DXC Response to The Office of Systems Integration’s RFI # 32236 Case Management, Information and Payrolling System (CMIPS) Electronic Visit Verification (EVV)

December 13, 2017
Section 8 – RFI Format and Submission

1 Cover Letter

December 13, 2017

Albert De León
Acquisitions & Contracting Services Division
Office of Systems Integration
Phone: (916) 263-4285
E-mail Address: solicitations@osi.ca.gov

Dear Mr. De León,

DXC Technology (DXC) appreciates the opportunity to respond to the Case Management, Information and Payrolling System (CMIPS) Electronic Visit Verification (EVV) RFI # 32236.

California Health and Human Services Agency has thoughtfully devised a solid plan for the future by exploring solutions that may be used to meet the requirements as defined in the 21st Century Cures Act for use of an Electronic Visit Verification (EVV) system by personal care service and home health care workers beginning January 2019 and January 2023, respectively. We have provided you a thorough and high quality response to aid you in this important decision.

We are very proud of our long term history of supporting the State of California over the past 38+ years. We are excited about the additional value we can provide as the prime contractor bringing energy and commitment, new technologies-and most importantly, an eye to the future. We look forward to supporting the Office of Systems Integration and the California Department of Social Services navigate the near and long term future and helping you achieve your goals.

The following individual will serve as our point of contact throughout the RFI/RFP process:

DXC Representative Name: Bill Woodruff
Email: bill.woodruff@dxc.com
Telephone: 916.934.3911

Sincerely,

William C Woodruff
Director, Healthcare DXC Technology
Important Notice

This document has been prepared by DXC Technology in response to RFI # 32236 Case Management, Information and Payrolling System (CMIPS) Electronic Visit Verification (EVV) issued by The Office of Systems Integration.

The information contained in all contents of this document and all schedules, annexures and attachments to it (collectively "Document") is confidential information of DXC Technology Company or its affiliates (collectively "DXC") and is provided for evaluation purposes only.

If there are any concerns, questions, or issues regarding this Document please contact:

DXC Representative Name: Bill Woodruff
Email: bill.woodruff@dxc.com
Telephone: 916.934.3911
# Table of Contents

Section 8 – RFI Format and Submission ........................................................................................................ i
1 Cover Letter.................................................................................................................................................. i
2 Brief Narrative............................................................................................................................................... 1
3 Additional Recommendations....................................................................................................................... 7
4 Attachment A - CMIPS RFI #32236 Questions......................................................................................... 8
2 Brief Narrative

A narrative describing the following:

a. The vendor’s primary business focus, areas of expertise, certifications and/or credentials relevant to the content of this RFI and experience with similar systems;

DXC Response:

DXC Technology was formed by the merger of CSC and the Enterprise Services business of Hewlett Packard Enterprise. Each company successfully guided the world's largest enterprises and government agencies through multiple change cycles for more than 60 years. Now combined as DXC, the technology independence, global talent and industry-leading partner network provide a clear vision as a trusted advisor to minimize business risk and seize opportunities.

Today, the strategic combination of these two companies into DXC Technology creates the world’s leading independent, end-to-end IT services company. We have more than 60 years of experience providing the services required by the State. We understand IT – the past, present, and future. We boast a long and proud history of innovation, service, and value. The State has worked with our company under various names – EDS/GM, EDS, HP, HPE and now DXC.

The merger brings together two leading healthcare and life sciences IT organizations. Together we have created a healthcare and life sciences technology powerhouse that can address the needs of clients across the healthcare continuum – payers, providers, government health, life sciences and medical distributors.

DXC has unparalleled expertise in the industry:

- Cross sector industry-leading IP
- Strong partner network
- Technology independence
- World-class talent
- Innovative, forward thinking thought leaders

And, a global scale and footprint that is unrivalled to meet client needs.

We have been and continue to be the same core company, with many of the same people on whom you have historically relied for on-time and within-budget services, augmented with new talent from global delivery centers who offer fresh perspectives and skills.

As the incumbent CMIPS contractor, and prime contractor on each of our Medicaid Management Information System (MMIS) contracts with 23 states, DXC has the experience addressing major system and service changes resulting from a high-impact legislative changes or state program mandates. This includes shifting functionality from the existing system to a third-party service provider.

Recently, in Connecticut, the State opted to add Electronic Visit and Verification (EVV) capability to the existing MMIS contract, using a third-party service provider as a subcontractor to DXC. As a leading, independent end-to-end IT services company we are technology agnostic and provide best of breed solutions to meet the unique requirements of our customers. DXC has partnered with leading EVV product vendors to provide total solutions to customers. We have worked with EVV product vendors both as a primary systems integrator assisting EVV pure plays implementing for a state as well as a Prime Contractor having an EVV vendor as a sub-contractor as demonstrated in EVV implementations at Rhode Island (Sandata), Florida (Sandata and Tellus), Kansas (First Data) and then Connecticut (Sandata) respectively. We also have experience on CMIPS transitioning existing functionality to a third-party
DXC Response to The Office of Systems Integration, December 13, 2017

service provider as demonstrated by the transition of ADA and Blind or Visually Impaired (BVI) services from DXC to a third-party service provider, Braille Works as a subcontractor.

DXC is uniquely qualified to address the requirements for both the individual providers as well as Agency provider model with the combination of our experience at CMIPS implementing the IHSS Portal as well as our experience in other accounts implementing and operating EVV systems.

Please find below the details on populations served by Medicaid for Connecticut, Florida, Kansas and Rhode Island.

<table>
<thead>
<tr>
<th>Connecticut</th>
<th>Since 1981</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers</td>
<td>47,369</td>
</tr>
<tr>
<td>Members</td>
<td>734,000</td>
</tr>
<tr>
<td>Recipients</td>
<td>16,000</td>
</tr>
<tr>
<td>Claims</td>
<td>48,703,532</td>
</tr>
<tr>
<td>Managed care population</td>
<td>NA</td>
</tr>
<tr>
<td>Managed care capitations</td>
<td>NA</td>
</tr>
<tr>
<td>Encounters</td>
<td>NA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Florida</th>
<th>Since 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers</td>
<td>174,133</td>
</tr>
<tr>
<td>Members</td>
<td>4,195,105</td>
</tr>
<tr>
<td>Recipients</td>
<td>3500</td>
</tr>
<tr>
<td>Claims</td>
<td>58,677,661</td>
</tr>
<tr>
<td>Managed care population</td>
<td>3,775,944</td>
</tr>
<tr>
<td>Managed care capitations</td>
<td>$15,838,605,379</td>
</tr>
<tr>
<td>Encounters</td>
<td>124,871,130</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Kansas</th>
<th>Since 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers</td>
<td>27,000</td>
</tr>
<tr>
<td>Members</td>
<td>409,000</td>
</tr>
<tr>
<td>Claims</td>
<td>1,980,000</td>
</tr>
<tr>
<td>Managed care population</td>
<td>405,000</td>
</tr>
<tr>
<td>Managed care capitations</td>
<td>$1,860,000,000</td>
</tr>
<tr>
<td>Encounters</td>
<td>20,112,787</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rhode Island</th>
<th>Since 1992</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers</td>
<td>14,900</td>
</tr>
<tr>
<td>Members</td>
<td>279,954</td>
</tr>
<tr>
<td>Claims</td>
<td>5,073,558</td>
</tr>
<tr>
<td>Managed care population</td>
<td>242,243</td>
</tr>
<tr>
<td>Managed care capitations</td>
<td>$7,297,061</td>
</tr>
<tr>
<td>Encounters</td>
<td>8,776,455</td>
</tr>
</tbody>
</table>

Figure 1: Details on Populations Served by Medicaid

With respect to our experience in implementing EVV solution as primary contractor or partnering with product vendors, the following table shows relevant DXC Collaboration Examples.

<table>
<thead>
<tr>
<th>Client</th>
<th>Project</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Connecticut Department of Social Services</td>
<td>Add Electronic Visit and Verification (EVV) capability to the existing Medicaid Management Information System (MMIS) contract</td>
<td>DXC subcontracted a third-party service provider, Sandata Technologies, LLC. The EVV project began in November 2015 and began a pilot test in August of 2016 that included 116 agencies’ visit scheduling and 37 agencies’ claims submissions. As of June 16, 2017, 291 agencies, 36,000 recipients, and 58,718 caregivers have been entered into the system. More than 2 million visits have been logged and 1.5 million claims processed since September 1, 2016.</td>
</tr>
<tr>
<td>State of Florida Telephonic Home Health Services Delivery Monitoring and Verification Program</td>
<td>Implement the Telephonic Home Health Service Delivery Monitoring and Verification (DMV) Program</td>
<td>As a result of anti-fraud and abuse provisions included in SB 1986, FL AHCA (Florida Agency for Healthcare Administration) contracted with Sandata Technologies, LLC who in turn subcontracted DXC, to assist them in the implementation of the Telephonic</td>
</tr>
</tbody>
</table>
### Client Project Description

**Home Health Service Delivery Monitoring and Verification (DMV) Program.**

Using the Santrax Payor Management (SPM) system, the vendor addressed aberrant billing practices, potential fraud and the quality of recipient care in Medicaid home health care. The contract was signed on April 8, 2010, and the DMV project was successfully launched on July 1, 2010.

Recently Florida contracted with Tellus for EVV.

**Rhode Island Department of Human Services**

Executive Office of Health and Human Services (EOHHS) had contracted with Sandata Technologies, LLC, an outside vendor, to implement the Electronic Visit Verification (EVV) system for Home Care and Personal Care services. EOHHS was looking to implement telephony-based technology and GPS tracking to capture time and service information about home and community-based member visits.

DXC coordinated with Sandata/EVV to provide regularly scheduled batch fed data to be used by the EVV application to assist providers in scheduling and billing for Home Care and Personal Care services. The approach was to implement EVV in three phases.

- **Phase I** effort included creating a process to generate the Member Extract and the Prior Authorization Extract for Placeholder PAs dated 6/1/2016 – 12/31/2078. It also included a process to create a list of providers (Provider Type 072 – Personal Care Aide/Assistant) authorized to administer Home Care/Personal Care services.
- **Phase II** included modifications to the Authorization Extract file to eliminate the Placeholder PA process and generate Umbrella (shared) authorizations that include the actual data from the prior authorizations in MMIS.
- **Phase III** included modifications to the Member and Authorization Extracts files to include the BHDDH (Dept. of Behavioral Healthcare, Developmental Disabilities and Hospitals) program.

