



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

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BEFORE THE
SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
VA'S FIDUCIARY PROGRAM: ENSURING VETERANS' BENEFITS ARE PROPERLY MANAGED
SEPTEMBER 28, 2023

Chairman Luttrell, Ranking Member Pappas, and members of the Subcommittee, thank you for the opportunity to testify on the Office of the Inspector General's (OIG) oversight of the Veterans Benefits Administration's (VBA) Fiduciary Program. The OIG is committed to conducting independent audits, reviews, and inspections that result in clear findings and practical recommendations to help VA promptly provide veterans with the quality care, services, and benefits they are due. To that end, the OIG works diligently to ensure every report it releases—even if focused on a single medical facility or benefits office—serves as a road map for VA leaders nationwide and contributes to overall program improvements. It also vigorously pursues criminal investigations involving potential fraud and other crimes affecting veterans and VA operations, programs, and services.

The purpose of the Fiduciary Program is to protect VA beneficiaries who are unable to manage their VA benefits as a result of injury, disease, the infirmities of advanced age, or being younger than 18 years old. VA appoints fiduciaries to receive direct payments on behalf of beneficiaries and disburse those funds for beneficiaries' care, support, welfare, and other needs.¹ During fiscal year 2022, the Fiduciary Program served more than 108,000 beneficiaries who received \$2.6 billion in VA-derived funds.²

Given the amount of money at issue and VA's commitment to serving vulnerable veterans, the need for strict accountability and effective oversight are vitally important to the continuous improvement of the

¹ VA beneficiaries rely on their appointed fiduciaries to make financial decisions in their best interests. When choosing a fiduciary, VA considers factors including a beneficiary's preference (such as a spouse or other family member if qualified), the identified individual's willingness to serve, and the potential fiduciary's ability to act in the beneficiary's interest.

² VBA, [Annual Benefits Report Fiscal Year 2022](#), p. 142.

program.³ The OIG's recent reviews have found weaknesses in program governance that have allowed gaps in workflow management and inadequate oversight processes to persist. The OIG has identified delays in determinations of whether a fiduciary is warranted, veterans' reimbursements when their benefits have been misused, and the distribution of deceased veterans' fiduciary-controlled funds to their heirs or back to VA. The delays often created unnecessary risks to veterans' welfare and exposed beneficiaries and their families to potential hardships when VA's assistance was critical. In addition to this oversight work, the OIG's Office of Investigations is deeply involved in criminal cases that identify bad actors to help deter fiduciary fraud and reduce its impact on victims.

This statement focuses on the OIG's most recent report on the Fiduciary Program, which reviewed allegations that deceased beneficiaries' VA-derived funds were not being timely and appropriately disbursed as required. The report illustrates deficiencies in VBA's oversight of the program and describes how the identified weaknesses can deprive veterans' heirs (or others named in their wills) of benefit funds to which they are entitled. The concerns with lax program oversight and inadequate processes are not new; prior oversight of the Fiduciary Program reflects similar findings as described in this statement.⁴ These weaknesses increase opportunities for bad actors. OIG investigators routinely work with their law enforcement partners to bring to justice those individuals who have defrauded or stolen vulnerable veterans' pensions and VA benefit compensation.

RECENT OVERSIGHT OF THE FIDUCIARY PROGRAM

In a report released last month, the OIG assessed an anonymous allegation to its hotline that two fiduciaries under the jurisdiction of a VBA hub in Indianapolis, Indiana, had not released the funds of four deceased beneficiaries who died in 2010, 2013, 2015, and 2020.⁵ During the course of the review, the OIG was made aware of two additional cases, for a total of six cases, associated with the two fiduciaries.

The OIG substantiated allegations that VA-derived funds were not always promptly disbursed to the deceased beneficiaries' heirs or returned to VA when there was no valid will or heir. Although the OIG's review focused only on the two fiduciaries related to the initial allegations, the process deficiencies that the review team identified could have significant effect across the Fiduciary Program.

