US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Audit of Veterans' Community Care Eligibility Determinations

Audit	25-01014-139	June 17, 2026

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Executive Summary

As mandated by the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, the VA Office of Inspector General (OIG) initiated an audit in January 2025 to assess whether VA accurately identified veterans eligible for community care and informed them of their eligibility, in accordance with existing community care eligibility criteria under the MISSION Act and related regulations and guidance.[1] The Dole Act did not change previously established community care eligibility criteria. The OIG also issued a companion report to meet the Dole Act requirements that focuses on the timeliness of processing consults for VA and community care.[2] The reports are separate because each audit had different objectives, populations, and methodologies. The OIG acknowledges that at the time of publication of this report, the Veterans Health Administration (VHA) had planned significant changes to the structure of its management and operations. The findings and recommendations in this report can help guide VHA's reorganization efforts and implementation.

Under the MISSION Act and related regulations, veterans are eligible to receive community care under certain circumstances such as access standards or being in the veteran's "best medical interest."[3] When veterans are eligible for community care, VA must inform them of their care options so they can decide whether to pursue direct (VA-provided) or community care.

The audit team reviewed VA appointment and community care consult data from October 1 through December 31, 2024—the first quarter of fiscal year (FY) 2025—and the final claims data for these consults as of July 2025. The team's fieldwork continued through February 2026, which collectively served as the basis for the findings and recommendations in this report. The OIG found that VHA is not effectively identifying and informing all eligible veterans about all their care options within and outside VA. Not only were some eligible veterans not informed of their entitlement to community care, but ineligible veterans were also improperly approved for it—risking both underutilization and misuse of the Veterans Community Care Program. The OIG estimated that VHA could have potentially avoided spending $440 million

[1] Pub. L. No. 118-210, § 110, 138 Stat. 2706; VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393; 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2023); 38 C.F.R. § 17.4040 (2023).

[2] VA OIG, *Audit of Consult Timeliness for VA and Community Care*, Report No. 25-01015-138, June 17, 2026.

[3] MISSION Act; 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2023); 38 C.F.R. § 17.4040 (2023).

(or $1.7 billion in monetary benefits over a full fiscal year) on community care if schedulers had consistently made accurate eligibility determinations and referred veterans to VA medical facilities with available services.

During briefings in September and October 2025, VHA leaders confirmed the challenges identified in this report were still present and that they had not yet implemented solutions to the scheduling issues identified in this report. For example, VHA schedulers cannot always schedule at other VA medical facilities that could have provided care within the wait-time and drive-time standards because of scheduling system limitations. Furthermore, VHA lacks the ability to assess the accuracy of wait-time eligibility determinations. However, recent changes such as the expansion of VHA's External Provider Scheduling System, which allows VA to schedule directly into participating community provider schedules, show progress toward addressing these issues.

This audit is critical for several reasons. First, accurately identifying and informing eligible veterans of their right to receive community care is essential to ensuring timely access to treatment. When veterans are not made aware of their eligibility, they may face avoidable delays. At the same time, approving veterans who do not meet program requirements can result in unnecessary expenditures and place additional strain on a costly program.

The OIG made six recommendations to improve the effectiveness of the Veterans Community Care Program and ensure a veterans-first approach. The under secretary for health concurred with recommendations 1 through 4 and 6, and concurred in principle with recommendation 5. The under secretary also submitted responsive corrective action plans to address each recommendation. The full list of recommendations is in the report; VA's response and action plans are in appendix E.

What the Audit Found

VHA staff did not consistently make accurate determinations of veterans' eligibility for community care, nor did they reliably inform veterans of their options for receiving direct or community care for VA appointments and community care consults completed during the first quarter for FY 2025. Specifically, OIG testing revealed that medical facility staff referred about 25 percent of community care consults for mental health care or specialty care—an estimated 340,000 of 1.4 million total consults—to providers outside VA, despite veterans not meeting eligibility requirements. Staff also referred an estimated 38 percent of appointments (about 1.8 million of about 4.8 million) to VA facilities when they were in fact eligible for community care—without documenting an assessment of these veterans' eligibility for community care. These issues arose because guidance from VA's Office of Integrated Veteran Care (IVC) was inconsistent with the MISSION Act and due to scheduling system limitations, which prevented schedulers from seeing appointment availability across all VA medical facilities that were within wait-time and drive-time standards.

Schedulers also lacked full access to community care wait-time data to inform veterans about which care option was most expedient. As a result, about 13 percent of wait time–eligible community care consults (about 38,100 of 287,000) indicated the veteran could have received care faster by opting *out* of community care and taking the next available VA appointment. Conversely, about 58 percent of primary care, mental health care, or specialty care appointments occurring within VA that the OIG identified as eligible for community care (about 1.1 million of about 1.8 million) had no documentation that the veteran had opted out of community care—meaning there was no evidence these veterans knew all their care options before they were scheduled for direct care within VA.

Access to care challenges—within VA and through community providers—have become a growing focus, with particular emphasis on compliance with the MISSION Act. Until medical facility staff can effectively identify appointment availability and schedule care across VA medical facilities, VA will continue to miss opportunities to make accurate eligibility determinations for community care under the MISSION Act and its implementing regulations—to be able to fully inform veterans of all their care options. Obtaining access to community care appointment data would also help ensure veterans can make fully informed decisions. Finally, having systems and processes in place allows comprehensive monitoring of community care eligibility determinations, which is essential for program oversight.

Next Steps

The OIG will monitor VHA's corrective actions and will close the recommendations once VHA provides sufficient evidence that it has strengthened its oversight processes and addressed the risks identified in this report.

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Contents

Abbreviations

FY	fiscal year
IVC	Office of Integrated Veteran Care
MISSION Act	VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The Veterans Health Administration (VHA) provides care to veterans in VA medical facilities, which were, at the time of this report, organized into 18 regional Veterans Integrated Service Networks (VISNs) that manage the day-to-day functions of medical centers and provide administrative and clinical oversight. In addition to delivering direct care (VA-provided) through its own medical facilities, VA is authorized under the MISSION Act to approve and pay for veterans to receive care from community healthcare providers when specific eligibility criteria are met.[4] These criteria include situations where VA does not offer the requested services, a veteran lives in a US state or territory without a full-service VA medical facility, or the wait or drive times to a VA facility exceed established standards. It is critical for VHA to appropriately assess veterans for community care eligibility and make them aware of all care options so they can be actively engaged in deciding the most appropriate care for their distinct needs.

The Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, signed into law on January 2, 2025, required the VA Office of Inspector General (OIG) to assess VA's performance in "appropriately identifying veterans eligible for care and services" under the Veterans Community Care Program, "informing veterans of their eligibility for such care and services," and "delivering such care and services in a timely manner."[5]

The OIG initiated this audit to assess whether VA effectively identified veterans eligible for community care and informed veterans of their eligibility, in accordance with existing community care eligibility criteria under the MISSION Act and related regulations and guidance. The Dole Act did not change previously established community care eligibility criteria. While the audit team reviewed VA appointment and community care consult data from October 1 through December 31, 2024—the first quarter of fiscal year (FY) 2025—the team also reviewed the final claims data for these consults as of July 2025. The team's fieldwork continued through February 2026, which collectively served as the basis for the findings and recommendations in this report. This report presents findings from this audit. A concurrent OIG report addresses whether VA met its timeliness standards for VA and community care.[6] The reports are separate because each audit had different objectives, populations, and methodologies. The law requires the OIG to report its results by July 2026.

The OIG acknowledges that at the time of publication of this report, VHA had planned significant changes to the structure of its management and operations. The information in this

[4] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393.

[5] Pub. L. No. 118-210, § 110, 138 Stat. 2706; MISSION Act; 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2023); 38 C.F.R. § 17.4040 (2023).

[6] VA OIG, *Audit of Consult Timeliness for VA and Community Care,* Report No. 25-01015-138, June 17, 2026.

report is based on conditions that existed at the time of the audit. The OIG's findings and recommendations can help guide VHA's reorganization efforts and improve implementation.

Request for Care by Veterans Enrolled in VA Health Care

Veterans have three primary ways to ask for care: (1) a veteran-initiated appointment request, (2) a provider request for a follow-up appointment, and (3) a provider referral to specialty care. Veterans can also receive three types of care:

- **Primary care** covers wellness, prevention, and treatment for common illnesses in which providers can coordinate care with specialists, according to VA's Patient Care Services. It provides long-term relationships between a patient and their provider and coordinates care across a range of health services.[7]
- **Mental health care** includes inpatient and outpatient services at VA medical facilities, community-based outpatient treatment services, and individual and family services for conditions such as posttraumatic stress disorder, military sexual trauma, and depression, according to VHA Directive 1160.01.[8]
- **Specialty care** is advanced medical care that focuses on a specific disease or patient group, such as dermatology, oncology, and cardiology, according to VHA Directive 1159.[9]

VHA's consult management directive states that a VA provider can request care for a patient by initiating and creating a consult, which is a request for clinical services on behalf of a patient.[10] Once a request for healthcare services is made, VHA staff evaluate the veteran's eligibility for community care by applying the legal criteria established under the MISSION Act.

Community Care Eligibility

The MISSION Act consolidated several community care initiatives into one permanent program, known as the Veterans Community Care Program. The Community Care Network groups VA medical facilities into five regions managed by two third-party administrators to improve care coordination and make it easier for community providers and VA staff to deliver care to veterans. In line with community care contracts and to ensure an adequate and accessible

[7] "VA Primary Care" (web page), VA Patient Care Services, accessed March 4, 2025, https://www.patientcare.va.gov/primarycare/index.asp.

[8] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.

[9] VHA Directive 1159, *VHA Specialty Care Program Office and National Programs*, March 9, 2022.

[10] VHA Directive 1232(5), *Consult Process and Procedures*, December 5, 2022; VHA Directive 1232, *Consult Management*, November 22, 2024. VHA Directive 1232 superseded the earlier guidance in November 2024—during the scope of this audit—but the standards did not change.

provider network, the standards that the third-party administrators must adhere to vary by veteran location (such as urban, rural, and highly rural). Figure 1 outlines the general community care eligibility determination process.

