United States General Accounting Office

GAO

Report to Congressional Requesters

October 1993

VA HEALTH CARE

Medical Care Cost Recovery Activities Improperly Funded

GAO/HRD-94-2

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-250956

October 12, 1993

The Honorable John D. Rockefeller IV
Chairman, Committee on Veterans Affairs
United States Senate

The Honorable Patrick J. Leahy
United States Senate

The Department of Veterans Affairs (VA) operates 158 medical centers that provide a wide range of medical services to veterans. Before 1990, these centers used medical care appropriations to finance the recovery of health care costs from certain veterans or third parties. In November 1990, the Congress established a Medical-Care Cost Recovery (MCCR) Fund to finance all recovery expenses related to collecting the cost of medical care and services provided by VA.

You asked us to examine whether medical centers were using only the MCCR Fund to finance cost recovery activities. As agreed with your offices, we also reviewed VA's efforts to improve the efficiency of its recovery activities.

Results in Brief

As required by law, VA medical centers used the MCCR Fund in fiscal year 1992 to finance cost recovery activities. However, they also used VA medical care appropriations to finance cost recovery activities—apparently unaware that federal law prohibits such use. VA needs to examine medical centers' internal accounting and administrative controls and initiate appropriate actions to ensure that all medical care cost recovery activities are correctly identified and charged to the Medical-Care Cost Recovery Fund.

Further, the two medical centers we visited during our review were also using inefficient recovery procedures, which increased their administrative costs. These procedures included labor-intensive processes for determining billable medical care costs and reconciling amounts owed and collected. VA has several departmentwide actions under way, which, when completed, will help its medical centers better contain recovery costs.

Background

For many years, VA has had limited authority to recover costs for medical care provided at VA facilities. Under the 1962 Medical Care Recovery Act

(P.L. 87-693), VA collects from tortfeasors[1] the cost of providing medical care to certain veterans and their dependents. Also, VA collects the costs of providing medical care covered by workers' compensation, automobile insurance, or states for crime victims compensation programs. The medical care appropriation financed the entire cost of these recovery efforts.

The Veterans' Health Care Amendments of 1986 (P.L. 99-272) expanded VA's authority to recover medical care costs. The amendments authorized VA to collect from third-party insurers the cost of medical care or services provided to certain eligible veterans for conditions unrelated to military service. Also, the amendments authorized VA to collect copayments from certain veterans for health care received at VA. Medical care appropriations financed the new costs of these recovery efforts, and VA deposited the collections in the U.S. Treasury.

VA's efforts to implement the 1986 amendments started slowly. In fiscal year 1988, VA collected about $100 million, which represented an estimated one-third of possible recoveries at that time. Inadequate procedures and resources hindered centers' recovery efforts. In an earlier report,[2] we found that centers were reluctant to commit sufficient resources because, by law, (1) all recovery costs were to be paid from centers' medical care appropriations and (2) all amounts collected had to be returned to the Treasury. We recommended ways that VA's billing and collection processes could be improved.

The Congress Established a Medical-Care Cost Recovery Fund

In November 1990, the Omnibus Budget Reconciliation Act (P.L. 101-508) established a Medical-Care Cost Recovery Fund to finance VA's cost recovery activities—the necessary expenses for identifying, billing, and collecting the cost of medical care or services provided. The MCCR Fund is separate from the medical care appropriation. As a result, the recovery costs, which the medical care appropriation previously financed, are required to be financed from the collections deposited in the MCCR Fund. This act also expanded VA's authority to collect copayments from certain veterans for medications.

[1]A person who is found to have been at fault in injuring another individual.

[2]VA Health Care: Better Procedures Needed to Maximize Collections From Health Insurers (GAO/HRD-90-64, Apr. 6, 1990).

Collections deposited in the MCCR Fund are used to finance necessary recovery costs. Excess monies in the MCCR Fund are deposited annually as miscellaneous receipts in the U.S. Treasury.

VA's fiscal year 1992 appropriation act limited the Medical-Care Cost Recovery Fund expenditures to $77 million. At VA's request, the Congress did not include a spending limit in VA's fiscal year 1993 appropriation act. The Office of Management and Budget has authorized VA to spend up to $96 million from the MCCR Fund in fiscal year 1993.

VA Established a Medical Care Cost Recovery Office

In 1990, VA established an office within the Veterans Health Administration to oversee Medical-Care Cost Recovery Fund activities. This office is responsible for formulating and recommending plans, regulations, policies, and administrative procedures; it also implements budgeting and accounting controls for the MCCR Fund.

VA medical centers have significantly increased their medical care cost recoveries since the establishment of the MCCR Fund and the MCCR Office in 1990. In fiscal year 1992, VA medical centers collected $448 million, compared to $148 million in fiscal year 1990. Officials of the MCCR Office attribute the increases to stronger commitments to recovery activities by medical centers and improved policies and procedures. VA estimates it will recover about $551 million in fiscal year 1993.

Requirements Analysis Report

The MCCR Office allocates specific amounts from the MCCR Fund to each of its medical centers based on staffing and equipment needs for collection activities from insurers and certain veterans for their copayments. Medical centers are to prepare a requirements analysis report that justifies planned expenditures from the MCCR Fund. These planned expenditures are not to exceed the allocation made by the MCCR Office. In the reports, centers describe how they will use MCCR funds for personnel, equipment, and other services. The MCCR Office staff uses this report to ensure that planned expenditures from the MCCR Fund do not exceed the total amount allocated.

