DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS BENEFITS ADMINISTRATION

Alleged Unauthorized Control over a VA Beneficiary's Funds

REVIEW | REPORT #20-02071-167 | JULY 6, 2021

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Executive Summary

The VA Office of Inspector General (OIG) conducted this review to assess the merits of an August 2019 hotline allegation. The complainant, the daughter of a now-deceased veteran for whom no VA fiduciary was appointed, alleged that staff at a California state veterans home moved her father to a memory care unit without a diagnosis of impaired memory and took control of his funds. Because of the seriousness of the allegation, the OIG undertook the review.

The team reviewed VA records and documentation provided by the complainant. To assess the allegations, the review team also contacted the state veterans home, a non-VA facility, for information to compare with VA records and documentation provided by the complainant. The team determined that the VA and non-VA evidence reviewed was sufficient to assess the merits of this hotline allegation.

What the Review Found

Although evidence confirmed that the veteran was transferred to the state veterans home's memory care unit in February 2014, the OIG did not substantiate the allegation that staff moved him there without a diagnosis of impaired memory and took control of his funds. Accordingly, the OIG made no recommendations.

The review team assessed three pieces of medical evidence that supported the veteran's cognitive decline. In February 2014, state veterans home medical records noted the veteran was transferred to the home's memory care unit because his "mental status [had] declined." The veteran's Veterans Benefits Administration (VBA) electronic claims file contained a statement dated March 2016, signed by a nurse practitioner at the home, declaring that the veteran was unable to manage his funds because of cognitive decline; the signed statement included an opinion that the veteran's cognitive decline would only worsen. In April 2016, as a result of the signed statement, VBA staff generated an incompetency proposal for the veteran but did not finalize that decision.[1] The veteran's death certificate listed the cause of death as cardiorespiratory arrest, progressive debility and decline, and cognitive decline.

VA records and documentation provided by the complainant did not show the home took control of the veteran's funds but indicated the state had intervened to recoup from the veteran's estate the cost of the veteran's care. The team found that a bank statement provided by the complainant as evidence of control named the veteran and did not name the state veterans home on the account. Additionally, the veteran's VA direct deposit account information had remained

[1] VBA staff propose "incompetency" if they receive medical evidence that a beneficiary is incapable of managing VA benefits payments. The beneficiary is given the opportunity to provide evidence of competency. Staff consider the evidence and prepare an incompetency decision. If the beneficiary is determined to be incompetent for VA purposes, staff withhold retroactive benefits until the fiduciary hub of jurisdiction assigns the beneficiary a fiduciary.

unchanged for more than 10 years, and the direct deposit form submitted to VA was signed by the veteran and the financial institution with no joint account holders listed. A representative from the California Department of Veterans Affairs confirmed that the veteran's funds were frozen in June 2019 to recover unreimbursed care costs. According to California law, the State of California has the authority to recover any unreimbursed costs of care from the personal property assets of veterans who pass away while residing at a California state veterans home.[2]

Although the OIG did not substantiate the allegation, the review team determined that VBA had not finalized a decision regarding the veteran's ability to manage his VA benefits payments, which might have resulted in VA appointing a fiduciary. The OIG addressed this issue in a separate management advisory memorandum to VA.[3] The appendix details the review scope and methodology.

VBA Response

In a memorandum dated June 4, 2021, the acting under secretary for benefits responded that VBA appreciated the opportunity to review the OIG's report and concurred without comment.

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[2] California Military and Veteran Code § 1035 and § 1035.05; 12 California Code of Regulations §510.10.

[3] VA OIG, *Fiduciary Program: Some Incompetency Decisions Not Completed, Putting Those Beneficiaries' Funds at Risk*, Memo No. 20-02071-49, January 27, 2021.

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Introduction

The VA Office of Inspector General (OIG) conducted this review to assess the merits of an August 2019 hotline allegation. The complainant, the daughter of a now-deceased veteran for whom no VA fiduciary was appointed, alleged that staff at a California state veterans home moved her father to a memory care unit without a diagnosis of impaired memory and took control of his funds. Because of the seriousness of the allegation, the OIG undertook the review.