**Kansas Kansas Authenticare System**

FirstData supports the Kansas Authenticare system which is a claims billing system for the waiver services provided to beneficiaries on the Home and Community Based Services (HCBS) waivers.

DXC worked with FirstData to integrate their solution into our MMIS system. For Authenticare to bill these claims, DXC extracted beneficiaries (enrolled in HCBS), providers (enrolled in Waiver programs), and Plan of Care data for those services from the MMIS and send them through FTP on a daily basis. FirstData also has an electronic
### Client

<table>
<thead>
<tr>
<th>Alabama Medicaid Agency, Florida Agency for Health Care Administration, Nevada Department of Health and Human Services</th>
<th><strong>Project</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>System turnovers</td>
<td>Collaborated with 3&lt;sup&gt;rd&lt;/sup&gt; parties to make changes related to a CMS-directed move to modular systems. Specifically, DXC transitioned Electronic Visit Verification (EVV) to a 3&lt;sup&gt;rd&lt;/sup&gt; party service supplier in Alabama and Florida. In Nevada, we transitioned the data warehouse and decision support system (DSS) solution from DXC to Truven.</td>
</tr>
</tbody>
</table>

| California Department of Social Services In-Home Supportive Services Program | **Operational system upgrades** | Collaborated with OTech, the State data center, through monthly face-to-face meetings and weekly conference calls to improve infrastructure and environment maintenance |
| Pennsylvania Department of Public Welfare | **Electronic health record incentive program support** | Collaborated with the Center for Medicare and Medicaid Services, Pennsylvania Department of Public Welfare, and 12 additional states to implement the Medical Assistance Provider Incentive Repository (MAPIR) application simultaneously for the states in the first year of program availability |
| Wisconsin Division of Health Services, Division of Healthcare Access and Accountability | **Converted more that 37 million encounter claims** | Collaborated with 17 HMO providers to help them prepare to begin using the X12 HIPAA 837 transactions |

<table>
<thead>
<tr>
<th>Why DXC</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 50+ years delivering healthcare and life sciences IT services to payer, provider, government, and life science organizations</td>
</tr>
<tr>
<td>• DXC is the recognized industry leader in state and local government health care- with over 25 state and local industry awards in the past two years</td>
</tr>
<tr>
<td>• We are the Prime MMIS Contractor in 23 states, out of which 19 are in production. We are the fiscal agent in 15 of the 19 states in production while four of them are systems only.</td>
</tr>
<tr>
<td>• We were the first fiscal agent in the country to receive certification using the new CMS Medicaid Enterprise Certification Toolkit (MECT) and checklists for our Wisconsin customer.</td>
</tr>
<tr>
<td>• DXC received the National Governors Association 6th Annual Public-Private Partnership Award for the Medical Assistance Provider Incentive Repository (MAPIR) application</td>
</tr>
<tr>
<td>• We lead the industry in certifications</td>
</tr>
<tr>
<td>• ~19,000 IT professionals dedicated to supporting health and life sciences clients worldwide.</td>
</tr>
</tbody>
</table>
DXC Response to The Office of Systems Integration, December 13, 2017

- Market leader in clinical administration, electronic health records, population health management, claims management and regulatory transformation for life sciences.
- Largest installed base of most certified solution in Medicaid
- Proven success: 13 implementations on time, more than any MMIS competitor, based upon last client approved schedules

Global Scale

- 1.3 billion healthcare claims processed annually
- 671 million (60%) of Medicare Part A and B claims processed annually in DXC data centers
- 100 million electronic medical records maintained
- 24.5 million lives touched as the largest provider of Medicaid process management services
- 1 million users of software and integrated systems products
- 15,000 pharma product approvals supported
- 6 of the top 10 Fortune 500 healthcare companies are DXC clients
- 9 of the 11 Global Fortune 500 Pharma companies are DXC clients
- 7 of the 11 U.S. Fortune 500 Pharma companies are DXC clients
- 84%+ of top 50 global pharma companies use DXC regulatory transformation solutions

b. The vendor’s experience doing business with the State of California.

**DXC Response:**

Our current California business includes CMIPS (In-Home Supportive Services timesheets, payroll, and travel claim processing), DentiCal (dental Medicaid claims processing system and clerical functions), CalWIN (Medicaid eligibility for a subset of counties), SFIS (Statewide Finger imaging system), California Immunization Registry (CA IR) and CalHEERS (eligibility, enrollment, and retention system related to ACA). We have supported California Blue Cross/Blue Shield for several decades.

**California Experience at IHSS/CMIPS**

For 38+ years DXC has supported the In-Home Supportive Services program by developing and operating the Case Management Information and Payrolling System (CMIPS) in California. CMIPS II is a new web-based application with three main components: Case Management for more than 565,000 recipients residing within the state of California; payrolling for close to 480,000 providers who perform services for the recipient population including the tax fillings and W2 processing; and Timesheet Processing occurring daily for the provider population and resulting in more than 1 million timesheets being processed in a month. The CMIPS solution integrates three COTS packages designed and integrated by DXC to support Case Management, Payroll/Financials, and Reporting.

CMIPS II interfaces with several state entities within California including the State Controller’s Office (SCO), Department of Health Care Services (DHCS), Statewide Client Index (SCI), Employment Development Department (EDD) for tax filing and time sheet printing, Health Benefits Managers (HBMs), and Unions for dues deductions. The current contract is with the Office of Systems Integration (OSI) with the California Department of Social Services (CDSS) being the In-Home Supportive Service (IHSS) program sponsor. DXC has been a preferred contractor with the State and works closely with the 58 counties in California as the actual users for the CMIPS II application. DXC has been instrumental in several system redesigns and enhancements of CMIPS during the life of the program.
California Experience at CalWIN

The DXC/CalWIN (California Work Opportunity and Responsibility to Kids Information Network) relationship spans more than 30 years. The CalWIN counties rely on DXC to help them with some of their most important work. The CalWIN system is a modern technological solution for efficiently administering public assistance programs and providing quality services to California communities.

CalWIN is a client-based, online, real-time, automated eligibility determination, benefit calculation, and management system. It includes 26 core subsystems that administer many complex Federal, State, and county program rules and regulations. CalWIN includes automated interfaces with State and Federal agencies and partners to manage case and benefit information.

CalWIN automates program administration tasks so that counties can focus on helping clients. Counties use CalWIN to provide benefits such as CalWORKs/TANF, CalFresh, Medi-Cal, Refugee Cash Assistance, County Medical Service Program, Cash Assistance Program for Immigrants, In-Home Support Services, Foster Care, Kinship Guardianship Assistance Program, Cal-Learn, General Assistance/General Relief, and Employment Services programs for Welfare To Work, Child Care, CalFresh Employment and Training Program and other county-specific employment programs.

The CalWIN system is one of the largest human services public assistance administration systems in the United States, as illustrated by the following list of accomplishments.

- Manages 39 percent of caseloads in California
- Supports 30,000 users in 485 sites
- Provides benefits to 3.5 million Californians every month
- Processes 21 million online transactions daily with sub-second average response time
- Produces more than 3.7 million pieces of client correspondence per month in 14 languages

With DXC’s support, the CalWIN program has won numerous awards including these:

- 2006 USDA Food and Nutrition Award for successful completion of California Statewide Automated Welfare System (CalWIN)
- 2007 Best of California for best application serving multiple jurisdictions
- 2008 Center for Digital Government “Best Fit Integrator”
- 2010 Oracle Fusion Middleware Innovation Award
- 2011 Center for Digital Government “Best Fit Integrator” for Benefits CalWIN and Access
3 Additional Recommendations

Any additional recommendations that the vendor determines are relevant to EVV.

**DXC Response:**

Electronic Visit Verification can be an effective tool to verify the delivery of home health care services. However it is important to recognize that there is a difference between home health care and personal care services, both in the timing and duration of their delivery as well as the demographics of the person delivering them.

Home health care is typically provided based on a referral from a doctor or other health care provider. The person delivering the home health care is typically a person engaged in this as their profession. A regular schedule of visits and duties is determined and scheduled by the home health care agency, based on the orders of the referring entity. Integrating Electronic Visit Verification into the delivery of home health care is fairly straightforward.

Personal care services, especially those provided for by the IHSS program, are intended to provide support to an individual to allow them to remain in their home, with a degree of independence. The services are needed in short segments, separated by periods of break, before services are needed again. For example, one might require personal care services to help them out of bed in the morning, to help them toilet, to help them get dressed, and to prepare a meal for them. These are all individual activities, which are relatively brief, however they are performed over a period of perhaps 60 to 90 minutes. Integrating Electronic Visit Verification in real time and for each service into this delivery pattern will be challenging, and the time spent recording the visits and activities must be manageable.

The person delivering personal care services in the IHSS program is not typically a person who does this as a profession. It is far more commonly a family member of the person receiving services. The personal relationship between this provider and their family member recipient creates an environment where the provider isn’t necessarily viewing this in the detached, professional way a health care provider might. They are focused on caring for their loved one, and providing whatever assistance is needed, often beyond that which is authorized by the IHSS program. Integrating Electronic Visit Verification into the daily activities of these providers will be challenging. An extended timeframe for outreach and training may be required as both the changes coming due to EVV as well as a reinforcement of their role as an IHSS provider must be addressed.

Home health care is prescribed and provided prospectively. In treating a condition or problem, the health care professional determines what services need to be provided at home, a provider is located, and services begin. With IHSS, by virtue of the rules regarding Medi-Cal eligibility, a recipient has often been receiving care prior to ever being approved for IHSS. Once approved for IHSS, the care which has been provided in the past is often compensable. For ongoing cases, a recipient’s condition may deteriorate, and their provider may need to perform additional services. This change in condition may result in the recipient’s IHSS authorization being increased retroactively, and again the care which has been provided in the past may be compensable. In both of these situations, EVV was not possible at the time services were provided, as they weren’t actually authorized services, or even eligible recipients and providers, at the time services were rendered.

