US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

DEPARTMENT OF VETERANS AFFAIRS

Fiscal Year 2026 Inspector General's Report on VA's Major Management and Performance Challenges



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To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

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Foreword

The Office of Inspector General (OIG) serves Veterans and taxpayers by conducting independent oversight of VA programs, operations, and services. As mandated by the Reports Consolidation Act of 2000, the inspector general provides an annual summary of VA's top management and performance challenges, which in fiscal year (FY) 2026 continued to fall into five broad categories: (1) health care, (2) benefits, (3) information systems, (4) governance, and (5) financial management.

OIG personnel have identified these challenges in the course of their work and with assistance from the Veteran community, Congress, and other stakeholders. The OIG remains fully committed to recommending improvements to VA programs and operations, providing analysis and solutions to increase efficiency across the department's vast enterprise, and rooting out fraud, waste, and abuse. The OIG recognizes the challenges VA faces and appreciates the work VA personnel at every level do each day on behalf of Veterans, their families, and caregivers.

The challenges are complex. VA remains in a period of transformation, having recently reorganized its Veterans Integrated Service Networks (VISN) from 18 networks to 5. The department has resumed deployment of its multibillion-dollar electronic health records system, and it continues to scale up a new financial management system and to explore potential uses for artificial intelligence.

OIG work has shown that Veterans face persistent barriers to timely, coordinated health care, where breakdowns in phone systems, consult processing, scheduling, and care coordination can cause delays in access to care. Expanded eligibility under the PACT Act, meanwhile, has increased reliance on automation for benefits claims processing, but many systems still need validated logic, consistent controls, and accurate data inputs. VA's governance issues, including variable interpretations of directives as well as delayed decision-making, continue to hinder timely and consistent responses to quality-of-care failures and systemic risks. Finally, financial management is a key area for improved stewardship of taxpayer dollars as the department grapples with issues in supply chain controls, procurement oversight, and system modernization.

The FY 2026 major management challenges relayed in this report provide a framework for the OIG's statutory audit, inspection, and investigative efforts and for addressing waste, fraud, and operational risk in programs and services that serve the Nation's Veterans.



CHERYL L. MASON
Inspector General

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OIG Challenge #1: Healthcare Services

The Veterans Health Administration (VHA) is the largest integrated health care system in America and is responsible for providing care to more than 9 million enrolled Veterans, which includes an increasingly older population with complex needs. The VA continues to face departmentwide challenges in ensuring Veterans receive timely, equitable, well-coordinated healthcare services across direct VA care, specialty care, community care, clinical contact centers (call centers), and clinical resource hubs (virtual care).

These challenges span critical access areas including phone responsiveness, appointment scheduling, consult processing, oversight, performance measurement, and accurate determinations of community care eligibility. For example, the OIG identified substantial delays in processing both VA and community care consults, with widespread failures to meet timeliness standards across all stages—from scheduling appointments to obtaining medical records—highlighting persistent risks to Veterans' timely access to care.

OIG oversight in FY 2026 demonstrated gaps in systems supporting access, continuity, and follow-through—especially for Veterans requiring multi-step diagnostic evaluation or those relying on contracted community providers. These deficiencies manifest as delayed consult scheduling, incomplete transfer of critical clinical information including imaging results, and fragmented oversight of clinical programs.

Additionally, OIG reviews and investigations noted fraud risks in community care programs including improper billing, duplicate payments, and unnecessary services. By applying lessons from previous investigations and best practices from agencies such as the Department of Health and Human Services, the National Healthcare Anti-Fraud Association, and DOJ's newly created National Fraud Division, VA can improve fraud detection with advanced analytics to identify abnormal billing patterns and enable preventive action.

Why This Is a Challenge

VA continues to grapple with aging infrastructure, workforce attrition, and rising demand for services—partly due to the PACT Act—while undergoing major organizational restructuring. These factors collectively complicate the safe and effective implementation of large-scale system changes, such as the EHRM initiative.