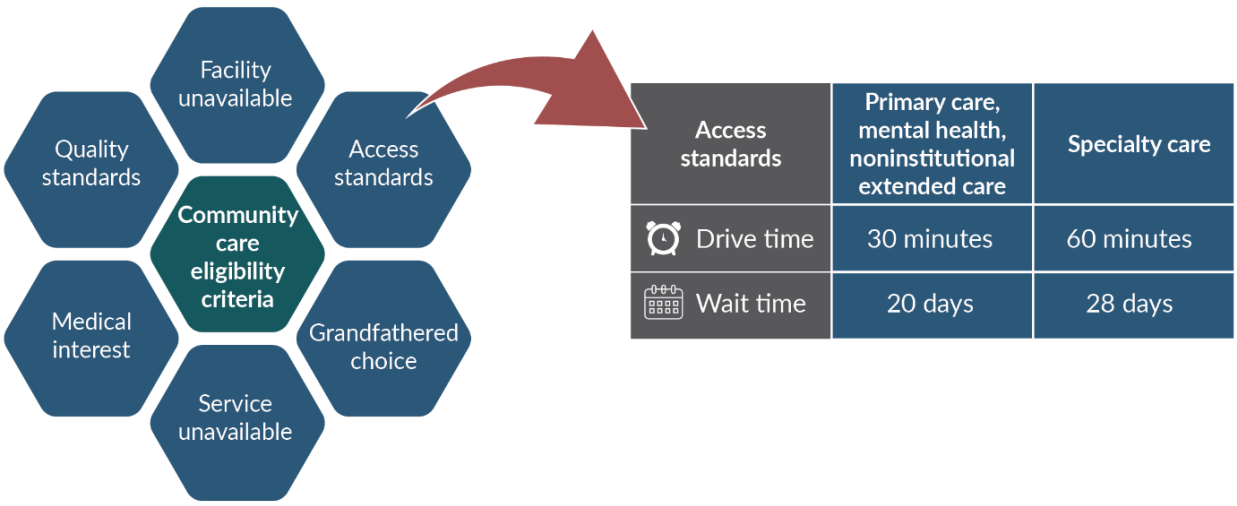

Figure 1. *Overview of community care eligiblity determination process.*
Source: VA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

Under the MISSION Act and related guidance from VHA, veterans are eligible to receive community care in any of the following circumstances:[11]

- **Facility unavailable:** A veteran lives in a US state or territory without a full-service VA medical facility.
- **Quality standards:** The service at the VA medical facility does not meet specific quality standards.
- **Medical interest:** A veteran's provider, with agreement from the veteran, determines community care is in the veteran's "best medical interest."
- **Service unavailable:** A veteran needs a service not available at a VA medical facility.
- **Grandfathered choice:** A veteran living in Alaska, Montana, North Dakota, South Dakota, or Wyoming who: (1) on the day before June 6, 2018, qualified for eligibility under the Veterans Access, Choice, and Accountability Act of 2014 if

[11] VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019; 38 C.F.R. § 17.4040 (2023).

they lived more than 40 miles from the nearest VA facility, and (2) continues to live in a location that would qualify them under that criterion.[12]

- **Access standard:**
  - A veteran's average drive time to a VA medical facility is at least 30 minutes for primary care, mental health care, or noninstitutional care services or at least 60 minutes for specialty care at a VA medical facility.
  - A veteran's wait time for an appointment at a VA medical facility is more than 20 days for primary care, mental health care, or noninstitutional extended care services or is more than 28 days for specialty care.

Determining Eligibility

VA providers must follow a standard process to assess veterans' eligibility for community care, which includes reviewing the criteria detailed in the MISSION Act. This assessment identifies wait times, drive times, and the available VA locations that provide the requested service. The audit team focused specifically on three community care eligibility criteria: wait time, drive time, and the absence of a full-service VA (see appendix A for more details on the scope and methodology and appendix B for additional exclusion criteria).

Wait Time

In line with the issued scheduling guidance, VHA uses the following terms when determining wait-time eligibility:

- **The file entry date** documents the day a VHA provider requests a consult with another provider (in other words, makes a referral) or a veteran requests an appointment.[13]
- **The patient indicated date** is the appointment date a provider requested or the date a patient would like to be seen absent a provider's input. VHA guidance states that this date cannot be changed due to scheduling capacity or access reasons at a facility or clinic.
- **The appointment date** is when a veteran is scheduled to receive care.

To determine whether veterans meet the wait-time standard, schedulers should first calculate the number of days between the file entry date and the patient indicated date. If the patient indicated

[12] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146.

[13] Office of Integrated Veteran Care (IVC), *Standard MISSION Act Guidance Patient Eligibility and Scheduling Reference Sheet*, February 26, 2023.

date exceeds the applicable standard (20 or 28 days, depending on the type of care), the veteran is not eligible for community care under the wait-time standard because they do not require an appointment within that time frame. However, if this number falls within the applicable wait-time standard, the scheduler must then determine whether a VA appointment can be scheduled within 20 or 28 days of the file entry date. If no VA appointment is available within that time frame, the veteran qualifies for community care under the wait-time standard. Figure 2 illustrates this process.

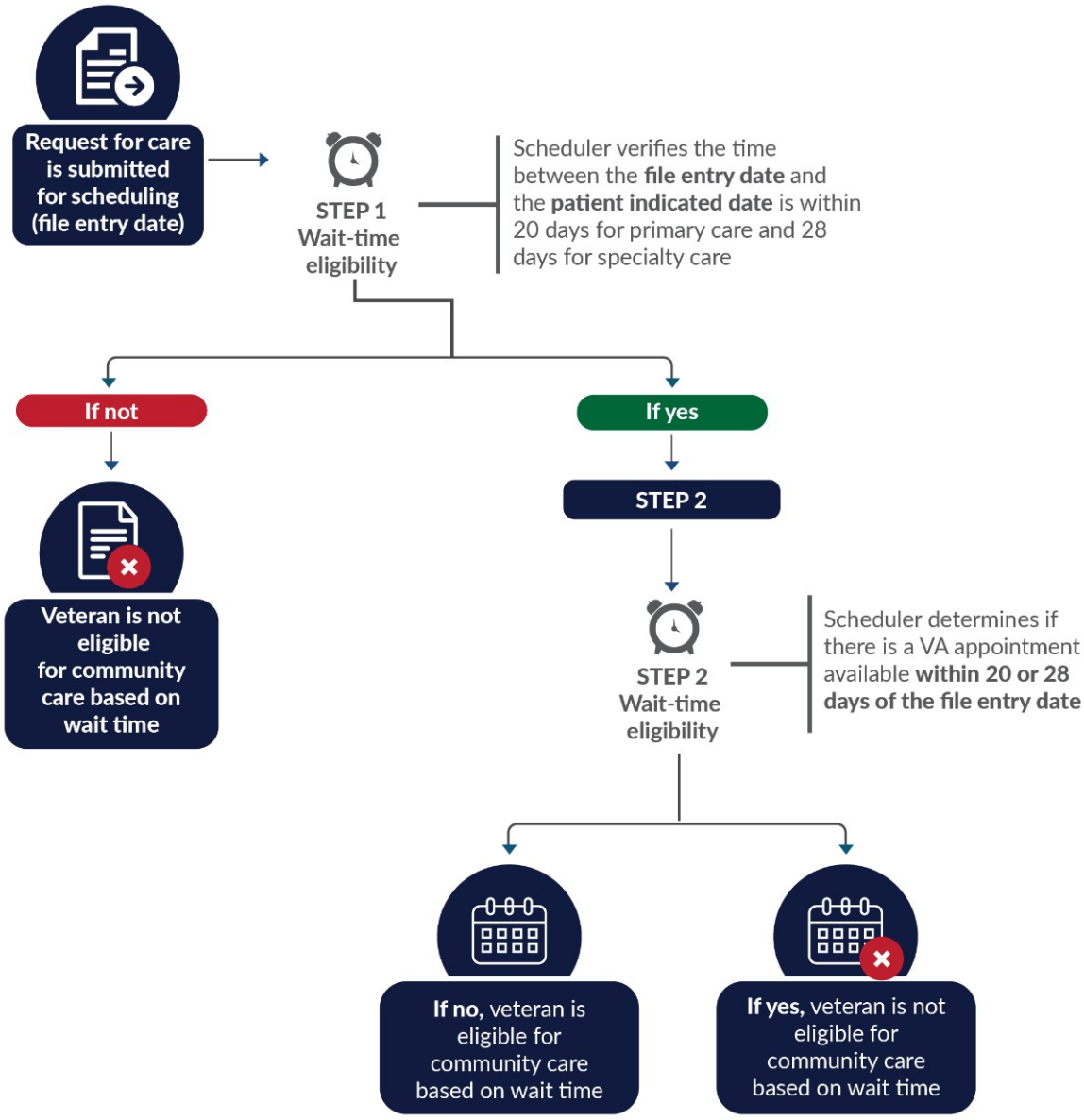

Figure 2. *Process for determining wait-time eligibility for community care.*

Source: OIG analysis of "Eligibility, Referral, and Scheduling," chap. 2 in IVC's Community Care Field Guidebook.

Drive Time

VHA staff determine average drive time by using the Consult Toolbox—discussed in greater detail below—to calculate the distance from a veteran's residence to the nearest VA facility that offers the needed service. The toolbox considers inputs such as traffic to calculate the average drive time by drawing on navigational software. For a veteran to meet eligibility this way, the average drive time from a veteran's home to a specific medical facility must be at least 30 minutes for primary care and mental health care or 60 minutes for specialty care.

Informing Veterans of Care Options

If a veteran is not eligible for community care, VA staff will schedule the appointment or submit a consult referral (when applicable) to the VA service line (for example, cardiology or neurology).

When a veteran is eligible for community care, VA staff are required to provide the veteran with the option of receiving care from VA (if available) or from a community provider; they must also provide key information, such as wait times at the VA and in the community if available, to help the veteran decide which option to choose. According to VHA's Office of Integrated Veteran Care (IVC) *National Standardized Scheduling Audit Guidebook*, VA staff should also use the Consult Toolbox to document a specific code that indicates whether a veteran opted in or out of community care. If a veteran chooses community care, VHA staff should document the veteran's preferences (including preferred provider, location, and appointment availability) and then forward the consult to the facility's community care department for processing. Finally, VA staff should forward the consult to the facility's community care department for scheduling if they are not making the appointment while talking with the veteran.

Consult Toolbox

According to the "Mandatory Use of Consult Toolbox (CTB) For Consult Management" memorandum sent by the acting assistant under secretary for health for IVC to VISN directors in September 2023, staff are mandated to use the Consult Toolbox as the software program to document actions and track and manage each consult. VHA started requiring the use of the toolbox nationally in September 2023; it concluded the rollout in December 2023. The toolbox is meant to make it easy for staff to document completed actions quickly and consistently.[14]

The toolbox helps standardize how VHA staff decide the appropriate location for a veteran to receive care by showing available services within VA and information about the veteran's eligibility for community care—it does not include information on available services in the

[14] The web-based interface uses buttons, drop-down options, and other mechanisms that generate standardized codes (consult factors) that are then recorded in the veteran's electronic health record, which facilitates reporting efforts.

community. Additionally, it enables staff to document the outcomes of decisions by adding codes that help standardize comments for each consult, such as veterans' preferences to opt in or out of community care. It also allows VA providers to view relevant data to help guide conversations with veterans so they can decide whether a consult should be referred to a nearby VA facility or a community provider. The toolbox considers

- drive-time standards associated with the requested consult service;
- average wait times for the requested clinical service at VA facilities near the veteran's home and average wait times for community care appointments (when available); and
- the next available appointment date for direct care, which allows users to input or select a calendar icon to select a date. (This is a required field.)

To be clear, average wait times are not used to determine wait-time eligibility. Eligibility is always based on the number of days from the file entry date to the next available appointment in the VA (unless a veteran prefers a later appointment date). The toolbox merely provides average wait times within VA and the community (when available) to help veterans decide where to receive care.

National Use of VA and Community Care

During FY 2025—October 1, 2024, through September 30, 2025—VA provided health care to about 5.2 million veterans. To provide this care, according to data from the VHA Support Service Center, VHA staff processed—meaning they completed or scheduled care—more than 27.8 million consults for direct care and more than 6.9 million consults for community care during that year. Figure 3 shows the number of consults for direct and community care at each VISN that full year.

