

**STATEMENT OF GARY K. ABE
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DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON "EXPLORING VA'S FIDUCIARY PROGRAM"
JUNE 11, 2015**

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss the work of the Office of Inspector General (OIG) related to the Department of Veterans Affairs (VA) Fiduciary Program and how the Veterans Benefits Administration (VBA) can better protect veterans, who, because of injury, disease, or the infirmities of age, are in need of assistance managing their financial affairs. I am accompanied today by Mr. Quentin Aucoin, Assistant Inspector General for Investigations, and Mr. Timothy Crowe, Director, OIG Bay Pines Audit Operations Division.

BACKGROUND

VBA can determine a veteran or other beneficiary is unable to manage his or her financial affairs based on receipt of medical documentation or if a court of competent jurisdiction has already made this determination. VA will then appoint a fiduciary, either an individual or entity, and with the authority contained in Section 5502(a)(1) of Title 38, United States Code, Payments to and Supervision of Fiduciaries, will disburse VA benefits on behalf of the beneficiary for the use and benefit of the beneficiary.

Fiduciaries appointed by VBA may be the spouse of a veteran; the chief officer of an institution in which a veteran is receiving care; a legal custodian who is the person or entity caring for the beneficiary and his or her estate; or another responsible person. Payments may also be made to a state court-appointed fiduciary, to a fiduciary whose duties and authority are established by Federal statute, or by means of supervised direct payment to an adult beneficiary. In all cases, VBA maintains oversight responsibility to ensure that the VA-derived income and estates of incompetent beneficiaries are used solely for the care, support, welfare, and needs of those beneficiaries. The Fiduciary Program reported overseeing more than 147,000 beneficiaries who received approximately \$2.6 billion in VA benefit payments in fiscal year (FY) 2013, which represents the most recent program data reported by VBA. In response to a recent OIG report, VBA stated that the program supervised almost 173,000 beneficiaries in FY 2014.

Since our 2010 report, *Audit of the Fiduciary Program's Effectiveness in Addressing Potential Misuse of Beneficiary Funds* (March 31, 2010), VBA has made significant changes to the structure of the Fiduciary Program. In April 2011, VBA established the Pension and Fiduciary Service, in part, to strengthen oversight of VA-appointed

fiduciaries. In March 2012, VBA completed consolidation of Fiduciary Program operations from 56 VA Regional Offices (VAROs) to 6 Fiduciary Hubs and the Fiduciary Activity at the VARO in Manila, Philippines. VA's *FY 2014 Budget Submission* stated the consolidation was intended to improve operational efficiencies. The Hubs are located in Indianapolis, Indiana; Louisville, Kentucky; Lincoln, Nebraska; Columbia, South Carolina; Salt Lake City, Utah; and Milwaukee, Wisconsin.

OIG OVERSIGHT OF THE FIDUCIARY PROGRAM

The OIG has an aggressive and comprehensive program in place to provide oversight of VBA's Fiduciary Program through a combination of audits, recurring inspections of VARO operations, review of allegations received by the OIG Hotline, and criminal investigations. OIG audit and evaluation reports, Hotline reviews, and inspection reports conducted by our Benefits Inspection Division since FY 2009 have consistently identified the vulnerability of VA-derived beneficiary estates to fraud, as well as opportunities for VBA to provide more consistent and effective oversight of the Fiduciary Program.

