






Charlie Crist
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MEMORANDUM

Date: March 26, 2009

To: James D. Boyd, Inspector General 

From: Michael J. Bennett, Director of Auditing 
Tim Byrnes, Senior Management Analyst II 

Subject: C-09-01 : DME Procurement Process within Children's Medical Services and the Brain and Spinal Cord Injury Program

Based upon your request, we have conducted a review and analysis of the practices used by the Department's of Health's (DOH) Children's Medical Services (CMS) program and the Brain and Spinal Cord Injury Program (BSCIP) for procuring Durable Medical Equipment (DME). The purpose of the review was to assess the current policies, procedures and practices within the two programs and analyze data related to DME purchases made by these programs during the time period between July 1, 2007 and June 30, 2008.

Background

DME is defined as medically-necessary equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home. DME items can range anything from a transfer board, costing only a few dollars, to a custom wheelchair, costing several thousands of dollars.

Within the Department of Health, there are two programs that primarily purchase DME equipment for their particular clientele:

Children's Medical Services

CMS provides children with special health care needs a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric care. Children with special health care needs are those children under age 21 whose serious or chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children. The program operates under authority granted by Chapter 391, Florida Statutes.

CMS maintains 21 area offices around the state. Each area office has the flexibility to operate somewhat independently of the other area offices. This allows each office to tailor its operation to best serve the clients in the particular area they serve.

CMS utilizes the following three funding sources for DME purchases:

- Medicaid (Title XIX) - for clients enrolled in the Medicaid program and the purchase qualifies as a Medicaid-eligible purchase.
- KidCare (Title XXI) – for clients enrolled in the KidCare program.
- Purchase Client Services (commonly referred to as Safety Net) – for clients not enrolled in either Medicaid or KidCare. Also, for Medicaid clients where needed equipment does not qualify to be paid for by Medicaid.

DME items paid for by Medicaid are handled through the Agency for Health Care Administration. DME items not paid for by Medicaid are paid from one of the two remaining resources, both of which are administered by CMS. During the 2007-08 fiscal year, CMS spent \$1,523,853.50 on DME purchases (See Appendix A).

Providers who wish to sell DME to CMS clients must go through a specific DME approval process. In most cases, the provider needs to already be an approved Medicaid provider prior to applying to CMS. CMS then conducts a limited approval process that helps ensure the provider is able to meet the needs of the children served by the program.

Once a provider is approved, there are several ways the provider's services are utilized. Some CMS offices invite DME providers on-site for highly specialized services, such as custom wheelchairs. In these situations, several providers may be brought in together to meet with various clients at one time while in other instances the providers may be brought in one at a time on a rotation basis.

Another method by which the provider participates is to submit quotes for specific DME procurements. State purchasing regulations require written quotes, written records of telephone quotes, or informal bids, whenever practical, to be obtained for items between \$2,500 and \$25,000. Providers who sell the item that is to be procured are typically contacted by CMS to submit a quote. Some offices seek the minimum of two providers required while others may seek more than two.

CMS area offices vary in their procedures for procuring DME items under \$2,500. Some area offices still obtain quotes. Other methods utilized include, but are not limited to, negotiating with providers for an agreed-upon rate or paying providers at Medicaid-approved rates. CMS staff has full discretion to solicit business from the providers they feel are best able to provide the product and/or service. They often select providers based on their ability to serve children who have medically complex needs.

Beyond meeting all minimum purchasing requirements, CMS also stresses family choice as a key factor in provider selection during DME procurements. It is the belief of CMS that the family should be adequately taken care of and be satisfied with the provider of the service and/or equipment they receive. In fact, in many instances, these families have already been dealing with a particular provider for obtaining other services and/or equipment and thus have built up an acceptable relationship with that provider.

It should also be noted that in select areas of the state, CMS contracts with two Integrated Care System (ICS) contractors (South Florida Community Care Network and Ped-I-Care) to handle aspects necessary to purchase supplies and equipment for children with special health care needs. The majority of clients served by the ICS contractors reside in South Florida.

The ICS contractors operate as managed systems of care for children with special health care needs to achieve a comprehensive system of care that meets family needs and links families with a wide array of services. ICS contractors perform several administrative functions, including medical management, claims authorization and payment, enrollee services, and provider/network services. The ICS contractors are paid on a capitated rate basis and have their own network of providers who offer DME, separate from the approved CMS provider list. (ICS contractor purchases for DME items are not part of the data shown in Appendix A.)

We have been told that the ICS contractors tend to select providers based primarily on family or physician preference. Providers must go through a credentialing process with the ICS contractor. However, there do not appear to be any restrictions on using the same provider(s) a majority of the time.