Pharmacy-related errors pose significant patient safety risks, and lack of oversight in prescribing, dispensing, or reconciling medications can lead to adverse drug events. Health care fraud schemes identified by Federal agencies—including upcoding, billing for services not rendered, unnecessary procedures, and duplicate billing—can cause financial losses and undermine the integrity of VA health care programs.

Breakdowns in fundamental access channels such as phone systems, consult processing, scheduling, and care coordination directly affect Veterans' ability to obtain timely care. Specialty clinics often lack reliable phone access due to inaccurate directories, nonfunctioning lines, and insufficient call tracking. Oversight challenges extend to clinical resource hubs, where inconsistencies in workload capturing and labor mapping result in incomplete or unreliable productivity data. Many hub specialty practices fail to meet minimum productivity thresholds due to unaccounted or improperly coded encounters.

VHA's regional call centers (called clinical contact centers) continue to face gaps in timeliness and service integration. While clinical triage meets national standards, scheduling services have high call abandonment rates and limited coverage. Challenges in meeting scheduling and appointment standards led to delays in Veterans receiving care. These issues are compounded by inconsistent tool usage, high volumes of pending consults, and reliance on manual workarounds.

Reliable systems connecting episodes of care are essential. Each handoff—from primary to specialty care, between VA and community providers, or across clinical service lines—raises the risk of missed steps if processes are not well-defined and enforced. Examples include prolonged delays in high-priority community-care consults, challenges in timely receipt and upload of imaging, insufficient tracking of abnormal results, and low adherence to suicide-risk screening in certain clinics.

Department's Corrective Actions

VA has made notable strides in improving access to care and service delivery for Veterans. The department achieved record-high rates in suicide risk screenings and follow-up evaluations, reflecting its commitment to mental health and patient safety. Efforts to streamline processes led to improved timelines for prosthetic device delivery. Despite the challenges, VA maintained positive results in Veteran satisfaction surveys, underscoring the effectiveness of ongoing quality improvement initiatives.

To address previously identified pharmacy-related risks associated with the EHRM initiative, in response to oversight recommendations, VA implemented targeted system configuration updates, enhanced user training, and instituted ongoing monitoring of medication management processes. These actions aim to strengthen safety and reliability in pharmacy operations.

VA began addressing gaps in phone access, consult management, community care scheduling, and oversight. Some facilities are working to update inaccurate phone numbers and adjust call routing prompts, and the Office of Information and Technology launched a national dashboard to better track and retrieve voicemails. VA facilities expanded and centralized call queues and standardized call flows, resulting in improved call resolution and assistance for Veterans. The consolidation of operations into clinical contact centers improved efficiency, with centers submitting action plans to enhance schedulers' performance and address operational inefficiencies. VHA began the VA Health Connect initiative to transform facilities' call centers

into regional units called clinical contact centers. The goal was to standardize facility call center operations nationwide and provide Veterans access to services 24 hours a day. This contributed to measurable gains, including a higher volume of calls answered, lower abandonment rates, and reduced average answer times. Meanwhile, oversight of community care improved with the expansion of the External Provider Scheduling System, allowing VA schedulers to book directly with community providers. VHA also completed actions to improve the tracking of consults that have not yet been acted upon.

VA also enhanced training programs for Veterans' self-scheduling, developed quality assurance dashboards, and standardized guidance to improve consistency and access across scheduling processes. These improvements mark significant progress and demonstrate that VA must continue strengthening its core access-to-care areas to ensure timely, consistent, equitable health care for Veterans.

OIG Challenge #2: Benefits for Veterans

The Veterans Benefits Administration (VBA) is responsible for providing millions of Veterans, family members, caregivers, and survivors with their earned benefits and services. However, VBA faces persistent challenges ensuring the accuracy, integrity, and timeliness of various benefits programs, including disability compensation payments, service-connected death benefits, fiduciary oversight, recurring benefits reviews for elderly and foreign beneficiaries, and refunds of funding fees for VA home loans.