This only touches on the challenges to be overcome implementing Electronic Visit Verification for the IHSS program. Because of these, and many others, we don’t believe the best solution is a standalone commercial EVV system. In order to be effective, easy to use, minimally burdensome, and flexible, an EVV system for the IHSS program needs to specifically meet the program’s rules, participants and unique characteristics. These requirements, we believe, are well beyond the configurability of existing COTS and SaaS Solutions. However, we believe the appropriate solution may include integrated use of some aspects of existing EVV software available on the market.
4 Attachment A - CMIPS RFI #32236 Questions

1. Describe how your company delivers this type of electronic verification solution or service in similar Medicare and Medicaid settings, or other similar health care settings for consumer directed personal care and/or home care service delivery. Include a description of the population characteristics of individuals currently served by your system(s) and include the number of members.

**DXC Response:**

DXC has provided below a case study which showcases our in depth experience in implementing EVV Solution at the Connecticut Department of Social Services.

**The Connecticut Department of Social Services (DSS)**

The Connecticut Department of Social Services (DSS) in 2015 opted to add Electronic Visit and Verification (EVV) capability to the existing Medicaid Management Information System (MMIS) contract. DSS wanted to support the interests of individuals receiving services at home instead of in a long-term care facility, reduce the burdens associated with manual timesheets, and document services received. DSS also wanted to ensure accountability for paying only for services actually provided and to comply with a 2019 federal requirement for using an EVV system, as well as further the interests of the administration, the legislature, and the taxpaying public.

Due to the fact that the Agency Provider model was used in Connecticut, to support the DSS decision, DXC subcontracted with a 3rd party service provider, Sandata Technologies, LLC. The EVV project began in November 2015 and began a pilot test in August of 2016 that included 116 agencies’ visit scheduling and 37 agencies’ claims submissions. This was followed by a non-mandatory use period for caregivers providing assistance with daily living. January 2017 marked the beginning of mandatory use for those caregivers, followed in May by mandatory use for skilled caregivers, such as nurses. As of June 16, 2017, 291 agencies, 36,000 recipients, and 58,718 caregivers had been entered into the system. More than 2 million visits have been logged and 1.5 million claims processed since September 1, 2016.

The Connecticut EVV System is a telephonic and computer-based in-home visit scheduling, tracking, and billing system that documents the precise time and type of care provided by caregivers at the point of care. The system incorporates a caregiver-enabled smartphone application, a small in-home device, and a telephone-based tracking program. System functions include the following:

- Electronic visit verification to track time and tasks
- Provider EVV Web access for viewing and managing Home & Community Based Services (HCBS)
  - Provider scheduling module for scheduling visits based on authorized services
  - Provider billing module to validate HCBS claims prior to submission
- Jurisdictional view to allow DSS to view and report on the HCBS activity

Provider EVV benefits include the list that follows:

- The tool is free
- Providers receive alerts when a care plan changes
- Claim submission is simple, and the related billing accuracy reduces the risk of failed audits and payment delay
- Electronic billing results in faster payment than the paper claims submission process
- Providers have the ability to fix visit data if necessary, such as if they forget to check in

DXC has integrated the EVV with DXC systems to seamlessly support business processes with client and authorization data. System access is defined through roles, based on DSS security rules. Referrals, authorizations, and billing are managed electronically.
Prior to submission for payment, the EVV system validates claims for the right client, authorized services, right caregiver type, and verified visit data. EVV check in and check out determine visit duration for a claim. The system also accommodates 837 formatting.

As a result of implementing EVV, late and missed visit occurrence have been reduced. Also, caregivers are able to report client condition changes, such as a fall, a change in mental status, skin condition changes, change in informal support, or refusal of service. Moreover, DSS projects annual savings of 5 to 10 percent of Medicaid expenditures for home care services, estimated at $8 to 15 million per year, as a result of removing fraud, waste, and abuse.

2. Provide a detailed description of the EVV System:
   a. Functionality of the system including the devices, methods of data collection, technology and infrastructure requirements for both individuals receiving services (Recipients) and service providers (Providers), (e.g., land-line telephones, cell phones, in-home fixed device, tablet, internet, GPS).

 DXC Response:

Depending on how the State intends to write the RFP towards the existing processes used in California or whether it would move to a more rigid interpretation of the Federal act could differ substantially in how the end solution would come together. DXC is prepared in either case to meet the need based on our experience. We have spoken already about how we have implemented in Connecticut a more rigid interpretation of the Federal act. However, in working with the Federal Government as to how this might be interpreted for California’s needs, another approach is also available. Another EVV solution approach for the Individual Provider population is comprised of multiple options and components in order to meet the specific requirements of California’s diverse population of IHSS participants:

- A native app for mobile devices with the capability to have real-time interface with CMIPS as well as work in offline mode. This will satisfy the store-forward requirement for areas with no data coverage.
- Electronic Timesheets System (ETS) would be enhanced to allow the users to make corrections to data transmitted by the TTS as well as the native app.
- TTS (Telephonic Timesheet System) to check-in, check-out and approve timesheets by recipients. This solution meets the requirement for people who are unwilling/unable to use a computer (or mobile devices), or live in areas without access to the internet.
- Paper timesheets are enhanced to include the EVV data elements and would be available but only allowed on an exception basis upon approval of the State based on the recommendation of the County to cover for circumstances in which an electronic or telephonic system cannot be used to report timesheets.

We will present the State with how these different options and components come together for a comprehensive solution that serves California’s IHSS population in our response to the EVV RFP. We expect the EVV RFP will include more specific requirements based on the State’s interpretation of the Federal act. Our response to the RFP will include business and technical architecture diagrams, visually depicting how these options and components work together, and with the existing investments in CMIPS.

The table on the following page summarizes the devices, methods of data collection, technology and infrastructure requirements for both Recipients and Providers:
Table 2: Summary of the Devices, Data Collection Method, Technology and Infrastructure Requirements

<table>
<thead>
<tr>
<th>No.</th>
<th>Devices</th>
<th>Data Collection Method</th>
<th>Technology Requirements</th>
<th>Intended Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Land-line telephone</td>
<td>Timesheet data submission: Voice, telephone keypad is used to check-in and checkout and specify service type. Caller-ID is used to match against the recipient's phone number on record to establish the location</td>
<td>Current CMIPS TTS is enhanced (Leveraged service based on Avaya IVR)</td>
<td>Providers</td>
</tr>
<tr>
<td>2</td>
<td>Land-line telephone</td>
<td>Timesheet data approval: Voice, telephone keypad is used to approve/reject timesheet</td>
<td>Current CMIPS TTS is enhanced</td>
<td>Recipients</td>
</tr>
<tr>
<td>3</td>
<td>Smart Phone, Tablet</td>
<td>Timesheet data submission: GPS-based location tagging, date/timestamped check-in/checkout, real-time access to CMIPS (where there is internet access), and store and forward data collection for areas with no coverage</td>
<td>Android or iOS based mobile device, native EVV app invoking CMIPS APIs using enhanced ETS APIs</td>
<td>Providers, Recipients (this option is not recommended for live-in providers)</td>
</tr>
<tr>
<td>4</td>
<td>Laptop/Desk top</td>
<td>Timesheet data submission: IP-based location tagging, date/timestamped check-in/checkout, real-time access to CMIPS (where there is internet access)</td>
<td>Website accessed through a browser</td>
<td>Providers, Recipients</td>
</tr>
<tr>
<td>5</td>
<td>Smart Phone, Tablet, Laptop/Desk top</td>
<td>Data Correction: ETS application is enhanced to display timesheet data submitted via the EVV app and the TTS, and to allow corrections</td>
<td>IHSS Portal hosted at the IBM cloud and OTech (existing)</td>
<td>Providers</td>
</tr>
<tr>
<td>6</td>
<td>Existing Paper Timesheets scanned and fed into CMIPS</td>
<td>Timesheet data submission: Current timesheets are modified to include location, service categories, and date/timestamps for population unable to use the electronic data collection methods</td>
<td>Current TPF technology</td>
<td>Providers, Recipients</td>
</tr>
</tbody>
</table>

The proposed EVV solution for the Agency Provider population is based on leveraging existing EVV services offered by vendors specializing in this domain. DXC has partnered with such vendors in implementing EVV solutions in other States [Connecticut, Alabama, Florida, and Georgia]. Such services offer a better fit for Agency Providers and can be offered to California's Agency Provider population with little or no need for customization for the IHSS program.

b. Describe how your EVV solution could meet challenges inherent to California. Include challenges specific to the large volume of Recipients and Providers and how to address the fact that approximately half of IHSS and WPCS Providers are family members and/or live in the household with the Recipient.

DXC Response:

Our proposed solution is based on providing multiple options for IHSS participants. Our experience from the Blind and Visually Impaired (BVI) project shows that the “one size fits all” approach would fail due to the diversity of Provider and recipients’ profile. For example:
Different levels of technology literacy,
Different levels of physical and mental capability, and
Large and different geographical area such as very large metropolitan areas as well as rural areas where there is no access to the internet and spotty access to telephone lines.

