Insurance Authority Joint Powers Agreement. It is the intent of these Guidelines to comply with all applicable Labor Code and California Code of Regulations Sections. In the event that there exists a conflict between the Guidelines, the Labor Code or the Code of Regulations, the most stringent requirement shall apply.

I. CLAIM HANDLING - ADMINISTRATIVE

A. Case Load

1. The claims examiner assigned to the Member shall handle a targeted caseload of 150 but not to exceed 175 indemnity claims. This caseload shall include future medical cases with every 2 future medical cases counted as 1 indemnity case.

2. Supervisory personnel should not handle a caseload, although they may handle specific issues.

B. Case Review and Documentation

1. Documentation should reflect any significant developments in the file and include a plan of action. The examiner should review the file at intervals not to exceed 45 calendar days. Future medical files should be reviewed at intervals not to exceed 90 calendar days. The supervisor shall monitor activity on indemnity files at intervals not to exceed 120 calendar days. Future medical files shall be reviewed by the supervisor at intervals not to exceed 180 calendar days. An accomplishment level of 95% shall be considered acceptable.

2. File contents shall comply with Code of Regulations Sections 10101, 10101.1 and 15400, and be kept in a neat and orderly fashion. An accomplishment level of 95% shall be considered acceptable.

3. All medical-only cases shall be reviewed for potential closure or transfer to an indemnity examiner within 90 calendar days following claim file creation. An accomplishment level of 95% shall be considered acceptable.

C. Communication

1. Telephone Inquiries

Return calls shall be made within 1 working day of the original telephone inquiry. All documentation shall reflect these efforts. An accomplishment level of 95% shall be considered acceptable.

2. Incoming Correspondence

All correspondence received shall be clearly stamped with the date of receipt. An accomplishment level of 95% shall be considered acceptable.

3. Return Correspondence

All correspondence requiring a written response shall have such response completed and transmitted within 5 working days of receipt. An accomplishment level of 95% shall be considered acceptable.

D. Fiscal Handling

1. Fiscal handling for indemnity benefits on active cases shall be balanced with appropriate file documentation on a semi-annual basis to verify that statutory benefits are paid appropriately. Balancing is defined as, "an accounting of the periods and amounts due in comparison with what was actually paid". An accomplishment level of 95% shall be considered acceptable.

2. In cases of multiple losses with the same person, payments shall be made on the appropriate claim file. An accomplishment of 95% shall be considered acceptable.

E. Medicare Reporting

Proper verification of a claimant's status as to Medicare eligibility shall be completed and documented in the claim file. In those cases where the claimant does meet the eligibility requirements, mandatory reporting to the Center for Medicaid Services (CMS) must be completed directly or through a reporting agent in compliance with Section 111of the Medicare Medicaid and SCHIP Extension Act of 2007 ("MMSEA"). An accomplishment of 100% shall be considered acceptable.

II. CLAIM CREATION

A. Three Point Contact

Three point contact shall be conducted with the injured worker, employer representative and treating physician within 3 working days of receipt of the claim by the third party administrator or self administered entity. If a nurse case manager is assigned to the claim, initial physician contact may be conducted by either the claims examiner or the nurse case manager. In the event a party is non-responsive, there should be evidence of at least three documented attempts to reach the individual. Medical-only claims shall have this three point contact requirement as well. An accomplishment level of 95% shall be considered acceptable.

B. Compensability

1. The initial compensability determination (accept claim, deny claim or delay acceptance pending the results of additional investigation) and the reasons for such a determination shall be made and documented in the file within 14 calendar days of the filing of the claim with the employer. In the event the claim is not received by the third party administrator or self administered entity within 14 calendar days of the filing of the claim with the employer, the third party administrator or self administered entity shall make the initial compensability determination within 7 calendar days of receipt of the claim. An accomplishment level of 100% shall be considered acceptable.

2. Delay of benefit letters shall be mailed in compliance with the Division of Workers' Compensation (DWC) guidelines. In the event the employer does not provide notice of lost time to the third party administrator or self administered entity timely to comply with DWC guidelines, the third party administrator or self administered entity shall mail the benefit letters within 7 calendar days of notification. An accomplishment level of 100% shall be considered acceptable.

3. The final compensability determination shall be made by the claims examiner or supervisor within 90 calendar days of employer receipt of the claim form. An accomplishment level of 100% shall be considered acceptable.

C. AOE/COE Investigation

If a decision is made to delay benefits on a claim, an AOE/COE investigation shall be initiated within 3 working days of the decision to delay. This may include, but is not limited to, assigning out for witness/injured worker statements, initiating the QME/AME process, requesting medical records, etc. An accomplishment level of 95% shall be considered acceptable.

D. Reserves

1. Using the information available at claim file set up, an initial reserve shall be established for the most probable case value. An accomplishment level of 95% shall be considered acceptable.

2. The initial reserve shall be electronically posted to the claim within 14 calendar days of receipt of the claim. An accomplishment level of 95% shall be considered acceptable.

E. Indexing

All claims shall be reported to the Index Bureau at time of initial set up and re-indexed on an as needed basis thereafter. An accomplishment level of 95% shall be considered acceptable.

The EIA maintains membership with the Index Bureau that members can access.