Cost Distribution Report

The cost distribution report serves as a budget tool for headquarters managers to obtain estimates of costs for different medical center activities. The Veterans Health Administration budget office requires medical centers to prepare a cost distribution report that estimates costs among various activities within a medical center, including medical care cost recoveries. Medical centers submit information monthly for the cost

distribution report. VA officials emphasize that the cost distribution report is not an accounting record for actual expenditures.

Two services generally perform medical care cost recovery activities at the medical centers: the Medical Administration Service, which provides administrative support and prepares the bills; and the Fiscal Service, which handles mailing and collection responsibilities. These services' staffs may perform both cost recovery (financed by the MCCR Fund) and non-cost-recovery (financed by medical care appropriation) activities. The time each employee spends on different activities can vary daily. The services estimate the time devoted to each activity and report it in the cost distribution report.

To develop the cost distribution report, the chiefs of the Medical Administration Service and the Fiscal Service estimate their services' expenses for recovery activities. The instructions for the cost distribution report state that the most accurate method for developing this information would be to list each employee who performs cost recovery activities and distribute his/her time actually spent on these activities.

In addition to providing estimates for medical care recovery costs, the cost distribution report is VA's official basis for computing the charges for medical care and services. The cost distribution report provides basic costs by types of inpatient care and outpatient care. The rates generated, based on the cost distribution report and other factors, are the same rates prescribed by the Office of Management and Budget and published in the Federal Register for use under the 1962 Medical Care Recovery Act.

Accounting Practices

The Veterans Health Administration requires VA medical centers to record MCCR Fund expenditures in its computerized accounting system, known as the Centralized Accounting Local Management system. This system maintains VA's official accounting information for the MCCR Fund. However, recovery costs not charged to the MCCR Fund are not included in this system, such as costs that the medical centers may have charged to the medical care appropriation.

Scope and Methodology

To assess VA's use of the MCCR Fund, we reviewed operating policies and procedures and discussed them with officials of VA's MCCR Office. We also discussed them with officials of VA's Medical Administration Service, Fiscal Service, and Office of General Counsel.

We obtained fiscal year 1992 information on the MCCR Fund allocations and reimbursements for 159 medical centers.[3] We visited two VA medical centers: a large, urban center in West Los Angeles, California, and a small, rural center in White River Junction, Vermont. At the centers, we discussed the MCCR Fund operating policies and procedures with staff, mainly from the Medical Administration Service and the Fiscal Service, and reviewed supporting documentation for the centers' requirements analysis reports.

We also obtained recovery cost information that the 159 medical centers reported on their cost distribution reports for fiscal year 1992. To estimate the amount of medical care appropriations that medical centers used for medical care cost recovery activities, we compared each center's recovery costs reported in the cost distribution report to its MCCR Fund reimbursements. During our visits to the two centers, we also reviewed supporting documentation for these reports and discussed them with center officials. We interviewed 69 staff at the two centers who were identified as performing cost recovery activities to obtain information on salaries and on types of duties and amounts of time spent on these duties. We did not review documentation supporting the cost recovery estimates reported by the other 157 medical centers.

We conducted our work from March 1992 to August 1993 in accordance with generally accepted government auditing standards.

Medical Centers Used Medical Care Appropriations for Cost Recovery Activities

In 1992, VA medical centers used VA medical care appropriations for cost recovery activities at the two centers we visited, and centers nationwide also appear to have used medical care appropriations for recovery activities. Medical care appropriations were used at the two centers visited because the MCCR Fund allocations were insufficient to cover all recovery activities, medical center staff said, and nationwide VA officials were unaware that certain medical care recovery costs should not be financed by medical care appropriations.

At the two medical centers we visited, officials reported using a total of $740,000 of medical care appropriations for medical care cost recovery activities in fiscal year 1992. Officials in the headquarters MCCR Office believed that the MCCR Fund allocations to the medical centers were sufficient to finance expenses for cost recovery activities from health

[3]VA operated 159 medical centers until December 1991, when the center in Martinez, California, closed.

insurers and veterans for their copayments. However, officials at the two centers we visited stated that the MCCR Fund allocations were insufficient. The two centers reported that they used medical care appropriations to support these cost recovery activities and could not have fully carried out their billing and collection responsibilities without doing so.

The West Los Angeles Medical Center reported total recovery costs of about $1.3 million (involving 33 full-time equivalent employees [FTEE]) on its cost distribution report for fiscal year 1992. Of that amount, the center charged $776,000 to the MCCR Fund for 17 FTEEs and other related costs. This sum was the total MCCR Fund amount allocated to the West Los Angeles Center. Medical center officials said they also used an estimated $535,000 of medical care appropriations for cost recovery activities. The center collected about $2,061,000 in fiscal year 1992.

For the same period, the White River Junction Medical Center reported total recovery costs of about $446,000 (involving 13 FTEEs) on its cost distribution report. Of this amount, the center charged $241,000 to the MCCR Fund for six FTEEs and other related costs. This amount also represented the total MCCR Fund amount allocated. Like West Los Angeles, officials at the White River Junction Center told us that they also used an estimated $205,000 for cost recovery activities financed by the medical care appropriation. In fiscal year 1992, the center collected about $3,064,000.

Officials at the two medical centers we visited stated that their cost distribution reports provided reasonable estimates of total recovery costs. To assess this assertion, we interviewed 29 staff at White River Junction and 40 staff at the West Los Angeles Medical Centers and asked them to (1) describe their duties and (2) estimate the percent of time they spent on cost recovery activities. The interviews supported the reasonableness of each medical center's reported recovery costs.