Brain and Spinal Cord Injury Program

The BSCIP serves individuals who have sustained a moderate-to-severe brain *and/or* spinal cord injury. The program provides services, education, prevention, and research activities related to brain and spinal cord injuries. Services include case management, acute care, inpatient and outpatient rehabilitation, transitional living, assistive technology, home and vehicular modification, and long-term community-based support. The program operates under authority granted by Chapter 381, Florida Statutes.

BSCIP maintains 14 offices throughout the state. Unlike CMS, all BSCIP offices, according to management, are required to follow the same procedures for procuring DME equipment under \$2,500.

BSCIP utilizes the following three funding sources for DME purchases:

- Medicaid (Title XIX) - for clients enrolled in the Medicaid program and the purchase qualifies as a Medicaid-eligible purchase.
- Medicaid Waiver - for clients enrolled in the Medicaid program that provide for purchases outside the normal Medicaid-eligible purchases which allow these clients to live in a non-institutionalized setting.
- Brain and Spinal Cord Injury Program Trust Fund - for clients who are not eligible for federal, state, or community assistance.

DME items paid for by Medicaid are handled through the Agency for Health Care Administration. DME items not paid for by Medicaid are paid from one of the two remaining resources, both of which are administered by BSCIP. During the 2007-08 fiscal year, BSCIP spent \$1,099,153.88 on DME purchases out of the Brain and Spinal Cord Injury Program Trust Fund (See Appendix B) and \$208,383.93 on DME purchases out of the Medicaid Waiver Fund (See Appendix C).

Providers wanting to do business with BSCIP must be registered with the Florida Alliance for Assistive Services and Technology (FAAST). This organization performs a thorough review of each provider to ensure the provider has the appropriate knowledge, experience and understanding of BSCIP clients to meet their many unique needs.

In contrast to CMS, family choice plays a very small role in the provider selection process. A brain and/or spinal cord injury usually occurs suddenly and thus the family has not built up a relationship with a particular provider. As a result, providers tend to be more proactive with BSCIP staff, such as showcasing their particular products and services at regional BSCIP quarterly/monthly staff meetings.

According to management, all BSCIP offices are required to obtain at least three quotes, if possible, for each DME procurement, regardless of cost. For items under \$1,000, quotes may be solicited over the phone. For items over \$1,000, all quotes must be submitted to BSCIP as a written quote. BSCIP staff has full discretion to solicit the quotes from the providers they feel are best able to provide the product and/or service.

Review Scope

Our review consisted of reviewing the current practices within CMS and BSCIP regarding DME purchases; interviews with key CMS and BSCIP staff, including staff at selected area offices around the state; interviews with key staff within the Division of Administration, Bureau of General Services; reviews of relevant laws, rules, and regulations; and analysis of DME purchasing data.

It is important to stress that we did not conduct an investigation or an audit, but rather a review of the general procedures and processes used by CMS and BSCIP to purchase DME equipment and whether these practices comply with purchasing regulations. We also gathered and conducted extensive analysis on DME purchase data from all CMS and BSCIP offices.

Conclusions and Recommendations

Based upon the results of our review, we have concluded the following:

- The majority of clients within CMS and BSCIP are covered by the Medicaid program. Thus, DME purchases for these clients are primarily paid for by Medicaid and subject to Medicaid regulations. Medicaid leaves provider selection up to the recipient (or family) or the physician, as long as the provider is enrolled as a Medicaid provider. For those instances where neither the recipient nor the physician have a preference, CMS or BSCIP staff are available to help assist with provider selection.
- For non-Medicaid DME purchases, we have not seen any evidence whereby the practices utilized by CMS or BSCIP violate State purchasing regulations. (NOTE: We did not analyze Medicaid purchases since those are outside the control of DOH).