Across these areas, OIG reviews identified insufficient oversight of recurring benefit payments, such as those for elderly beneficiaries, including individuals aged 100 and older; errors in automated claim processing systems; and estimated underpayments to Veterans based on inaccurate mail processing. These issues raise significant concerns and increase the likelihood of improper payments, delayed benefits delivery, and potential harm to vulnerable populations.

Why This Is a Challenge

The PACT Act greatly expanded eligibility for benefits, leading to a sharp increase in claims volume. To manage this workload, VA has relied more heavily on automated decision tools. However, these tools pose risks when system logic, data inputs, or controls are not properly validated. Recurring benefit programs are especially vulnerable to improper payments if eligibility verification processes are not regularly updated.

Vulnerabilities in disability benefits stem from weak automation requirements, unclear guidance, insufficient quality controls, and inconsistent interpretation of standards across VBA offices. OIG reports noted that automated processes for service-connected death benefits resulted in legal and procedural errors, incomplete evidence summaries, and missing favorable findings. These deficiencies led to at least $2.7 million in improper payments. Additionally, automation failed to

identify funding-fee refunds for Veterans with dual entitlement on joint home loans, resulting in about $866,000 owed to Veterans.

In the fiduciary program, OIG oversight work identified that staff often failed to record the earliest date of misuse allegations and did not advance all allegations of potential misuse for investigation consistent with requirements, putting vulnerable beneficiaries at risk. And an OIG review of recurring benefits for beneficiaries aged 100 and older revealed significant inaccuracies, particularly among foreign beneficiaries. Common errors included incomplete requests for information, unaddressed death notifications, and lack of action after notices to terminate benefits.

Meanwhile, an OIG review of mail handling—including both physical and electronic copies of documents Veterans submitted—found that VBA incorrectly labeled some mail as unidentifiable. When this certification is applied incorrectly, Veterans might be underpaid or their disability, pension, or other claims may be delayed, denied, or missed altogether. Based on a sample of mail VBA certified as unidentifiable from July 2018 through March 2025, the OIG estimated that about 21 percent of mail packets actually contained enough information to match them to a claimant; therefore, Veterans could have been underpaid at least a combined $822,000. Nearly all packets reviewed showed missed steps, including incomplete documentation and not archiving mail as required. This occurred in part because staff did not always complete required actions when certifying unidentified mail and did not always have access to the systems and resources necessary to identify claimants.

Department's Corrective Actions

VA continues to address OIG recommendations by advancing fraud detection and response through strengthened data analytics, improved information sharing among program offices, and expanded benefit support access. VA is piloting several automation tools used to review and process benefits claims, such as the Salesforce Automation Validation Review Tool and a 2025 Super Intelligence (SI)-use case for an automation quality auditor, automated processing, and a predictive claims-processing capability. These tools are being developed with quality review mechanisms to identify and correct errors in decision-making.

Recent actions reflect VA's commitment to addressing deficiencies in benefits delivery and oversight, with ongoing corrective measures requiring sustained follow-through. Of note, VBA is strengthening disability claims processing through improved controls over military sexual trauma denials, enhanced oversight of vendors who complete contract exams, and clarifying and consolidating PACT Act guidance. Following OIG findings on automation errors in death-claims processing, VBA eliminated outdated narrative requirements and transitioned to the Smart Pension Automation platform. New procedures address evidence documentation and notification gaps.

The fiduciary program now requires evaluation of all credible misuse allegations, clarifies definitions for "clear evidence" and "no basis in fact," and has approved a national quality-assurance program to strengthen oversight.

VA has also implemented updated system requirements for recurring benefits to improve service for foreign beneficiaries, including those in the Philippines. Additionally, the Loan Guaranty Service is identifying Veterans affected by funding fee refunds and considering system updates to correct automation errors.

Integrating governance across disability, pension, fiduciary, survivor, and loan-guaranty programs will help VA reduce systemic inconsistencies, and thoroughly testing automation systems will help the department incorporate legal requirements—such as evidence summaries, favorable findings, and correct coding.