III. CLAIM HANDLING – TECHNICAL

A. Payments

1. Initial Temporary and Permanent Disability Indemnity Payment

a. The initial indemnity payment shall be issued to the injured worker within 14 calendar days of knowledge of the injury and disability. In the event the third party administrator or self administered entity is not notified of the injury and disability within 14 calendar days of the employer's knowledge, the third party administrator or self administered entity shall make payment within 7 calendar days of

notification. Initial permanent disability payments shall be issued within 14 calendar days after the date of last payment of temporary disability. This shall not apply with salary continuation. An accomplishment level of 100% shall be considered acceptable.

b. The properly completed DWC Benefit Notice shall be mailed to the employee within 14 calendar days of the first day of disability. In the event the third party administrator or self administered entity is not notified of the first day of disability until after 14 calendar days, the DWC Benefit Notice shall be mailed within 7 calendar days of notification. An accomplishment level of 100% shall be considered acceptable.

c. Self imposed penalty shall be paid on late payments in accordance with Section III. A.7 of this document. An accomplishment level of 100% shall be considered acceptable.

d. Overpayments shall be identified and reimbursed timely where appropriate. The third party administrator or self administered entity shall request reimbursement of overpaid funds from the party that received the funds. If necessary, a credit shall be sought as part of any resolution of the claim. An accomplishment level of 95% shall be considered acceptable.

2. Subsequent Temporary and Permanent Disability Payments

a. Eligibility for indemnity payments subsequent to the first payment shall be verified, except for established long-term disability. An accomplishment level of 100% shall be considered acceptable.

b. Self imposed penalty shall be paid on late payments in accordance with Section III. A.7 of this document. An accomplishment level of 100% shall be considered acceptable.

3. Final Temporary and Permanent Disability Payments

a. All final indemnity payments shall be issued timely and the appropriate DWC benefit notices sent. An accomplishment level of 100% shall be considered acceptable.

b. Self imposed penalty shall be paid on late payments in accordance with Section III. A.7. of this document. An accomplishment level of 100% shall be considered acceptable.

4. Award Payments

a. Payments on undisputed Awards, Commutations, or Compromise and Releases shall be issued within 10 calendar days following receipt of the appropriate document. An accomplishment level of 95% shall be considered acceptable.

b. For all excess reportable claims, copies of all Awards shall be provided to the Authority at time of payment. An accomplishment level of 95% shall be considered acceptable.

5. Medical Payments

a. Medical treatment billings (physician, pharmacy, hospital, physiotherapist, etc.) shall be reviewed for correctness, approved for payment and paid within 60 working days of receipt. An accomplishment level of 100% shall be considered acceptable.

b. The medical provider must be notified in writing within 30 working days of receipt of an itemized bill if a medical bill is contested, denied or incomplete. An accomplishment level of 100% shall be considered acceptable.

c. A bill review process should be utilized whenever possible. There should be participation in a PPO and/or MPN whenever possible.

6. Injured Worker Reimbursement Expense

a. Reimbursements to injured workers shall be issued within 15 working days of the receipt of the claim for reimbursement. An accomplishment level of 95% shall be considered acceptable.

b. Advance travel expense payments shall be issued to the injured worker 10 working days prior to the anticipated date

of travel. An accomplishment level of 95% shall be considered acceptable.

7. Penalties

   a. Penalties shall be coded so as to be identified as a penalty payment. An accomplishment level of 100% shall be considered acceptable

   b. If the Member utilizes a third party administrator, the Member shall be advised of the assessment of any penalty for delayed payment and the reason thereof, and the administrator's plans for payment of such penalty, on a monthly basis. An accomplishment level of 95% shall be considered acceptable.

   c. If the Member utilizes a third party administrator, the Member, in their contract with the administrator, shall specify who is responsible for specific penalties.

B. Medical Treatment

1. Each Member shall have in place a Utilization Review process. An accomplishment level of 100% shall be considered acceptable.

2. Disputes regarding spine surgery shall be resolved using the process set forth in Labor Code Section 4062(b). An accomplishment level of 100% shall be considered acceptable.

3. Nurse case managers shall be utilized where appropriate. An accomplishment level of 95% shall be considered acceptable.

4. If enrolled in a Medical Provider Network, the network shall be utilized whenever appropriate.

C. Apportionment

1. Investigation into the existence of apportionment shall be documented. An accomplishment level of 100% shall be considered acceptable.

2. If potential apportionment is identified, all efforts to reduce exposure shall be pursued. An accomplishment level of 100% shall be considered acceptable.

D. Disability Management

1. The third party administrator or self administered entity shall work proactively to obtain work restrictions and/or a release to full duty on all cases. The TPA or self-administered entity shall notify a designated Member representative immediately upon receipt of temporary work restrictions or a release to full duty, and work closely with the Member to establish a return to work as soon as possible. An accomplishment level of 95% shall be considered acceptable.

2. The third party administrator or self administered entity shall notify a designated Member representative immediately upon receipt of an employee's permanent work restrictions so that the Member can determine the availability of alternative, modified or regular work. An accomplishment level of 100% shall be considered acceptable.

3. If there is no response within 20 calendar days, the third party administrator or self administered entity shall follow up with the designated Member representative. An accomplishment level of 100% shall be considered acceptable.

4. Members shall have in place a process for complying with laws preventing disability discrimination, including Government Code Section 12926.1 which requires an interactive process with the injured worker when addressing a return to work particularly with permanent work restrictions.

5. Third party administrators or self administered claims professional shall cooperate with members to the fullest extent, in providing medical and other information the member deems necessary for the member to meet its obligations under federal and state disability laws.

E. Supplemental Job Displacement Benefits

1. Supplemental Job Displacement Benefits – Dates of injury 1/1/04 and after: Benefits pursuant to Labor Code Section 4658.5 shall be timely provided. An accomplishment level of 100% shall be considered acceptable.

2. The third party administrator or self administered entity shall secure the prompt conclusion of vocational rehabilitation/SJDB and settle where appropriate. An accomplishment level of 95% shall be considered acceptable.

F. Reserving

1. Reserves shall be reviewed at regular diary and at time of any significant event, e.g., surgery, P&S/MMI, return to work, etc., and adjusted accordingly. This review shall be documented in the file regardless of whether a reserve change was made. An accomplishment level of 95% shall be considered acceptable.

2. Indemnity reserves shall reflect actual temporary disability indemnity exposure with 4850 differential listed separately. An accomplishment level of 100% shall be considered acceptable.