- Some area offices within both programs were found to have instituted additional procedures that establish tighter controls than the State's purchasing regulations require. For example in CMS, one area office requires two written quotes for all **DME** items costing over \$500. In BSCIP, all offices are required to obtain telephone quotes for **DME** items under \$1,000 and written quotes for **DME** items costing over \$1,000. State purchasing regulations require written quotes, written records of telephone quotes, or informal bids, whenever practical, to be obtained only for items over \$2,500. Department purchasing policies and procedures encourage written quotes whenever possible.
- State purchasing regulations are structured in a way that could allow for the possibility of "provider preference." For example: purchasing regulations require at least two quotes or informal bids to be obtained for an item or service between \$2,500 and \$25,000. There is nothing in the purchasing regulations that prevent obtaining quotes from the same two or three providers each time, thus excluding other providers in the area that could also provide the same product or service. Additionally, Section 287.057 (5)(e), Florida Statutes, allows prescriptive assistive devices for the purpose of medical, development, or vocational rehabilitation of clients to be exempt from competitive-solicitation requirements. These devices can be procured pursuant to an established fee schedule or other method which ensures the best price for the state, taking into consideration the needs of the client. Prescriptive assistive devices include, but are not limited to, prosthetics, orthotics, and wheelchairs.
- Our data analysis does show that some CMS and BSCIP offices do award a majority of **DME** purchases to a select few providers in the area while other providers have been awarded very little business. However, it must be stressed that during interviews with CMS and BSCIP staff (before gathering the data) there were some explanations given for awarding purchases to certain providers (family preference, physician preference, able to meet delivery deadlines, reliability of product, actually carries the item or service, warranty coverage, provider location, acceptance of the Medicaid rate, etc.). To date, we have no specific evidence that suggests there is a conscious effort by any CMS or BSCIP office to purposefully and intentionally exclude a provider from the procurement process.

While we have seen no evidence to suggest providers have been intentionally excluded, there may be at least a perception problem in some areas that products or services are awarded to only a select few providers. It may be necessary for agency management to discuss whether the current DOH purchasing practices should be changed or "tightened" to further ensure that all providers in a given area are afforded a fair opportunity to participate in **DME** purchases.

Thus, in order to further enhance the practices utilized within CMS and BSCIP and help eliminate possible perceptions of unfair treatment, we offer the following **recommendations for consideration** by Agency management:

- **Standardize the provider participation process for DME procurements.**

During our review, it was determined that there are various procedures, thresholds, and practices that exist, not only between CMS and BSCIP, but also within the different area

offices themselves, especially within CMS, that are used for provider selection of DME purchases. As an example, some offices use a rotation basis while others contact only the minimum number of providers, thus discounting other providers in the area who may have been willing to submit a quote and be considered.

While our review saw no specific evidence that any of these varying practices were in violation of any State purchasing requirements, the differences that do exist may lead to a perception problem that a particular awarding of a DME procurement was not handled fairly. In addition, without a detailed and extensive monitoring effort, allowing varying processes at the area office level makes it difficult for management to ensure that acceptable practices are being followed in a consistent manner throughout the Department.

Since CMS and BSCIP serve different purposes and the clients have differing needs and circumstances, it stands to reason that the procedures between CMS and BSCIP may differ. However, within each of those two programs, it is important that each area office follow similar baseline requirements to help ensure compliance and consistency.

Thus, **we recommend** CMS and BSCIP management establish standardized policies within their respective programs to ensure eligible providers willing to participate are given an opportunity to submit a quote for each DME procurement when quotes are used as the method of procurement.

- **Standardize the process for DME procurements and award determinations.**

As mentioned earlier, there are various practices utilized within the different area offices in regards to the DME procurement process. While no practices or policies were found to be in violation of procurement regulations, there were notable differences in the details and documentation maintained for procurements between some of the area offices we contacted.

We discovered that in at least one CMS area office, providers are contacted in advance to obtain quotes and/or negotiate for certain DME items between \$2,500 and \$25,000. Therefore, the CMS area office avoids the time and expense necessary to obtain quotes prior to each purchase of these particular DME items, especially given the fact that very few providers carry these high-cost items. While this practice does not directly violate State purchasing regulations, questions remain as to whether this practice meets the spirit of the regulations, especially given the fact that there are no specific time frames for how long these rates and the provider exclusivity remain in place. It is also worth noting that an analysis of data showed that purchases of DME equipment over \$2,500 in this particular CMS area office only amounted to approximately 2% of their total DME purchases during FY 2007-08.

Furthermore, following discussions with program management, it was agreed that there are several other areas that should be looked at more thoroughly by management to

determine if further strengthening and/or standardizing of program policy should occur. Key areas include, but are not limited to :

- o Ensuring that all solicitations for quotes contain all conditions necessary to be considered as part of the quote by the providers (such as due dates and delivery expectations and any other element that will be factored into the evaluation);
- o Ensuring each solicitation is handled timely and eligible providers willing to participate are informed in a similar manner as to any conditions or requirements necessary to fulfill the solicitation;
- o Requiring adequate documentation be maintained detailing all providers participating in the solicitation; and
- o Establishing a clear, consistent method for notifying providers the results of each procurement.

Thus, we recommend CMS and BSCIP management review the detailed aspects of DME procurement and award notifications and take appropriate action to further strengthen or standardize any areas deemed necessary.

- Evaluate the advantages and disadvantages of purchasing frequently used **DME** items on State contract.