³ The Pension and Fiduciary Service establishes policy and procedures, provides training, and generally oversees claims-processing accuracy. The program is implemented by six VBA fiduciary hubs—each responsible for administering the program in an assigned geographic region.

⁴ VA OIG, [VBA's Fiduciary Program Needs to Improve the Timeliness of Determinations and Reimbursements of Misused Funds](#), July 21, 2021; VA OIG, [Fiduciary Program: Some Incompetency Decisions Not Completed, Putting Those Beneficiaries' Funds at Risk](#), January 27, 2021.

⁵ VA OIG, [The Fiduciary Program Needs to Verify the Prompt Return of Deceased Beneficiaries' Funds to VA](#), August 17, 2023.

Background

When a beneficiary dies, the fiduciary must disburse the remaining VA “funds under management.”⁶ If the beneficiary has a valid will or heir, the fiduciary must hold the remaining funds under management in trust for the deceased beneficiary’s estate until the will is probated or heirs are ascertained and then disburse the funds according to applicable state law. If the beneficiary died without a will and no heir has been identified, the funds that would typically revert to the veteran’s state of residence are returned to VA.⁷

Although federal regulations require a fiduciary to submit a final accounting to VA within 90 days of the beneficiary’s death, neither statute nor regulation includes a timeliness standard for fiduciaries to distribute VA-derived funds of deceased beneficiaries to heirs or return them to VA.⁸

Until March 2021, VBA procedures required fiduciary hub staff to verify that the fiduciary had indeed disbursed the remaining funds under management for deceased beneficiaries to both heirs and VA. The Pension & Fiduciary (P&F) Service terminated this procedure with regard to a veteran’s estate, as no statute requires them to do so, and this is consistent with a VA Office of General Counsel opinion that states, “VA’s responsibilities with regard to protection of estate assets for the benefit of others generally cease with the death of the veteran.”⁹

In contrast, the opinion states that, generally, VA is authorized to assure the preservation of assets that *must be returned to VA* when no valid will or heir exists. Although the procedure to verify disbursement to an heir was removed, other procedures stated that a determination must be made as to the existence of a will or heir to determine whether funds must be distributed through the estate or returned to VA.¹⁰ Procedures and any related guidance do not, however, outline steps the fiduciary hub staff must take to make such a determination, such as actions and evidence needed to verify whether the fiduciary identified any valid will or heir.

⁶ 38 C.F.R. § 13.250 (2018). For the purposes of this report, VA-derived “funds under management” are beneficiaries’ unspent VA disability compensation or pension benefits payments. VA has no oversight responsibility for other sources of income beneficiaries may have, such as social security or retirement income.

⁷ 38 U.S.C. § 5502; 38 C.F.R. § 13.250.

⁸ 38 U.S.C. § 5502; 38 C.F.R. § 13.250; 38 C.F.R. § 13.280 (2018). A fiduciary accounting is a written report outlining the management of a beneficiary’s VA benefits payments and expenses for a specified period.

⁹ VA Office of General Counsel Precedent Opinion, VAOPGCPREC 5–98 (April 2, 1998). The General Counsel has the power to designate an opinion as precedential, and opinions involving veterans’ benefits are binding for VA officials and employees in subsequent matters involving the legal issue.

¹⁰ VA Manual M21-1MR, “Actions Required to Determine if Escheat is in Order,” part XI, chap. 4, section D.16.d in Adjudication Procedures Manual, updated February 2, 2005. The Adjudication Procedures Manual serves as a general guide for processing and adjudicating claims for compensation, pension, and related benefits for veterans and their dependents. VBA’s Compensation Service is responsible for updating the Adjudication Procedures Manual.

In March 2021, VBA updated its procedures to include a requirement to establish electronic controls to track the workload only for cases in which VA-derived funds of deceased beneficiaries must revert to VA.¹¹ Because the manual does not designate a unique identifier for electronic controls related to the return of deceased beneficiaries' VA-derived funds to VA, it is difficult for staff to monitor this workload.