Nationwide, medical centers appear to have used medical care appropriations in fiscal year 1992 to finance recovery activities, such as costs for collecting the cost of medical care from tortfeasors who injured veterans or their dependents. This situation occurred, in part, because medical centers had used medical care appropriations to fund these recovery activities before the establishment of the MCCR Fund. As discussed more fully on page 8, centers were allowed to use medical care appropriations rather than the MCCR Fund because MCCR Office officials misinterpreted the law that established the MCCR Fund. They believed that

the law did not allow costs for recovery activities from tortfeasors to be charged to the MCCR Fund.

Our analysis of the other 157 medical centers' cost distribution reports showed that 126 centers reported recovery costs in excess of the amounts reimbursed from the MCCR Fund. This fact suggests that many of these centers may have used medical care appropriations to finance medical care cost recovery activities in fiscal year 1992.

Using Medical Care Appropriations for Cost Recovery Activities Violates Federal Law

The medical centers' use of medical care appropriations for medical care cost recovery activities violates federal law at 31 U.S.C. 1301(a) (1988). Specifically, federal funds may only be spent for purposes for which they were appropriated. Since its establishment in 1990, the MCCR Fund, which is separate from the medical care appropriation, should be used to finance all medical care cost recovery activities. Thus, centers are prohibited from using medical care appropriations for identifying, billing, and collecting the cost of medical care and services provided.

On November 10, 1992, we notified VA's General Counsel that the two medical centers we visited were using medical care appropriations for cost recovery activities (see app. I). On January 8, 1993, VA's General Counsel agreed, in principle, that the law does not permit medical care appropriations to be used for cost recovery activities (see app. II). Until then, VA's MCCR Office and finance officials had been unaware that medical care appropriations should not have been used to finance recovery costs.

On February 9, 1993, the Under Secretary for Health issued policy guidance to be used in determining direct and indirect charges to the MCCR Fund. This policy guidance describes what costs can and cannot be charged to the MCCR Fund (see app. III). In addition, it notified all centers that the costs of recovery activities cannot exceed MCCR Fund allocations and directed medical centers not to use medical care appropriations or other funds to subsidize the MCCR Fund.

Since the establishment of VA's policy guidance, officials in the MCCR Office told us that they have informally responded to medical centers' questions about activities not specifically addressed in the policy. Currently, they are working to clarify what charges can be included as overhead costs and what activities are or are not recovery activities, such as medical record coding.

The February 9, 1993, policy guidance (section 3b(1)d), however, incorrectly directs medical centers to use medical care appropriations to finance recovery costs related to collecting the cost of medical care or services from tortfeasors for care provided to veterans and dependents under the Civilian Health and Medical Program of VA, from ineligible (nonveteran) patients, and from emergency/humanitarian patients. As a result, this policy guidance requires medical centers to finance these activities in the same manner as they did before the establishment of the MCCR Fund. Medical center and MCCR Office officials were unaware that recovery costs for these activities should not be financed by medical care appropriations. However, by law, recovery costs for these activities and recovery costs for sharing agreements with other non-VA facilities should be entirely financed by the MCCR Fund when VA is attempting to collect the cost of medical care and services provided.

VA May Have Exceeded the Statutory Limit for Cost Recovery Activities

VA medical centers collectively reported in their cost distribution reports spending about $89 million for medical care cost recovery activities in fiscal year 1992. Of the $89 million, medical centers charged about $76 million to the MCCR Fund, and 128 medical centers reported using another $13 million of medical care appropriations for cost recovery activities.[4] If medical centers used as little as $1 million of the reported $13 million in medical care appropriations for cost recovery activities, VA exceeded the statutory limit of $77 million established by VA's fiscal year 1992 appropriations act. (Of the estimated $13 million, expenditures for individual medical centers ranged between $4,800 and $653,000; the majority exceeded $100,000 (see app. IV).[5])

Officials of VA's MCCR Office questioned the reliability of the cost distribution reports. They stated that because centers use a formula to estimate recovery costs included in the reports, the estimate may not fully account for actual workload changes, especially for staff that perform recovery and nonrecovery activities. The two centers we visited accounted for about $740,000 of the estimated $13 million, and officials told us that these expenditures were for cost recovery activities.

Given the lack of accounting records for cost recovery activities that centers charged to the medical care appropriation, the cost distribution

[4]VA's accounting system does not capture medical care appropriations used for medical care cost recovery activities.

[5]These amounts represent the difference between the total recovery costs included in centers' cost distribution reports and the amounts charged to the MCCR Fund.

reports provide the only available information pertaining to the estimated amount of medical care appropriations that the other centers may have used to finance cost recovery activities. While VA questions the reliability of the cost distribution report for estimating the total amount of recovery costs, VA continues to use the cost distribution report as the official basis for computing the amounts it charges for VA medical care and services. These charges are published in the Federal Register. VA officials told us that the charges do not reflect the actual costs, on a procedure-by-procedure basis. However, officials also told us that VA is required by Office of Management and Budget Circular A-25[6] to use existing data to compute such charges.

If VA medical centers used more than $1 million of medical care appropriations in fiscal year 1992 for cost recovery activities, the department violated the Antideficiency Act (31 U.S.C. 1341 (Supp. III 1991)) that prohibits expenditures from exceeding the amounts authorized for specific purposes. As previously mentioned, VA's appropriations act limited MCCR Fund expenditures to $77 million in fiscal year 1992. It is likely, however, that the centers spent more than this amount given that (1) medical centers charged about $76 million to the MCCR Fund, (2) the two centers we visited reported using about $740,000 in medical care appropriation for recovery costs, and (3) 126 other centers reported using about $12.3 million in medical care appropriations for cost recovery activities.