An analysis of data showed that many of the DME purchases (approximately 90% or greater) are for items that cost under \$2,500. As a result, it may benefit the programs to explore the possibility of purchasing frequently-used, standard DME items through the use of State contracts, either on an individual basis or in bulk.

In previous discussions with CMS and BSCIP management, it was mentioned that several key staff within each program (such as Nursing Directors in CMS and Case Managers in BSCIP) could analyze their respective program's frequent purchases of DME items and, where appropriate, take the necessary steps to initiate a State contract. This may also reduce the number of instances where items are procured through quotes and other similar methods and may also result in a cost savings to the State.

One key consideration for CMS will be whether a particular item on State contract would be more than the Medicaid reimbursement rate for that item. Section 391.045 (1), Florida Statute, requires that, "Medicaid reimbursement rates shall be utilized to the maximum extent possible, where applicable." Also, according to CMS Provider Reimbursement Policy, "DME not covered by the Medicaid benefit package, is to be reimbursed at no more than 80% of the usual and customary charge to the general public (suggested retail price, list price, or catalog price)."

Other factors that would have to be considered would include timeliness of delivery, servicing for items, and other factors that would relate to ensuring the quality of care for the recipient of the items.

Thus, **we recommend** CMS and BSCIP management proceed with their suggestion to analyze their respective program's frequent purchases of standard DME items and determine whether these items could be purchased in a more economical manner through a State contract.

Closing Remarks

We would like to thank the staff from Children's Medical Services, the Brain and Spinal Cord Injury Program, and the Division of Administration, Bureau of General Services for their cooperation during this review.

Appendix A

Children's Medical Services *
DME Expenditures by Area Office
July 1, 2007 - June 30, 2008

Area Office	Exoenditures	Percentage
Orlando	\$241,687.04	15.86%
W. Palm Beach	\$223,946.23	14.69%
Gainesville	\$146,446.20	9.61%
Tampa	\$119,954.46	7.87%
Sarasota	\$115,677.09	7.59%
Miami North	\$108,118.77	7.10%
St. Petersburg	\$104,709.53	6.87%
Jacksonville	\$68,574.16	4.50%
Miami South	\$66,123.04	4.34%
Ocala	\$60,663.56	3.98%
Rockledge	\$56,799.12	3.73%
Ft. Pierce	\$44,682.06	2.93%
Ft. Myers	\$36,087.47	2.37%
Lakeland	\$34,353.30	2.25%
Pensacola	\$33,366.64	2.19%
Daytona	\$23,747.51	1.56%
Panama City	\$20,424.17	1.34%
Naples	\$8,815.40	0.58%
Tallahassee	\$6,255.54	0.41%
Ft. Lauderdale	\$3,277.21	0.22%
Marathon	\$145.00	0.01%
TOTAL	\$1,523,853.50	100%

- These amounts do not reflect money expended by Integrated Care System (ICS) contractors to purchase DME equipment in selected areas of the state.

Appendix B

Brain and Spinal Cord Injury Program (Trust Fund)

DME Expenditures by Area Office

July 1, 2007 - June 30, 2008

Area Office	Expenditures	Percentage
Miami	\$238,840.54	21.73%
Orlando	\$217,282.61	19.77%
51. Petersburg	\$131,610.30	11.97%
Jacksonville	\$110,434.61	10.05%
Fl. Lauderdale	\$78,485.10	7.14%
Bradenton	\$65,373.83	5.95%
Fl. Pierce	\$56,156.78	5.11%
Winter Haven	\$47,147.15	4.29%
Pensacola	\$43,141.23	3.92%
Tallahassee	\$37,100.81	3.38%
Gainesville	\$26,489.70	2.41%
Cape Coral	\$22,681.32	2.06%
West Palm Beach	\$22,009.90	2.00%
Davtona	\$2,400.00	0.22%
TOTAL	\$1,099,153.88	100%

Appendix C

Brain and Spinal Cord Injury Program (Medicaid Waiver) **

DME Expenditures by Area Office ***

July 1, 2007 - June 30, 2008

Area Office	Expenditures	Percentage
Miami	\$48,385.70	23.22%
51. Petersburg	\$37,716.11	18.10%
Orlando	\$25,652.19	12.31%
Gainesville	\$21,903.81	10.51%
Tallahassee	\$21,058.41	10.10%
West Palm Beach	\$20,395.26	9.79%
Winter Haven	\$19,545.36	9.38%
Bradenton	\$13,727.09	6.59%
TOTAL	\$208,383.93	100%

** Money expended from this fund is later reimbursed by Medicaid back to the program.

*** Six BSCIP area offices did not have DME purchases through the Medicaid Waiver during FY 2007-08.