The OIG Found Fiduciaries Were Not Promptly Disbursing VA Funds

The OIG substantiated that, as of June 2022, two fiduciaries, under the jurisdiction of the Indianapolis hub, had not promptly released the funds of six deceased beneficiaries. Between August 2022 and November 2022, both fiduciaries returned the funds to either the VA or an heir. The delay, however, ranged from more than 19 months to 12 years from the time of death (or the date the final accounting was received by VA, if required) to the distribution of the funds.¹²

For two of the six cases, VA-derived funds were not promptly distributed to the deceased beneficiaries' heirs. In total about \$800,000 of VA-derived funds were not released for more than 19 months in one case and nearly seven years in the other.

For the remaining four cases, no heirs were identified, and VA-derived funds were not promptly returned to VA. For these four cases, about \$9,300 of VA-derived funds were not promptly returned to VA, with delays ranging from five to 12 years after the beneficiaries' deaths.

As stated earlier, neither statute nor regulation includes a timeliness standard for disbursement. As stewards of taxpayer dollars, however, VA should be promptly reclaiming funds when there is no valid will or heir to receive them. Heirs also should not have to wait excessive periods to receive funds to which they are entitled. Even though it is not a statutory requirement, VBA is not prohibited from verifying disbursement of funds due to deceased beneficiaries' estates. Such verification would not only ensure heirs received funds to which they are entitled, it would also help identify funds that must be returned to VA if potential heirs thought to have existed at the time that the case was initially reviewed could not be verified. Moreover, a fiduciary can dispose of related records after two years from the date that VA either removes the fiduciary or the fiduciary withdraws. As a result, there is a potential risk of fraud, theft, and loss, if there has been no verification within those two years that funds were properly distributed.

¹¹ VA, Fiduciary Program Manual, "Actions Required When Escheat is in Order," part 2, chap. 1, sec. C, topic 3.e, updated March 17, 2021. The Fiduciary Program Manual serves as a general guide for activities and decisions inherent to providing fiduciary assistance to VA beneficiaries. The Pension and Fiduciary Service is responsible for updating the Fiduciary Program Manual.

¹² A delay in probate proceedings could cause a delay in disbursement. However, the OIG team found no evidence that any of the six cases were involved in probate.

What the OIG Recommended

To address identified weaknesses, the OIG made four recommendations to the under secretary for benefits to ensure that the P&F Service conducts the following actions:

1. Clarify procedural requirements to fiduciary hub staff on how to verify whether VA-derived funds of deceased beneficiaries must be returned to VA, including whether the fiduciary identified any valid will or heir to whom the funds are otherwise due.
2. Consider reimplementing the procedural requirement to verify the disbursement of VA-derived funds to deceased beneficiaries' estates when a valid will or heir exists.
3. Identify existing electronic controls or implement new ones that allow VBA staff to track Fiduciary Program tasks, timelines, and workload related to the return of deceased beneficiaries' VA-derived funds to VA that would otherwise escheat (revert) to a state if not disbursed to heirs.
4. Collaborate with the Office of Field Operations to establish a methodology and monitor the workload to ensure the prompt return of deceased beneficiaries' VA-derived funds.¹³

The OIG found that VA submitted actions plans generally responsive to the recommendations. The review team acknowledged VBA's decision not to reimplement the procedural requirement to verify the disbursement of VA-derived funds to deceased beneficiaries' estates when a valid will or heir exists, as proposed in recommendation 2, but reiterates that VBA is not prohibited from doing so to help ensure fiduciaries promptly disburse funds to individuals to whom the funds are due.

The OIG will monitor implementation of all planned actions and will close recommendations 1, 3, and 4 when VBA provides enough evidence to demonstrate sufficient progress in addressing the intent of the recommendations and the issues identified.¹⁴

PREVIOUS OIG WORK ON THE VA FIDUCIARY PROGRAM

As stated earlier, the OIG's prior oversight of the Fiduciary Program also showed insufficient monitoring and workflow management, leading to significant delays in essential tasks. These delays included finalizing incompetency determinations and reimbursing misused funds—increasing risks of poor outcomes for eligible beneficiaries also more vulnerable to fraud, theft, or financial loss.