Further, standardizing quality review processes will help VA make sure automated decisions are subject to the same scrutiny as manual claims—focusing on documentation, evidence verification, and transparency. VBA can realize additional improvements by continuing work that streamlines and clarifies procedural guidance for misuse-allegation standards, expands proof-of-life verification and jurisdiction for foreign beneficiaries, and disability claims evidence requirements. Finally, strengthening data analytics and cross-system validation is essential to detect anomalies, prevent improper payments, and enable timely corrective actions across all benefits programs.

With regard to errors in mail handling, VBA expedited contract employee access to VHA records that can help identify a claimant, thereby potentially reducing the number of packets being certified as unidentifiable. VBA can further strengthen controls, training, and oversight in this area by requiring detailed documentation of all actions taken when certifying mail as unidentifiable, ensuring staff who handle unidentified mail have the system access they need, and adding quality reviews and mandatory training on processing unidentified mail.

OIG Challenge #3: Information Systems and Innovation

VA's rapid adoption of digital tools and technologies has at times outpaced the development of governance structures necessary for safe and effective management. OIG inspections identified oversight gaps in generative SI, incomplete interoperability in image-sharing processes, and insufficient monitoring of EHR documentation timeliness—all of which can affect patient safety and care reliability.

VA leaders continue to face challenges in modernizing and securing information systems that support financial management, acquisition, health care delivery, and benefits processing. Persistent issues in system design, automation logic, access controls, and cybersecurity disrupt operations and expose sensitive information. Crucially, when mission-critical systems lack

appropriate visibility, controls, or decision support, transparency decreases and risks of improper payments, inaccurate decisions, and delays in care increase.

Why This Is a Challenge

VA systems are interconnected and complex, making modernization difficult. OIG reports continue to identify deficiencies in planning, functionality, oversight, and security controls, leading to delays, manual workarounds, increased user burden, and operational risk. For example, scheduling system limitations prevented staff from viewing appointment availability across facilities and restricted visibility into community care wait times, reducing VA's ability to assess the accuracy of community care eligibility determinations. Automation weaknesses also created risk in benefits processing. The OIG found legal and procedural deficiencies in automated decisions for service-connected death claims.

The OIG also found repeated instances of inadequate security and access controls. For example, the Patient Advocate Tracking System-Replacement, which collects Veteran sensitive information, lacked security controls consistent with its risk level. Additionally, access controls for the Integrated Financial and Acquisition Management System were insufficient to ensure least-privilege access to sensitive acquisition and financial information. The OIG's FY 2025 audit of VA's compliance with the Federal Information Security Modernization Act found ongoing challenges in meeting federal requirements due to deficiencies in access controls, configuration management, security management, and vulnerability management.

Furthermore, OIG inspections highlighted that departmentwide governance issues mirror operational security problems at the facility level. At the VA Spokane Healthcare System in Washington, deficiencies persisted in configuration management, security management, and access controls—including unresolved vulnerabilities, unsupported software, unnecessary access to unredacted personally identifiable information, and weaknesses in physical and logical access protections.

Deploying technology without adequate risk mitigation, oversight, or clear responsibilities results in unsafe or inconsistent outcomes. VA lacked an SI-specific safety reporting mechanism, with general-purpose chat tools used in clinical contexts. One facility had delays in breast-image transfer and limitations in image sharing, while others faced documentation-timeliness gaps and weak view-alert oversight.

Department's Corrective Actions

The OIG recognizes that implementing lasting corrective actions for VA's mission-critical systems and automation tools is a complex and gradual process. VA made measurable progress in Federal information security compliance. Six prior-year recommendations were closed due to improvements in contractor system monitoring, detection of unauthorized vulnerability scans, infrastructure visibility, host-based protections, and remediation of network device

vulnerabilities. VA also addressed security concerns and prevented disruptions to mission-critical systems related to recommendations reported in three OIG information security inspections.