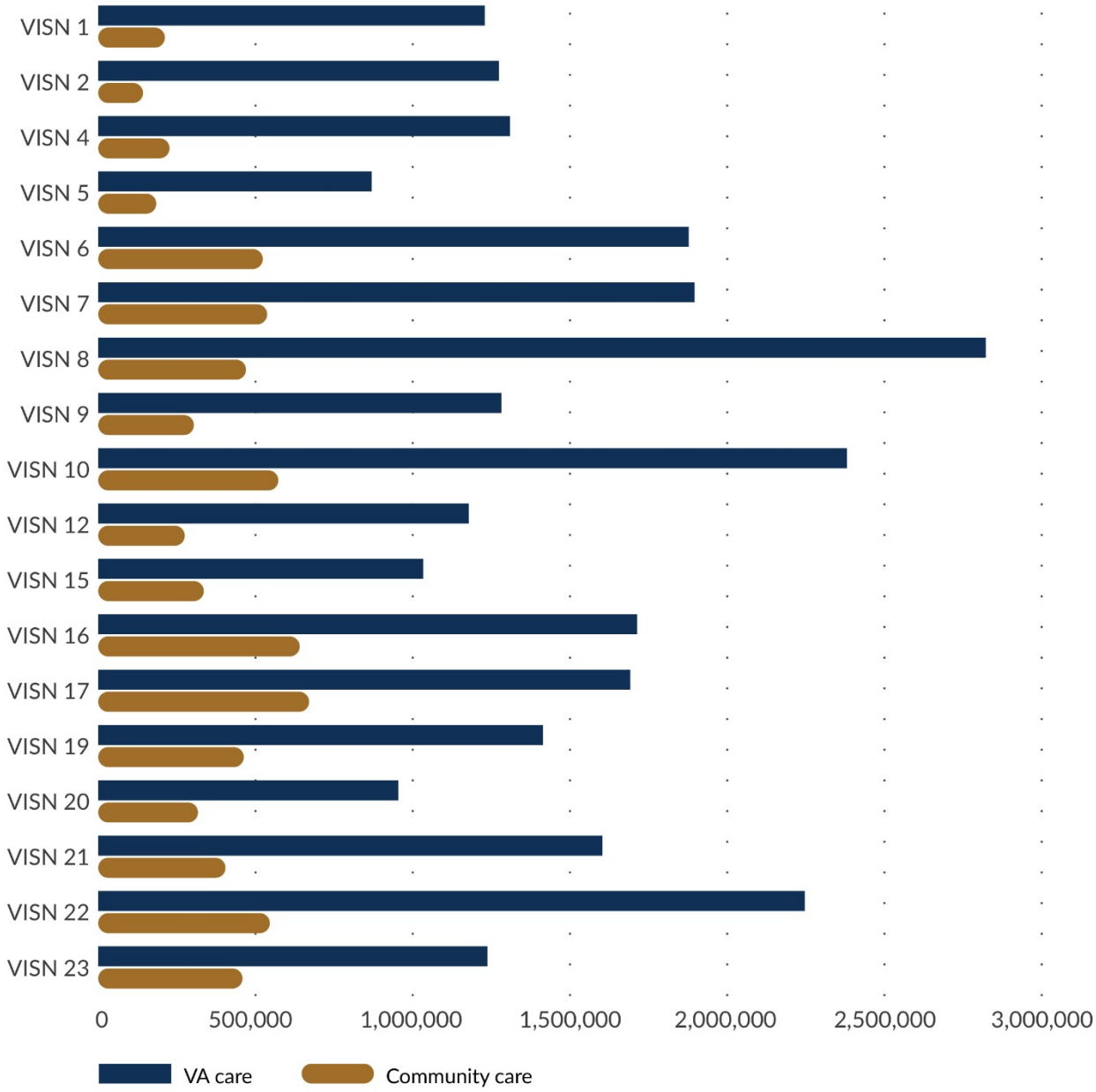

Figure 3. *VA and community care consults, by VISN (October 1, 2024, through September 30, 2025).*
Source: Data are as of January 13, 2026, from the VHA Support Service Center.

VHA data showed that completed consults for direct care increased about 20 percent from FY 2021 through FY 2025—from about 23.2 million to about 27.9 million. Similarly, during the same time, completed consults for community care increased about 41 percent from FY 2021 through FY 2025—from about 4.9 million to about seven million. Most VISNs saw an increase in requests for community care from FY 2021 through FY 2025.

Oversight Responsibilities

As noted previously, VHA has announced significant changes to the structure of its management and operations. The responsibilities detailed in the sections that follow represent those at the time of the audit.

Various entities have oversight responsibilities for community care—including consult scheduling—at the national, VISN, and local levels.

Office of Integrated Veteran Care

In 2022, VHA combined its Office of Veterans Access to Care and its Office of Community Care into a single office, to form IVC, to better coordinate services at VA facilities with those provided in the community. IVC is responsible for the following related to their national program and any suboffices organized within the program office: allocating resources within their span of control, developing training, setting standards for education, and managing professional standards within their span of control.[15]

Veterans Integrated Service Network

In addition to the oversight IVC provides, each VISN director is responsible for the following:

- **Managing performance within the VISN.** Ensuring IVC procedures and policies are communicated to the VISN's medical facilities to identify risk, improve processes, and share best practices among facilities.
- **Assisting with oversight of policy implementation.** This includes regularly reviewing and applying corrective measures to address VISN data on consults and implementing standardized processes for consult management and reporting across the VISN, according to VHA Directive 1232.[16]

Medical Facility Director

Facility directors are responsible for monitoring compliance with VHA's outpatient scheduling directive and reporting noncompliance to the VISN director. They are also charged with

- providing scheduling resources (including staff, consult naming conventions, and consult setup rules) to meet veterans' needs,
- making sure consults are scheduled in accordance with policy,
- creating a clearly defined local policy for managing and prioritizing consults, and

[15] VHA Directive 1217, *VHA Operating Units*, August 14, 2024.

[16] VHA Directive 1232, *Consult Processes and Procedures*, August 24, 2016, amended November 22, 2024.

- following policy and guidance from IVC on community care coordination procedures in compliance with VHA Directive 1232.

Schedulers

The following staff are among the facility-level schedulers responsible for consult management:

- A facility's **referral coordination team** receives, refers, and schedules consults in compliance with VHA consult-processing standards. The team provides care options that veterans are eligible for at VA medical facilities or with a community provider so patients can make informed healthcare decisions.
- The **consult referring service** or the **referring clinician** is responsible for entering consults with a clinically appropriate date (patient indicated date).
- The **consult receiving service** or the **receiving clinician** is responsible for acting on consults received to provide timely scheduling information to veterans.
- **Receiving service administrative staff** are responsible for notifying veterans and scheduling appointments from consults, according to VHA procedures.[17]

The audit team refers to these roles throughout the report collectively as "schedulers."

[17] VHA, "Consult Timeliness Standard Operating Procedure"; December 1, 2022; VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure," July 28, 2022.

Results and Recommendations

Finding: VHA Could Improve its Administration of the Community Care Program to Ensure It Consistently Identifies and Informs All Eligible Veterans of Their Options

In the first quarter of FY 2025, VHA schedulers did not accurately determine each veteran's eligibility for community care or inform all veterans of their eligibility as the MISSION Act and related regulations require. The OIG found VHA staff incorrectly processed some community care consults and VA appointments during these three months because of scheduling system limitations, improper documentation of available appointment dates, and errors in the Consult Toolbox. Notably, the OIG estimated:

- About 25 percent of community care consults related to mental health, primary, or specialty care (340,000 of about 1.4 million) were sent outside VA when the veteran was not eligible for community care—costing VHA potentially about $440 million (or $1.7 billion in monetary benefits over the fiscal year)—because schedulers did not accurately determine eligibility and, thus, did not send veterans to VA medical facilities that had the available services.[18]
- About 38 percent of the 4.8 million appointments related to mental health, primary, or specialty care where a veteran *was* eligible for community care but was seen within VA (or about 1.8 million) had no evidence that medical facility staff first assessed these veterans for eligibility. Furthermore, for 58 percent (about 1.1 million) of those 1.8 million appointments, schedulers did not document veterans' decision to opt out of community care as required.

The OIG also determined that if they had been made aware of the next available appointment options at a VA facility and of the community wait times, veterans associated with about 38,100 consults could have received care faster by opting out of community care and taking the next available appointment within VA. Estimating conservatively, the OIG projected that VA incurred about $114.4 million per year in added costs because these veterans opted for community care and it is not clear whether they would have chosen otherwise.

These issues occurred in part because VHA's processes to assess eligibility are not consistent with the plain language of the MISSION Act. For example, even though the MISSION Act

[18] This cost represents what VA paid to community care providers. The OIG did not offset this cost by what it would have cost to see the patient in the VA for direct care because no new services or increases to providers were required to deliver the care. Dollar value estimates in this report are conservative because payment data were not available for all consults at the time of these projections—as of July 2025, only 75 percent of consults in the population were paid.

makes no distinction between new and established patients, IVC guidance requires VA staff to check all eligibility criteria only for new patients. For established patients, schedulers routinely assess for wait-time eligibility and only check drive time if the veteran requests an assessment of their drive-time eligibility. This reflects VHA's interpretation of the MISSION Act and 38 U.S.C. § 1703(d) and also promotes continuity of care.

What the OIG Did

To assess whether schedulers determined community care eligibility in accordance with law and guidance and informed veterans of all their care options, the audit team analyzed VA and community care consults with a file entry date from October 1 through December 31, 2024, as well as VA appointments that occurred during those three months, and the final claims data for the consults as of July 2025. For this analysis, the OIG applied exclusion criteria to identify the testing population. This was to ensure the analysis represented a fair comparison of direct care and community care, and excluded consults that requested a specific date outside the access standard.

The team also selected and analyzed a statistical sample of about 250 consults and 130 VA appointments that the team tested for the accuracy of eligibility determinations and whether veterans were informed of their options. Specifically, the team analyzed veteran medical records, appointment data, and services offered at VA medical facilities. In addition, to give VHA the opportunity to comment on the OIG's analysis, the team provided this sample to originating facilities and to the facilities the team identified that could have provided the care within the veterans' wait-time and drive-time standards. This process reduced the error rate, ensuring the OIG's results were conservative and only included confirmed errors. All estimates in this report are based on projections from the sample results and verification provided by the facilities.

The team interviewed VHA and IVC officials and facility staff responsible for overseeing or scheduling appointments at the VA and in the community to discuss how they process consults, assess community care eligibility, and inform veterans of care options. The team also used its professional judgment to select three VA medical facilities (discussed further in appendix A) to visit, review samples with facility subject matter experts, understand local procedures, and identify best practices. Finally, the team analyzed VHA and IVC guidance and met with VHA and IVC leaders to discuss the OIG's analysis, the audit methodology, and any identified concerns related to VA's noncompliance or weaknesses with systems and processes.

Because VHA does not track the actual wait time used at the time of the consult, the OIG calculated *average* wait times to assess the accuracy of wait-time eligibility determinations. The OIG shared this methodology with VHA and IVC during briefings in September and October 2025. VHA and IVC expressed concerns about the OIG using average wait times since it can change daily but could not provide an alternative methodology. Ultimately, VHA and IVC

agreed with the OIG's approach, which was based on processes and system limitations at the time of the audit.