Investigative Work

The OIG Office of Investigations through its criminal investigation activities, aggressively combats fiduciary fraud by pursuing prosecution and court-ordered restitution against those individuals diverting funds intended for VA beneficiaries and highlights Fiduciary Program vulnerabilities that are exploited by unscrupulous individuals at the expense of VA beneficiaries. From April 1, 2010, to March 31, 2015, the OIG conducted 216 investigations involving fiduciary fraud and arrested 94 fiduciaries and/or associates. For example:

- In Houston, Texas, an attorney and his wife, who served as his legal assistant, were sentenced to 46 months' incarceration, 3 years' supervised release, and ordered to pay restitution of \$2,352,107 to VA and \$282,112 to the Internal Revenue Service. The OIG investigation revealed that the attorney, who served as a court-appointed guardian and Federal fiduciary for 54 veterans, and his wife conspired to steal \$2,352,107 from veterans' fiduciary bank accounts and failed to report the stolen income on their Federal tax returns. Prior to becoming a guardian for veteran clients, the attorney was employed by the VA's Regional Counsel in Houston, Texas. His duties were consistent with duties now performed by VBA Field Examiners. After a reorganization of VA legal services, he was assigned to the Fiduciary Section of VARO Houston. He retired from his position and opened a private law practice.
- In Memphis, Tennessee, a former VBA Field Examiner and a former court-appointed fiduciary were sentenced to 3 and 2 years in prison, respectively. They were also ordered to pay \$889,626.87 in restitution to VA. An OIG and FBI investigation revealed that from 1999 until October 2008, both individuals conspired to alter annual accountings to conceal the theft of \$889,626.87 from 13 veterans. The investigation also revealed that the former Field Examiner suggested to the fiduciary that they take money from the guardianship accounts.

- In Tuskegee, Alabama, an administrative assistant for an attorney appointed as a fiduciary for several VA beneficiaries was sentenced to imprisonment for 33 months followed by 60 months of supervised probation. She was ordered to make restitution in the amount of \$681,965. The OIG investigation revealed that the administrative assistant devised a scheme to embezzle \$681,965 from 25 beneficiary accounts.
- In Lexington, Kentucky, an attorney serving as a VA fiduciary for a VA beneficiary was sentenced to 41 months' imprisonment, 36 months' supervised release, ordered to pay \$460,679 in restitution to VA, as well as \$176,246 restitution to the Social Security Administration. The investigation revealed that the fiduciary embezzled VA and Social Security benefits from a veteran. Following the conviction in this case, in April 2013, the OIG issued a management implication notice to the former VBA Deputy Undersecretary for Field Operations, detailing Fiduciary Program weaknesses exploited by this defendant.
- In Newfields, New Hampshire, the daughter of an incompetent veteran serving as the fiduciary was sentenced to 366 days' incarceration, followed by 24 months' supervised release. Prior to sentencing the defendant paid full restitution to VA in the amount of \$251,534. The OIG investigation revealed that the daughter admitted to taking her father's VA benefits and falsifying the annual accountings and supporting bank records to conceal her illegal activities from VA.
- In Pearl, Mississippi, a former local prosecutor was sentenced to 120 months of incarceration followed by 60 months of supervised probation. The sentence also included a restitution order of \$198,669. The OIG investigation revealed that while serving as the appointed fiduciary for five veterans, the fiduciary embezzled funds from accounts under his care as legal custodian.
- In Mansfield, Massachusetts, an attorney who was the VA-appointed fiduciary for his disabled veteran brother-in-law was sentenced to 6 months' home confinement, 5 years of supervised probation, and ordered to pay restitution to VA in the amount of \$137,493. The OIG investigation revealed that the fiduciary embezzled the VA funds from his disabled brother-in-law while serving as a VA-appointed fiduciary.
- In Manchester, New Hampshire, the daughter who was the VA-appointed fiduciary of a disabled veteran was sentenced to 18 months' imprisonment and 24 months' supervised probation. She was also ordered to pay restitution of \$221,905 to VA and \$22,768 to the Social Security Administration. The investigation revealed that the fiduciary depleted her father's savings and continued diverting VA benefit payments for her own personal use.
- In Greenville, Mississippi, a former VA-appointed fiduciary was sentenced to 5 years' supervised probation and ordered to pay VA restitution of \$30,240 after pleading guilty to embezzlement. An OIG investigation revealed that the fiduciary failed to notify VA that a widow beneficiary had died. The fiduciary subsequently received

and negotiated VA benefit checks issued after the beneficiary's death and used the funds for personal expenses.