VA strengthened governance of innovation tools and modernization platforms. The EHR system now requires consistent post-incident reporting, downtime training for clinicians, and improved identification of major incidents and negative patient outcomes. Meanwhile, security controls for the Patient Advocate Tracking System-Replacement were enhanced with updated risk categorization, privacy protections, restricted access to medical records, and automated deactivation of inactive accounts. VA also developed plans to ensure users of iFAMS have appropriate access. To address deficiencies in automated decisions for service-connected death claims, VBA is transitioning to the Smart Pension Automation platform and revising the automation quality checklist to improve consistency.

VA can continue improvements by strengthening governance, system design, automation oversight, and cybersecurity controls. Specifically, the Department can focus on scheduling reliability at medical facilities and community care providers, validating rules for automated decisions before broad deployment, enforcing least-privilege access and periodic reviews in iFAMS, and remediating vulnerabilities and unsupported configurations promptly.

Meanwhile, VA is drafting guidance for clinical SI use, planning integration of SI-related events into patient safety programs, improving community-care image exchange, strengthening documentation oversight, and advancing collaboration and system improvements for the National Teleradiology Program. OIG recommendations in this area include establishing unified SI governance frameworks with risk assessment and safety reporting, modernizing interoperability for automatic transfer of diagnostic images and documents, expanding automated oversight of documentation timeliness, and integrating technology-risk indicators into leadership dashboards.

OIG Challenge #4: Governance

VA faces ongoing challenges in establishing strong leadership and effective governance to consistently manage health care services, Veterans' benefits, and capital investments across its administrations. Recent OIG reports cite unclear roles and responsibilities, insufficient oversight, and weak follow-through as factors limiting the effectiveness of community-based outpatient clinic (CBOC) contracts, leading to errors in benefits decisions, delaying modernization of the VA police program, and causing significant delays and increased costs for major construction projects. OIG teams observed inconsistent execution of governance, variable interpretation of directives, and delays in decision-making during this transition. These issues hinder timely and consistent responses to quality-of-care failures and systemic risks.

Why This Is a Challenge

The OIG recently identified control failures in healthcare contracting, benefits processing, police staffing, and major construction, jeopardizing care quality, claims accuracy, facility safety, and fiscal stewardship.

In health care contracting, a VA OIG review found that national program offices monitored CBOC contracts at the award stage but neglected ongoing oversight, contrary to governance expectations. Contractors at sampled CBOCs failed to meet 56% of required performance metrics yet still received full payment, and weak oversight allowed poor performance to persist.

In benefits processing, despite awareness of the issues at multiple leadership levels, controls were not strengthened to ensure accurate rating decisions. One OIG report found that a VBA employee in Philadelphia authorized about 15,600 decisions over 6 months, with 84% of the decisions containing errors, resulting in $2.2 million in improper payments. Leadership tone and performance pressures led managers to overlook opportunities to strengthen internal controls and effectively respond to the associated risks.

OIG oversight work also identified education program oversight issues, specifically with education compliance surveys. Until survey processes are improved, institutions receiving VA education benefit funding, as well as Veterans and beneficiaries attending these institutions, may continue to receive improper payments. VA has limited assurance these institutions are complying with applicable statutes and regulations, which increases the possibility of education benefits fraud.

At the Palo Alto VA Medical Center in California, meanwhile, governance failures allowed a major construction project to proceed without proper control of requirements, risk, or decision authority. With the project more than 21 years behind schedule and completion expected no sooner than 2036, estimated project costs have risen from $450.3 million to $1.6 billion.

Department's Corrective Actions

The Restructure for Impact and Sustainability Effort (RISE), aimed at modernizing and streamlining VHA's leadership and operational structure, involves consolidating VISNs, creating a Medical Operations Center, and shifting responsibilities among the VHA Central Office, VISNs, Health Service Areas, and local facilities. The effort is intended to strengthen accountability and establish consistent national standards. VA also initiated steps to strengthen governance in several areas in response to OIG recommendations. VA leaders made improvements to peer-review timeliness and decision roles; reinforced leadership ownership of processes to disclose adverse events to patients; and advanced recruitment for critical sterile-processing positions. Early steps in the transformation effort—defining policy roles at VHA central offices, establishing the Medical Operations Center, and consolidating VISNs and

clarifying operational expectations for Health Service Areas—show progress toward a more unified governance model across the department.