Upon discovering a potential Antideficiency Act violation, we notified VA's Office of the General Counsel. After receipt of our November 10, 1992, letter, VA's General Counsel informed us that the VA Chief Financial Officer was asked in January 1993 to conduct a factual inquiry into whether VA had exceeded the $77 million available in fiscal year 1992 for MCCR Fund activities. In August 1993, however, VA's Deputy Chief Financial Officer told us that he has no plans to conduct a factual inquiry for fiscal year 1992 because the data are not readily available, and they would be very expensive to collect.

VA Efforts to Improve Efficiency of Cost Recovery Processes

VA has efforts under way to improve the efficiency of medical centers' billing and collection processes. These activities include developing individual veteran accounts and enhancing computer software for identifying billable costs for medical care.

[6]For establishing the amount of user charges, the full cost shall be determined or estimated from the best available records of the agency, and new cost accounting systems need not be established solely for this purpose.

Individual Veterans' Accounts

In September 1992, the MCCR Office released new computer software, designed to (1) set up individual veteran accounts and (2) accept payments from veterans, regardless of whether the system generated a bill. In addition, VA is designing software that will automatically archive paid bills.

When we visited the West Los Angeles and White River Junction medical centers, the computer systems were slow and overloaded because (1) they created individual bills for each patient visit, rather than veteran accounts that contained all patient activity, and (2) they did not remove paid bills from the system. In addition, the centers could not easily accept payments from veterans until the system generated a bill because it was not possible to create a credit balance for them.

As a result, centers spent extra time sending out bills and collecting from veterans when they could have collected the amounts while the patients were at the medical center. Further, the computer system sometimes generated bills before the centers had provided the services. At the White River Junction medical center, for example, veterans received bills for prescription copayments before the pharmacy had mailed the prescriptions to them. This situation causes confusion and requires more staff time to explain the process to veterans.

Itemized Bills

In September 1992, VA also provided medical centers with software to develop customized forms for itemized outpatient insurance company bills. This action should reduce costs by lowering staff time. Previously, clerks manually reviewed either outpatient routing slips or veterans' medical records to obtain patient diagnoses and services provided in order to prepare itemized bills.

Conclusions

Based on our work, VA directed medical centers to no longer use medical care appropriations to finance recovery costs related to veterans' health insurance and copayments. However, VA's February 1993 policy guidance, directing medical centers to charge certain cost recovery expenses to the medical care appropriation, is incorrect. In this regard, medical care appropriations cannot be used to finance any medical care cost recovery activities. By law, all expenses for medical care cost recovery must be charged to the MCCR Fund.

Current VA practices and procedures make it difficult to ensure that the financing of medical care cost recovery activities conforms to applicable laws. Some medical care cost recovery expenses remain inadequately defined, such as costs for overhead and medical record coding. Also, the method for allocating personnel costs between activities for staff that perform both medical care cost recovery and non-cost-recovery activities is inadequate. Without better definitions for cost recovery activities and a reasonable method for allocating personnel costs between different activities, some cost recovery expenses may continue to be improperly charged to the medical care appropriation.

It remains unresolved whether VA violated the Antideficiency Act by spending more than the $77 million appropriated for medical care cost recovery activities in fiscal year 1992. The exact amount spent on medical care cost recovery activities is unknown because VA's accounting system does not adequately capture expenses for cost recovery activities charged to its medical care appropriation. In addition, the problems associated with the definition of cost recovery activities and the method for allocating personnel costs between different activities have contributed to the confusion over the exact amount VA spent for the medical care cost recovery activities. As a result, neither VA nor our office is able to reasonably determine the exact amount of funds that medical centers may have used to finance medical care cost recovery activities in fiscal year 1992.

Recommendation to the Secretary of Veterans Affairs

We recommend that the Secretary of Veterans Affairs direct VA's Chief Financial Officer to examine medical centers' internal accounting and administrative controls and, with the assistance of the VA's Under Secretary for Health, initiate appropriate actions to ensure that all medical care cost recovery activities are correctly identified and charged to the MCCR Fund. For those staff that perform both cost recovery and non-cost-recovery activities, the Chief Financial Officer and the Under Secretary for Health should develop specific guidelines for allocating personnel costs to the appropriate activity.

Agency Comments

We requested written comments from the Department of Veterans Affairs, but none were provided. However, at several meetings with officials in VA's Office of Financial Management, Veterans Health Administration, and Office of General Counsel, we discussed our findings with VA officials and obtained their oral comments. We made appropriate changes to the report

based on comments received from these officials, including the Deputy Chief Financial Officer, the Deputy Under Secretary for Health for Administration and Operations, the Director of the Medical Care Cost Recovery Office, and officials in the Office of General Counsel.

In general, these officials stated that there are problems with (1) accounting for the medical care cost recovery expenses, largely due to inadequacies in VA's present accounting system, and (2) determining whether certain activities are or are not medical care cost recovery activities. They agreed, in principle, with our report recommendation and acknowledged that actions need to be taken to address these issues.

As agreed with your offices, unless you publicly announce its contents earlier, we will make no further distribution of this report until 14 days from the date of this letter. At that time, we will send copies of this report to the Secretary of Veterans Affairs; the Chairman, House Committee on Veterans' Affairs; the Chairpersons, Senate Committee on Appropriations and its Subcommittee on VA, HUD and Independent Agencies; the Chairmen, House Committee on Appropriations and its Subcommittee on VA, HUD and Independent Agencies; the Director, Office of Management and Budget; and other interested parties. Copies will also be made available to others upon request. If you have any questions regarding this report, please contact me on (202) 512-7101. Other major contributors to this report are listed in appendix V.