Audit Work

The OIG last testified about the Fiduciary Program in April 2010 shortly after releasing our audit report, *Audit of the Fiduciary Program's Effectiveness in Addressing Potential Misuse of Beneficiary Funds*. In that report, we concluded the Fiduciary Program was inconsistent in taking timely actions to ensure VA-derived funds and estates of beneficiaries determined to be unable to manage their financial affairs were used solely for the care, support, welfare, and needs of those beneficiaries or adequately protected from diversion or misuse. Specifically, the Fiduciary Program was not consistently:

- Taking effective action to obtain the fiduciary's written accounting of his/her management of a beneficiary's income and estate which had become seriously delinquent
- Verifying questionable beneficiary expenditures reported by fiduciaries
- Replacing fiduciaries when appropriate
- Reviewing and investigating allegations of misuse of beneficiary funds by fiduciaries

We concluded that this occurred because the Fiduciary Program lacked the elements of an effective management infrastructure to guide the program. Specifically, we determined that the program's case management system had severe functional and data limitations that negatively affected management's ability to support program operations. The program also lacked a staffing and workload model to guide resource allocation decisions and other elements necessary to effectively monitor the program. In response to our report, the then Acting Under Secretary for Benefits indicated that VBA would undertake a series of measures in response to our report's findings.

VBA took steps to address our concerns to improve Fiduciary Program operations. For example, in 2014, VBA replaced the program's inadequate case management system, implemented policy requiring receipts for some unbudgeted and budgeted expenses meeting specified thresholds, now includes misuse allegations processing data in the Fiduciary Program section of VBA's *Annual Benefits Report*, developed a program staffing model for the Fiduciary Hubs, and launched a web-based portal providing resources to assist fiduciaries. However, work the OIG conducted recently concerning some of the Fiduciary Program's most important functions indicates that VBA still faces challenges in meeting its mission of protecting some of VA's most vulnerable constituencies.

Review of Alleged Mismanagement at VBA's Eastern Area Fiduciary Hub

In May 2013, the OIG Hotline received allegations of mismanagement at the Eastern Area Fiduciary Hub (EAFH) located in Indianapolis, Indiana. This Hub is responsible for all beneficiaries in VBA's Eastern Area, which spans 14 states and encompasses fiduciary activities of 16 VA Regional Offices. We substantiated the three allegations in our report, *Review of Alleged Mismanagement at VBA's Eastern Area Fiduciary Hub*

(May 28, 2014), which concerned processing allegations of misuse of beneficiary funds, processing in-coming correspondence, and completing field examinations timely.

Hub staff did not timely complete various steps required by VBA policy after receipt of allegations of misuse of beneficiary funds. We analyzed 214 merit reviews and 23 investigations to determine compliance with VBA timeliness standards and policies. Additionally, in those cases where VBA determined that misuse of beneficiary funds had occurred, we followed up with EAFH and Pension and Fiduciary Service to determine whether misused funds had been repaid by the fiduciary and reissued to the beneficiary. We found the following:

- The Hub did not timely review and investigate misuse of beneficiary fund allegations. Of the 214 merit reviews of allegations of fiduciary misuse of funds initiated by the Hub, 190 (89 percent) were not completed within 14 days of receipt, as required by program policy. It took Hub staff an average of 162 days to review the 190 allegations for merit, which includes 87 reviews that were not completed as of July 2013, the time we completed onsite field work at the Hub. We also found the Hub EAFH had not processed and completed 17 of 23 fiduciary misuse of funds investigations (74 percent) within 45 days of the completed merit review, as required. The average time to complete the 17 investigations was 174 days, which included 5 investigations that were not completed as of July 2013.
- We also determined the Hub made 12 determinations concluding fiduciaries misused approximately \$944,000 of beneficiary funds. However, required actions in response to identifying misuse of funds, such as replacing the fiduciary or requesting repayment from former fiduciaries, were not completed or completed timely by EAFH. For example, it took the Hub an average of 98 days from the date the misuse allegation was received to replace 5 of the 12 fiduciaries, ranging from 72-175 days. For the remaining seven determinations, three fiduciaries were replaced timely, three beneficiaries passed away prior to the Hub receiving the allegation, and one was an allegation against a previously replaced fiduciary.
- Internal reviews by Pension and Fiduciary Service staff to determine if VBA was negligent in its oversight of the fiduciaries in instances where misuse of funds occurred were not consistently conducted as required.