The Veteran's Benefits and Medical History

The Veterans Benefits Administration (VBA) granted the veteran VA disability pension benefits effective December 2, 1993.[4] Medical records showed the veteran was admitted to a California state veterans home in October 1999. In February 2014, state veterans home medical records noted the veteran was transferred to the home's memory care unit and indicated a decline in his mental status. In March 2016, VBA received a medical statement with a diagnosis of cognitive decline signed by a nurse practitioner at the state veterans home. In April 2016, as a result of the signed statement, VBA staff generated an incompetency proposal for the veteran but did not finalize that decision.[5] If VBA staff had finalized the decision, the veteran might have been assigned a VA-appointed fiduciary. The veteran died in April 2019, at the age of 98.

Fiduciary Program

The VA Fiduciary Program provides oversight of beneficiaries who are unable to manage their VA benefits on their own. This might be because of injury, disease, advanced age, or youth. VA appoints fiduciaries who manage VA benefits for these beneficiaries. A fiduciary is a person or legal entity charged with managing the estate of an incompetent beneficiary. Fiduciaries appointed by VA to manage the VA funds of a beneficiary are also responsible for monitoring the beneficiary's well-being and using available funds to ensure that the beneficiary's needs are met.[6] VA also monitors fiduciaries to ensure they meet VA beneficiaries' needs.

State Veterans Homes

According to information on VA's website, state veterans homes are facilities that provide nursing home, domiciliary, or adult day care. They are certified by VA but owned, operated, and managed by state governments. Federal law gives VA no authority over the management or

[4] 38 C.F.R. § 3.3. Veterans with wartime service may be eligible for VA disability pension benefits, which are based on income.

[5] VBA staff propose "incompetency" if they receive medical evidence that a beneficiary is incapable of managing VA benefits payments. The beneficiary is given the opportunity to provide evidence of competency. Staff consider the evidence and prepare an incompetency decision. If the beneficiary is determined to be incompetent for VA purposes, staff withhold retroactive benefits until the fiduciary hub of jurisdiction assigns the beneficiary a fiduciary.

[6] 38 C.F.R. § 13.140.

control of any state veterans home but allows the department to inspect any state veterans home to make sure it continues to meet VA standards.[7]

California State Law

According to California law, "All moneys and other personal property of any [veteran] held by a home, or by its authority, ... shall, upon the death of the [veteran], be held by the home in trust to be paid ... to the heirs of the [veteran]" less any funds owed to the home, "including the cost of any care rendered by a home in excess of the fees paid by the [veteran] to the home."[8]

[7] 38 U.S.C.§ 1742.

[8] California Military and Veterans Code § 1035 and § 1035.05; 12 California Code of Regulations §510.10.

Results of the Review

Finding: Alleged Unauthorized Control over a VA Beneficiary's Funds Was Not Substantiated

Although evidence showed that the veteran was transferred to the state veterans home's memory care unit in February 2014, the OIG did not substantiate the claimant's allegation that staff there moved her father to the unit without a diagnosis of impaired memory and took control of his funds before his death. Accordingly, the OIG made no recommendations.

Although the OIG did not substantiate the allegation, the OIG found that VBA had not finalized a decision regarding the veteran's ability to manage his VA benefits payments, which might have resulted in VA appointing a fiduciary. The OIG addressed this issue in a separate management advisory memorandum to VA.[9]

What the OIG Did

The review team examined VA records and documentation submitted by the complainant. To assess the allegations, the review team also contacted the state veterans home, a non-VA facility, for information to compare with VA records and documentation submitted by the complainant. The OIG determined that the VA and non-VA evidence reviewed was sufficient to assess the merits of this hotline allegation. The appendix details the review scope and methodology.

Available Evidence Indicated the Veteran Experienced a Cognitive Decline

The complainant alleged a licensed clinical social worker at the state veterans home moved her father to the memory care unit without a diagnosis of Alzheimer's, senility, or dementia. The review team did not substantiate this allegation. Although the team did not find medical evidence of these diagnoses, documentation indicated the veteran's cognitive state had declined.