3. Permanent disability indemnity exposure shall include life pension reserve if appropriate. An accomplishment level of 100% shall be considered acceptable.

4. Future medical claims shall be reserved in compliance with SIP regulation 15300 allowing adjustment for reductions in the approved medical fee schedule, undisputed utilization review, medically documented non-recurring treatment costs and medically documented reductions in life expectancy. An accomplishment level of 100% shall be considered acceptable.

G. Resolution of Claim

1. Within 10 working days of receiving medical information indicating that a claim can be finalized, the claims examiner shall take appropriate action to finalize the claim. An accomplishment level of 95% shall be considered acceptable.

2. Settlement value shall be documented appropriately utilizing all relevant information. An accomplishment level of 95% shall be considered acceptable.

H. Settlement Authority

1. No agreement shall be authorized involving liability, or potential liability, of the Authority without the advance written consent of the Authority. An accomplishment level of 100% shall be considered acceptable.

2. The third party administrator shall obtain the Member's authorization on all settlements or stipulations in excess of the settlement authority provided in any provision of the individual

contract between the Member and the claims administrator. An accomplishment level of 100% shall be considered acceptable.

IV. LITIGATED CASES

The third party administrator or self administered entity shall establish written guidelines for the handling of litigated cases. The guidelines should, at a minimum, include the points below, which may be adopted and incorporated by reference as "the guidelines".

A. Defense of Litigated Claims

1. The third party administrator or self administered entity shall promptly initiate investigation of issues identified as material to potential litigation. The Member shall be alerted to the need for in-house investigation, or the need for a contract investigator who is acceptable to the Member. The Member shall be kept informed on the scope and results of investigations. An accomplishment level of 95% shall be considered acceptable.

2. The third party administrator or self administered entity shall, in consultation with the Member, assign defense counsel from a list approved by the Member. An accomplishment level of 95% shall be considered acceptable.

3. Settlement proposals directed to the Member shall be forwarded by the third party administrator, self administered entity or defense counsel in a concise and clear written form with a reasoned recommendation. Settlement proposals shall be presented to the Member as directed so as to insure receipt in sufficient time to process the proposal. An accomplishment level of 95% shall be considered acceptable.

4. Knowledgeable Member personnel shall be involved in the preparation for medical examinations and trial, when appropriate or deemed necessary by the Member so that all material evidence and witnesses are utilized to obtain a favorable result for the defense. An accomplishment level of 95% shall be considered acceptable.

5. The third party administrator or self administered entity shall comply with any reporting requirement of the Member. An accomplishment level of 95% shall be considered acceptable.

B. Subrogation

1. In all cases where a third party (other than a Member employee or agent) is responsible for the injury to the employee, attempts to obtain information regarding the identity of the responsible party shall be made within 14 calendar days of recognition of subrogation potential. Once identified, the third party shall be contacted within 14 calendar days with notification of the Member's right to subrogation and the recovery of certain claim expenses. If the third party is a governmental entity, a claim shall be filed with the governing board (or State Board of Control as to State entities) within 6 months of the injury or notice of the injury. An accomplishment level of 95% shall be considered acceptable.

2. Periodic contact shall be made with the responsible party and/or insurer to provide notification of the amount of the estimated recovery to which the Member shall be entitled. An accomplishment level of 95% shall be considered acceptable.

3. The file shall be monitored to determine the need to file a complaint in civil court in order to preserve the statute of limitations. An accomplishment level of 95% shall be considered acceptable.

4. If the injured worker brings a civil action against the party responsible for the injury, the claims administrator shall consult with the Member about the value of the subrogation claim and other considerations. Upon Member authorization, subrogation counsel shall be assigned to file a Lien or a Complaint in Intervention in the civil action. An accomplishment level of 95% shall be considered acceptable.

5. Whenever practical, the claims administrator shall aggressively pursue recovery in any subrogation claim. They should attempt to maximize the recovery for benefits paid, and assert a credit against the injured worker's net recovery for future benefit payments. An accomplishment level of 95% shall be considered acceptable.

V. EXCESS COVERAGE

A. Claims meeting the definition of reportable excess workers' compensation claims as defined by the Memorandum of Coverage Conditions Section shall be reported to the Authority within 5 working days of the day on which it is known the criterion is met. Utilize the Excess Workers' Compensation First Report Form available through the EIA website. An accomplishment level of 100% shall be considered acceptable.

B. Subsequent reports shall be transmitted to the Authority on a quarterly basis on indemnity claims and on a semi-annual basis on future medical claims sooner if claim activity warrants, or at such other intervals as requested by the Authority, in accordance with Underwriting and Claims Administration Standards. Utilize the Excess Workers' Compensation Status Report Form available through the EIA website, or a comparable form to be approved by the Authority. An accomplishment level of 95% shall be considered acceptable.

C. Reimbursement requests should be submitted in accordance with the Authority's reporting and reimbursement procedures on a quarterly or semi-annual basis depending on claims payment activity. Utilize the Excess Workers' Compensation Claim Reporting and Reimbursement Procedures available through the EIA website. An accomplishment level of 95% shall be considered acceptable.

D. A closing report with a copy of any settlement documents not previously sent shall be sent to the Authority. An accomplishment level of 95% shall be considered acceptable.

APPENDIX D
PRICING PROPOSAL

Proposers must submit pricing using this form, which shall be used as the basis for Phase III of the Evaluation Process. Proposers may submit an alternate pricing proposal separately in addition to this required Pricing Proposal. Such alternate pricing will not be considered as part of the evaluation process but may be incorporated into the final agreement.

The Pricing Proposal format is intended to identify ALL potential fees/costs that may be incurred during the term of the agreement. Additional space has been provided for "Other Charges" to document any potential costs not already identified within the pricing categories provided within the form.