Below table is a summary of the challenges inherent to California and how our proposed approach addresses them:

**Table 3: Summary of the Challenges and DXC’s Approach to Mitigate**

<table>
<thead>
<tr>
<th>No.</th>
<th>Challenges Inherent to California</th>
<th>How EVV Solution Meets the Challenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Large volume of Recipients and Provider</td>
<td>The DXC solution is scalable to large number of users due to usage of scalable cloud technology as well as usage of personal mobile devices already in the hands of Providers and Recipients</td>
</tr>
<tr>
<td>2</td>
<td>Approximately half of IHSS and WPCS Providers are family members and/or live in the household with the Recipient. Because they live with the recipient and deliver services in small amounts over the course of the day, check-in and clock out many times during the day would impact the recipient and become too burdensome for the Provider.</td>
<td>Our proposed solution recommends allowance for either real time or retroactive entering of EVV data elements for live-in Providers. For example, the live-in Provider may be allowed to enter the EVV data into a native phone app real time or a website at the end of the day (or week, or pay period depending on the business decision) based on their recollection of the time, duration, and service type he/she provided and when doing such data entry is not impacting the quality of care for the Recipient or burdensome to the Provider.</td>
</tr>
<tr>
<td>3</td>
<td>Different levels of access to and ability to use technology</td>
<td>DXC’s proposal is based on utilizing multiple options, including using paper timesheets which would be usable (as it is today) for those IHSS participants with limited access to and literacy of technology</td>
</tr>
<tr>
<td>4</td>
<td>California is a large state with many areas without access to the internet</td>
<td>DXC’s solution allows for capturing the data in areas with no access to the internet (temporarily storing it in the device), and transmitting it to CMIPS when access to CMIPS is established (i.e. “store and forward” approach). In addition, the State may choose to allow the continuation of Paper timesheets (modified to capture the EVV data elements) in such areas.</td>
</tr>
</tbody>
</table>

c. **Security features of the system that confirms the identity of both the Providers and Recipients and how that data is kept secure.**

**DXC Response:**

DXC’s proposal is leveraging the current proven security architecture implemented for the IHSS Portal. The current solution may be further extended to include the following:

- Usage of biometric identifier (such as device finger print, face and iris recognition) as part of a two-factor authentication (the user would have to provide two means of identification) are becoming more established and may be used as optional enhancements. Capturing the Recipient and Provider’s unique personal characteristics such as profile picture and fingerprint can be implemented with the introduction of mobile case management allowing the case worker to capture this data as part of the normal eligibility verification process at the Recipient’s home.
The data architecture will be following the current guiding principle to limit the data stored outside the boundaries of the State data center, especially PHI and PII related data which are not be stored in the public cloud. Similarly, sensitive data will not be stored in the mobile device when it is operating in online mode (i.e. internet access is available CMIPS is up and running). For situations when the real-time access to CMIPS is not possible, EVV data is captured and stored in the device after being encrypted. Such data is deleted from the mobile device after successful communication with CMIPS is reestablished.

- All data in transit and at rest will be encrypted.
- Our proposed solution will be fully compliant with the requirements of HIPAA privacy and security law.

**d. Data collection, including information identified in this RFI Section 5 Proposed Environment.**

**DXC Response:**

The following table describes our proposed approach to data collection based on section 5 of the RFI:

<table>
<thead>
<tr>
<th>No.</th>
<th>RFI Section 5 Proposed Environment</th>
<th>DXC’s Solution</th>
</tr>
</thead>
</table>
| 1   | Capture all data elements necessary to verify a visit:  
      - The date of service  
      - The start and end times of the service  
      - The type of service performed  
      - The individual receiving the service  
      - The individual providing the services  
      - Location of the service delivery | Yes. DXC’s proposed solutions (native app on mobile device, enhanced ETS application, enhanced telephonic timesheet system, enhanced paper timesheet) will be capturing all these data elements. We are assuming the current 25 IHSS service types will be consolidated into a smaller group of service categories to allow for faster data capture. Similar to today’s ETS application design, the name of the Recipient receiving the service is either defaulted (i.e. when the Provider is providing service to only one Recipient), or the list of Recipients for whom the Provider is working is displayed as a drop down. Hence, searching for the Recipient's name is not necessary. This feature makes the app easy to use and is made possible by using real time interface to CMIPS which holds the master database establishing Provider-Recipient relationships. |
<p>| 2   | Track time in hours and minutes | Yes. Consistent with how the existing IHSS paper and electronic timesheets are capturing time in hours and minutes |
| 3   | Track other types of information such as paid time off, sick leave, and travel time between Recipients | Yes. The proposed enhancements to the above mentioned solutions can include the capturing of “other” types of paid time. However, processing the time captured for these purposes will also require changes to the CMIPS case management and payroll systems and could be implemented as separate but related projects. |
| 4   | Be minimally burdensome per section 12006 of Public Law 114-255 | Yes, the key to being minimally burdensome is having a short list of service types (see the answer to question #3) and the timing of EVV data element data capture. While it would be easy for a professional individual Provider who owns a smart phone with internet access to simply tap in to start the start and end times, the same is not true for a live-in Provider who provides many different services throughout the day, some overlapping with other services and taking short amounts of time. For the live-in Providers, it is easier to enter their time at a quiet time after the |</p>
<table>
<thead>
<tr>
<th>No.</th>
<th>RFI Section 5 Proposed Environment</th>
<th>DXC’s Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Be user friendly with basic literacy levels</td>
<td>Yes, Enhanced paper timesheets will allow the simplest form of data capture for users with limited literacy and technology skills. The TTS system is designed for using audio and does not require literacy. The new EVV native app and the enhanced ETS application are designed to be super easy to use.</td>
</tr>
<tr>
<td>6</td>
<td>Be accessible to individuals with disabilities</td>
<td>Yes. Similar to the ETS application which is ADA compliant, the new native app and the enhanced ETS, TTS, and enhanced paper timesheets will be usable by people with disabilities (e.g. screen readable, large fonts, audio-based for the BVI community)</td>
</tr>
</tbody>
</table>
| 7   | Accommodate multiple programs with varying lists of services:  
- Permit Recipients to be linked to multiple programs and Providers.  
- Permit Providers to be linked to multiple programs and Recipients | Yes, the list of services can be dynamically generated based on the program. For example, if a Provider is providing services to multiple Recipients belonging to different programs (e.g. IHSS and WPCS), the list of services shown will be appropriate for the program to which the Recipient belongs. |
<p>| 8   | Allow for review and signature/approval of both the Provider and Recipient | Yes. Similar to today's ETS application, the enhanced EVV solutions will continue to provide the capability to review and approve the data captured by both Providers and Recipients. In addition, timesheet corrections made at the enhanced ETS application would be subject to the Recipient’s approval before they be processed for payment. |
| 9   | Allow for submission of daily hours for payment (&quot;timesheet&quot;) | Yes. The EVV solutions will allow for submission of hours on demand. The time captured for each service type (or category) given throughout the day will be totaled for each day. |
| 10  | Provide multiple devices/methods for Provider check in/out | Yes. Please see the answer to question 2.a for a list of devices and the functionality they support. |
| 11  | Allow Providers to modify or “fix” information (e.g., if they forget to check in/out) | Yes. Please see the answer to question 2.a, row #5 in the table. Also, please see the answer to section 2.e. |
| 12  | Provide real time prompts in multiple languages(e.g., a Provider enters time worked that exceeds the weekly maximum time allowed and the system prompts them with a notification that the entry they are making exceeds the weekly maximum) | Yes. Our proposed solution is based on having real time interfaces with the Case Management system which we have already implemented for the ETS application. The ETS interface architecture to CMIPS allows for leveraging the same set of interfaces for multiple data capture methods (&quot;presentation layers&quot;) including a mobile app, the enhanced ETS application, and the TTS telephonic solution (IVR system). |
| 13  | Provide alerts (e.g., when a Recipient hasn’t received services for specified time periods) | Yes. Our proposed solution will leverage the alert mechanisms built for ETS (via emails) and TTS (via outbound phone calls). In addition, the native app will have the capability to push notifications to the device based on business rules. Furthermore, tasks can be |</p>
<table>
<thead>
<tr>
<th>No.</th>
<th>RFI Section 5 Proposed Environment</th>
<th>DXC’s Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>added to the case management system alerting the case worker if EVV data has not been received for a configurable amount of time (depending on the method of EVV data capture and the Recipient’s condition). The case worker can then decide to make a call or pay a visit to the Recipient to investigate the reason.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Create a file and interface with the current CMIPS system and Regional Center Provider system, including payroll and IHSS Portal or offer another solution in lieu of interfacing with the CMIPS</td>
<td>Yes. The EVV vendors’ solution used for the Agency Provider population will be able to produce a batch interface file which can be used to input the captured, corrected, and validated data into CMIPS.</td>
</tr>
<tr>
<td>15</td>
<td>Track status of timesheet payment processing</td>
<td>Yes. Similar to today's ETS application, the status of the timesheet payment processing will be sent to the users via email and can also be sent through text messages. In addition, the EVV app will have the configurable feature to push notifications to the mobile device as the status of payment processing at CMIPS changes.</td>
</tr>
<tr>
<td>16</td>
<td>Produce reports of all information captured</td>
<td>Yes. The proposed solution will leverage the existing CMIPS reporting architecture which can be enhanced to include the new EVV data elements.</td>
</tr>
<tr>
<td>17</td>
<td>Flexible system that easily accommodates policy change</td>
<td>Yes. The proposed solution is architected based on leveraging the existing micro services to view/update/submit timesheet data and execute the related business rules already in use for the case management and payroll applications. This allows us to keep maintenance costs down by not replicating the logic in multiple places, having real-time access to functionality and the CMIPS master data.</td>
</tr>
</tbody>
</table>

**e. Features that address the requirement that allows Providers to modify or “fix” information (i.e., if they forget to check in/out).**

**DXC Response:**

We understand that there will be situations in which the Provider may forget to check-in or check-out the beginning or the end of the service period. Such situations are more likely during the EVV’s initial rollout period as the Providers go through the learning experience. Furthermore, the Provider may have inadvertently entered incorrect information which he/she might want to revise before submitting. Hence, there may be a need for a mechanism to update/correct the timesheet information.

In our proposed solution, the provider is first notified (via email, text, or phone calls) about gaps or potential inaccuracies in the data captured, either through the native app, the TTS, or the paper timesheet (assuming the Provider has an electronic means of being contacted). The Provider will be asked to log into the enhanced ETS application to review the list of gaps (items requiring correction) and apply the required updates. The enhanced ETS application will validate the data by executing CMIPS business rules so that only validated data is submitted for payroll processing. A few examples of validation rules may include:

- For each service provided, the date of the service must be within the pay period belonging to the timesheet being prepared.
For each service provided, there needs to be start and end times. The end times must be after start times. The duration of the service cannot be less than X minutes or more than Y hours (X and Y would be configurable values and could be different for each service type).

- The location data must be within the geographical boundaries of the Recipient’s county of residence, or some other boundary criteria as appropriate.

- The total time entered for each week or pay period must adhere to overtime violation rules.

**f. Features that conform to the concept of being minimally burdensome.**

**DXC Response:**

The concept of “being minimally burdensome” must be evaluated within the context of different communities of Providers and Recipients. California’s IHSS program serves a very diverse community of participants who cover a broad spectrum of ages, ethnicities, languages, abilities, familial and professional relationships, literacy levels, and familiarity with technology. What may be considered burdensome to one Provider or Recipient may be quite acceptable to another. Hence, it is important to offer a variety of solutions and capabilities that are appropriate and least burdensome to the respective target user groups.