The team met with leaders from VHA and IVC multiple times throughout the audit to discuss the team's preliminary results. During a briefing on VHA scheduling initiatives in October 2025, leaders confirmed the issues identified in this report were still present at that time because VHA had not yet implemented a scheduling system that allows for visibility and scheduling at other VA medical centers or in the community. However, IVC officials said they were working on several scheduling initiatives—such as an expansion of VHA's External Provider Scheduling System—which will allow VA to schedule directly into participating community provider schedules and to speed up scheduling for community care. The success of this system will depend in part on how frequently it is used. For example, the community care chief at the Phoenix Health Care System in Arizona said that although the facility processes about 10,000 referrals a month, schedulers had booked only about 110 appointments using the External Provider Scheduling System as of April 2025 because not all care categories are available in the system and not enough local vendors have registered to use it.

Table 1 details the number of appointments and consults that met the OIG's testing criteria for accuracy and evidence of informing veterans of eligibility.

Table 1. Number of VA Appointments and VA and Community Care Consults Tested for Accuracy of Eligibility Determinations and Whether Eligible Individuals Were Informed

Testing category	Type of referral	Number tested (rounded)
Accuracy of community care eligibility determination (wait time, drive time, no full-service VA)	Community care consults with file entry dates from October through December 2024	1,400,000
Accuracy of VA eligibility determinations	VA appointments with appointment dates from October through December 2024	4,800,000
Evidence informing veterans of community care eligibility	VA appointments among the 4,806,456 the OIG tested for accuracy identified as eligible for community care	1,800,000

Source: Data obtained on consults with a file entry date and appointments dated from October through December 2024 from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

Note: The audit team tested VA appointments—rather than consults—for community care eligibility and to verify whether there was evidence that veterans were informed, because consults alone typically do not include this information, as eligibility determinations are not made at the time a consult is placed.

See appendix A for more details on the scope and methodology, appendix B for additional details on the OIG's exclusion criteria, and appendix C for additional information on the sampling methodology.

Identification of Veterans Eligible for Community Care

Schedulers did not accurately determine community care eligibility for all veterans who received direct care or community care. Sometimes veterans were found eligible when direct care options were available within wait-time or drive-time standards established under the MISSION Act and related VA regulations; in other cases, veterans were sent to direct care without evidence they were first assessed for community care eligibility. These issues occurred in part because VHA's guidance requires VA staff to check all eligibility criteria only for new patients and only wait-time eligibility for established patients. This requirement is a result of VHA's interpretation of the MISSION Act and 38 U.S.C. § 1703(d).

Accuracy of Community Care Eligibility Determinations

For community care consults completed in the first quarter of FY 2025, schedulers did not consistently identify direct care options for veterans who were sent to community care. The OIG estimated that medical facility staff sent about 25 percent of community care consults related to mental health care, primary care, or specialty care (about 340,000 of about 1.4 million) outside VA even though the veteran was ineligible for community care. Rather, the OIG determined VA medical facilities could have provided the requested services within the veterans' drive and wait times.

The OIG estimated that VHA could have potentially saved about $440 million in community care services from October through December 2024 (or $1.7 billion in monetary benefits over a full year) by making sure schedulers accurately determined eligibility and sent veterans to VA medical facilities that had the available services (see appendix D for more on the monetary benefits the OIG identified). Table 2 details the results of these analyses.

Table 2. Estimated Results of VA Community Care Eligibility Determinations

Testing outcome	Estimated number of community care consults	Percentage of community care consults
Confirmed eligibility for community care—that is, OIG testing matched VA's decision	1,000,000	74%
Eligibility was based on different criteria—that is, OIG testing confirmed community care eligibility but on different criteria than VA's basis for its decision	14,000	1%
Did not confirm VA's finding of eligibility for community care	340,000	25%
Total	**1,400,000***	**100%**

Source: Data obtained on consults with a file entry date from October1 through December 31, 2024, from VA's Corporate Data Warehouse through VA's Integrated Care Workspace.

** Total does not sum precisely due to rounding.*

VHA's Consult Toolbox can identify other VA medical facilities within a veteran's drive time and wait time—but as of October 2025, the toolbox lacked the capability for schedulers to schedule at those other medical facilities (as discussed later in this report). The OIG determined this was a major contributing factor in veterans appearing eligible for community care when, based on MISSION Act criteria, they were not. The following example reflects a situation where VA could have provided services in-house within a veteran's wait or drive times.

Example 1

On November 8, 2024, a veteran went to the dental clinic at the Edward Hines Jr. VA Hospital in Hines, Illinois as a walk-in appointment and complained of pain in two teeth. After an exam, the dentist determined the veteran needed specialized treatment from an endodontist. Though the Hines facility provides this specialized care, the documented next available appointment date was noted as February 4, 2025—88 days after the patient went to the dental clinic—so the veteran was referred to community care based on wait time.

However, the veteran lives about 52 minutes from the Jesse Brown VA Medical Center in Chicago, Illinois, which also provides the treatment this veteran needed. The veteran's electronic health record does not have evidence that Hines facility staff attempted to contact the Jesse Brown facility to coordinate care despite the Jesse Brown facility being within the veteran's drive-time threshold. According to the OIG's calculations, the average wait time for the dental clinic at the Jesse Brown facility, leading up to the care request, was about 18 days. The veteran likely could have received more timely care within a VA facility with no additional cost incurred by VA, whereas the care in the community cost over $6,200.

Eligibility determination errors were most commonly related to wait times; a smaller percentage related to general drive time and drive time–specific clinical service. The drive time–specific clinical service option is intended to be used when VA facilities within the drive-time standard offer related services but not the *specific* service being requested. For example, a VA medical center might offer cardiology services but not a specific cardiology procedure, and no other VA medical facility offers the procedure within 60 minutes of a veteran's address. In that case, the veteran would be eligible for community care based on drive time for the specific clinical service. Table 3 details the estimated breakdown of errors and associated eligibility determinations.

Table 3. Estimated Breakdown of Errors by Eligibility Determination

Testing outcome	Estimated number of community care consults	Percentage of community care consults
Drive time	35,000	2.5%
Drive time, specific clinical service not offered*	69,000	5%
Wait time	240,000	17%
Total	**340,000‡**	**25%‡**

Source: Data obtained on consults with a file entry date from October 1 through December 31, 2024, from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

** The facility may offer some services but not the exact clinical service needed.*

‡ The OIG did not estimate errors associated with "no full-service" results because the estimate was relatively imprecise.

Accuracy of Direct Care Eligibility Determinations

Schedulers did not consistently identify community care as an option for veterans and scheduled them for direct care with no documented indication the veterans were first assessed or offered community care when they were eligible. As noted previously, the Consult Toolbox should be used to document community care eligibility and veterans' preferences to opt in or out of community care. For VA appointments completed in the first quarter of FY 2025, the OIG estimates schedulers sent about 38 percent of appointments that were eligible for community care (about 1.8 million of 4.8 million) to VA without evidence that staff first assessed these veterans for community care eligibility. Examples 2 and 3 reflect situations where schedulers did not properly document in healthcare records that veterans were informed they were eligible for community care before they sought care within VA.

Example 2

On October 31, 2024, a veteran was scheduled for a kinesiotherapy appointment at the Tuscaloosa VA Medical Center in Alabama despite being eligible for community care based on drive time. Facility staff told the audit team the veteran opted out of community care and chose to travel 80 miles to obtain care at the VA medical center. Facility staff acknowledged the medical support assistant did not update the Consult Toolbox to reflect that this veteran had declined community care. However, without the opt-out recorded in the toolbox, there is no evidence this veteran decided to drive beyond the drive-time standard for care. In response to this example, facility leaders said they would reeducate relevant staff to prevent similar errors in the future.

Example 3

On November 27, 2024, a veteran was scheduled for a podiatry appointment at the Miami VA Medical Center in Florida despite meeting drive-time eligibility criteria for community care. This scheduling error, identified by the audit team, required the veteran to drive 135 miles to receive care at the Miami facility. Facility staff acknowledged they did not inform the veteran of their community care eligibility based on staff's interpretation that MISSION Act guidance indicated drive-time eligibility needs to be assessed only for new patients. The veteran was an established patient, so facility staff did not assess the veteran's eligibility for community care.

Systems and Processes Used to Identify Veterans Eligible for Community Care

Medical facilities did not have ways to schedule care at other available VA medical facilities when a requested service was not available at a veteran's home facility. The absence of this capability contributed to the errors the audit team identified given that the MISSION Act (and 38 C.F.R. § 17.4040) is clear that veterans are eligible for community care only when they do not meet access standards—regardless of where a veteran is registered to receive care. In addition, weaknesses in VHA's scheduling process meant veterans may not have been aware of all their direct care options during the first three months of FY 2025. The OIG determined IVC did not have a process to validate eligibility determinations as part of its oversight and cannot do so for wait-time eligibility—the systems do not maintain the data needed for this type of oversight. Without appropriate oversight and validation, VHA cannot be sure that schedulers were appropriately assessing eligibility for community care.

Assessment of Consult Toolbox

System limitations hindered how VHA staff could use the Consult Toolbox to identify other medical facilities within a veteran's drive time and wait time. While the toolbox can provide the average wait time for appointments at other facilities, the OIG found

- schedulers cannot schedule at other VA facilities within drive-time standards,
- schedulers do not have consistent access to wait times for community care, and
- the Consult Toolbox identifies only general services and not a specific service, which sometimes leads to inaccurate eligibility determinations.

Access to Drive-Time Information for Community Care

The Consult Toolbox shows all VA medical facilities within a 90-minute drive of a veteran's home address that may offer the clinical service requested in a consult. Drive times appear in

10-minute ranges, starting at 0–10 minutes and going up to 80–90 minutes (beyond the 30- or 60-minute standards set by the MISSION Act and related VA regulations). The system calculates average drive time based on past traffic patterns at a veteran's local time. Figure 4 illustrates how the system portrays average drive-time, wait-time, and community care wait-time information.

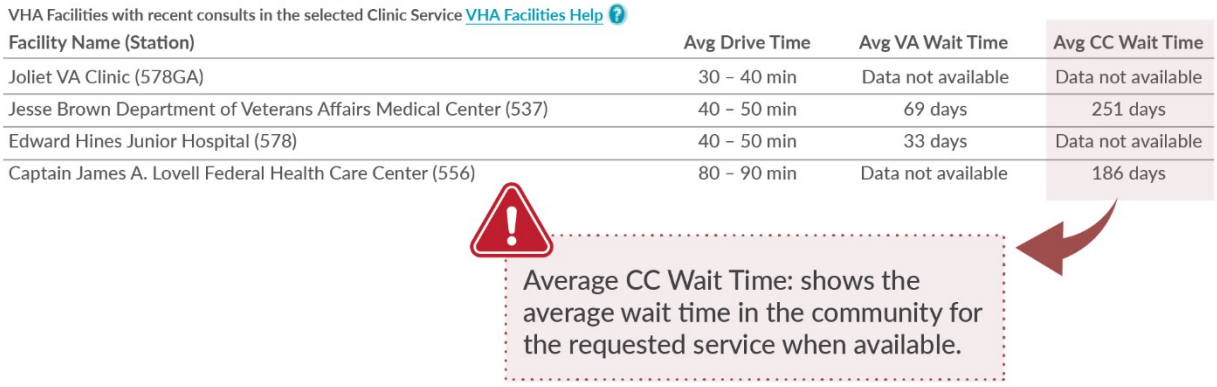

Figure 4. *Illustration of the Consult Toolbox's drive-time identification.*

Source: Consult Toolbox User Guide, *September 2023.*

Note: For accessibility, the OIG created the image based on a screenshot from the Consult Toolbox.