In February 2026, the Under Secretary for Health formed a work group to assess and standardize oversight of CBOC contracts. The Office of Acquisitions, Logistics, and Construction will oversee all departmental acquisition functions, including CBOC contracts. VA aims to enhance accountability by assigning responsibility for contract monitoring, reassessing contract metrics, and updating templates and accountability mechanisms.

To address issues with benefits processing, VBA leaders are reviewing and correcting OIG-identified processing errors and evaluating the need for stronger controls for authorization-rate outliers highlighted in the Philadelphia review. VBA is also improving controls for productivity outliers to capture any unusual volumes and ensuring prompt review and action.

For police staffing, VA plans to finalize, validate, distribute, and enforce a reliable staffing model. To improve police operations, VA established an integrated project team to clarify stakeholder roles, update and validate the police manpower model, and assign responsibility for its implementation under a new command structure. The Department also announced reforms including a unified law-enforcement chain of command.

Finally, following the Palo Alto construction review, VA updated its capital plan to reflect a more accurate total project cost and made changes to how major VA construction projects will be managed to foster more consistent acquisition practices, maintenance of business cases and baselines, and formal approval and analysis before scope or schedule changes.

OIG Challenge #5: Financial Management

VA oversees a substantial portfolio of high-risk spending programs that demand robust cost controls and oversight. OIG reports identified ongoing issues including improper payments, weak internal financial controls, and fraud involving employees and contractors.

VA faces recurring weaknesses in financial controls, contract oversight, purchasing and inventory accountability, and documentation across multiple programs. These deficiencies affect financial reporting, community care contracting, supply chain management, pharmaceutical purchasing, education benefits oversight, and funds control processes. In many cases, oversight is hindered by the systems the department uses to govern spending. For example, audits identified material weaknesses in information technology (IT) and internal software. At the program level, the OIG identified unreviewed open obligations in VBA, pharmaceutical purchases outside prime vendor contracts in VHA, inventory discrepancies in former VISNs 8 and 22, and weaknesses in community care contract management leading to overpayments and fraud vulnerabilities.

VA continues to face challenges in responsible stewardship of federal resources. FY 2026 OIG reports cite repeated infrastructure deficiencies, ineffective oversight of equipment and clinical

support operations, and delayed corrective actions, undermining cost-effectiveness and increasing risks of waste, operational disruptions, and emergency spending.

Why This Is a Challenge

The PACT Act led to a substantial expansion in eligibility for VA benefits, resulting in a marked increase in the volume of claims processed by the Department. VA used automated decision-making tools to manage this surge in claims. These tools introduce risks, particularly when their underlying logic, data inputs, or control mechanisms are not thoroughly validated. Without regular updates and comprehensive verification processes, benefit programs are exposed to the possibility of improper payments.

Furthermore, weak operational controls can limit VA's ability to ensure funds are used appropriately, at fair prices, with proper documentation, and in compliance with oversight requirements. For example, the OIG found nearly $895.3 million in VBA's general operating expenses account that was no longer needed but had not been deobligated as required, preventing timely reallocation for Veterans' support. And, in the education compliance survey program, VBA failed to adequately monitor contractor performance before approving payments, leading the OIG to question over $19 million paid for contracted services where VA did not ensure contract performance requirements were met.

Inadequate stewardship increases VA's costs and causes missed savings. The OIG reported that VHA staff often could not show they attempted to use the prime vendor or conduct market research before buying drugs on the open market, missing opportunities for lower prices. Poor oversight of VA's national reverse distribution contract resulted in over $4.1 million in unreceived drug return credits. Meanwhile, OIG testimony regarding the community care program highlighted about $178.5 million in estimated outpatient payment errors and over $900 million paid to third-party administrators above what was paid to community providers for dental services.