The DXC response calls for initially keeping the paper timesheet option, after it is enhanced to capture the additional required data elements for EVV (location, date and timestamp, and service type). This “low tech” option, is the least burdensome to those Providers and Recipients who are unable to use an electronic-based solution due to where they live (i.e. no access to the internet), or their inability to use a computer or smart phone.

In addition, DXC proposes using a solution for Providers who live with their Recipients that allows them to enter the timesheet data retroactively when data entry is not impeding their ability to take care of the Recipient. Policy rules may be established to ensure the timing of data entry is close to the time the service was rendered in order to increase the accuracy of the data entered. Retroactive data entry for this group of Providers and Recipients is required in order to be minimally burdensome. Capturing all the required data elements in real time when there are many service types, each lasting a short period of time, would interrupt the service, impacting the Recipient’s quality of care and be burdensome to the Provider.

For Providers and Recipients who live within areas with reliable access to the internet, and do not live together, the native app can be used to electronically capture the location coordinates and the start and finish timestamps when the Provider arrives and leaves the location of the service (which may or may not be the Recipient’s home). The Provider may then retroactively log into the enhanced ETS application to augment the data transmitted by the native app including the service types and the start/end time of each service.

**g. Features of the system that conform to the Americans with Disabilities Act (ADA) and address needs of special populations of Providers and Recipients, such as developmental disabilities and visual/hearing disabled.**

**DXC Response:**

As mentioned in the answer to item 2.d, row #6 in the table, similar to the ETS application which is ADA compliant, the new native app and the enhanced ETS, TTS, and paper timesheets will be usable by people with disabilities. The following table describes how each solution component will be conforming to the ADA requirements:
Table 5: How EVV Solution conforms to ADA requirements

<table>
<thead>
<tr>
<th>No.</th>
<th>EVV Solution Component</th>
<th>How EVV Solution conforms to ADA requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Land-line telephone</td>
<td>California Telephone Access Program (CTAP) provides free specialized phones and accessories for mobile phone to all qualified Californians. These devices make it easier to hear, dial, and call. This program is offered by the California Public Utilities Commission. See <a href="http://www.californiaphones.org/">http://www.californiaphones.org/</a> for more details.</td>
</tr>
<tr>
<td>2</td>
<td>Smart Phone, Tablet, Laptop/Desktop</td>
<td>The application will be compliant with screen readers and will leverage the device’s capabilities to use large fonts</td>
</tr>
<tr>
<td>3</td>
<td>Enhanced Paper Timesheets</td>
<td>Existing large font paper timesheets will also be enhanced to include the EVV data elements</td>
</tr>
</tbody>
</table>

h. Features of the system that address the needs of special populations that cannot be near electronic devices.

**DXC Response:**

As discussed in answers to question 2b, rows numbers 3 and 4, the paper timesheets can be enhanced to capture the new EVV data elements. The usage of the paper timesheets must be approved on an exception basis and with the approval of the case worker.

In addition, at least a portion of the special population who cannot be near electronic devices can be near a telephone line and hence can use the enhanced TTS to submit and approve the timesheet data. Caller-ID can be used to match against the recipient’s phone number on record to establish the location where the service was rendered.

i. Features of the system that address the provision of EVV in rural areas where technology infrastructure may be limited or unavailable.

**DXC Response:**

The EVV solution for IHSS participants living in rural areas where technology infrastructure may be limited or unavailable is the same solution described in the answer to question 2.h which addresses the needs of special populations that cannot be near electronic devices.

j. Additional features the system offers outside of EVV.

**DXC Response:**

In addition to the basic EVV functionality, the proposed solution can bundle in functionality for the following IHSS requirements:

- Capturing and submitting paid Sick Leave
- Capturing and submitting Travel Time

k. Service level metrics including system availability and system capacity.

**DXC Response:**

The proposed solution will leverage the existing CMIPS system monitoring and reporting capabilities. The current IHSS Portal is available 24 by 7 except for approved and planned maintenance windows.
DXC Response to The Office of Systems Integration, December 13, 2017

I. Contingency plans for system outages or unavailability.

**DXC Response:**

The proposed solution will leverage the existing disaster recovery and redundancy solutions in place for the IHSS Portal and the CMIPS as a whole. The IHSS Portal is hosted on the IBM Cloud which takes advantage of virtual infrastructure, capable of falling back to an alternate data center during an unplanned outage.

m. Flexibility of the system to implement changes and how quickly changes can be made. Describe how the system has built in flexibility such as the ability to meet business needs or make changes through simple configuration set up and/or configuration changes.

**DXC Response:**

The proposed solution will leverage the existing flexible and proven architecture of the IHSS Portal where changes can be delivered quickly using Agile methodology. The interfaces to CMIPS data and services are highly reusable by multiple entry points including the enhanced ETS application, the EVV native app, the TTS, and potentially 3rd party EVV service providers utilized for Agency Providers.

n. Types of analytics and reporting provided.

**DXC Response:**

Enhanced analytics of the data collected can provide insights into:

- Which service types are being rendered the most? How can they be improved for the recipient?
- How can the Provider training and outreach programs take advantage of service utilization statistics and trends?
- Correlation between Service type and service location: What kind of services are being rendered inside and outside the Recipient’s home?
- How can Travel Time be reduced by matching Providers to Recipients who are located in close proximity of each other?
- Improved fraud detection: Are location and timing of the services reasonable or suspicious (e.g. bathing services rendered away from the Recipient’s home at unusual times may be an indication of inaccurate or fraudulent data.)

The analytics solution used for EVV can be part of a more over-arching analytics solution for IHSS. While such a solution is outside of the scope of the EVV project, the EVV analytics solution must be extendable enough to encompass the larger IHSS analytics requirement. For example, a new timesheet data mart can be created upon which ad-hoc and predefined reports are produced. These reports can be generated using the existing CMIPS tools (SAP’s Webi and Crystal Reports) leveraging existing investments in software licenses and infrastructure.

o. Typical account set up time and check in/out time for Providers and Recipients.

**DXC Response:**

For those Providers and Recipients who have already switched to using the Electronic Timesheets application, no additional setup time is required. Depending on how granular the tracking of service types must be, the check in/out times will vary. The fewer the service types, the easier the check in/out times.

Let’s take an example for a typical visit:

- Background:
  - Provider lives in an area with cell coverage and owns a smart phone
  - Provider does not live with the Recipient
3. Describe if/how the system groups or categorizes tasks to simplify system operation, tracking, Provider and Recipient use, etc.

DXC Response:

Tracking the services provided is an important part of the Electronic Visit Verification process, both to verify that the proper services are being provided as well as to gather useful information about the needs and current condition of the recipient. However, the accuracy of the data collected can be impacted by the degree of difficulty involved in providing it.

We understand that IHSS provides for 25 different services a recipient may be eligible to receive. Although most recipients are only authorized for a subset of these services, expecting a provider to account for time spent delivering this many different services will invariably result in inaccurate data due to factors such as approximating or estimating. If the data isn’t accurate, or reasonably accurate, reliable decisions cannot be made using the data.

Working with the State, we propose grouping the services in meaningful categories that both serve the needs of the State and facilitate relatively easy entry by the provider.

The services available through IHSS can be seen below.

- Domestic Service
- Preparation of Meals
- Meal Clean-up
- Laundry
- Shopping for Food
- Other Shopping & Errands
- Respiration
- Bowel & Bladder Care
- Feeding
- Routine Bed Bath

- Dressing
- Menstrual Care
- Ambulation
- Transfer
- Bathing, Oral Hygiene, Grooming
- Rubbing Skin, Repositioning
- Care and Assistance with Prosthesis

- Accompaniment to Medical Appointment
- Accompaniment to Alternative Resources
- Protective Supervision
- Paramedical Services
- Heavy Cleaning
- Yard Hazard Abatement
- Removal of Snow, Ice
- Teaching and Demonstration

These services represent a range of categories including domestic and related, personal care, accompaniment, paramedical and protective supervision.
One way these could be categorized would be to group them into those logical categories:

- **Domestic & Related**
  - Domestic Service
  - Preparation of Meals
  - Meal Clean-up
  - Laundry
  - Shopping for Food
  - Other Shopping & Errands
  - Heavy Cleaning
  - Yard Hazard Abatement
  - Removal of Snow, Ice
  - Teaching and Demonstration

- **Personal Care Services**
  - Respiration
  - Bowel & Bladder Care
  - Feeding
  - Routine Bed Bath
  - Dressing
  - Menstrual Care
  - Ambulation
  - Transfer
  - Bathing, Oral Hygiene, Grooming
  - Rubbing Skin, Repositioning
  - Care and Assistance with Prosthesis

- **Accompaniment Services**
  - Accompaniment to Medical Appointment
  - Accompaniment to Alternative Resources

- **Protective Supervision Services**
  - Protective Supervision

- **Paramedical Services**
  - Paramedical Services

This categorization would allow a provider to associate their time spent into one of five categories, simplifying the tracking and entry. At the same time, this categorization allows the State to gain insight into the condition of the recipient (are they utilizing more personal care services than anticipated) or to identify potential situations of danger (are they not receiving paramedical services that have been authorized).

Another characteristic of this type of classification is that certain categories are expected to be delivered in locations other than the recipient’s home. For example, a provider reporting a visit that included Accompaniment to Medical Resources wouldn’t necessarily report the end of that visit at the recipient’s home.

While that is one way of grouping tasks, others are possible as well, and provide other benefits.

For example, task could be grouped based on the frequency with which they are typically provided; Routine Tasks, Infrequent Tasks, etc.

- **Routine Tasks**
  - Preparation of Meals
  - Meal Clean-up
- Respiration
- Bowel & Bladder Care
- Feeding
- Routine Bed Bath
- Dressing
- Ambulation
- Transfer
- Bathing, Oral Hygiene, Grooming
- Rubbing Skin, Repositioning
- Care and Assistance with Prosthesis
- Protective Supervision
- Paramedical Services

- **Infrequent Tasks**
  - Domestic Service
  - Laundry
  - Shopping for Food
  - Other Shopping & Errands
  - Heavy Cleaning
  - Yard Hazard Abatement
  - Removal of Snow, Ice
  - Teaching and Demonstration
  - Accompaniment to Medical Appointment
  - Accompaniment to Alternative Resources
  - Menstrual Care

While this type of grouping may be easier for a provider to manage, it provides little analytical value to the State.