For purposes of developing your claims administration pricing proposal, you should assume 2.5 full- time Claims Examiners and a minimum of 1.5 technical support staff. The County may modify the final staffing profile of the program prior to final contract award, however all proposers must submit their pricing proposal with the same base staff for Claims Examiners and support staff.

It is up to each individual Proposer to add all other applicable costs into the proposed Claims Administration Flat Fee (management, overhead, supplies, printing, etc.). Your administrative charges must include all other projected costs/fees not already identified on an individual basis within your Pricing Proposal. The County will not pay for any services during the term of any future agreement that are not identified on your pricing proposal submitted during the RFP process, unless otherwise agreed to by the County during the term of the agreement.

For each item, please include the specific dollar or percentage "Rate" (dollar or percentage amount) as well as the "Frequency" of the charge (annual, monthly, weekly, per claim, per bill, etc.). If no fee is contemplated for a specific category, please respond with "No Charge."

Category	Rate		Frequency
Claims Administration			
Claims Administration Annual "Flat" Fee Year One	$ 483,933		Annual
Claims Administration Annual "Flat" Fee Year Two	$ 496,031		Annual
Claims Administration Annual "Flat" Fee Year Three	$ 508,431		Annual
Other Administrative Costs			
Data Conversion	Waived		
Access to Database/Misc IT Charges	Free		
Bank Reconciliation	Free		
Subrogation	Free with attorney fees charged as allocated expense to claim file		
Indexing *(may be done at no charge through CSAC-EIA)*	Free		
Claim file storage including closed inventory	Free		
Claim file storage including closed inventory	Free		
Medicare Reporting	York provides free Medicare Reporting through Gould & Lamb.		
Ad hoc report programming per hour	Free		
Medical Provider Network Administration	Option 1	$150	Per provider contract with County's existing MPN
	Option 2	$42	Per claim access for WellComp MPN
	Option 2	Waived	Filing Fee for WellComp MPN
	Option 3	$150	Per provider contract with WellComp MPN Custom Carve-Out

PRICING PROPOSAL – CONTINUED

Category	Rate	Frequency
Bill Review		
Fee per Bill to reduce to fee schedule	$7.50	Per Bill
% of Savings for PPO Savings below fee schedule	24%	
% of Savings for Hospital Inpatient	0%	
% of Savings for Hospital Outpatient	0%	
% of savings Negotiated Bill Review	0%	
Utilization Review		
Nurse Review - per hour	$95.00	~~Hourly~~ Per event
Doctor Review - per hour	$225.00	Hourly
Peer Review - per hour	$225.00	Hourly
Pre-Certification (hospital or surgery) - fee per case	$95.00	Per Case
Concurrent Review - fee per case	$95.00	Per Case
Nurse Case Management		
Telephonic Case Management - per hour	$98.00	Hourly
Field Case Management - per hour	$98.00	Hourly
Travel and wait time - per hour	$98.00	Hourly
Mileage charges for travel	IRS rate	Per Mile
Catastrophic Case Management	$98.00	Hourly
Other Charges	No other charges	

YORK

April 23, 2013

Mr. Jody Hayes and Ms. Peggy Huntsinger
Deputy Executive Officer/Assistant Risk Manager
Stanislaus County – Risk Management
1010 10th Street, Suite 5900
Modesto, CA 95354
VIA EMAIL

Re: Requested Information for County Risk Management

Dear Mr. Hayes and Ms. Huntsinger:

We appreciate you taking the time to speak with us on Wednesday, April 17 regarding some of the items outlined in our pricing proposal. As requested, we are providing clarification regarding our managed care pricing as follows:

- Medicare Reporting
  There is no fee directly associated with Medicare reporting regardless of the Reporting Agent the County utilizes.

- Medical Provider Network
  Based on the list Stanislaus County provided, there are 115 providers not currently contracted through the WellComp Medical Provider Network. Our goal is to contract with these physicians within 60 – 90 days, but this timeframe is largely dependent on physician response. Additionally, York will be able to file the MPN by January 1, 2014 in accordance with the new requirements set forth in SB 863. There will be no per claim access fee for the MPN during the transition period.

- Bill Review
  York would like to confirm that the only fees associated with percentage of savings for hospital inpatient, hospital outpatient, and negotiated bill review would be the per bill fee of $7.50 to reduce to fee schedule. As an example, if we received a hospital bill for $50,000 from a hospital that was not in a PPO network and reduced the bill to fee schedule of $20,000, we would only charge $7.50. We would not charge a percentage of the $30,000 savings.

  Stanislaus County requested an option for containing costs associated with bill review, and York is willing to cap PPO savings fees on a per bill basis at $5,000. Based on the bill review data the County provided, we have identified that the County currently achieves very low PPO penetration. We are confident that we will achieve a much higher PPO penetration, which will provide greater net bill review savings to the County overall. That said, we must pay the PPO. Our goal is to access the best PPO savings for the County on each bill, and, as a result, our average reimbursement rate to the PPO ranges from 10 to 18% of savings depending on which network we access.

  Here is an example of how this would work:

  A County Sheriff has an extended inpatient hospital stay. The hospital is in the PPO network and sends us a bill for $225,000. First, York reduces the bill to fee schedule or $140,000, which is $85,000 in fee schedule savings. To do this, we charge a fee of $7.50. Then, York

identifies that we can take additional PPO savings, which reduces the bill an additional $60,000 so the County will pay $80,000 on the $225,000 bill. Without the $5,000 per bill cap on PPO charges, the County would pay York $14,400 in PPO savings fees ($14,400 is 24% of the $60,000 in PPO savings). With the cap, however, the County will never pay more than $5,000 in PPO savings. Assuming a reimbursement rate of 18% to the PPO network, York will pay the PPO $10,800 while only charging the County $5,000 to access the network.

Should the County have further questions regarding our managed care pricing, please do not hesitate to contact us.