Incomplete data, outdated systems, and dispersed oversight roles hinder effective financial oversight. The OIG's FY 2025 financial statement audit highlighted persistent internal control weaknesses in IT, service-organization monitoring, and revenue processes. Other reviews cited legacy system issues, incomplete reports, inconsistent documentation, and poor communication as causes of stale obligations and delayed deobligations.

Department's Corrective Actions

VA took steps to enhance financial management while actively addressing internal control weaknesses. However, to reduce overbilling and fraud, especially in high-value procurement, VA must continue its efforts to strengthen acquisition oversight and contract governance. Modernizing enterprise-wide financial systems should improve spending visibility and decrease reliance on fragmented processes. Advanced analytics and financial management tools should

enable VA to identify and monitor high-risk spending areas, such as community care and contract services, and detect anomalies.

VA started corrective-action planning to address operational risks. The Department's initial planning for its next community care contract showed improvements in medical documentation return requirements, which would support continuity of care and fraud prevention. In addition, to prevent overpayments related to dental services, VA created oversight and internal controls and developed contract language for the upcoming community care contracts to limit reimbursements for Community Care Network claims that do not have a Medicare or VA fee schedule rate. Lastly, VA implemented billing code changes to address deficiencies related to the significant cost of community care residential substance use disorder treatment for Veterans with mental health conditions.

In October 2025, to reinforce fiscal oversight and accountability, VA moved finance and budget supervision to its Office of Management. VBA's Office of Financial Management implemented a tool to streamline monthly reviews and alert offices to stale obligations. Meanwhile, VHA improved supply chain oversight by adding user access controls and establishing security documentation, connecting inventory data to the Corporate Data Warehouse and enforcing routine barcode controls. VHA is planning to adopt dashboards to enforce timely completion of reports of survey; create a process for obtaining an explanation for lost, damaged, or stolen property; and evaluate options for using equipment location tracking systems to improve accountability of mobile equipment. Routine reviews of open market purchases were standardized, and prime vendor program oversight strengthened, including validating order-fulfillment metrics and monitoring monthly control-plans.

VBA published updates to Manual M22-4 to ensure statutorily required VA educational benefits programs are included in active student accounts. It also strengthened procedures for scheduling and surveying institutions by updating VBA Manual 22-4 with procedures to identify, waive, and assign compliance survey workload.

Overall, VA can improve its stewardship controls across financial policy, contracting, program management, supply accountability, and data quality. Standardized monthly reviews, reconciliations, and documentation for open obligations and high-risk transactions will help identify stale obligations and operational needs, allowing timely deobligation and reallocation of funds. Implementing stronger operational controls over purchasing and supply accountability; addressing root-cause issues in information systems and governance; and aligning policy, systems, training, and accountability mechanisms will help the Department make sure funds are traceable, cost-effective, and protected. Meanwhile, clearer guidance and improved visibility into pharmaceutical transactions will help VA detect noncompliance, pricing inefficiencies, and potential fraud, while stronger oversight can help ensure supplies and equipment are not lost, outdated, overstocked, or unavailable.

Finally, VA can continue improvements by investing in stronger contract development and payment management, expanding its monitoring of automated infrastructure, and enforcing consequences for unresolved deficiencies; linking resource allocation to quality management and compliance can also reduce waste and protect taxpayer funds.

VA Management's Response
VA acknowledges the challenges presented in the OIG report and appreciates the OIG's dedication to identifying opportunities for improvement in VA programs and operations. For additional information on management's response and the measures VA is implementing to address each challenge, refer to the individual OIG reports related to each challenge as provided in the following table.

Appendix: Related Reports and Congressional Testimony

The reports and congressional testimony listed below support the OIG's identification of VA's FY 2026 major management challenges. All OIG publications are available at www.vaoig.gov/.