¹³ The Office of Field Operations sets production goals and manages the employees who process veterans' claims.

¹⁴ The OIG requests updates on the status of all unimplemented recommendations every 90 days. This is reflected on the recommendations dashboard found on the OIG [website](#). For this report, the OIG will request the first update in late November 2023.

Some Incompetency Decisions Were Not Timely Completed, Affecting Beneficiaries' Receipt of Funds

In January 2021, the OIG published a management advisory memorandum after assessing the merits of a hotline allegation that a deceased veteran's VA funds had been misused while he was living at a California nursing home.¹⁵ As part of its assessment, the OIG discovered VBA had not finalized the veteran's incompetency proposal, despite VBA staff receiving medical evidence that the veteran was incapable of managing the VA benefit payments. This proposal, which can result in VA appointing a fiduciary, was not completed for three years prior to his death. This delay conflicts with VBA guidance that the decision be made and a fiduciary appointed within 141 days.¹⁶

The OIG expanded its review to identify broader process issues and found VBA had not finalized incompetency proposals for 221 beneficiaries from January 1, 2016, through December 31, 2019.¹⁷ Generally, the incomplete decisions occurred because staff did not update the workload management tool to show an incompetency proposal was pending a decision. Without that update, the case does not appear in the inventory of incompetency proposals requiring final action, so no decision is made or fiduciary appointed, and vulnerable beneficiaries' funds could be mismanaged. VBA agreed that 52 of the 55 records the OIG reviewed were incomplete (stalled); the others were on appeal or had been flagged for a decision. The OIG provided VBA with the remaining 166 of the 221 records found to have incomplete decisions so that VBA could determine whether further action was needed to ensure incompetency proposals were finalized.

VBA Needs to Improve the Timeliness of Determinations and Reimbursements of Misused Funds

In a July 2021 report, an OIG review team examined whether program staff properly addressed allegations of benefit payments being misused by fiduciaries and then reimbursed beneficiaries as required.¹⁸ Program staff initiated inquiries into approximately 12,000 allegations of fiduciary misuse of funds from January 1, 2018, through September 30, 2019.¹⁹

The team assessed staff actions for a sample of misuse determinations and did not find systemic issues. However, there were instances of significant wait times for program staff to determine misuse and

¹⁵ VA OIG, [Fiduciary Program: Some Incompetency Decisions Not Completed, Putting Those Beneficiaries' Funds at Risk](#), January 27, 2021.

¹⁶ This includes a 65-day due process period and a 76-day target for completing the initial appointment process.

¹⁷ VA OIG, [Fiduciary Program: Some Incompetency Decisions Not Completed, Putting Those Beneficiaries' Funds at Risk](#), January 27, 2021.

¹⁸ VA OIG, [VBA's Fiduciary Program Needs to Improve the Timeliness of Determinations and Reimbursements of Misused Funds](#), July 21, 2021.

¹⁹ Misuse occurs when a fiduciary spends a beneficiary's benefit payments for something other than the "use and benefit" of the beneficiary. Use and benefit is any expense reasonably intended for the care, support, or maintenance of the beneficiary or the beneficiary's dependents.

negligence and to reimburse misused funds. For example, one beneficiary waited 19 months after an initial determination of misuse before staff completed a negligence determination. VA then reimbursed the beneficiary over \$20,000 in misused funds. Another beneficiary waited 14 months after the misuse determination before VA staff authorized reimbursement of approximately \$5,800. The report concluded that VBA should consider whether the average number of days taken to complete each type of misuse action is acceptable to meet oversight responsibilities and fulfill the stated mission of protecting vulnerable veterans and other beneficiaries.