Best regards,

Jon Lord
Managing Vice President, Public Entity Sales
Phone: (714) 620-1375

Jody Gray
President, Public Entity
Phone: (714) 620-1336

APPENDIX E

Stanislaus County
Performance Based Contract Provision - TPA

CSAC Excess Insurance Authority will conduct a biennial claims audit, which will be used as one of the bases for evaluating performance, in addition to providing timely, and accurate claim data as requested.

The claims audit will evaluate compliance with the CSAC EIA Workers' Compensation Claims Administration Guidelines (claim guidelines). The claims audit will measure the percentage of compliance achieved in each of seven (7) selected audit categories.

If the claims audit composite score is below 90%, penalties to the claims administration fees would apply as outlined below.

If the performance as identified by the audit is at a level significantly below the 90% composite score noted previously, such that the County schedules an interim audit with an independent auditor, the cost of said interim audit will be the responsibility of TPA to reimburse the County upon submission of the paid invoice.

Penalty Calculation

TPA can be assessed a penalty of up to $7,000 or $1,000 for each of the audit categories listed below where the composite rating for a category is below 90%:

Audit Category

- Medicare Reporting
- Three Point Contact
- Indexing
- Disability Management
- Reserving
- Reimbursement & Recovery
- Excess Reporting

Auditor Controls

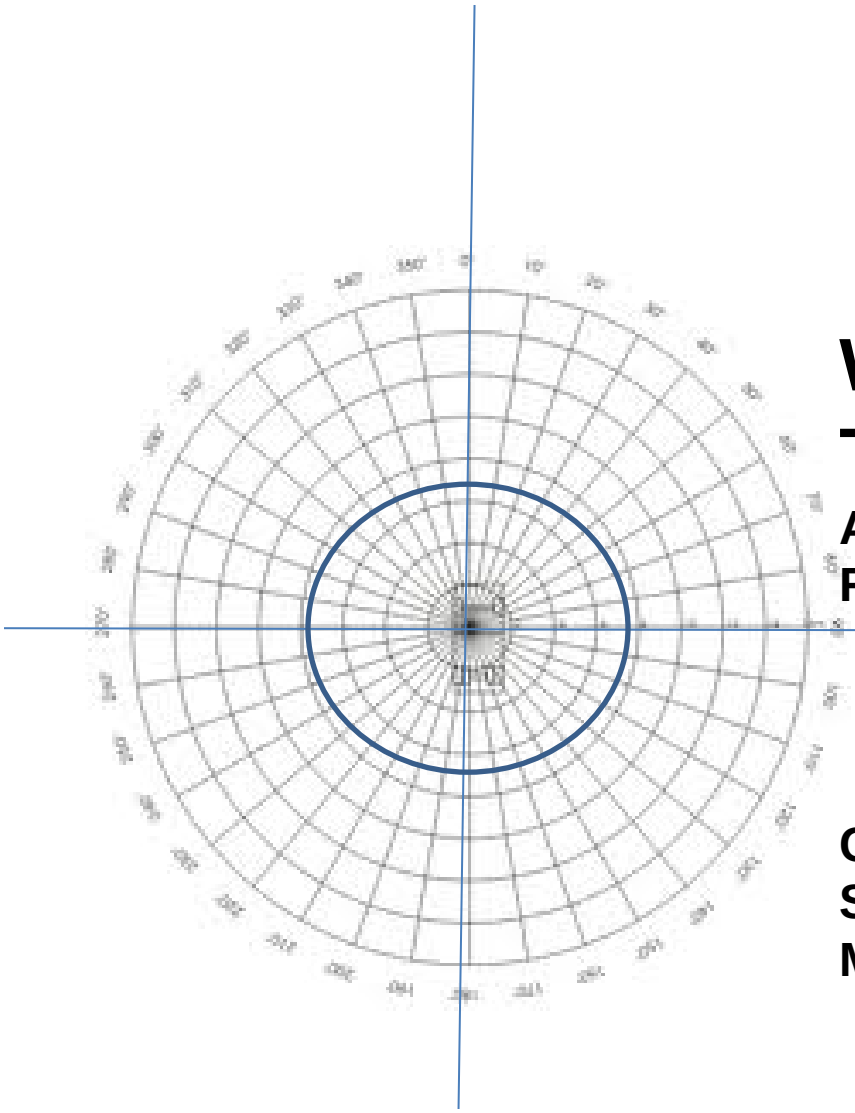
In conducting the annual audit, the auditor will limit the evaluation to areas directly under TPA's control. The audit will be limited to activity performed by TPA since the previous audit. The sample size obtained for each audit category shall be at least forty (40) files representing all County claims, or that audit category will be disregarded. As respects the audit category of "Reserving", the auditor shall consider a file to be in compliance if reserve changes are properly considered and documented and the auditor's reserve recommendation is within 5% of the indicated reserve. However, in the event of a dispute the independent auditor's final opinion will be the determining factor.

Payment of Penalty

The penalty shall apply to claims administration fees earned during the July 1st to June 30th contract year during which the audit is completed. The penalty shall be payable in equal monthly installments over the contract year immediately following the subject audit year. (For example, if the audit is completed during the 2012/13 contract year, the penalty shall be assessed during the 2013/14 contract year.) The penalty is separate from the annual administration fee. Should this contract be cancelled, or not renewed beyond the term of this Agreement, the balance of the penalty shall be payable within thirty (30) days of the termination or non-renewal.

Claim Reports

The monthly, quarterly and annual claim reports are to be fully checked for quality prior to submitting to the County, and will be provided by or before the 15th of the month. Failure to provide accurate and timely reports will result in a $100 penalty for the first report missed. Late or inaccurate reporting penalty will be capped at $2,500 for each contract year, with the penalty being assessed at the end of that contract year. If the County is required to re-request data due to errors identified, or the reports are submitted after the indicated due date and time, the penalty provision will apply.