Showing VA medical facilities close to a veteran is where the Consult Toolbox's capability ends. VHA staff who use the toolbox told the audit team they cannot access or even see other medical facilities' calendars, so they cannot schedule veterans at those facilities. Some schedulers noted they have established relationships with local facilities to request scheduling information, but this is not the case for all schedulers.

As a result of these limitations, VHA could not identify all opportunities when VA facilities could have provided services. IVC leaders acknowledged that they were aware of these challenges and said in October 2025 they were planning a fix for scheduling direct care within the Integrated Scheduling Solution—a web-based scheduling application that will replace its current scheduling system—but the system is still unable to allow scheduling across different VISNs and medical facilities for direct care. The system will, however, provide the following capabilities (implementation expected in December 2025), which should expand schedulers' options and allow veterans to make better-informed decisions about their care:

- Multiple scheduling actions consolidated into a single platform—such as the ability to have provider-based scheduling and different appointment types, compare available VA and community care appointments, and directly schedule available community care appointments
- The ability to identify available virtual and in-person appointments and schedule across medical facilities
- More online scheduling options for veterans' direct care

Some medical facilities have the Integrated Scheduling Solution, but it is too early for the OIG to determine whether the new system is mitigating scheduling challenges.

Recommendation 1 calls on VHA to establish and use agreements with other VA medical facilities to help identify and schedule direct care when local services are not available.

Access to Wait-Time Information for Community Care

When the Consult Toolbox debuted in September 2023, IVC officials intended it to eventually display average community care wait times so that providers, schedulers, and veterans could compare VA and community wait times and make informed decisions. But, at the time of this audit, average community care wait times were not consistently available in the toolbox. This leaves both schedulers and veterans in the dark when making decisions on where to receive care.

In analyzing just over 287,000 wait time–eligible community care consults that were completed in the first quarter of FY 2025, the team found that for about 13 percent (38,100), the veteran would have received care faster by opting out of community care and taking the next available VA appointment. While the OIG cannot know whether veterans would have chosen to receive VA direct care in these instances, providing the veterans with accurate wait-time information would have allowed them to make a truly informed choice. Conservatively, the OIG calculated that VA incurred additional costs totaling about $114.4 million per year because these veterans opted for community care.

Though schedulers at some medical facilities are obtaining and checking average wait times for appointments—typically within referral coordination teams—this is not often the norm. More than 40 percent of wait time–eligible veterans wait over a month longer to get care in the community than they would have if they had taken the next available VA appointment. Table 4 breaks down the ranges of times veterans waited for community care beyond the next available VA appointment date.

Table 4. Range of Times Veterans Waited for Community Care Beyond the Next Available VA Appointment Date

Testing outcome	Estimated number of community care consults	Percentage of community care consults
Two weeks	13,200	34.6%
Two weeks to one month	8,200	21.6%
One to two months	8,100	21.3%
Two to three months	3,800	10.1%
Three to six months	3,800	9.9%
Six to nine months	730	1.9%
Nine months to one year	200	0.5%

Testing outcome	Estimated number of community care consults	Percentage of community care consults
Over one year	50	0.1%
Total	**38,100***	**100%**

Source: Data obtained on consults with a file entry date from October through December 2024 from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

** Total does not sum precisely due to rounding*

The toolbox shows the average wait time (rather than the exact wait time) of all VA appointments booked or completed under specific care categories related to a requested clinical service, based on the previous 90 days of data. Therefore, for the toolbox to show the average community care wait time, an appointment must have been scheduled with a community provider within the past 90 days. The exact wait time is determined at the time of scheduling when actual appointment times are available.

The average wait time is an important factor veterans should consider in deciding whether to receive care within VA or the community. If schedulers cannot check the average wait time for community appointments or if the wait times are not available, they cannot provide veterans with the best information for them to fully consider all care options. Referral coordination team members said when community wait time is about the same as the wait time for direct care, many veterans preferred VA. Reasons for this included familiarity, convenience, and not having to find a new provider.

Recommendation 2 calls on VHA to assess options to improve the scheduling process and system to provide schedulers with access to community provider appointment availability when discussing care options with wait time–eligible veterans.

Consult Toolbox Limitations

The Consult Toolbox sometimes made inaccurate eligibility determinations because it did not show all available VA medical facilities that provided the requested clinical service. Schedulers at multiple facilities said the toolbox was limited to showing only broad categories of care, such as dermatology, cardiology, or podiatry; it does not identify VA facilities that can provide a specific service (for example, skin grafts, surgeries, or diabetic foot care, respectively). This occurred because of inaccurate data connections to the toolbox, resulting in incorrect eligibility determinations.

For example, if a veteran needed an echocardiogram, a scheduler should know to search for "cardiology" in the toolbox. But because each facility is responsible for listing services under its broad categories of care, the data reflect only the services that the facility has entered as available, even though a service might actually be offered but not recorded. Therefore, if the data the toolbox searches do not link an echocardiogram to the cardiology department at that facility,

the toolbox would show the veteran is eligible for community care because the toolbox believes the facility does not offer the requested service.

An experienced scheduler might question that eligibility determination because they know a VA facility *does* offer echocardiograms or that it would be unusual for a cardiology department to not offer this service. But an inexperienced scheduler may push the consult to community care without verifying the specific service is available.

Meanwhile, for veterans who are drive time–eligible for community care, the toolbox automatically applies that designation based on a veteran's address and the VA medical facilities that have the requested clinical service if those facilities are outside the drive-time parameters. However, a scheduler can override that designation, which may result in viable alternatives being overlooked.

For example, a scheduler in Kansas City, Missouri, said the medical facility director told them to assess a veteran's community care eligibility based only on their distance from *that* facility. A veteran registered at the Kansas City facility might live five minutes from a different medical facility in Columbia, Missouri, which provides the service the veteran needs. The toolbox would show the veteran is outside the drive time for the Kansas City facility, and a scheduler would not consider the Columbia, Missouri location and, thus, would deem the veteran eligible for community care based solely on the distance from the Kansas City facility.

While the Kansas City facility has since corrected this practice, the OIG is concerned that other facilities' schedulers may also be overriding ineligibility decisions without proper justification. In other words, if a scheduler is not looking at the full picture the toolbox generates, they can easily override a correct determination of ineligibility for community care and send a veteran to the community even though VA could have provided the care.

Likewise, a scheduler in Tennessee Valley told the OIG they faced similar issues in Atlanta and Birmingham, where schedulers at those facilities encouraged border-area veterans to enroll in Tennessee Valley to qualify for community care. This practice let veterans bypass VA medical facilities that potentially offered available services within the veterans' drive time and showed additional confusion about enrollment locations and the impact to eligibility determinations.

Recommendation 3 calls on VHA to review services in the Consult Toolbox to make sure it accurately reflects available services and avoids inaccurate eligibility determinations.

Implementation of MISSION Act Criteria to Assess Eligibility for Community Care

As noted previously, the OIG concluded that how VHA assesses community care eligibility for established patients is not consistent with the plain language of the MISSION Act. OIG testing and interviews with IVC staff revealed that schedulers did not generally assess established patients for any community care eligibility criteria except wait time. They also did not routinely

document, as required, veterans' decisions to opt out of community care—both for new and established patients. As a result, VHA cannot be sure these veterans were given all available options to receive care.

The audit team could not identify any support in the MISSION Act or the implementing regulations for IVC's requirement that schedulers check all eligibility criteria for new patients but check only wait-time eligibility for established patients. Neither the MISSION Act nor regulations distinguish between community care eligibility for new patients versus existing patients. Federal law also sets forth the criteria under which the Secretary "shall, subject to the availability of appropriations, furnish hospital care, medical services, and extended care services to a covered veteran through [community] health care providers" (38 U.S.C. § 1703(d)(1)). Also, veterans should be assessed and offered community care when the criteria applies, and the decision to receive community care services "shall be at the election of the veteran" (38 U.S.C. § 1703(d)(3)).

An estimated 43 percent of VA appointments that the OIG testing identified as drive-time eligible did not have documentation that VA actually assessed for drive-time eligibility because they were for established patients (about 458,000 of about 1.1 million appointments). Although assessing established patients only for wait times has been a long-standing VHA practice, the OIG concluded in a previous report related to the Elizabeth Dole Act that it does not align with the plain language of the MISSION Act, and it hinders veterans' awareness of all care options to ensure their soonest and best care.[19]

IVC leaders agreed with the OIG that the MISSION Act requires VHA to assess *all* veterans for each eligibility type. However, they also told the audit team in January 2025 they had intended to ask Congress to align the eligibility assessment requirements with IVC's guidance—that is, so schedulers would have to check only wait-time eligibility for established patients. This effort was on hold as of September 2025.

The OIG identified instances where schedulers did not follow other MISSION Act criteria to assess wait-time eligibility. First, at the Fayetteville VA Medical Center in North Carolina, the audit team learned that rather than identify the next available appointment date, schedulers applied 30 or even 90 days—which are longer than the MISSION Act's implementing regulations' 20-day or 28-day standards—as the next available VA appointment because they knew the wait times for direct care were greater than the access standard. The team identified instances of this at other medical facilities, too. As a result, schedulers potentially missed opportunities to identify appointments that became available due to cancellations.

[19] VA OIG, *VISN 12 Needs to Improve How It Administers the Veterans Community Care Program,* Report No. 24-01757-146, August 27, 2025.

Second, during an interview with a scheduler from the Fayetteville VA Medical Center, the team learned facility leaders instructed schedulers to record the next available VA appointment date as one month after the file entry date without checking the actual appointment schedule. The dental chief told the audit team that they instructed schedulers to record the next available date as 30 days after file entry without checking appointment availability at the facility because the dental service was usually booked far out to schedule appointments for new patients. This practice distorted the picture in at least three ways:

- Veterans were not assessed for wait-time eligibility using standards from the implementing regulations of the MISSION Act.
- Schedulers would not be able to see appointment cancellations and other last-minute openings without checking actual appointment availability.
- VISN and IVC analysts would have inaccurate trends on veterans' access to care due to documenting all next available appointment dates as 30 or more days.

Recommendation 4 calls on VHA to reinforce requirements for schedulers to review scheduling systems to identify the next available date for appointments and input that information in the Consult Toolbox.

Recommendation 5 calls on VHA to implement a process to verify that schedulers check all community care eligibility criteria for all veterans.

Informing and Documenting When Eligible Veterans Opt Out of Community Care

For VA appointments completed during the first quarter of FY 2025, among about 1.8 million appointments where OIG testing identified that a veteran was eligible for community care but was scheduled for direct care, about 58 percent of appointments (about 1.1 million) had no documentation that the veteran had opted out of community care. Specifically, the audit team could not confirm VHA schedulers assessed—and therefore, informed—veterans of their choice between VA or community care because the veterans' health records lacked the required evidence.

Schedulers must use an opt-out code to document when a veteran is eligible for community care but declines. Without documentation of this code, there is no way to verify that a scheduler actually assessed a veteran for community care. This lack of documentation could have occurred because schedulers inaccurately identified community care eligibility for these appointments or because they did not appropriately document when veterans opted out of community care.

Furthermore, facility managers told the audit team a scheduler used the opt-out code without informing veterans of their community care eligibility. To remedy this situation, managers

informed the audit team that they will provide comprehensive training to ensure staff understand proper code usage, and the need to communicate options to veterans before applying the code.

Incorrect use of the opt-out code can skew the data VA leaders use to measure the number of veterans who are eligible for community care, and it also implies a veteran declined care outside VA. Not using the opt-out code at all makes it unclear whether an assessment occurred or whether a veteran knew of their eligibility for community care.