Another way to group tasks which may provide more analytical or research value would be to group tasks into Activities of Daily Living, such as bathing or dressing, and Instrumental Activities of Daily Living, such as meal preparation & shopping for food. While this grouping might facilitate epidemiological studies of the IHSS population, understanding and accurately applying this classification system may be difficult for the providers and recipients to master.

Since the need for IHSS services is assessed on a task by task basis, and the authorization of hours is made both at the task level as well as calculated into an overall monthly authorization, implementing EVV allows for additional management and oversight of this authorization. The State should consider whether functionality is needed, or even desirable, to either alert providers when they are performing more hours of one type of service than has been authorized, or to prevent them from doing it.

Regardless of how the State chooses to classify IHSS tasks, since the proposed EVV solution is a combination of custom (for Individual Providers) and EVV vendor services (for Agency Providers), it can be built to support the chosen categorizations.

4. **Describe the system’s capability to interface with other systems, for eligibility, timekeeping, payroll or data collection purposes.**

DXC Response:

The new EVV system will communicate in real-time with Cúram Case Management through the Business Process Manager (BPM) interface component to access information related to eligibility, timekeeping, and payroll or data collection for IHSS and WPCS programs. To accomplish this, the following will occur.
The EVV system will be hosted in cloud similar to IHSS website. This application will be invoking REST APIs to the back-end for eligibility and payroll/timesheet related business rules in the Case Management application.

**Connectivity Layer (Secure Gateway):** This layer will utilize the Bluemix service “Secure Gateway” which provides for secure communication between Bluemix and the Back-end component (CMIPS hosted at OTech data center).

**Business Process Manager:** This component is the gateway and entry point into CMIPS for transactions initiated from external interfaces, including EVV. BPM will receive the EVV transactions and pass-through the transactions to Cúram application servers.

5. Describe your experience with implementing EVV systems including high-level timelines for implementation and training for all user populations. Describe implementation challenges and lessons-learned. Describe how to overcome implementation challenges. Distinguish implementation(s) for government entities versus private entities. If implemented for state entities, please identify which states and provide contact information.

**DXC Response:**

As previously mentioned DXC implemented EVV in Connecticut and Rhode Island and from these implementations a comprehensive analysis of implementation challenges and successes were identified. The lessons learned included the need for early engagement of the stakeholders and an opportunity for those stakeholders to be involved throughout the process as functionality is developed, and improvements identified.

They also found that there was an underlying need for a strong communication cadence that included responding to questions and supporting escalations; some stakeholders will always work outside of the process, and it’s important that they are looped back in quickly, to avoid falling through the cracks. The States also shared that you can never do enough training, and that training should be mandated, but also flexible enough to accommodate individuals who are unfamiliar with the technology and may need one on one instruction.

One final recommendation was for the early development of a business continuity plan, in advance of the implementation.

Taking these into consideration, and augmenting with our prior CMIPS II implementation experiences we believe that introducing an EVV system that is dependent upon wholesale changes in how Providers and Recipients interact with the system will generate several challenges for the State, as described in the response to Questions 2b and 6.

These challenges can be mitigated through execution of a comprehensive and strategic approach to change management and a fluid implementation plan that allows waves to be defined based upon geography, language, functionality, or a combination thereof. The implementation plan should assume that a certain percentage of the population will use an enhanced paper timesheet and require program education, and not training on a web or mobile tool. The plan should also assume that individuals may opt to use both mobile and web based verification, or land telephone lines (TTS), either together or interchangeably, and training should be flexible enough to accommodate this. The implementation plan should be centered on readily assessable and comprehensive outreach and a training process that introduces change through a series of communications that are progressively increasing in detail.

Communications should be available in most popular languages (not just the four threshold languages of English, Spanish, Armenian, and Chinese), and offered through multiple avenues including in-person, web-based and written materials. The flow of communication, while progressive in detail, should be accessible on an ongoing basis, and leveraged for refresher training and on-going stakeholder use, as they support new recipients or providers entering the program.

In addition to direct outreach and training to Providers and Recipients, Counties and other stakeholders, such as partner agencies, labor unions and advocacy groups should be included from the start so that they can support
the overall training process. We recommend a series of train the trainer sessions and webinars targeted to these specific audiences and their needs. Content for all outreach and training will be owned by the State so that consistency from County to County, and Stakeholder to Stakeholder is maintained.

For optimum results the Provider and Recipient should be in agreement on the mode of verification to be used, receive the same outreach materials and attend the same type of training and we suggest that this training be mandatory, with attendance tracked through LMS and class registrations.

The following figure shows an example of a high-level timeline for EVV implementation. The timeline assumes that the strategic planning and procurement is complete by June 2018 and that development of outreach and training materials can immediately begin, in parallel to development of an enhanced website and implementation of an EVV tool from the selected vendor. This functionality will be introduced during a Pilot Wave that potentially includes all Agency Providers, gaining immediate and full compliance for that small segment of the population. The implementation timeline then progresses through a series of five waves, equal in size, and incremental in functionality. Each wave will be supported by ongoing outreach and training, and fine-tuning of the education materials in addition to fine-tuning and enhancement of the EVV functionality.

### Figure 2: Sample Implementation Timeline

This approach, with incremental functionality being provided as development is completed, is based on an expectation that CMS will not be receptive to granting the State a waiver. If CMS is amenable to granting a waiver until 2021, for example, a different approach would be possible. Complete development of the solution could be accomplished prior to commencing implementation, allowing for a more streamlined rollout to the population.

6. Describe how to overcome implementation challenges inherent to California such as the change management for a large and vulnerable population. Describe mitigation strategies that could be used to address challenges.

**DXC Response:**

As the state has discussed in the questions for this RFI, approximately half of Providers are family members and/or live in the same home as their recipient.

Because of this, providers often don’t understand the “professional” relationship that exists between them and their Recipient. They are performing services for their Recipient in the same way any other health care or home health provider would. The Recipient (or their designated representative) is responsible for scheduling and directing the care, and the Provider is responsible for providing only those services which have been authorized by the State, up to the amounts authorized by the State.

Instead, Providers (especially family member providers) who live with their Recipient are often accustomed to providing care, in varying degrees, throughout the day. They often don’t differentiate between services authorized
by the IHSS program, or services they are simply providing on their own, due to their relationship with the Recipient. This causes several problems for some of these providers.

Many family-member providers were caregivers of their Recipients even before the Recipient was approved for IHSS. Now that the provider is in the new role of being an IHSS Provider, they have difficulty comprehending that they are now in an employer-employee relationship with their Recipient. They are expected to complete a timesheet where they record the hours worked each day for their Recipient, and submit this timesheet for payment. Because the Provider doesn’t recognize that they are now an employee of the Recipient, they do not track their time to a schedule so it can be reported on the timesheet. In addition, the Recipient (or their designated representative) isn’t effectively managing the work of the Provider, and providing them with a schedule of hours they are expected to work. Again, because of the relationship that exists between the Provider and their Recipient, the Provider continues to perform services that aren’t authorized by the program, or delivers an amount of service that exceeds what has been authorized by the program.

As a result, when the Provider completes their timesheet, many different approaches are used. Some providers claim far more hours per day than are actually associated with delivery of approved IHSS services. In doing this, they claim a disproportionately high percentage of the monthly authorization in the first couple of weeks of the month. Other Providers simply divide the Recipient’s monthly authorization equally across the days of the month, and claim that amount each day. County staff are often called upon to assist with this calculation, or even suggest this strategy to Providers who have difficulty understanding and managing a schedule. The result of these actions are timesheets that don’t accurately reflect the IHSS work that was performed, nor the timeframes in which it was performed.

This challenge isn’t unique to live-in or family-member Providers.

In order to address this challenge, it will be important to include a comprehensive Recipient and Provider orientation and training program with the implementation of EVV. Before Providers even begin to learn how to report time with the EVV system, they must first fully understand their role as a home health care provider. They will need to differentiate between the hours and services they are performing as a part of the job of being an IHSS Provider from those hours and services they provide voluntarily as a result of the caring relationship they have with their Recipient.

Managing the process of educating nearly 1 million people about the EVV process, and their role in providing, receiving and tracking In-Home Supportive Services is significant. The IHSS population is diverse in many ways, including cognitive or physical disabilities, cultural and language differences, varying levels of education, varying degrees of exposure and access to technology, residences that range from urban to extremely rural and remote, etc.

Addressing these challenges will likely include many approaches to educating and informing Providers and Recipients about the change. It will be important to utilize technology whenever possible, such as developing video presentations that can be viewed online or in sessions hosted at locations easily accessed by the Recipients and Providers. These presentations must be made available in all the languages spoken by both the Recipients and Providers. It is not enough to make them available in the threshold languages of English, Spanish, Chinese and Armenian. Many participants in the program do not speak or read those language, and they must still learn about the changes.

We recommend developing at least 2 components of outreach related to this change. The first is to develop materials and conduct a campaign targeted at educating Recipients (or their designated representative) and Providers about the employer/employee relationship that exists in IHSS, and the limits and constraints that places on the services provided. While it is true that this information is covered during intake and orientation of IHSS Recipients and Providers, the fact that time is still reported the way it is, by such a large number of Providers, suggests that it isn’t fully effective.
The second component of outreach can then build upon this foundation. That second component is to educate the Recipients and Providers in the use of the new EVV system.

This education campaign should also involve a series of increasingly detailed communications. Starting very early, Recipients and Providers should receive brief, high-level summaries of the changes that are coming. As they receive and understand those, additional, more detailed information should be shared. Again, it is important to understand that not all Recipients and Providers will understand a single form or style of communication. Multiple formats, including written materials, videos, web conferences and in-person town halls should be considered. Technology should be leveraged when possible, including the use of tools like Learning Management Systems. This would allow more oversight and visibility into the training being received. Partnering with other community resources including advocacy organizations, labor organizations, adult day health care centers, etc., are potential strategies to increase the reach of communications.