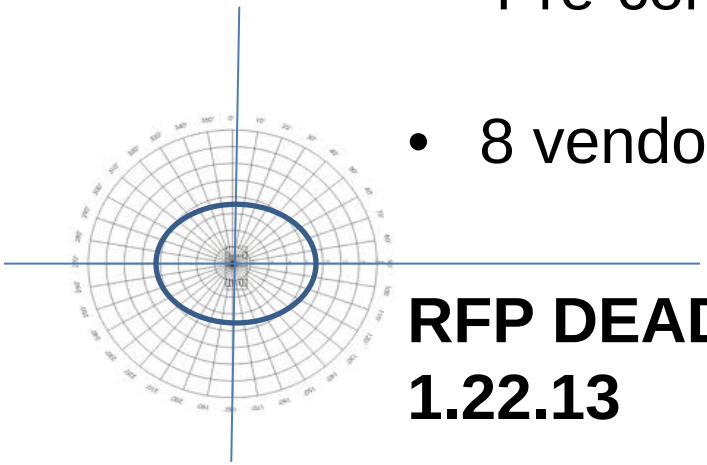
Workers' Compensation Third Party Administration

Appeal and Associated Actions
RFP #12-58 MP

County Board of Supervisors
Special Meeting
May 10, 2013

RFP APPROVED BY THE BOARD AND PUBLISHED12.11.13

- Sent Electronically to 374 vendors
- 34 vendors downloaded the RFP
- 15 vendors attended the mandatory Pre-conference
- 8 vendors submitted proposals



RFP DEADLINE 1.22.13

PHASE I – FINANCIAL REPORT	MAXIMUM POINTS
Review and Evaluate Proposal Submission and Financial Report	PASS/FAIL
Notify Vendors Proceeding onto Phase II	

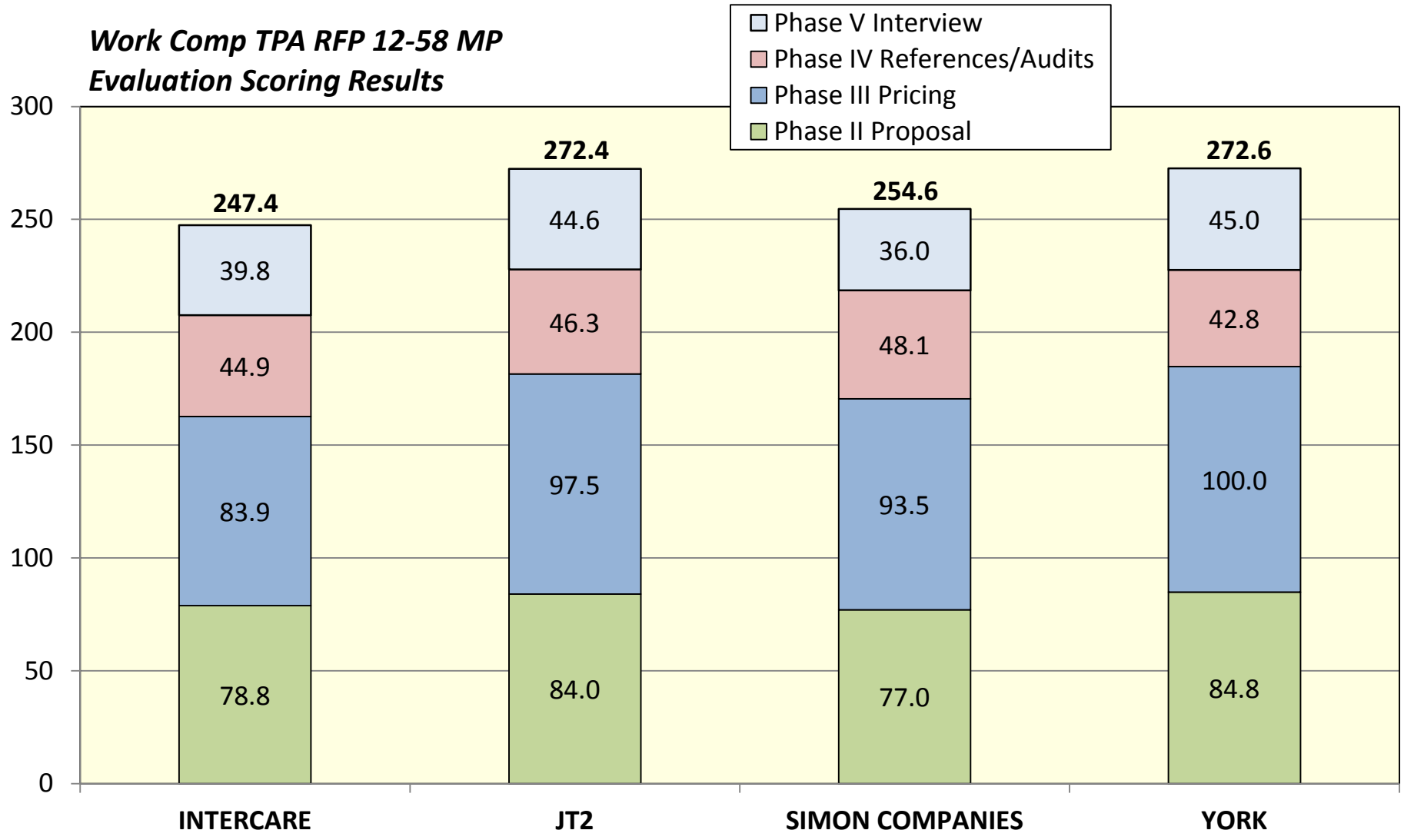
PHASE II – EVALUATION OF QUALIFICATION PROPOSAL	MAXIMUM POINTS
A. Claims Management Services	75
B. Managed Care Services	25
Maximum Available Points – Phase II	100
Notify Proposers Proceeding to Phase III (min. score of 75 required)	