David P. Baine

David P. Baine
Director, Federal Health
Care Delivery Issues

Contents

Abbreviations

FTEE	full-time equivalent employee
HUD	Department of Housing and Urban Development
MCCR	Medical Care Cost Recovery
VA	Department of Veterans Affairs

Letter From GAO's Office of the General Counsel to VA's Office of the General Counsel

GAO

United States
General Accounting Office
Washington, D.C. 20548

Office of the General Counsel

B-250956

November 10, 1992

James A. Endicott, Jr., Esq.
General Counsel
Department of Veterans Affairs

Dear Mr. Endicott:

We are writing to request the Department's opinion on what appears to be improper funding of medical care cost recovery (MCCR) activities.

The Senate Committee on Veterans Affairs asked the General Accounting Office to examine two VA medical centers to determine whether VA uses funds from the medical care appropriation for MCCR activities and whether VA implements MCCR activities efficiently. We found that the two centers used funds from the medical care appropriation for salaries of medical center personnel working on MCCR activities. The West Los Angeles Medical Center spent $250,000 in fiscal year 1991 and $134,000 in fiscal year 1992 from the medical care appropriation for MCCR activities; and the White River Junction Medical Center spent $42,000 for fiscal year 1991 and $145,000 for fiscal year 1992 from the medical care appropriation for MCCR activities. (The fiscal year 1992 amounts represent costs only through June 30, 1992.) Fiscal services personnel and MCCR coordinators at the medical centers identified personnel performing MCCR activities whose salaries were charged against the medical care appropriation.

The Omnibus Budget Reconciliation Act of 1990 established the Medical Care Cost Recovery Fund explicitly for the administration and collection of MCCR payments, including salaries, equipment, supplies, personnel training and travel, and reasonable charges for certain overhead items. The medical care appropriation does not authorize its use for MCCR activities.

Generally, an appropriation for a specific object, like the MCCR fund, is available to the exclusion of a more general appropriation, like the medical care appropriation, which

might otherwise be considered available for the same object. The exhaustion of the specific appropriation does not authorize charging additional amounts to the more general appropriation. Congress limited the amount available from the MCCR fund for fiscal year 1992 to $77 million. VA may have exhausted this amount in 1992 and used the medical care appropriation to augment it.

Use of the medical care appropriations for MCCR activities would violate 31 U.S.C. § 1301(a) (1988), which provides that funds may only be spent for the purposes for which they have been appropriated. In addition, spending more than $77 million in 1992 for MCCR activities would violate the Antideficiency Act, which prohibits expenditures from exceeding the amount available. 31 U.S.C. § 1341 (1988 and Supp. II 1990). To the extent VA incurred expenses exceeding its obligational authority in violation of the Antideficiency Act, VA would be required to report to the President and Congress all relevant facts and a statement of actions taken. 31 U.S.C. § 1351 (1988).

In order that we may take the Department's views into account, while making a timely report to the Committee, we ask that you respond within 30 days. Susan Poling of my staff (275-5881) can answer any questions.

Sincerely yours,

Barry R. Bedrick
Associate General Counsel

Letter From VA's Office of the General Counsel to GAO's Office of the General Counsel

DEPARTMENT OF VETERANS AFFAIRS
Office of the General Counsel
Washington DC 20420

January 8, 1993

In Reply Refer To: 024J

Barry R. Bedrick, Esquire
Associate General Counsel
Office of the General Counsel
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Bedrick:

Our office is in receipt of your letter dated November 10, 1992 (numbered B-250956), in which you question the Department's apparent use of Medical Care funds to support Medical Care Cost Recovery activities. You have requested that we provide a legal response concerning whether such action, if true, violates section 1301(a) of title 31, United States Code, and the provisions of the Antideficiency Act.

In this regard, we requested and received some factual information from appropriate VA officials. However, upon review of that information, we discovered that a complex interrelationship exists between these programs and that additional fact-finding would be necessary in order to provide your office with an informed legal opinion. We are accordingly requesting VA's Chief Financial Officer to lead the factual inquiry, since his staff is familiar with the funding operations of both accounts. Once he determines whether in fact Medical Care funds supported Medical Care Cost Recovery activities, and the extent to which that may have occurred, the Department would be pleased to promptly reply to your letter.

Although the factual inquiry is not complete, we agree with the principle, enunciated in your letter, that funds from a general appropriation cannot be expended on activities which are specifically funded in another appropriation. Such expenditures would violate section 1301(a) of title 31, United States Code. Upon receipt of the information referenced above, we will respond to the two issues raised in your letter of November 10, 1992.

2.

Barry R. Bedrick, Esquire

We are hopeful that this matter can be resolved in a timely manner. If you have any questions, Mr. Al Neviaser of my staff may be contacted at 633-7237.

Sincerely yours,

James A. Endicott, Jr.
General Counsel

1993 VA Directive Concerning MCCR Appropriation

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 10-93-013

February 9, 1993

TO: Regional Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics, Regional Offices with Outpatient Clinics and Information Systems Centers

SUBJ: MCCR (Medical Care Cost Recovery) Appropriation

1. PURPOSE: The purpose of this VHA (Veterans Health Administration) directive is to provide guidance for management of the MCCR Appropriation, 36X5014, Operating Budget. This directive will not be incorporated into a permanent issue at this time.