The OIG also found VBA did not adequately monitor all follow-up actions on reported misuse. VBA was unaware of many of the unprocessed negligence determinations that the team identified. Additionally, the team examined the workload management plans and the systematic analysis of operations for the two fiduciary hubs visited but none of the related documentation discussed or identified pending reimbursements.

The OIG made two recommendations to VBA to ensure prompt completion of determinations and reimbursements. In response, VBA implemented new information technology that allowed for electronic monitoring of negligence determinations and reimbursements. Both recommendations have been closed as implemented after reviewing VBA's responsive actions.

OIG CRIMINAL INVESTIGATIVE EFFORTS TO COMBAT FIDUCIARY FRAUD

The OIG's Office of Investigations has a robust approach to identifying and holding accountable individuals who have violated the law and their duty to protect vulnerable veterans' financial interests. The OIG criminal investigators' multi-tiered approach to combating fiduciary fraud includes

1. maintaining a close collaboration with VBA's fiduciary hubs to proactively share concerns, stay apprised of new schemes, and solicit referrals for OIG review;
2. promoting publicly a fraud toolkit on the OIG website that details key indicators of fiduciary and other types of fraud and additional information on making reports to the OIG hotline; and
3. investigating potential fiduciary fraud and pursuing the prosecution and conviction of bad actors.

Together, these efforts have helped increase the awareness of fiduciary fraud and led to the successful arrest and prosecution of many fraudsters who were stealing benefits and taking advantage of veterans.

OIG's Collaborative Efforts with Fiduciary Hubs

OIG criminal investigators have developed strong working relationships and communicate regularly with VBA personnel on cases of suspected misuse of benefits committed by VA-appointed fiduciaries. This highly effective engagement ensures that fiduciary hub personnel send referrals to the OIG for suspected criminal activity. The OIG also completes an annual comprehensive summary of all fiduciary-related actions taken during the previous fiscal year, to include investigations opened, cases prosecuted, indictments obtained, arrests made, restitution ordered, and other monies recovered by VA. This report

is provided to the P&F Service and incorporated into their Annual Benefits Report.²⁰ More information on reported investigations that flowed from these hubs and other sources is discussed in the section on fiduciary fraud criminal cases below.

OIG Public Outreach

The Fraud Indicator Toolkit, found on the OIG’s website, provides a list of key characteristics related to 10 types of fraud.²¹ It alerts VA personnel, contractors, and the veteran community when to report suspicious activity and alleged wrongdoing to the OIG hotline. The following examples from the toolkit relate to fiduciary fraud:

- The beneficiary has overdue or unpaid bills or medical copayments, or needs do not appear to be met (insufficient food, medication, clothing, heating, or other expected costs).
- The fiduciary is secretive or vague about spending or lacks documentation for expenses.
- The beneficiary’s VA benefits are deposited into an account that is also used for other non-VA deposits (comingled funds).
- VA benefits and other government deposits are distributed among various accounts or checks payable to “cash” are made from the beneficiary’s account.
- Large or repeated ATM withdrawals and/or in-person withdrawals are made from the beneficiary’s account.
- The fiduciary appears to be using or borrowing the beneficiary’s VA benefits for their own personal use, particularly when there have been purchases of high-priced vehicles, property, or other goods or services.

Examples of Recent OIG Fiduciary Fraud Investigations

The OIG receives and reviews referrals of potential cases of fiduciary fraud from the VBA hubs and the OIG hotline. Since October 1, 2019, the Office of Investigations has opened more than 115 criminal cases, made 55 arrests, and secured 51 convictions. During this period, there was a \$15 million dollar financial impact on VA and a \$10 million dollar impact on veterans.²² To appreciate the consequences for vulnerable veterans, the following are just a few examples of fiduciary fraud cases recently investigated by the OIG and prosecuted by our partners at the Department of Justice.

²⁰ VBA, [Annual Benefits Report Fiscal Year 2022](#), p. 143.

²¹ VA OIG, [Fraud Program FAQ](#).