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Review of VBA's Unidentifiable Mail Certification Process	8/12/2026		X			
Federal Information Security Modernization Act Audit for Fiscal Year 2025	7/27/2026			X		
Audit of the Education Service's Compliance Surveys	7/24/2026					X
Review of the Fiduciary Program's Misuse Allegation Process	7/24/2026		X			
Review of Medical Facilities' Management of Specialty Care Calls	7/23/2026	X				
Review of Open Obligations in VBA's General Operating Expenses Account	7/23/2026					X
Audit of Pharmaceutical Purchases Made Outside the Prime Vendor Contract	6/25/2026					X
Review of Primary Care Providers' Completion of Electronic Health Record Documentation at the VA Augusta Health Care System in Georgia	6/23/2026	X				
Audit of VISN 8 Supply Chain Management	6/18/2026					X
Audit of VISN 22 Supply Chain Management	6/18/2026					X
Audit of Consult Timeliness for VA and Community Care	6/17/2026	X		X		

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Audit of Veterans' Community Care Eligibility Determinations	6/17/2026	X				
Review of Ear, Nose, and Throat Surgery-Related Sterile Processing Services Concerns at the Michael E. DeBakey VA Medical Center in Houston, Texas	6/16/2026	X			X	X
Review of Generative Artificial Intelligence Chat Tools for Clinical Use	6/11/2026			X		
Audit of VA's Police Staffing Decision Tool	6/10/2026				X	
Review of the Peer Review Process at the VA Caribbean Healthcare System in San Juan, Puerto Rico	6/4/2026				X	
Inspection of Information Security at the VA Saginaw Healthcare System in Michigan	5/28/2026			X		
Review of the Availability of Community Care Breast Images and Impact to Surgical Care at the VA Eastern Colorado Health Care System in Aurora	5/21/2026	X	X	X		
Inspection of Information Security at the Battle Creek Healthcare System in Michigan	5/1/2025			X		
Review of VBA's Recurring Benefits for Beneficiaries Aged 100 Years or Older	4/30/2026		X			
Review of Automated Decisions for Veterans' Service-Connected Death Claims	4/30/2026		X	X		

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Review of Community Care Consult Management at the VA Fayetteville Coastal Healthcare System in North Carolina	4/8/2026	X				
Veteran Self-Scheduling Process Needs Better Support, Stronger Controls, and Oversight	3/19/2025	X				
Audit of Community-Based Outpatient Clinic Contracts	3/6/2026			X	X	
Inspection of Information Security at the VA Spokane Healthcare System in Washington	2/18/2026			X		
Audit of Integrated Financial and Acquisition Management System Access Controls	2/17/2026			X		
Follow-Up Inspection of Information Security at the VA Beckley Healthcare System in West Virginia	1/29/2026			X		
Audit of VA's Financial Statements for Fiscal Year 2025	1/27/2026		X			X
Review of VHA's Use of Generative Artificial Intelligence	1/15/2026			X		
Review of Leaders' Actions Affecting Clinical Services at the Syracuse VA Medical Center in New York	1/15/2026	X	X			
National Review of Mental Health Integration and Suicide Risk Identification in Audiology Clinic Settings	1/13/2026	X	X			
Review of Care Provided to a Patient Who Died by Suicide, Marion VA Health Care System in Illinois	1/8/2026	X	X			

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Independent Audit Report of Pharma Logistics LLC's Billing Compliance	12/16/2025					X
Review of Fire System and Life Safety Programs/Processes at the East Orange VA Medical Center in New Jersey	12/11/2025					X
Evaluation of Specimen Readings for Accuracy and Quality Assurance in the Laboratory at the John D. Dingell VA Medical Center in Detroit, Michigan	12/8/2025					X
Review of Veterans Health Administration's National Teleradiology Program	12/4/2025			X	X	
Audit of Funding Fee Refunds for Veterans Using Dual Entitlement on VA Joint Home Loans	12/2/2025		X			
Review of Clinical Contact Centers to Assess Leadership and Oversight	10/8/2025	X				

Congressional Testimony	Date	Challenge				
		#1	#2	#3	#4	#5
Building a 21st Century VA Health Care System: Assessing the Next Generation of VA's Community Care Network	2/11/2026	X		X		X
Medication Management in VA Health Care	12/3/2025	X				