2. POLICY: All VA (Department of Veterans Affairs) facilities participating in MCCR activities are to charge all necessary expenses for the identification, billing, and collection of the cost of care and services furnished under 38 U.S.C. (United States Code) Chapter 17, and for the administration and collection of payments required under 38 U.S.C., Section 1710(f), for hospital care or nursing home care, under 38 U.S.C., Section 1712(f) for medical services, under 38 U.S.C., Section 1722A for medications, and under 38 U.S.C., Section 1729 for recovery of cost of certain care and services to the 36X5014 Appropriation. While fulfilling this directive, all VA facilities must remain within the MCCR Appropriation funding allowances and are not to charge MCCR costs to other Appropriations. The Medical Care Appropriation cannot subsidize the MCCR activity and FTE (Full Time Equivalent) used to support MCCR cannot exceed the FTE allotted by the MCCR Program Office. All VA facilities are to efficiently manage their MCCR operating budget to ensure continued operation of the MCCR Program.

3. ACTION

a. All medical centers, outpatient clinics, regional offices and ISCs will follow the accounting procedures contained in the recently revised OMB Circular A-34 and MP-4, part V.

b. The following guidelines are to be used in determining direct and indirect charges to the MCCR Appropriation, 36X5014.

(1) Personal Services

(a) All employees engaged in full-time MCCR activities are to be costed (journalized) to the designated MCCR Appropriation cost center. Cost transfers will be prepared monthly for employees performing part-time MCCR activities. Total cumulative FTE may not exceed the FTE allotted by the MCCR Program Office. Costs for personnel and first-line supervisors providing direct service are to be charged to the MCCR Appropriation.

(b) If the first-line supervisor is at or above the service chief level, charges for direct service are not to exceed 10 percent of the supervisor's time. Higher level management costs in the performance of MCCR activities are not to exceed 5 percent of the manager's time. Physicians' time is not to be charged to the MCCR appropriation.

THIS VHA DIRECTIVE EXPIRES FEBRUARY 9, 1994

VHA DIRECTIVE 10-93-013
February 9, 1993

(c) Agent cashiers are to be charged to the MCCR appropriation for functions directly relating to the MCCR Program. Activities performed by agent cashiers prior to the establishment of the MCCR fund are to be charged to the medical care appropriation. The MCCR appropriation should not support all agent cashier functions.

(d) MCCR staff performing the collection activities for CHAMPVA (Civilian Health and Medical Program of the VA), sharing agreement reimbursements, ineligibles non-veteran patient reimbursements, tort feasor reimbursements, and emergency/humanitarian patient reimbursements must be charged to the medical care appropriation. Cost transfers for these employees must be accomplished monthly.

(e) Functions performed by medical record coders for inpatient activities are not chargeable to the MCCR appropriation. The proper coding of inpatient medical records is a necessary function of medical care. MCCR is a user of the inpatient medical record data and has not established new coding requirements. Inpatient coding functions are not supportable by MCCR since the data required by MCCR is common to the inpatient medical data requirements of VHA, independent of MCCR. Functions performed by medical record coders for outpatient activities are chargeable to the MCCR appropriation. The coding of outpatient medical records is not a medical care requirement. However, for MCCR to seek reimbursement from insurance carriers, coding of outpatient records is necessary. Therefore, the costs for outpatient coding activities is chargeable to the MCCR appropriation.

(2) Equipment. The costs of ADP and NON-ADP equipment used in the daily operation of MCCR activities are to be charged to the MCCR appropriation and recorded on each facility's MCCR CMR (Consolidated Memorandum of Record).

(3) Other Services. Most of the charges in this object class will reflect contractual services directly attributable to the operation of the MCCR program. M&R (maintenance and repair) services for equipment purchased with MCCR funds are included in this category.

(4) All Other. These charges comprise items that are a direct result of performing the MCCR functions. Included are direct charges for supplies and materials; rents and communications; printing and reproduction; and transportation of things. Charges to the Operating Supplies Subaccount will be closely monitored and must be for direct support of MCCR functions. Overhead charges for utilities and housekeeping should be based on an administrative square footage rate. Other overhead charges should be distributed based upon the percent of assigned MCCR FTE to the total FTE for the medical facility or outpatient clinic. This should be similar to the way overhead is charged to Canteen and Research Services.

(5) Central Funding. Training costs will be funded centrally and are not to be charged to the MCCR appropriation without prior approval from the MCCR Program Office. Funding for regional and national conferences will be managed centrally. All PCS (Permanent Change of Station) charges require prior authorization from the MCCR Program Office and will be funded centrally. Regular mail service and employee travel will be funded centrally and should not be charged to the MCCR appropriation without prior authorization. Requests for central funding initiatives must be submitted through the Regional Coordinators for medical centers and through the Director, MIRMO (Medical Information Resources Management Office) for the ISCs. The Director, MCCR Office, has final approval.

c. The MCCR appropriation, 36X5014, is a no-year fund. However, OMB (Office of Management and Budget) currently limits funding availability on an annual basis by four obligation categories: Personal Services, All Other, Equipment and Other Services. Therefore, facilities will not transfer funds between categories. As of the close of business on September 30 of each year, the unobligated balances, less the subsequent years apportioned balance, remaining in the 36X5014 appropriation are to be transferred to the Treasury as miscellaneous receipts. All unobligated funds from the preceding fiscal year will be withdrawn no later than January 1 of the current year. Facilities will not make obligations at the end of a fiscal year and then deobligate the funds in the next fiscal year in an effort to retain resources. An annual RAR (Requirements and Analysis Report) will be conducted to provide an opportunity to request nonrecurring funding and to establish an operating plan for the current fiscal year. Quarterly needs and excesses reports will be conducted.

(8) CDR (Cost Distribution Report). Costs transferred from the medical care appropriation to the MCCR appropriation will represent all support of the MCCR activity charged to medical care due to payroll and accounting systems limitations. The cost transfer transactions are to be completed prior to the closing of monthly accounting transactions. Reporting MCCR support cost on the CDR will no longer be allowed.