The team reviewed the veteran's VA electronic medical file, which included records from November 29, 1994, to January 17, 2019. Those records did not include a diagnosis of Alzheimer's, senility, or dementia. However, in February 2014, state veterans home medical records noted the veteran was transferred to the home's memory care unit because his "mental status [had] declined." Further, a review of the veteran's VBA electronic claims file showed that, in March 2016, a nurse practitioner at the home submitted a statement declaring the veteran unable to manage his funds due to cognitive decline. The signed statement included an opinion that the veteran's cognitive decline would only worsen. In April 2016, as a result of the signed

[9] VA OIG, *Fiduciary Program: Some Incompetency Decisions Not Completed, Putting Those Beneficiaries' Funds at Risk*, Memo No. 20-02071-49, January 27, 2021.

statement, VBA staff generated an incompetency proposal. The veteran's certificate of death listed the cause of death as cardiorespiratory arrest, progressive debility and decline, and cognitive decline.

Available Evidence Did Not Indicate State Veterans Home Staff Took Control of the Veteran's Funds

The complainant alleged the move to the memory care unit resulted in the veteran losing control of his assets. In addition, she alleged a staff member at the state veterans home took over the veteran's funds and changed his checking accounts. The team did not substantiate these allegations.

The evidence reviewed did not support the allegation that state veterans home staff took control of the veteran's funds before his death. The team found a bank statement provided by the complainant as evidence of control named the veteran and did not name the state veterans home on the account. Additionally, the veteran's VA direct deposit account information had remained unchanged for more than 10 years, and the direct deposit form submitted to VA was signed by the veteran and the financial institution with no joint account holders listed.

Evidence that the complainant provided explained the financial intervention after the veteran's death. The complainant furnished the team with a June 2019 letter from the State of California indicating the veteran had incurred unreimbursed care expenses that exceeded the amount in the veteran's bank account. According to California law, the State of California has the authority to recover any unreimbursed cost of care from the personal property assets of veterans who pass away while residing at a California state veterans home.[10] A representative from the California Department of Veterans Affairs confirmed the veteran's funds were frozen to recover costs associated with the veteran's care.

Conclusion

The OIG did not substantiate the complainant's allegation that staff of a state veterans home moved her father to a memory care unit without a diagnosis of impaired memory and took control of his funds without authorization. Accordingly, the OIG made no recommendations.

VBA Response

In a memorandum dated June 4, 2021, the acting under secretary for benefits responded that VBA appreciated the opportunity to review the OIG's report and concurred without comment.

[10] California Military and Veteran Code, § 1035 and § 1035.05; 12 California Code of Regulations §510.10.

Appendix: Scope and Methodology

Scope

The review team conducted its work from July 2020 through May 2021. In addition to considering the documents submitted by the complainant, the team reviewed VBA's electronic records from March 2016, the date VBA received the written statement from a state veterans home nurse practitioner, through April 2019, the date of the veteran's death. The team also reviewed relevant veteran medical files, which included VA electronic medical records from November 29, 1994, to January 17, 2019, and state veterans home medical records dated February 21, 2014; June 16, 2014; and January 17, 2019.

Methodology

To conduct this review, the team examined relevant records associated with the claimant's hotline allegation in VBA electronic systems. The team reviewed key documentation, such as the hotline allegation evidence submitted by the complainant, the written statement from the state veterans home nurse practitioner, medical documents submitted by the state veterans home, and VBA's incompetency proposal. The team also reviewed applicable VA criteria.

Data Reliability

To test the reliability of the data, the review team compared information contained in hard-copy documents with information reflected in VBA's Veterans Benefits Management System. The team also assessed whether any data analyzed from the Veterans Benefits Management System were missing from key fields, included any calculation errors, or were outside the time frame under review. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements.

Testing disclosed the data were sufficiently reliable for the review objective. Comparison of data obtained by the team with information contained in VBA's electronic systems did not disclose any issues with data reliability. Accordingly, the team determined the computer-generated data in the Veterans Benefits Management System were sufficiently reliable to support the review's objective and conclusion.

Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation* for competency, independence, professional judgment, quality control, planning, data collection and analysis, evidence, timeliness, fraud, records maintenance, and reporting.

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