PHASE III – EVALUATION OF PRICING PROPOSAL	MAXIMUM POINTS
Proposed cost	100
Notify Proposers Proceeding to Phase IV (top 5 highest scores)	

PHASE IV – REFERENCE CHECKS & AUDIT RESULTS	MAXIMUM POINTS
Total available points	50
Notify Proposers Proceeding to Phase V (min. score of 25 required)	

PHASE V – PRESENTATION & INTERVIEW	MAXIMUM POINTS
Total available points	50

OVERALL MAXIMUM AVAILABLE POINTS:	**300**

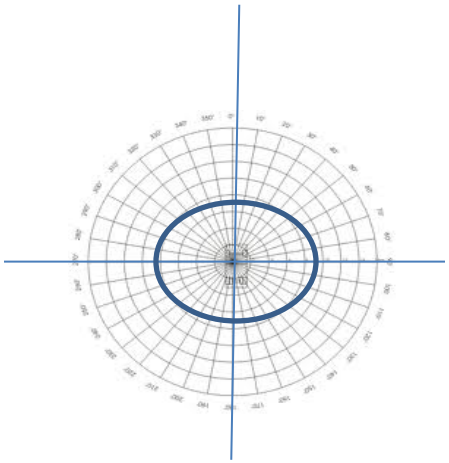

Work Comp TPA RFP 12-58 MP
Evaluation Scoring Results
Phase V Interview
Phase IV References/Audits
Phase III Pricing
Phase II Proposal
300
250
200
150
100
50
0
247.4
39.8
44.9
83.9
78.8
272.4
44.6
46.3
97.5
84.0
254.6
36.0
48.1
93.5
77.0
272.6
45.0
42.8
100.0
84.8
INTERCARE
JT2
SIMON COMPANIES
YORK

Protest Time Line

March 13
County Staff meet with JT2 to discuss
Concern with final scoring – staff share York
Scoring – per request

March 13
JT2 submits formal Protest Letter

1. Protest Issue #1 - Medicare Reporting
2. Protest Issue #2 - Medical Provider Network (MPN) Administration



March 26
County GSA responds with Protest Denial Letter

April 5
JT2 submits formal appeal to Board of Supervisors/
County Purchasing Agent

JT2 Appeal

Appeal Issue #1 – Medicare Reporting

JT2 pricing proposal states “$20.00 Per Report”

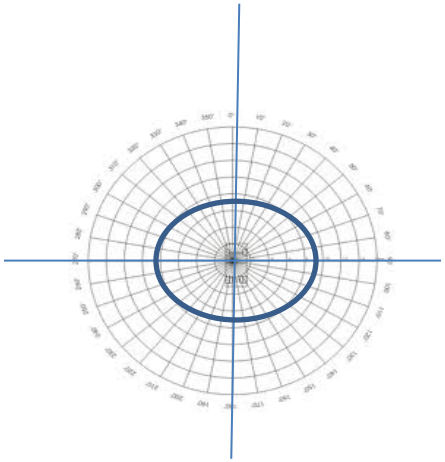
Staff clarified the frequency of the fee during Phase V interview

Staff estimated 10 reports per quarter

10 x $20 = $200 per quarter or $800 per year

$800 x 3 years = $2,400 for three year contract

JT2’s appeal states that they can provide this service at no charge through the County’s existing relationship with a third party (Gould and Lamb), and therefore their pricing proposal should be reduced by $2,400



York’s pricing proposal states “York provides free Medicare Reporting through Gould & Lamb” therefore staff did not include any cost for York in this category

Staff requested further clarification from York should the County not use Gould and Lamb, York replied “There is no fee directly associated with Medicare reporting regardless of the Reporting Agent the County utilizes

JT2 Appeal

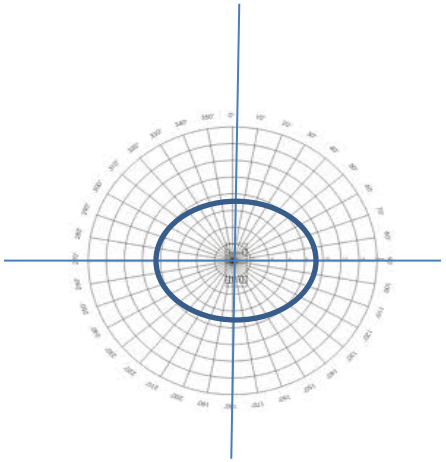
Appeal Issue #2 – Medical Provider Network (MPN) Administration

JT2 pricing proposal states “$3.00 Per Bill”

RFP Addendum #2 provided the number of bills processed annually

Staff calculated $3.00 x 6,223 = $18,669 per year
$18,669 x 3 years = $56,007 for three year contract

JT2’s appeal states that the $3.00 per bill charge will only be charged in limited circumstances (3-5% of the time), and estimates MPN administrative fees to be $1,800 over a three year period



Information provided by JT2 during protest was not provided in JT2’s pricing proposal submitted with the RFP and was provided after they had reviewed York’s pricing calculations

JT2 Pricing Proposal Submitted With RFP

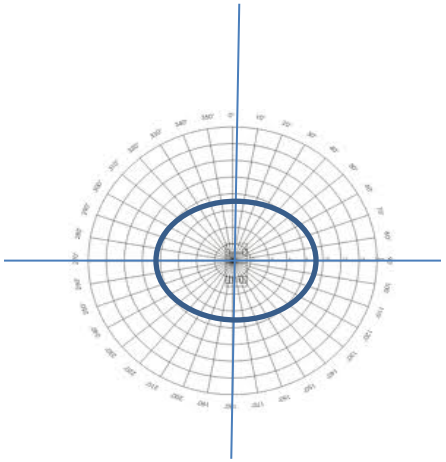
Other Administrative Costs		
Data Conversion	$ 0.00	
Access to Database/Misc IT Charges	$ 0.00	
Bank Reconciliation	$ 0.00	
Subrogation	$ 0.00	
Indexing *(may be done at no charge through CSAC-EIA)*	$ 0.00	CSAC
Claim file storage including closed inventory	$ 0.00	
Claim file storage including closed inventory	$ 0.00	
Medicare Reporting	$ 20.00	Per Report
Ad hoc report programming per hour	$ 0.00	
Medical Provider Network Administration	$ 3.00	Per Bill