4. REFERENCES

a. Title 38, U.S.C. Chapter 17.

b. OMB Circular A-34.

c. MP-4, part V.

5. FOLLOW-UP RESPONSIBILITY: Director, Medical Care Cost Recovery Office (165).

6. RESCISSIONS: This VHA directive will expire February 9, 1994.

James W. Holsinger, Jr., M.D.
Under Secretary for Health

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VA Expenditures Reported for MCCR Activities in Fiscal Year 1992

VA facility	MCCR allocation	MCCR Fund spending	Estimated medical care funds used	Estimated medical care spending above MCCR Fund spending (percent)
Albany, NY	$1,180,968	$1,180,950	$116,368	10
Albuquerque, NM	284,018	283,954	262,563	92
Alexandria, LA	343,356	343,356	159,556	46
Allen Park, MI	563,678	563,674	0	0
Altoona, PA	421,465	420,975	0	0
Amarillo, TX	261,932	254,575	111,020	44
American Lake, WA	205,486	205,437	111,567	54
Anchorage (OC), AK	137,057	137,014	104,724	76
Ann Arbor, MI	514,517	514,505	339,601	66
Asheville, NC	480,915	480,915	0	0
Atlanta, GA	376,760	376,733	0	0
Augusta, GA	527,555	527,551	231,236	44
Baltimore, MD	377,638	377,608	0	0
Batavia, NY	192,940	192,933	64,811	34
Bath, NY	239,040	238,868	75,301	32
Battle Creek, MI	355,761	355,753	13,085	4
Bay Pines, FL	570,804	570,791	0	0
Beckley, WV	207,161	207,161	76,353	37
Bedford, MA	289,181	288,923	47,639	16
Big Spring, TX	282,401	282,322	130,473	46
Biloxi, MS	368,175	368,171	348,631	95
Birmingham, AL	560,871	560,673	270,918	48
Boise, ID	251,819	251,819	11,931	5
Bonham, TX	229,224	229,224	107,950	47
Boston, MA	683,116	683,107	652,863	96
Brockton, MA	455,763	455,746	52,380	11
Bronx, NY	481,861	481,767	327,711	68
Brooklyn, NY	652,622	652,621	375,184	57
Buffalo, NY	563,650	563,620	161,539	29
Butler, PA	294,017	294,017	67,907	23
Canandaigua, NY	248,248	248,248	45,893	18
Castle Point, NY	211,271	211,265	107,872	51
Charleston, SC	373,900	373,895	108,558	29
Cheyenne, WY	216,661	216,646	211,915	98
Chicago (LS), IL	377,983	377,983	95,051	25
Chicago (WS), IL	681,575	681,559	79,266	12

(continued)

VA facility	MCCR allocation	MCCR Fund spending	Estimated medical care funds used	Estimated medical care spending above MCCR Fund spending (percent)
Chillicothe, OH	286,035	285,992	72,732	25
Cincinnati, OH	409,948	406,629	120,950	30
Clarksburg, WV	247,310	247,309	0	0
Cleveland, OH	963,892	963,790	0	0
Coatesville, PA	258,847	258,787	0	0
Columbia, MO	425,480	425,478	0	0
Columbia, SC	415,491	415,458	324,613	78
Columbus (OC), OH	235,720	235,675	49,938	21
Dallas, TX	1,056,931	1,056,891	0	0
Danville, IL	384,475	384,470	58,437	15
Dayton, OH	244,004	244,004	155,591	64
Denver, CO	435,491	435,491	27,959	6
Des Moines, IA	269,695	269,612	105,915	39
Dublin, GA	271,791	271,351	116,954	43
Durham, NC	386,891	386,889	209,039	54
East Orange, NJ	605,511	605,503	396,813	66
El Paso (OC), TX	96,966	96,880	117,388	121
Erie, PA	224,689	224,687	132,297	59
Fargo, ND	230,989	230,989	0	0
Fayetteville, AR	185,972	185,221	60,633	33
Fayetteville, NC	232,792	232,774	54,512	23
Fort Harrison, MT	204,968	204,927	0	0
Fort Howard, MD	437,205	437,205	45,369	10
Fort Lyon, CO	143,777	143,652	22,543	16
Fort Meade, SD	298,270	298,270	0	0
Fort Wayne, IN	205,033	205,011	0	0
Fresno, CA	393,008	393,002	0	0
Gainesville, FL	457,494	457,360	9,513	2
Grand Island, NE	185,417	185,165	135,762	73
Grand Junction, CO	174,726	174,579	61,069	35
Hampton, VA	486,471	486,451	0	0
Hines, IL	948,625	948,304	4,848	1
Honolulu (OC), HI	119,419	119,415	157,864	132
Hot Springs, SD	159,804	159,804	15,890	10
Houston, TX	759,957	759,936	88,321	12
Huntington, WV	230,845	230,808	136,030	59
Indianapolis, IN	448,043	448,038	93,580	21

(continued)