Recommendation 6 is for VHA to emphasize to schedulers at least annually the proper methods (including the use of appropriate codes) to document when veterans opt out of community care.

Conclusion

Schedulers did not consistently ensure veterans were correctly identified as eligible for community care and that they were offered all options to schedule their appointments either within VA or the community. Part of this was due to system limitations in VA's Consult Toolbox. Until medical facility staff have the capability to effectively identify available appointments—not only across VA facilities but also in the community—VA's efforts to make sure veterans are fully informed of their care options will be hindered.

Furthermore, VHA could have potentially saved about $1.7 billion over a full year in community care services if schedulers accurately determined eligibility and sent veterans to VA medical facilities that had the available services and if VHA had implemented processes to obtain and provide available community care wait-time data to veterans when informing them of their care options. VHA could have saved an additional $114.4 million and provided faster care to wait time–eligible veterans if schedulers communicated that wait times for community appointments were longer than those available through VA.

Recommendations 1–6

The OIG recommended the under secretary for health:

1. Establish and use agreements with other VA medical facilities to help identify and schedule direct care when local services are not available.
2. Assess options to improve the scheduling process and system to provide schedulers with access to community care provider appointment availability when discussing care options with wait time–eligible veterans.
3. Review services in the Consult Toolbox to make sure it accurately reflects available services and avoids inaccurate eligibility determinations.
4. Reinforce requirements for schedulers to review scheduling systems to identify the next available date for appointments and input that information in the Consult Toolbox.

5. Implement a process to verify that schedulers check all community care eligibility criteria for all veterans.
6. Emphasize to schedulers at least annually the proper methods (including the use of opt-out codes) to document when veterans opt out of community care.

VA Management Comments

The under secretary for health concurred with recommendations 1 through 4 and 6, and concurred in principle with recommendation 5. The under secretary submitted responsive corrective action plans to address each recommendation. These include plans to reinforce the need for cross-facility scheduling through additional training; assess enhancements to the External Provider Scheduling platform; review the Consult Toolbox to ensure it accurately reflects available services at each facility; and review annual scheduler training and related guidance to ensure it properly instructs staff on documenting when veterans opt out of community care. For recommendation 5, VHA concurred in principle and indicated plans to assess what is required to ensure schedulers verify all community care eligibility criteria for all veterans, by evaluating potential changes to information technology systems, policy, regulations, and operational processes to support consistent and veteran-centric eligibility determinations.

The under secretary for health also stated that "VHA provides veterans with real-time information about actual wait times when discussing care options." He further stated a "retrospective review of wait times does not serve as an appropriate method to determine whether sites complied with community care eligibility requirements regarding wait times."

OIG Response

The OIG will close the recommendations when VHA provides additional evidence that actions have fully addressed the identified issues. The full text of the under secretary for health's comments and target completion dates can be found in appendix E.

In addition, the under secretary's assertion that a retrospective review of wait times is not an appropriate method mischaracterizes the OIG's approach. Average wait times were one diagnostic input—not the sole basis for determining compliance with community care eligibility. To ensure accuracy, the OIG provided sampled cases to facilities that the team identified as having availability to provide the questioned care at the time it was required. This included having each facility validate that the care could have been provided within the veteran's drive and wait time. The OIG then removed any unsubstantiated cases from the sample projections. These validation efforts reduced the error rate and ensured the OIG's results were conservative and limited to confirmed errors.

The OIG's methodological approach was developed in consultation with program stakeholders and shared in detail with VHA and IVC officials during briefings in September and

October 2025. During these meetings and at the exit conference, while VHA and IVC officials raised concerns about the use of average wait times, they could not present any viable, testable alternative methodology aligned to the systems and data available to allow the OIG to conduct the work required of the Dole Act.

Appendix A: Scope and Methodology

Scope

The VA Office of Inspector General (OIG) conducted its work from January 2025 through March 2026. The scope of the audit comprised community care consults and VA appointments and consults from October 1 through December 31, 2024—the first quarter of fiscal year (FY) 2025. Table A.1 details the number of consults and appointments within the time frame the OIG reviewed and the number that met the team's testing criteria.

Table A.1. Scope of Community Care and VA Consults and Appointments

Scope of analysis	Community care consults (assessed to determine accuracy of eligibility determinations)	VA appointments (assessed to determine whether eligibility for community care was documented or veterans were informed of care options)
Overall	2,274,737	22,906,324
Count that met criteria for testing	1,356,696	4,806,456

Source: Data obtained in March 2025 from the Veteran Health Administration's Corporate Data Warehouse through VA's Integrated Care Workspace.

Methodology

To address the audit objective, the team

- obtained community care consult data and VA appointment and applied exclusions criteria to create a testing population (see appendix B for more details on the exclusion criteria);
- tested the data to determine how well the Veterans Health Administration (VHA) assessed and informed veterans of their community care eligibility;
- interviewed Office of Integrated Veteran Care (IVC), Veterans Integrated Service Network, and VA medical facility leaders and staff involved with implementing the Veterans Community Care Program—including clinical and administrative referral coordination team members, community care staff, and medical support assistants;

- visited three medical facilities, chosen based on the team's professional judgment: the Phoenix Health Care System in Arizona, the Tennessee Valley Health Care System in Nashville, and the Kansas City Health Care System in Missouri;[20]
- reviewed veterans' medical records for a sample of community care consults and VA appointments and consults used to answer the objective of verifying errors and determining whether community care discussions were documented in the medical record notes for veterans where the opt-out code (#COO#) is not identified; and
- developed two data collection tools—which included preloaded sample information, key data points to review, and standardized interview questions—to ensure the consistency of medical record reviews and data received at each site.

In choosing the three medical facilities to visit, the team selected two sites that had a high number of exceptions and one site that had a low number of exceptions. The team considered exceptions as (1) eligibility for community care was inaccurate, (2) the eligibility type was inaccurate, (3) a veteran was not informed of the community care option or such a conversation was not documented, and (4) community or direct care exceeded processing-time standards.

For community care, the analysis focused on verifying the accuracy of drive-time calculations and confirming the availability of services within drive time–eligible VA medical facilities. For VA appointments, the team reviewed the data to determine whether the wait-time calculations were reasonable compared to wait times at identified VA medical facilities that provided similar services. The team provided sample items to medical facility staff and requested responses on whether each associated facility could provide the indicated service in the consult or any constraints the facility faced in providing the service. The team analyzed consults that had at least 500 occurrences within a specific service line during the first quarter of FY 2025 to ensure a similar comparison between community care and direct care.

The team also reviewed each veteran's medical record and determined whether these appointments lacked evidence of having been assessed for community care eligibility or whether they were informed of their eligibility for community care. This verification included providing medical facility staff with information related to the consults and appointments so they could review and provide verification that the identified medical facility could provide the requested services, and each veteran was assessed and informed of their eligibility for community care. The team also reviewed veterans' medical records to further validate responses.

[20] For the companion report, the team also visited the Miami Health Care System in Florida, the Fayetteville Coastal Health Care System in North Carolina, and the VA South Texas Health Care in Texas.

Internal Controls

The audit team assessed IVC's internal controls that are significant to the audit objective. This included an assessment of the five internal control components of control environment, risk assessment, control activities, information and communication, and monitoring.[21] In addition, the team reviewed the principles of internal controls as associated with the objective. The team identified two components and three principles as significant to the objective.[22] The team identified internal control weaknesses during this audit and proposed recommendations to address the following control deficiencies listed in table A.2:

Table A.2. VA OIG Analysis of Internal Control Components and Principles Identified as Significant

Component	Principle	Deficiency identified by this audit
Control activities	10. Management should design control activities to mitigate risks to achieving the entity's objectives to acceptable levels.	Schedulers could not consistently provide veterans with expected wait times for community care using the Consult Toolbox.
Control activities	10. Management should design control activities to mitigate risks to achieving the entity's objectives to acceptable levels.	Scheduling audits do not assess whether community care eligibility determinations are accurate.
Control activities	11. Management should design general control activities over information technology to mitigate risks to achieving the entity's objectives to acceptable levels.	The Consult Toolbox allows users to select and change eligibility reasons, potentially resulting in inaccurate data.
Monitoring	16. Management should establish and operate monitoring activities to monitor the internal control system and evaluate the results.	A veteran's decision to opt in or opt out of community care is not always documented in accordance with VHA policy.

Source: VA OIG analysis of internal control components and principles. The principles listed are consistent with the Government Accountability Office's Standards for Internal Control in the Federal Government.

Data Reliability

The audit team relied on computer-processed data to support the finding, conclusion, and recommendations of this audit. The team used electronic data retrieved from VHA's Corporate Data Warehouse and Palantir (a web application that allows for real-time access to data across

[21] Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

[22] Because the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

systems), specifically within the Integrated Care Workspace, to evaluate community care consults, VA consults, and VA appointments. The team evaluated the completeness and accuracy of the data from these systems by checking for missing or duplicate entries and text and the accuracy of number formats. The team then tested consult records' data entries against source consult documentation in Veterans Health Information System Technology Architecture electronic medical records. The audit team's assessment determined the electronic data the team relied on were complete, accurate, and relevant for supporting the audit objective and results.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards.[23] Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

[23] Government Accountability Office, *Government Auditing Standards 2024 Revision*, GAO-24-106786, February 2024.

Appendix B: Identification of Testing Population

To address the audit objective, the team performed several types of analyses on consults with a file entry date or VA appointment date during the first quarter of fiscal year (FY) 2025 to identify the testing population.

- **The accuracy and type of community care eligibility based on the type of consult or appointment**
    - For all community care consults, the team assessed whether the VA Office of Inspector General (OIG) could replicate the eligibility determination.
    - For VA appointments, the team assessed whether the veteran met community care eligibility criterion.
- **Whether VA informed eligible veterans of their choice between VA and community care based on the type of consult or appointment**
    - For all VA appointments and consults, the team assessed whether documentation indicated a veteran's choice to opt out of community care.
    - For VA consults, the team identified records as eligible for community care but that lacked an opt-out indication by reviewing files and visiting selected medical facilities to determine either why a veteran was not informed of their eligibility or why staff did not document this conversation.

To assess whether Veterans Health Administration (VHA) staff determined community care eligibility appropriately and informed veterans of all their options, the audit team analyzed community care and VA consults with a file entry date (that is, when the request for care was made) or VA appointment date during the first quarter of FY 2025. The team implemented several testing criteria to ensure the analysis represented a fair comparison of VA and community care services. Additionally, the team removed appointments and consults for each service type that had fewer than 500 consults.

The team analyzed data on all consults and appointments that met the criteria for testing to identify exceptions. The team classified two exceptions:

- **Accuracy exception:** OIG testing of wait-time and drive-time criteria identified nearby VA facilities that could provide the service within the accepted wait time or drive time for consults approved for community care within the population tested. The audit team also tested consults determined to be eligible based on no full-service VA facility near where a veteran lived, but these accounted for less than 1 percent of the population. The audit verified the service was available at the identified facilities.

- **Informing exception:** OIG testing of wait-time and drive-time criteria for VA appointments determined they met the eligibility standard but lacked documentation in appointment notes or consult that the veteran had opted out of community care.