We also substantiated the allegation that the Hub had a large backlog of pending field examinations by identifying more than 11,000 (69 percent) of 16,000 pending field examinations that exceeded VBA timeliness standards. Field examinations, which consist of in-person visits by program staff, are a critical tool for VBA to assess the competency and welfare of beneficiaries who are unable to manage their financial affairs. Initial Appointment (IA) field examinations assess the competency and welfare of the beneficiary and, if needed, the appointment of a fiduciary to receive VA benefits. Subsequent to an IA field examination, program staff conduct Fiduciary-Beneficiary (F-B) field examinations to periodically reassess the welfare of the beneficiary and the continued suitability of the fiduciary. As a result of a large backlog of field examinations

not being completed timely by VBA, the general health and well-being of beneficiaries are placed at increased and unnecessary risk.

We also identified more than 3,200 pieces of mail that had yet to be processed and exceeded EAFH's timeliness standards, some of which were time-critical. VBA policy requires Fiduciary Program staff to review all correspondence in conjunction with the fiduciary folder and provide a response, if necessary, generally within 10 workdays of receipt. The Hub had a local goal of processing incoming mail within 5 days of receipt. Delays in processing the 3,200 pieces of mail ranged from 11 to 486 workdays, with an average delay of 30 workdays. Mail not processed timely included allegations of misuse of beneficiary funds, competency restoration requests, and retroactive payment requests. By not effectively managing incoming mail, those receiving VA benefits may be affected.

In response to our report, VBA stated that the conditions we identified concerning processing allegations of misuse, field examination backlogs, and unprocessed incoming correspondence occurred primarily due to an increased workload and insufficient staff when consolidation of VA regional office Fiduciary Program operations into the EAFH were completed.

Audit of the Fiduciary Program's Management of Field Examinations

Following the results of our work at the Indianapolis Fiduciary Hub, we conducted work nationwide concerning the Fiduciary Program's field examination function. We issued our final report, *Audit of the Fiduciary Program's Management of Field Examinations* on June 1, 2015. Our work was conducted at four of the remaining five Fiduciary Hubs: Columbia, South Carolina; Salt Lake City, Utah; Louisville, Kentucky; and Lincoln, Nebraska.

We concluded that VBA faces a large and growing backlog of field examinations. Specifically, we determined VBA did not meet timeliness standards for about 45,500 (42 percent) of approximately 109,000 pending and completed field examinations during calendar year (CY) 2013, of which 18,100 (40 percent) were still pending and not completed as of December 31, 2014. We followed-up by examining reported program performance for the first 9 months of CY 2014 and determined that field examinations not completed and already exceeding timeliness standards increased approximately 15 percent from about 19,000 in January 2014 to approximately 21,900 in September 2014.

This occurred because Field Examiner staffing did not keep pace with the growth in the beneficiary population, VBA did not staff the Hubs according to their staffing plan developed in conjunction with Fiduciary Program consolidation to the six Hubs, and did not use all relevant performance measures for the field examination function. The 2011 VBA staffing plan set a target of 1 Field Examiner for every 325 beneficiaries. However, our analysis of VBA staffing reports for the period of January 2013 through December 2013 showed the Fiduciary Program had an average of 1 Field Examiner for every 363 beneficiaries. The situation did not improve during the first 9 months of 2014. As of

September 30, 2014, VBA employed 1 Field Examiner for every 386 beneficiaries supervised under the Fiduciary Program. While Field Examiner staffing has generally increased, the Fiduciary Program did not meet its staffing goal for Field Examiners in part due to the substantial growth in the beneficiary population. Specifically, although the beneficiary population increased by 10 percent from January 2013 through December 2013, the number of field examiners increased only 2 percent during this same period.