VA facility	MCCR allocation	MCCR Fund spending	Estimated medical care funds used	Estimated medical care spending above MCCR Fund spending (percent)
Iowa City, IA	341,041	341,040	24,653	7
Iron Mountain, MI	197,643	197,569	0	0
Jackson, MS	474,365	474,361	79,032	17
Kansas City, MO	559,236	559,133	0	0
Kerrville, TX	164,799	164,678	108,059	66
Knoxville, IA	199,282	199,093	11,372	6
Lake City, FL	290,437	290,424	22,620	8
Las Vegas (OC), NV	123,740	123,740	26,981	22
Leavenworth, KS	325,605	325,599	0	0
Lebanon, PA	306,183	306,032	0	0
Lexington, KY	517,825	517,783	0	0
Lincoln, NE	189,628	189,627	66,969	35
Little Rock, AR	893,124	893,123	0	0
Livermore, CA	188,179	188,087	93,722	50
Loma Linda, CA	381,679	381,336	242,151	64
Long Beach, CA	773,387	773,377	341,864	44
Los Angeles (OC), CA	135,658	135,658	87,572	65
Louisville, KY	558,844	558,843	121,946	22
Lyons, NJ	390,762	390,744	409,321	105
Madison, WI	339,776	339,736	33,529	10
Manchester, NH	198,936	198,759	171,397	86
Marion, IL	314,053	314,047	59,776	19
Marion, IN	180,180	180,180	59,558	33
Marlin, TX	148,861	148,861	8,975	6
Martinez, CA	508,736	508,736	46,880	9
Martinsburg, WV	701,946	701,943	122,727	17
Memphis, TN	446,163	446,163	45,775	10
Miami, FL	506,455	504,869	309,791	61
Miles City, MT	105,787	105,787	64,309	61
Milwaukee, WI	590,516	590,516	149,008	25
Minneapolis, MN	635,798	635,797	195,314	31
Montgomery, AL	190,855	190,855	0	0
Montrose, NY	268,638	268,038	7,764	3
Mountain Home, TN	308,406	308,396	83,406	27
Murfreesboro, TN	372,806	372,802	0	0
Muskogee, OK	361,659	361,474	174,344	48
Nashville, TN	446,675	446,674	61,829	14

(continued)

VA facility	MCCR allocation	MCCR Fund spending	Estimated medical care funds used	Estimated medical care spending above MCCR Fund spending (percent)
New Orleans, LA	608,599	608,559	0	0
New York, NY	562,903	562,903	0	0
Newington, CT	277,320	277,280	78,709	28
North Chicago, IL	499,158	499,156	344,414	69
Northampton, MA	337,147	337,136	21,887	6
Northport, NY	495,106	495,015	76,667	15
Oklahoma City, OK	532,798	532,797	25,262	5
Omaha, NE	421,460	421,455	119,148	28
Palo Alto, CA	475,377	475,251	598,386	126
Perry Point, MD	309,425	309,421	247,599	80
Philadelphia, PA	500,902	500,898	0	0
Phoenix, AZ	554,352	554,219	115,689	21
Pittsburgh (HD), PA	182,640	182,637	92,901	51
Pittsburgh, PA	454,004	453,959	257,767	57
Poplar Bluff, MO	277,227	277,222	0	0
Portland, OR	715,436	715,410	24,406	3
Prescott, AZ	234,767	234,764	50,815	22
Providence, RI	268,013	268,009	181,948	68
Reno, NV	255,656	255,646	212,690	83
Richmond, VA	688,098	688,093	113,646	17
Roseburg, OR	254,828	254,774	66,182	26
Saginaw, MI	310,998	310,941	122,285	39
Salem, VA	389,977	389,976	60,051	15
Salisbury, NC	393,622	393,622	35,777	9
Salt Lake City, UT	528,137	525,059	138,926	26
San Antonio, TX	658,270	658,269	267,183	41
San Diego, CA	357,991	357,990	303,270	85
San Francisco, CA	527,256	527,205	50,314	10
San Juan, PR	461,060	461,059	311,301	68
Seattle, WA	321,164	321,159	137,633	43
Sepulveda, CA	367,124	367,121	225,038	61
Sheridan, WY	139,458	139,179	27,818	20
Shreveport, LA	343,192	343,181	69,855	20
Sioux Falls, SD	299,090	299,090	0	0
Spokane, WA	231,594	231,594	36,701	16
St. Cloud, MN	251,831	251,831	79,304	31
St. Louis, MO	1,123,762	1,123,762	331,096	29

(continued)

VA facility	MCCR allocation	MCCR Fund spending	Estimated medical care funds used	Estimated medical care spending above MCCR Fund spending (percent)
Syracuse, NY	294,117	294,058	301,094	102
Tampa, FL	657,154	657,127	102,088	16
Temple, TX	290,765	290,680	121,178	42
Togus, ME	278,932	278,698	0	0
Tomah, WI	263,149	263,148	75,799	29
Topeka, KS	320,720	320,699	73,336	23
Tucson, AZ	503,611	503,611	67,499	13
Tuscaloosa, AL	234,174	233,972	77,734	33
Tuskegee, AL	350,116	350,116	34,708	10
Waco, TX	278,631	278,611	153,067	55
Walla Walla, WA	216,896	216,895	35,063	16
Washington, DC	572,357	572,304	257,246	45
Washington (VACO), DC	10,236,245	9,695,032	462,237	5
West Haven, CT	466,212	466,212	0	0
West Los Angeles, CA	776,633	776,408	524,678	68
White City (Dom), OR	137,874	137,874	2,501	2
White River Jct., VT	240,724	240,702	205,472	85
Wichita, KS	200,399	200,386	190,720	95
Wilkes-Barre, PA	348,466	348,466	265,074	76
Wilmington, DE	251,251	251,251	102,182	41

Legend

Dom = Domiciliary
HD = Highland Drive
LS = Lakeside
OC = Outpatient Clinic
VACO = VA Central Office
WS = West Side

Source: VA data for MCCR Allocation and MCCR Fund spending. Estimated medical care funds used is a GAO calculation (total recovery costs reported by the VA medical center in the center's cost distribution report less the amount the center charged to the MCCR Fund). Estimated medical care spending percentage is a GAO calculation (estimated medical care funds divided by MCCR Fund spending).

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