Change management for this large population will require multiple strategies as well as involve a larger community than just the Recipients and Providers.

There are four change management strategies that are used commonly for managing change; Empirical-Rational, Normative-Re-educative, Power-Coercive, and Environmental-Adaptive:

- **Empirical-Rational** can be viewed as the ‘carrot’ side of the carrot-and-stick approach. The premise is that, given sufficient communication and an appropriate incentive, people are willing to change.
- **Normative-Re-Educative** relies on people’s adherence to norms and the culture in which they were brought up. Over time these norms can be changed, and people will change to adhere to these new norms and values. However, this can be a very lengthy process.
- **Power-Coercive** change is essentially the ‘stick’ side of the carrot-and-stick approach. It relies on the belief that people will do what they are told.
- **Environmental-Adaptive** change uses the adaptive nature of people. To effect change, instead of trying to change one organization, you instead create a new one and transition the people to it.

The most likely approach to change management related to the implementation of the EVV system will be a combination of Empirical-Rational and Power-Coercive. However, to be successful, the organizations that support Recipients and Providers (Advocates, Labor Organizations, etc.) must be involved with and supportive of the changes.

In order to accomplish change of this magnitude, both the degree of change needed and the size of the population to which the change is occurring, sufficient time must be allocated. The state has outlined some aggressive timeframes associated with the implementation of EVV, essentially leaving little more than one year to accomplish the transition. It may not be practical to complete both the selection and implementation of a system, and the education and change management related to implementation by 1/1/2019. The state should consider seeking waivers from the CMS to allow additional time to comply, and show the good faith effort they are making to accomplish this change.

The state should also consider phasing the rollout of the EVV based on factors such as the technology needs or constraints of the population being implemented. The solutions we envision provide a multifaceted approach to meeting the needs of this diverse population. An implementation strategy that includes focusing on one area of functionality at a time, and the populations addressed with that specific functionality, may allow for a smoother overall implementation.
7. **Discuss strategies you have employed to garner customer satisfaction and include any satisfaction survey data, if available.**

**DXC Response:**

As would be expected in a program of the size of IHSS, there are many stakeholders, with various points of view and areas of interest. Buy-in from this stakeholder community is critical for the success of any significant change in the program.

The approach we propose to take for the development of the EVV solution for IHSS will follow the process we used with the Electronic Timesheet application.

In that project, we engaged various stakeholders early and often. We conducted focus groups with recipients and providers to assess their understanding of the system and to gain valuable input regarding usability. These recipients and providers reflected a range of users, with varying degrees of disability as well as varying degrees of familiarity with technology.

In addition to soliciting the input of the future users of the system, we also gathered feedback from other stakeholders. We conducted demonstrations of early prototypes to County IHSS staff, to both gather their direct feedback as well as to tap into their knowledge of the user population. County staff are the front line in the administration of IHSS, and their knowledge of the recipient and provider community, and the challenges faced working with that community, is invaluable.

The advocacy organizations, both advocates for recipients as well as Labor Organizations representing providers were engaged during the development process with the goal of gaining their support and buy-in. This was critical for a couple of reasons. First, as advocates for their various constituencies, they have great influence. If we were able to get their support, they would help build support within their areas of influence. This leads to the second reason their support was needed; the actual implementation. Reaching out to a population the size of the IHSS community is challenging, and numerous channels of communication are needed. The advocacy organizations played a critical role in communicating our message to their respective organizations.

Once developed, the Electronic Timesheet system was implemented in a phased approach. We started with a 'soft launch' to a select group of individuals, including key recipients and providers who participated in the focus groups during development. This allowed us to gather final usability input before beginning a full scale rollout.

Deployment of the system was conducted over the course of 6 months, to allow time for lessons to be learned and adjustments to be made. By the end of this rollout, interest statewide had grown tremendously, and providers in the counties not yet implemented were anxiously anticipating the system going live in their county.

We are pleased that the State has already begun to engage the stakeholder community regarding EVV, including the meetings held prior to the release of this RFI. We hope this is the beginning of a process that mirrors that which we took during the development and implementation of Electronic Timesheets.

8. **Describe the response to your EVV from a wide range of Recipients and Providers with a wide range of disabilities including blind and deaf and/or low literacy levels.**

**DXC Response:**

Our recommendation is for an EVV solution comprised of custom developed and COTS components tailored to meet the unique requirements of the IHSS program. This recommendation is based on a deep understanding of the community served by IHSS. This community, by its very definition, includes people with varying degrees of disabilities.

We have experience developing solutions to meet the needs of the aged, blind and disabled population. We have successfully leveraged technology to deliver various accommodations for blind and visually impaired IHSS recipients. Those include a range of options from simple solutions such as large font documents, to complex interactive voice response systems to approve timesheets over the telephone.
We built upon some of the technologies used to support the blind and visually impaired population when we developed the Electronic Timesheet application.

In all of these solutions, the end user is shielded from whatever complexity was required to develop it. They are presented with an easy to understand, easy to use solution.

The response to these solutions has been extremely positive. Looking at the Electronic Timesheet application, we have seen the adoption rate grow on a daily basis. As users become aware of the efficiencies this has brought to the IHSS payroll process, more and more users are enrolling in the service.

Since this is a solution based upon technology, one gauge we use to assess the response and attitudes of the users is to look at social media. We regularly see feedback on social media such as “Wow! Now that’s fast” and “Pretty easy website and user friendly.” Messages like the screenshot from Facebook are not uncommon.

![Facebook Post](image)

As we have discussed earlier, implementation of EVV will be challenging for this population, and there will likely be resistance to the change. Having the system be as easy to use as possible will be a key factor in a successful transition.

9. **Discuss ongoing maintenance of EVV systems.**

**DXC Response:**

Similar to all complex systems, the proposed EVV solution will require ongoing maintenance. In the table below, we discuss at a high level the ongoing maintenance required for each component of the proposed EVV solution.

<table>
<thead>
<tr>
<th>No.</th>
<th>Component</th>
<th>Sub-component</th>
<th>Required Maintenance by the State or EVV/CMIPS service provider</th>
<th>Maintenance Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Telephonic Timesheet System (TTS)</td>
<td>IVR system</td>
<td>Applying Server patches, application defect fixes</td>
<td>Monthly</td>
</tr>
<tr>
<td>2</td>
<td>Telephonic Timesheet System (TTS)</td>
<td>Back end CMIPS services</td>
<td>Applying Server patches, application defect fixes</td>
<td>Monthly</td>
</tr>
<tr>
<td>3</td>
<td>EVV App</td>
<td>Native Android/iOS App</td>
<td>Defect fixes</td>
<td>Monthly or more frequently as required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>running on smartphone, Tablet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>EVV App</td>
<td>Cloud API Services</td>
<td>Administration</td>
<td>Quarterly</td>
</tr>
<tr>
<td>No.</td>
<td>Component</td>
<td>Sub-component</td>
<td>Required Maintenance by the State or EVV/CMIPS service provider</td>
<td>Maintenance Frequency</td>
</tr>
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<td>-----------------------</td>
</tr>
<tr>
<td>5</td>
<td>EVV App</td>
<td>Back end CMIPS services</td>
<td>Applying Server patches, application defect fixes</td>
<td>Monthly</td>
</tr>
<tr>
<td>6</td>
<td>IHSS Portal, Enhanced ETS application</td>
<td>EVV data correction web site</td>
<td>Application defect fixes</td>
<td>Monthly</td>
</tr>
<tr>
<td>7</td>
<td>IHSS Portal, Enhanced ETS application</td>
<td>Back end CMIPS services</td>
<td>Applying Server patches, Application defect fixes</td>
<td>Monthly</td>
</tr>
<tr>
<td>8</td>
<td>Paper Timesheets</td>
<td>OCR, Interface to CMIPS</td>
<td>N/A (offered as a service)</td>
<td>N/A</td>
</tr>
<tr>
<td>9</td>
<td>COTS EVV Service for Agency Providers</td>
<td>Batch interface to CMIPS</td>
<td>N/A (offered as a service)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

10. Describe if/how the EVV solution can leverage the current IHSS Portal with the ETS feature and the pros and cons of doing so.

**DXC Response:**

As described in the answer to question #2, the proposed EVV solution will leverage the current IHSS Portal. The ETS application will be enhanced to display and allow the Provider to update and add to the time captured by the EVV native app and the TTS system. Some of the pros and cons of this approach include:

**Pros:**

- Providers and Recipients who have chosen to use ETS are already familiar with the IHSS Portal and will keep their login ID and passwords, hence there will be fewer questions and calls to the IHSS Help Desk.
- IHSS Portal has been a successful implementation and a proven solution. Its reputation for being a simple and user-friendly web site will improve the adoption rate for the whole EVV solution.
- The State has invested time and budget in the IHSS Portal and a solution that can leverage this capability further enhances the State's desire to spend taxpayer money wisely.
- The IHSS Portal is the online destination for future online services such as enrollment for Direct Deposit, online distribution of tax documents and forms, general and personalized communication and correspondence, etc. It would make sense for the Provider to visit the same portal for EVV related tasks.
- The approach to build versus buy this Portal allows the State to fine tune its features to the exact requirements of California's IHSS program which is unique in the county.

**Cons:**

- Selecting a commercially available EVV solution may have a shorter implementation timeframe, potentially avoiding penalties associated with non-compliance or delayed compliance with the 21st Century Cures Act. However, such a decision may require to make significant changes to the IHSS program's policies in order to conform with the EVV vendor's solution features.

11. Describe how an EVV solution can be effectively implemented for both the Individual Provider and Agency Provider employment models.

**DXC Response:**

Currently, the Agency Provider is managed by a commercial agency that hires the employee and arranges for the Provider to work for the Recipient. CMIPS application includes functionality to collect the hours spent by the Agency Provider against the Recipient's authorized hours as provided by the County interface file. It also provides
reporting and reconciliation of these hours versus the Case Management system and provides appropriate reporting to the CDSS accounting.

In our proposed solution, the in-house solution described in answer to question #2 is used for Individual Providers. We recommend that all commercial agencies be required to use a single State selected EVV solution provider. This approach will simplify systems integration and enforce process and technology standardization. When the Provider works for the Recipient, the EVV solution or service collects hours worked and perform payroll processing on behalf of the commercial agency. Instead of many commercial agencies, the EVV could provide invoice/claim information to the DHCS’s FI or the county.