JT2 Appeal

Staff recommend denial of JT2 Appeal

Pricing calculations and forms were clearly communicated in RFP process

Revision pricing (for JT2 or any other vendor) violates County purchasing standards



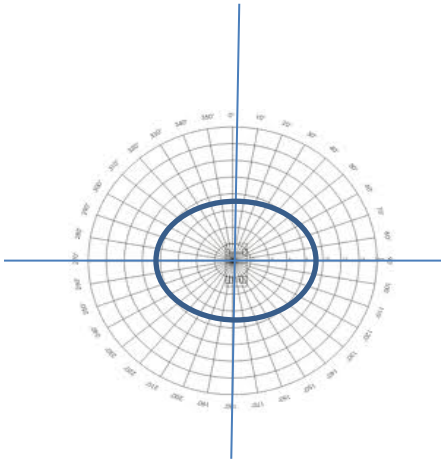
Staff Recommendations

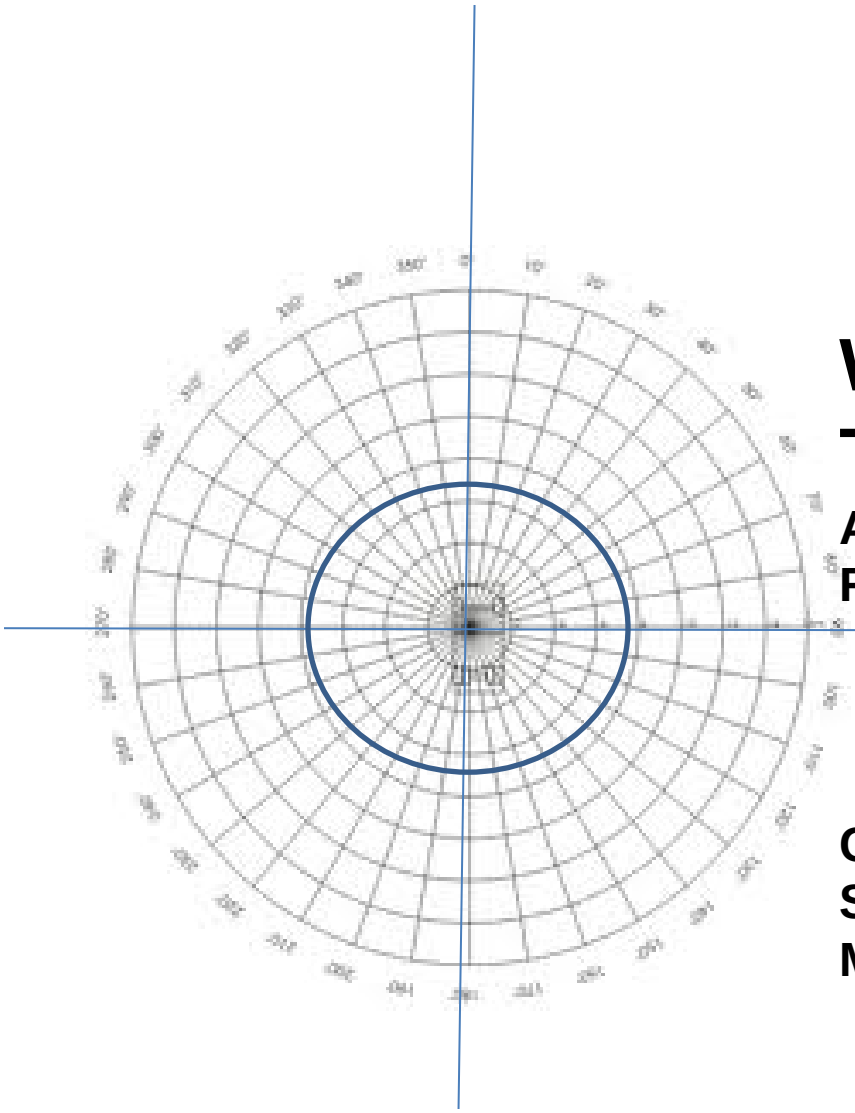
1. **Consider the letter of appeal submitted by JT2 Integrated Resources**

2. **Uphold the Purchasing Agent's decision to deny the protest submitted by JT2 Integrated Resources**

3. **Approve agreement with York Risk Services Group, Inc. for Workers' Compensation Third Party Administrator Services for the period of July 1, 2013 through June 30, 2013**

4. **Authorize the Purchasing Agent to sign the Agreement and any future amendments or extensions to the Agreement based on changes in the volume of claims or legislative changes impacting caseload standards**





Workers' Compensation Third Party Administration

Appeal and Associated Actions
RFP #12-58 MP

County Board of Supervisors
Special Meeting
May 10, 2013

STANISLAUS COUNTY GENERAL SERVICES AGENCY - PURCHASING DIVISION
PHASE IV EVALUATION SUMMARY FOR RFP 12-58 MP (See RFP § 6.3.5)
REFERENCE CHECKS & REVIEW OF AUDIT RESULTS

	TOTAL AVAILABLE	Audits	References	Total Awarded
INTERCARE	50	23.000	21.920	44.920
JT2	50	22.700	23.575	46.275
SIMON	50	23.400	24.700	48.100
YORK	50	22.200	20.600	42.800

Staff conducted five reference checks for each vendor

Staff evaluated all available audits for the last five years

- 7 audits available for Simon Companies
- 11 audits available for Intercare
- 15 audits available for JT2
- 59 audits available for York