²² Financial impact includes restitution, civil judgements, penalties, fines, forfeitures, and cost savings.

An OIG investigation revealed that a former VA-appointed fiduciary misappropriated more than \$143,000 in VA funds intended for her severely disabled veteran husband.²³ The fiduciary was married to a US Army Reservist who suffered a severe traumatic brain injury in a military service-connected accident. Because of this injury, her husband had many serious physical challenges. As his guardian and VA fiduciary, she subsequently received \$258,613 in VA disability payments and \$36,000 in Social Security payments intended for her husband. She withdrew \$199,649 in cash and accrued about \$900 in ATM and overdraft fees, and then misappropriated most of the funds by spending the money on methamphetamine for herself and others, living expenses for five other people, vehicles for numerous individuals, and other nonapproved items. In October 2022, she was sentenced in the Eastern District of Arkansas to 20 months' imprisonment, three years' supervised release, and restitution of \$143,000.

Another OIG investigation found that a former VA-appointed fiduciary embezzled VA funds intended for his veteran brother, including over \$130,000 in unauthorized money transfers, over \$25,000 in ATM cash withdrawals, and numerous purchases for his own personal use.²⁴ The purchases included a diamond ring, a pickup truck, and two motorcycles. In November 2021, the fiduciary was sentenced in the Western District of Pennsylvania to one day of incarceration, three years' supervised release, restitution of \$75,000, and a fine of \$4,000 after previously pleading guilty to misappropriation.

From November 2006 to July 2017, four defendants were found to have engaged in a sophisticated financial scheme to defraud victims of their VA and Social Security funds.²⁵ The investigation was conducted by the VA OIG, Social Security Administration OIG, Internal Revenue Service Criminal Investigation, and the Federal Bureau of Investigation. The defendants used a nonprofit corporation that provided guardianship, conservatorship, and financial management to hundreds of people with special needs. The organization also served as a VA-appointed fiduciary for dozens of veterans. The defendants used funds that were unlawfully transferred from their clients' accounts to purchase homes, vehicles, luxury recreational vehicles, and cruises. Fifty-two veterans were harmed by this scheme. The loss to VA was approximately \$3.3 million. In July 2021, the nonprofit owner was sentenced to 47 years' imprisonment, and her husband was sentenced to 15 years. The other two defendants were sentenced to 20 years in prison and five years and 11 months in prison, respectively. The owner of the nonprofit was also ordered to pay approximately \$6.8 million in restitution to the victims of the fraud scheme. The other defendants were ordered to pay the entire amount of the stolen funds as restitution to the victims.

CONCLUSION

²³ US Department of Justice, "Jonesboro Woman Sentenced to 20 Months in Prison," October 4, 2022, <https://www.justice.gov/usao-edar/pr/jonesboro-woman-sentenced-20-months-prison>.

²⁴ US Department of Justice, "New Kensington Man Sentenced for Misappropriating VA Benefits," November 1, 2021, <https://www.justice.gov/usao-wdpa/pr/new-kensington-man-sentenced-misappropriating-va-benefits>.

²⁵ US Department of Justice, "Albuquerque Couple Sentenced to Federal Prison in Ayudando Guardians Case," July 15, 2021, <https://www.justice.gov/usao-nm/pr/albuquerque-couple-sentenced-federal-prison-ayudando-guardians-case>.

An effective process to detect and resolve deficiencies is a fundamental element of accountability for any VA program. The OIG found that the P&F Service had deficiencies in both and should strengthen the fiduciary program's governance, including its oversight of the fiduciary hubs' operations. VBA leaders should ensure effective workflow management processes are in place and consistently implemented to make certain that there is adequate oversight of fiduciaries. This, in turn, will mitigate the risks that beneficiaries do not receive the program support to which they are entitled. The OIG is committed to continuing its oversight work in this area and investigating potential fiduciary fraud that not only affects program beneficiaries, but also makes the most effective use of taxpayer dollars.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the Subcommittee may have.