Using an external EVV solution provider for commercial agencies takes advantage of a proven solution already utilized in other States. While California’s IHSS program is mainly using the network of Individual Providers for which our proposed custom solution is more appropriate, the professional Agency Providers follow a more structured approach to providing care to recipients. For them, the rigor of using exact timekeeping for each service is an existing process and hence the commercially available EVV solution is a better choice.

12. Describe your business model (e.g., Software as a Service, Commercial Off-the-Shelf, Modified Off-the-Shelf, custom built, transactional).

DXC Response:

DXC Technology is the world’s leading independent, end-to-end IT services and solutions company, helping clients harness the power of innovation to thrive on change. For Individual Providers, we are proposing a solution which is based on the following components and business models:

Table 7: DXC’s Solution Description and Business Model

<table>
<thead>
<tr>
<th>No.</th>
<th>EVV Solution Component – Individual Provider</th>
<th>Solution Description &amp; Business Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Land line telephone used to capture EVV data</td>
<td>Enhanced TTS which is a custom built service built by DXC for IHSS. It is hosted at the DXC data center.</td>
</tr>
<tr>
<td>2</td>
<td>EVV app using Smart Phone, Tablet</td>
<td>Custom-built EVV app designed to meet IHSS requirements for the Individual Provider population, using real-time interfaces with CMIPS. The State will own the intellectual property for this app.</td>
</tr>
<tr>
<td>3</td>
<td>IHSS Portal, Enhanced ETS application to make corrections</td>
<td>Custom Built web site based on enhancements to the existing ETS application. It will be designed to meet IHSS requirements, using real time interfaces with CMIPS. The State owns the intellectual property for ETS and all its future enhancements.</td>
</tr>
<tr>
<td>4</td>
<td>Enhanced Paper Timesheets</td>
<td>Modified off the shelf solution based on enhancing the current paper timesheet solution offered as part of DXC services. DXC owns the infrastructure and software used for paper timesheet scanning, viewing, and the interface to CMIPS</td>
</tr>
</tbody>
</table>

For Agency Providers, we are proposing a commercial EVV solution provider. Such vendors offer a variety of pricing models. Based on the low number of Agency Providers used for IHSS, we propose using a transactional model to pay for the EVV solution and services.
13. Describe the costs and fee structure of EVV solution(s) for customers with requirements comparable to the IHSS, WPCS, and other HCBS Waiver programs. Differentiate between Individual Provider and Agency Provider employment models. Identify both one-time and on-going costs. Describe how the cost model would scale up to accommodate the large number of IHSS and WPCS Providers.

**DXC Response:**

For Individual Providers, we are proposing a solution which is based on the following components and fee structures:

**Table 8: Fee Structure**

<table>
<thead>
<tr>
<th>No.</th>
<th>EVV Solution Component – Individual Provider</th>
<th>Fee Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Land line telephone used to capture EVV data</td>
<td><strong>One Time Fees:</strong> Labor charges based on either Fixed Price, or Time and Material.&lt;br&gt;<strong>Ongoing Charges:</strong> Charges based on the consumption model (minutes used)</td>
</tr>
<tr>
<td>2</td>
<td>EVV app using Smart Phone, Tablet</td>
<td><strong>One Time Fees:</strong> Labor charges based on either Fixed price, or Time &amp; Material. Cloud hosting charges are separate.&lt;br&gt;<strong>Ongoing Charges:</strong> Charges based on fixed capacity to staff an agile project team used for ongoing maintenance and minor enhancements.</td>
</tr>
<tr>
<td>3</td>
<td>IHSS Portal, Enhanced ETS application</td>
<td><strong>One Time Fees:</strong> Labor charges based on either Fixed price, or Time &amp; Material. Cloud hosting charges are separate.&lt;br&gt;<strong>Ongoing Charges:</strong> Charges based on fixed capacity to staff an agile project team used for ongoing maintenance and minor enhancements. Cloud hosting charges to support both the app and the portal are based on both fixed and variable costs (based on number of user logins).</td>
</tr>
<tr>
<td>4</td>
<td>Enhanced Paper Timesheets</td>
<td><strong>One Time Fees:</strong> Labor charges to develop the required changes to modified paper timesheets based on either Fixed Price or Time and Material&lt;br&gt;<strong>Ongoing Charges:</strong> Timesheet processing transaction fees will remain as per contractual agreements</td>
</tr>
</tbody>
</table>

For Agency Providers, we are proposing a commercial EVV solution provider. Such vendors offer a variety of pricing models. Based on the low number of Agency Providers used for IHSS, we propose using a transactional model to pay for the EVV solution and services. The commercial EVV solution provider may require a one-time charge to cover the costs of IHSS specific customizations, or interface requirements above and beyond what is included in the standard service offering.

For both Individual and Agency Provider solutions, the ongoing charges related to transaction volumes can be structured based on a tiered pricing model in which the unit transaction price is reduced with increasing transaction volumes.

14. Describe how the EVV solution for personal care service that must be implemented in 2019 could be expanded to accommodate the 21st Century Cures Act home health care service EVV requirement by January 1, 2023.

**DXC Response:**

As we discussed in question #11, our proposed solution is for a EVV solution comprised of both custom developed and COTS components tailored to meet the unique, and quite large population of IHSS Providers and
their respective recipients. For the small subset of IHSS cases served by and Agency Provider, referred to as contract mode in IHSS, we are proposing the use of a commercial EVV system.

It is our recommendation that this chosen system also be used to meet the January 1, 2023 requirement to extend EVV to home health care service.

15. Describe the different means of communication (e.g., notifications) the system is capable of producing such as letters, e-mail, text, and phone in multiple language formats for visually and hearing disabled including large font, braille, and audio text.

**DXC Response:**

The CMIPS application has the architecture to generate different means of communication such as letters, e-mails, text and phone in multiple language formats for the visually and hearing disabled population, including large font, braille, audio and textual formats.

The EVV system architecture will leverage the capabilities of CMIPS for various communications. The EVV app will interface with CMIPS application to generate these communications like generate letters in multiple languages, emails, text, phone service, braille, audio and textual communications. In addition, the EVV app can use “push notification” technology to inform the user when certain processing events or business events require the user’s attention, acknowledgement, or action. For example, if the Provider Portal application detects gaps or inaccuracies in the way the visit information is recorded, the Provider is informed via an app notification to take the required corrective action. Another example could be to remind the Recipient to approve a submitted timesheet. “Push Notification” technology will be configurable, allowing system and business administrators to control the trigger events, the frequency, and the timing of the notifications in order to make them effective without being a nuisance to the end user.

**Letters:** The EVV system will leverage the CMIPS architecture for generating letters in regular and large fonts. The CMIPS application will continue to generate regular letters to county printers or to print vendors like EDD or ES. Counties can view and reprint the Large Font version of the documents from the Recipient’s Forms and Correspondence area.

**E-mail:** The new EVV system will leverage the CMIPS architecture to send emails. The new EVV system will have a real-time event/response interfaces that will communicate to and receive data. Based on the business need, for some emails EVV system will communicate with case management, which in turn will send emails.

**Text and Phone:** The EVV system will leverage and integrate into CMIPS architecture for Text and Phone methods of communication. The EVV system will interface with CMIPS application to send texts and utilize the outbound phone service. The CMIPS will use a real-time interface with the Telephone Timesheet System to allow the recipient to approve or reject the held timesheets for processing in Case Management. Based on the business need the CMIPS system will perform the appropriate communication campaign either through telephone calls or text.

**Braille, Audio and Textual Formats:** The EVV system will leverage and integrate into CMIPS architecture Braille, Audio and Textual Formats. The EVV system will interface with CMIPS application to generate and mail Braille, Audio and Textual files to Recipients based on the opted delivery option. During nightly batch processing, the relevant documents would be generated and mailed.

16. Describe how your system is kept current and how it keeps up with technology changes.

**DXC Response:**

For the EVV solution proposed for the Individual Provider population, DXC will follow its standard practice of application management services and its contractual obligations with the State to keep the software versions and other solution components up to date as technology changes and new versions are released. DXC has been
upgrading all CMIPS components to make sure all software is supported by the commercial software vendor or
the open source community. Systems must be kept up to date at all levels, from hardware and network, to
Operating systems, middleware, and business applications. For the proposed EVV solution, the infrastructure and
software upgrade can be described at a high level as follows:

Table 9: Infrastructure and Software Upgrade

<table>
<thead>
<tr>
<th>No.</th>
<th>EVV Solution Component – Individual Provider</th>
<th>Infrastructure Upgrade</th>
<th>Software Upgrade</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Land line telephone used to capture EVV data</td>
<td>DXC’s Telecomm Infrastructure is leveraged for many customers. It is kept up to date with planned maintenance windows and technology refresh plans</td>
<td>The IVR system uses the Avaya platform and the customized software used for TTS is using Java. As new versions are released, the team applies the updates</td>
</tr>
<tr>
<td>2</td>
<td>EVV app using Smart Phone, Tablet</td>
<td>The IBM Cloud service Bluemix is maintained by IBM</td>
<td>Open Source and business application logic is upgraded following the application and software roadmap (similar to ETS). System upgrades are included in the “backlog” of tasks and are included in Sprints based on capacity and business priority.</td>
</tr>
<tr>
<td>3</td>
<td>IHSS Portal, Enhanced ETS application</td>
<td>The IBM Cloud service Bluemix is maintained by IBM</td>
<td>Open Source and business application logic is upgraded following the application and software roadmap (similar to ETS). System upgrades are included in the “backlog” of tasks and are included in Sprints based on capacity and business priority.</td>
</tr>
<tr>
<td>4</td>
<td>Enhanced Paper Timesheets</td>
<td>DXC’s TPF facility keeps the infrastructure up to date with planned maintenance windows and every technology refresh calendars</td>
<td>DXC’s TPF support team upgrades the scanning and OCR software used for the paper timesheets. All Software is kept under vendor premium support.</td>
</tr>
</tbody>
</table>

The details of the maintenance plan for EVV solution for the Agency Providers will be determined as part of a more detailed vendor selection process.