As a result, untimely field examinations placed approximately \$360.7 million in benefit payments and \$487.6 million in estate values at increased risk. In addition, we determined that VBA did not schedule required field examinations for a projected 1,800 beneficiaries in CY 2013. Lapses in field examination scheduling occurred because of inadequate management oversight to ensure required field examinations were scheduled. As a result, we project the Fiduciary Program did not schedule field examinations for about 1,800 beneficiaries, placing beneficiaries' well-being and approximately \$36.1 million in benefit payments at increased risk in CY 2013.

We recommended the Under Secretary for Benefits implement a plan to meet timeliness standards, expand program performance measures, improve controls to identify unscheduled field examinations and enhance case management system functionality. The Under Secretary concurred with our recommendations and provided acceptable plans to complete all corrective actions.

Audit of the Fiduciary Program's Processing of Misuse Allegations

We recently provided VBA with a draft report on the extent to which VBA protects the VA-derived income and estates of beneficiaries who are unable to manage their financial affairs when misuse of beneficiary funds is alleged. This work was a direct result of our work at the Hub located at Indianapolis, Indiana, and our follow-up work in the management of field examinations.

Section 6106(b) of Title 38, United States Code, Misuse of Benefits by Fiduciaries, defines misuse as any case where a fiduciary receives payment under the laws administered by the VA Secretary, for the use and benefit of a beneficiary and uses any part of the payment for other than for the use and benefit of a beneficiary or the beneficiary's dependents. VBA is made aware of allegations or indications of misuse of funds by fiduciaries through multiple sources, such as the beneficiaries themselves, third parties, or VBA employees while performing duties. Once misuse is alleged or indicators of misuse exist, program policy requires staff take specific actions to review, investigate, and determine misuse within specified timeliness standards.

If VBA does not timely complete misuse actions, beneficiary funds are at increased risk of misuse. We projected VBA did not timely complete required misuse actions to ensure the protection of 758 beneficiaries' VA-derived estates valued at about \$45.2 million. VBA also did not restore approximately \$2.1 million of misused funds to beneficiaries. Additionally, unless VBA improves the timeliness of actions in response to allegations and indications of misuse, we project VBA may not adequately protect

annual benefit payments to beneficiaries valued at approximately \$16 million, or \$80 million during CYs 2014 through 2018.

CONCLUSION

Despite some of the significant changes to structure, oversight and operation of the Fiduciary Program since our 2010 audit, significant challenges remain. The OIG's most recent work demonstrates that conditions that put beneficiaries and their VA-derived estates at unnecessary risk persist. Past and recent cases have uncovered unscrupulous fiduciaries who have misappropriated tens of thousands to even millions of dollars from the accounts of unsuspecting VA beneficiaries under the supervision of the Fiduciary Program. This type of theft can only be stopped by aggressive and consistent oversight by the Fiduciary Program.

As the veteran population ages, more VA beneficiaries will likely require the appointment of a fiduciary to assist them in managing the monetary benefits provided by VA. In order to meet these challenges, VBA needs to revisit its staffing model and resource allocation decisions for the Fiduciary Program, as well as the programs' work processes and tools. Without more effective controls, including more consistently and timely completion of some of the Program's most important functions, unacceptable risks to the general well-being and VA benefits of some of VA's most vulnerable beneficiaries will remain.

Mr. Chairman, this concludes my statement and we would be happy to answer any questions that you or Members of the Committee may have.