Appendix C: Statistical Sampling Methodology

Approach

To accomplish the objective, the audit team reviewed two statistical samples: (1) community care consults with a file entry date in the first quarter of fiscal year (FY) 2025—October 2024 through December 2024—and (2) VA appointments with a relevant date in the first quarter of FY 2025. The team used statistical sampling to quantify the extent schedulers made accurately eligibility determinations and informed veterans of their care options.

Population

Table C.1 details the number of consults and appointments within the time frame the VA Office of Inspector General (OIG) team reviewed (all records), the number within the audit's scope (the audit population), and the number the OIG determined to be potential exceptions. The sampling frames used for this audit consist only of potential exceptions. Other records within the audit population are not part of the sampling frame because the OIG determined these records are not exceptions. The team adjusted the potential exceptions if VA could provide information to demonstrate that consults were eligible for community care, despite the lack of available documentation in electronic records.

Table C.1. Scope of Community Care and VA Consults and Appointments

Scope of analysis	Community care consults (assessed to determine accuracy of eligibility determinations)	VA appointments (assessed to determine whether eligibility for community care was documented or veterans were informed of care options)
All records	2,274,737	22,906,324
Audit population	1,356,696	4,806,456
Sampling frame (potential exceptions)	496,554	1,495,925

Source: Data obtained in March 2025 from the Veterans Health Administration's (VHA) Corporate Data Warehouse through VA's Integrated Care Workspace.

Accuracy of eligibility determinations. Based on an analysis of all data during this period, the audit team constructed two sampling frames from the population of community care consults:

- Consults correctly deemed eligible but with the wrong determination (38,306 consults)—that is, consults that were presumably eligible for community

care but whose eligibility was apparently based on the wrong eligibility determination (for example, wait time instead of drive time)

- Consults incorrectly deemed eligible (458,248 consults)—that is, consults that were presumably ineligible for community care (based on ineligibility with respect to at least one VA clinic)

The team used sampling to determine whether consults within these sampling frames were indeed exceptions, along with the total dollar amount of the exceptions.

Informing veterans of care options. In summary, the population of all VA appointments was split into two sampling frames (representing two subpopulations):

- Established, drive time–eligible appointments
- Other appointments

The team used sampling to determine whether these appointments were indeed eligible for community care and whether scheduling staff informed veterans of their care options.

For both the consult samples and the appointment samples, the audit team provided information to the responsible facilities and provided facility staff with an opportunity to concur that the consult or appointment met or did not meet eligibility criteria and was informed of their options. The audit team reviewed the responses and conducted supplementary reviews of the veterans' medical records to validate responses and make the determination on each consult.

Sampling Design

Unless otherwise noted, the sample size for each stratum was about proportional to the number of consults associated with each stratum—and within each stratum, consults were selected with equal-probability sampling. In addition, the audit team provided consult and appointment information to the responsible facilities and provided facility staff with an opportunity to either concur that the consult or appointment met or did not meet eligibility criteria and was informed of their options. The audit team reviewed the responses and conducted supplementary reviews of the veterans' medical records to validate responses and made the final determination on each consult.

Accuracy of eligibility determinations. The audit team selected a statistical sample of 253 consults from the two sampling frames: eligible consults but potentially with the wrong determination and potentially ineligible consults. Of the 253 sampled consults, 30 were assigned to the sampling frame of eligible but with potentially the wrong determination. These 30 consults are detailed in table C.2.

Table C.2. Eligible for Community Care but with the Wrong Determination

Eligibility designation	Number of consults	Percentage	Number of samples
Drive time	7,252	18.93%	6
Drive time (specific clinical service)	30,846	80.53%	22
No full-service VA facility	149	0.39%	1
Wait time	59	0.15%	1

Source: VA OIG statistician's stratified population of data from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

Of the 253 sampled consults, 223 were assigned to the potentially ineligible sampling frame. Within the "Other, paid" stratum, consults were selected with probability proportional to the total of paid amounts for each consult, as available at the time the sample was obtained. For the other two categories of consults ("Discontinued, canceled" and "Other, unpaid"), consults were selected with equal-probability sampling. These sampled consults are detailed in table C.3.

Table C.3. Ineligible for Community Care

Eligibility designation	Category	Number of consults	Percentage	Number of samples
Drive time	Discontinued, canceled	6,385	1.39%	9
Drive time	Other, paid	24,533	5.35%	35
Drive time	Other, unpaid	11,492	2.51%	16
Drive time (specific clinical service)	Discontinued, canceled	23,533	5.14%	14
Drive time (specific clinical service)	Other, paid	94,813	20.69%	58
Drive time (specific clinical service)	Other, unpaid	45,470	9.92%	28
No full-service VHA facility	Discontinued, canceled	101	0.02%	1
No full-service VHA facility	Other, paid	330	0.07%	1
No full-service VHA facility	Other, unpaid	185	0.04%	1
Wait time	Discontinued, canceled	37,791	8.25%	9
Wait time	Other, paid	143,805	31.38%	34
Wait time	Other, unpaid	69,810	15.23%	17

Source: VA OIG statistician's stratified population of data from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

Consults were categorized as "paid" or "unpaid" according to payment records at the time sampling occurred. Subsequent payment extraction showed some consults that were not paid at

the time of sampling had payments later, at the time projections were made. However, the projections account for the original strata within which each consult was categorized at the time of sampling.

Informing veterans of care options. The audit team selected a statistical sample of 130 appointments from the two sampling frames noted above. Of the 130 sampled appointments, 30 were assigned to the sampling frame in table C.4.

Table C.4. Established, Drive Time–Eligible Appointments

Clinic group	Consult status	Number of appointments	Percentage	Number of samples
Mental health	Completed	50,023	8.31%	3
Mental health	Other	39,602	6.58%	2
Primary care	Completed	145,839	24.22%	7
Primary care	Other	74,477	12.37%	4
Specialty care and all other	Completed	170,468	28.31%	8
Specialty care and all other	Other	121,836	20.23%	6

Source: VA OIG statistician's stratified population of data from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

Of the 130 sampled appointments, 100 were assigned to the sampling frame detailed in table C.5.

Table C.5. Other Appointments

Clinic group	Consult status	Number of appointments	Percentage	Number of samples
Mental health	Completed	20,329	2.27%	3
Mental health	Other	29,630	3.32%	3
Primary care	Completed	64,739	7.24%	7
Primary care	Other	61,830	6.92%	7
Specialty care and all other	Completed	289,289	32.37%	32
Specialty care and all other	Other	427,863	47.88%	48

Source: VA OIG statistician's stratified population of data from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

Weights

Samples were weighted to represent the population from which they were drawn, and the weights were used in the estimate calculations. For example, the team calculated the numbers of exceptions by summing the sampling weights for all sample records associated with an exception.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this audit with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value about 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate estimates, margins of error, and confidence intervals that account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistic concerns of the sample review. While precision improves with larger samples, the rate of improvement decreases significantly as more records are added to the sample review.

Figure C.1 shows the effect of progressively larger sample sizes on the margin of error.

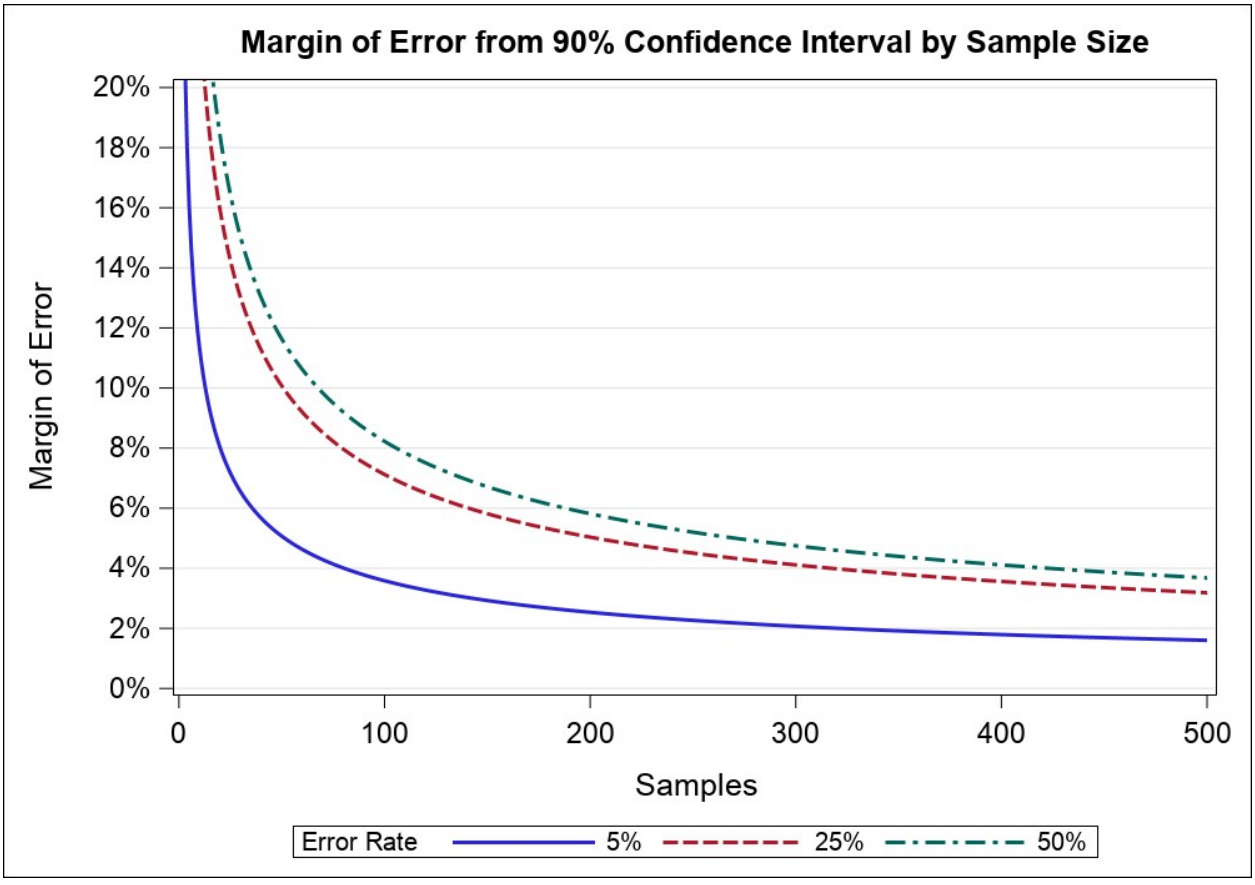

Figure C.1. *Effect of sample size on margin of error.*

Source: VA OIG statistician's analysis

Projections

Accuracy of eligibility determinations. The tables in this section contain statistical projections for the audit of community care consults. Confidence intervals for all projections are based on stratification, using the Clopper Pearson method. The OIG also used the generalized Clopper Pearson method for estimating percentages (such as error rates) and totals based on these percentages. The advantage of this method is that the resulting confidence limits are generally very conservative. Based on the method by which Clopper Pearson intervals are constructed, the margin of error cannot be simply subtracted from or added to the estimate to get the lower and upper limits, respectively. Additionally, the OIG used ratio estimation to improve statistical precision.

Table C.6 shows the results of the statistical sample for those consults that appeared eligible for community care but had the incorrect eligibility determination.

Table C.6. Statistical Projections Summary for Consults Correctly Deemed Eligible for Community Care but with the Wrong Reason, with a 90 Percent Confidence Interval

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count/sample size
Found eligible for wrong reason	13,693	6,488	7,712	20,687	11/30
As percentage of all consults	1.0%	0.5%	0.6%	1.5%	11/30

Source: VA OIG statistician's stratified population of data from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

The next three tables contain projections for eligibility errors (for instance, a consult was deemed eligible for community care when it was actually ineligible). Tables C.7 and C.8 are applicable to the number of errors; table C.9, indicates the dollar amounts associated with these errors. As previously described, these dollar-amount estimates are conservative because not all payment data for all consults were available at the time of these projections.

Table C.7. Statistical Projections Summary for All Eligibility Errors, with a 90 Percent Confidence Interval

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count/sample size
All eligibility errors	339,633	27,964	310,038	365,966	141/223

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count/sample size
As percentage of all consults	25%	2.1%	22.9%	27.0%	141/223

Source: VA OIG statistician's stratified population of data from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

Table C.8. Statistical Projections Summary for Eligibility Errors, by Eligibility Type, with a 90 Percent Confidence Interval

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count/sample size
Drive-time eligibility errors	34,520	14,363	22,189	50,915	44/223
As percentage of all consults	2.5%	1.1%	1.6%	3.8%	44/223
Drive-time specific clinical service eligibility errors	69,422	23,523	48,354	95,399	38/223
Above, as percentage of all consults	5.1%	1.7%	3.6%	7.0%	38/223
Wait-time eligibility errors	235,074	26,142	208,873	261,157	56/223
Above, as percentage of all consults	17.3%	1.9%	15.4%	19.2%	56/223

Source: VA OIG statistician's stratified population of data from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

Table C.9. Statistical Projections Summary for Dollars Corresponding to Eligibility Errors, with a 90 Percent Confidence Interval

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count/sample size
Total cost	$436,211,308	$54,851,084	$380,809,319	$490,511,486	103/214

Source: VA OIG statistician's stratified population of data from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

Sample size note: For estimating monetary amounts, the audit team removed the drive time discontinued/canceled stratum. The sample for this stratum did not include any consults with paid amounts. Therefore, the OIG cannot include any such strata. When payment amounts did not exist in a stratum's sample, the OIG could not obtain an estimate of the ratio of bad payments to total payments for that stratum. By removing strata without payments, the team conservatively assumed any such strata contributed no bad payments (payments associated with exceptions) to the total.

In reality, the total amount of payments associated with the drive time discontinued/canceled stratum was extremely small. Therefore, the effect of removing this stratum is negligible for the OIG's dollar-amount projections. Note that the sample size associated with this stratum (nine consults) is not included in the reported sample size for these dollar-amount projections.

Informing veterans of care options. The tables in this section contain statistical projections for the audit of VA appointments. Confidence intervals for all projections are based on stratification, using the Clopper Pearson method. Ratio estimation was used to improve statistical precision.

Table C.10 shows the results of the statistical sample for those consults that appeared eligible for community care.

Table C.10. Statistical Projections Summary for Appointments Eligible for Community Care, with a 90 Percent Confidence Interval

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count/sample size
Number eligible	1,825,481	78,022	1,734,394	1,890,438	117/130

Source: VA OIG statistician's stratified population of data from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

Table C.11 provides an estimate of the number of appointments that were eligible for community care but that were not supported with available electronic documentation showing veterans were informed of this eligibility.

Table C.11. Statistical Projections Summary for Appointments that Were Eligible for Community Care but Were Not Supported, with a 90 Percent Confidence Interval

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count/sample size
Eligible and maybe not informed	1,345,126	78,022	1,254,039	1,410,083	117/130

Source: VA OIG statistician's stratified population of data from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

Table C.12 projects the number of appointments made without informing veterans of their eligibility for community care. The team expressed this number as a percentage of the set of appointments that were potentially eligible for community care and the set of appointments that were actually eligible for community care.

Table C.12. Statistical Projections Summary for Appointments that Were Eligible for Community Care but Veterans Were Not Informed, with a 90 Percent Confidence Interval

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count/sample size
Not informed	1,066,497	107,295	953,130	1,167,719	91/130
As percentage of potentially eligible	22.2%	2.2%	19.8%	24.3%	91/130
As percentage of eligible	58.4%	5.0%	52.9%	63.0%	91/117

Source: VA OIG statistician's stratified population of data from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

Finally, table C.13 distinguishes the projections of eligible veterans who were not informed into two categories: established patients who are drive time–eligible and all other veterans.

Table C.13. Statistical Projections Summary for Breakout of Veterans Not Informed of Eligibility, with a 90 Percent Confidence Interval

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count/sample size
Not informed: established drive time–eligible	457,780	104,475	358,373	567,322	23/130
As percentage of veterans not informed	42.9%	9.0%	34.1%	52.1%	23/91
Not informed: other veterans	608,717	110,939	500,200	722,078	68/130
As percentage of veterans not informed	57.1%	9.0%	47.9%	65.9%	68/91

Source: VA OIG statistician's stratified population of data from VHA's Corporate Data Warehouse through VA's Integrated Care Workspace.

Population and Projection Summary

This section of the report categorizes VA appointments for easier interpretation of statistical results. VA databases include information for 22.9 million appointments for VA care for the first quarter of FY 2025 (the numbers in this section are rounded).

- **Of the 22.9 million total appointments**, 4.8 million appointments were potentially eligible for community care based on available drive-time and wait-time data. The remaining appointments were ineligible for community care based on other considerations.
- **Of 4.8 million appointments potentially eligible for community care**, VA data indicate that two million appointments were likely eligible for community care based on drive time or wait time. This likely eligibility is based on available electronic VA data. If these data are correct, the two million appointments are indeed eligible for community care.
- **Of two million appointments likely eligible for community care**, available electronic VA data did not substantiate that VA informed veterans of their eligibility for community care for 1.5 million appointments. These 1.5 million appointments were identified as potential errors. They are only true errors if they are indeed not eligible for community care or if they are eligible for community care, but the veterans were not informed of the community care option.
- The OIG obtained a probability sample of these **1.5 million potential errors**. Based on a thorough review of this sample, including correspondence with VA to ensure proper evaluation of each case, the OIG estimated 1.3 million of these appointments were actually eligible for community care. This number is less than the 1.5 million likely eligible appointments because VA showed evidence, outside the available electronic record, that some sampled appointments were not eligible for community care.
- Of 1.3 million appointments that were eligible for community care but that were not supported with available documentation showing that veterans were informed of this eligibility, VA made **1.1 million appointments without informing veterans of their eligibility for community care**. This number is based on sample results, with VA showing in some cases that the veterans were informed, despite the lack of substantiation in the available electronic record.

Appendix D: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[24]
1	The VA Office of Inspector General (OIG) questioned about $1.7 billion in community care claims payments based on the team's analysis of eligibility determinations, which revealed an estimated 340,000 consults from October 1 through December 31, 2024 (totaling about $440 million in costs to VA) were approved for community care without meeting the eligibility criteria.[25]	$0	$1,744,845,232
	Total	**$0**	**$1,744,845,232**

[24] The OIG questions costs when VA action or inaction (such as spending or failure to fully compensate eligible beneficiaries) is determined by the OIG to violate a provision of law, regulation, contract, grant, cooperative agreement, or other agreement; when costs are not supported by adequate documentation; or when they are expended for purposes that are unnecessary or unreasonable under governing authorities. Within questioned costs, the OIG must, as required by section 405 of the IG Act, report unsupported costs. Unsupported costs are those determined by the OIG to lack adequate documentation at the time of the audit. The audit team did not identify unsupported costs.

[25] The audit team calculated questioned costs by multiplying the per-quarter estimate by four to represent the cost over a full fiscal year, from October 2024 through September 2025.

Appendix E: VA Management Comments, Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: May 1, 2026

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Audit of Veterans' Community Care Eligibility Determinations (VIEWS 14630495)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on OIG's report, Audit of Veterans' Community Care Eligibility Determinations. The Veterans Health Administration (VHA) concurs with recommendations 1 through 4 and 6. Additionally, VHA concurs in principle on recommendation 5 and included an action plan as an attachment.
2. VHA provides Veterans with real-time information about actual wait times when discussing care options, so they can access up-to-date scheduling availability when making appointments. This provides the most accurate information on wait times when scheduling or making a decision on receiving care in the community. Due to the nature of the appointment and scheduling software, most modifications that occur cannot be seen when conducting a retrospective review of past appointments. As a result, a retrospective review does not serve as an appropriate method to determine whether sites complied with community care eligibility requirements regarding wait times.

The OIG removed point of contact information prior to publication.

(Original signed by)

John J. Bartrum, JD, MBA

Attachments

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan
OIG Draft Report – Audit of Veterans' Community Care Eligibility Determinations
(Project # 2025-01014-AE-0048)

Recommendation 1: Establish and use agreements with other VA medical facilities to help identify and schedule direct care when local services are not available.

VHA Comments: Concur

Veterans should be provided information and opportunities on accessing care from other Veterans Affairs (VA) medical facilities. VHA has existing guidance and resources that define the standardized processes facilities may establish and use in order to identify and schedule direct care when local services are not available.

VHA will reinforce the need for cross-facility scheduling and localized coordination through training and memorandum.

Status: In-Progress **Target Completion Date:** October 2027

Recommendation 2: Assess options to improve the scheduling process and system to provide schedulers with access to community care provider appointment availability when discussing care options with wait time–eligible veterans.

VHA Comments: Concur

VHA Integrated Veteran Care believes providing greater information on expected wait times to Veterans can better inform their health care decisions. VHA is assessing options to improve the community care scheduling process and system through expansion of the External Provider Scheduling (EPS) platform.

Status: In-Progress **Target Completion Date:** June 2027

Recommendation 3: Review services in the Consult Toolbox to make sure it accurately reflects available services and avoids inaccurate eligibility determinations.

VHA Comments: Concur

VA will review the Consult Toolbox to ensure it correctly reflects which services are available at each facility to guide more accurate eligibility discussions. VHA will develop a review process with VISNs to ensure facilities have their consults aligned with the appropriate stop codes so services are accurately captured.

Status: In-Progress **Target Completion Date:** July 2026

Recommendation 4: Reinforce requirements for schedulers to review scheduling systems to identify the next available date for appointments and input that information in the Consult Toolbox.

VHA Comments: Concur

VHA Integrated Veteran Care will reinforce requirements for capturing the next available appointment date in Consult Toolbox (CTB) to determine community care eligibility by wait time through training, education, and oversight.

Status: In-Progress **Target Completion Date:** July 2026

Recommendation 5: Implement a process to verify that schedulers check all community care eligibility criteria for all veterans.

VHA Comments: Concur in principle

VHA Integrated Veteran Care (IVC) will take concrete steps to determine the feasibility and requirements for checking all community care eligibility criteria for all Veterans. As part of this effort, VHA will identify and analyze potential enhancements or modifications needed across information technology systems, regulations, national policy guidance, and operational processes. This analysis will help establish what changes are necessary to support consistent implementation, documentation, and oversight of community care eligibility determinations through a clinically meaningful and Veteran-centric process.

Status: In-Progress **Target Completion Date:** June 2027

Recommendation 6: Emphasize to schedulers at least annually the proper methods (including the use of opt-out codes) to document when veterans opt out of community care.

VHA Comments: Concur

VHA Integrated Veteran Care will review annual scheduler refresher training and associated guidance and resources (including the IVC Field Guidebook and associated system resources) to ensure training includes proper methods to document when veterans opt out of community care.

Status: In-Progress **Target Completion Date:** October 2026

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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