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Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Audit of Processing of Community Care Requests for Services

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Executive Summary

The Veterans Health Administration (VHA) provides veterans direct care through VA medical facilities and is authorized under the MISSION Act to approve and pay for veterans to receive care from community providers when specific eligibility criteria are met.[1] This includes when VA cannot provide the requested service, or where veterans meet drive-time or wait-time criteria. Community care is provided through VHA's Veterans Community Care Program and delivered through a Community Care Network. When community providers determine more or different care is required from what was originally approved by VHA, they submit "requests for services" to the medical facilities for approval. The VA Office of Inspector General (OIG) conducted this audit to determine whether VHA processed community care provider requests for services in accordance with timeliness and notification requirements established in the VHA *Community Care Field Guidebook*.[2] The OIG team focused on requests entered in the Consult Toolbox—the system VHA uses to manage documentation and workflows for VA and community care—from October 1, 2024, through January 31, 2026 (the audit period).

To refer a veteran for care, a VA provider must make a request on the veteran's behalf by submitting a referral, which VA calls a "consult." VHA staff will then use eligibility criteria from the MISSION Act to determine whether the veteran is eligible for community care. When veterans are eligible for and elect community care, VA community care staff should approve the care through an authorization that identifies the approved provider, services, and time period for the care. If additional care is needed, the provider should submit a request for services with supporting medical records to the referring VA medical facility. According to VHA's *Community Care Field Guidebook*, a formal decision must be made, documented, and communicated to both the veteran and the community provider within three business days of the date the request is received by the VA medical facility.

What the Audit Found

The OIG found that VA medical facilities did not always meet the three-business-day standard for making decisions and notifying veterans and providers about requests for services. During the audit period, only about 1.2 million of the almost 2.6 million requests (45 percent) had decisions made within three business days—the first step in this process—and only about 1.4 million of the requests (54 percent) had a notification made to either a veteran or provider. Furthermore, notifications took an average of about 12 days from the date of receipt, compared to the

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

[2] Office of Integrated Veteran Care (IVC), "How to Coordinate Care in the Community," chap. 3 in *Community Care Field Guidebook* (not publicly accessible).

three-business-day standard. Delayed approval for requests may delay care for veterans and reduce their opportunity for earlier diagnoses or treatment, hinder care continuity, or result in veterans receiving unauthorized care.

During site visits to four medical facilities, the OIG team identified several barriers to meeting the three-business-day standard, including backlogs when entering requests into the Consult Toolbox, staff shortages, and the multiple systems and steps needed to process the requests. In addition, limited oversight of the process has resulted in inconsistent data entry, ineffective processing, inappropriate notifications, and a lack of national data to reinforce accountability and support corrective action. While VHA has previously taken steps to address processing challenges with requests for services, such as implementing processes for facilities to review and reduce backlogs, challenges persist.

In December 2025, VHA announced plans for significant changes to its management and operations. On July 13, 2026, VHA announced the establishment of the VHA Office of Veterans Community Care to unify community care programs and operations. In addition, because the existing Community Care Network contracts started expiring in 2026, VA released a request for proposals in December 2025 for new contracts. According to VHA officials, the review, decision, and documentation of outcomes for requests for services will remain at the facility level. The OIG's findings in this report can help guide VHA during this reorganization to improve the timeliness of approvals for requests for services for veterans.

In accordance with the OIG's statutory responsibility to improve the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, the OIG made six recommendations to the under secretary for health to improve the processing of requests for services.[3] In August 2026, the acting under secretary concurred with all six recommendations and provided corrective actions. The full response and action plans can be seen in appendix B.

Next Steps

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

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[3] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

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Abbreviations

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

Introduction

The Veterans Health Administration (VHA) provides veterans direct care through VA medical facilities and is also 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] This includes when VA cannot provide the requested service or where drive-time and wait-time standards are not met. This care is provided through VHA's Veterans Community Care Program and delivered through its Community Care Network, which is managed by two third-party administrators. Community providers deliver authorized services and submit claims for reimbursement after veterans receive care. While the third-party administrators manage the network, VA medical facilities oversee key steps in the process of providing care in the community, such as approving and scheduling care and communicating with veterans, third-party administrators, and providers. As part of this process, when community providers determine more or different care is required from what was originally approved, they submit "requests for services" to medical facilities for approval. Monthly requests for services increased about 13 percent from October 2024 to October 2025, from about 203,000 to about 229,000.[5]

The VA Office of Inspector General (OIG) conducted this audit to determine whether VHA processed community care provider requests for services in accordance with timeliness and notification requirements established in VHA's *Community Care Field Guidebook*.[6] The OIG team focused on requests entered in the Consult Toolbox—the system VHA uses to manage documentation and workflows for VA and community care—from October 1, 2024, through January 31, 2026 (the audit period).[7] The team identified about 2.6 million requests for services with a decision to approve or disapprove that were entered in the Consult Toolbox during this period.

In December 2025, VHA announced plans for significant changes to its management and operations, including potential changes to VHA's Office of Integrated Veteran Care (IVC), the program office responsible for community care oversight at the time of this audit. In May 2026, VHA released a revised organization structure that includes a "Community Care Hub," a veteran-centric community care system designed to deliver timely access, accurate payments,

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

[5] This audit did not include the six facilities that had transitioned to the new Federal Electronic Health Record scheduling system at the time of this audit. While the request for services process is similar, those sites do not use the Consult Toolbox to document consult activities.

[6] Office of Integrated Veteran Care (IVC), "How to Coordinate Care in the Community," chap. 3 in *Community Care Field Guidebook* (not publicly accessible).

[7] VA Office of Information and Technology, *Consult Toolbox (CTB) User Guide*, September 2025.

and consistent, standardized processes for community care consults. However, as of June 2026, there had been no changes to the request for services process. The OIG's findings in this report can help guide VHA during this reorganization to improve the timeliness of approvals for requests for services for veterans. In addition, the existing Community Care Network contracts started expiring in 2026—VA released a request for proposals in December 2025 for new community care contracts intended to improve healthcare choice and quality for veterans. According to VHA officials, under the new contracts, third-party administrators will be responsible for coordinating with community providers to submit completed requests for services to VA medical facilities. However, VHA officials told the OIG team that VA will be responsible for the final decision and documentation of outcomes for requests for services.

Processing Requests for Services

To refer a veteran for care, a VA provider must, according to VHA's standard operating procedure, create a consult, which is "a request for clinical services on behalf of a patient."[8] Once a request for healthcare services is made, VHA medical facility staff evaluate the veteran's eligibility for community care by applying the legal criteria established under the MISSION Act. When veterans are eligible for and choose community care, VA community care staff should approve the care through an authorization that identifies the approved provider, services, and time period for services.

During treatment, if community providers determine a need for additional services or visits beyond what was initially authorized, VHA's *Community Care Field Guidebook* requires the provider to submit a request for services (VA Form 10-10172) with supporting medical records to the referring VA medical facility.[9] Providers may submit requests through various platforms, such as the electronic Health Share Referral Manager, electronic fax, or secure email.

VHA's *Community Care Field Guidebook* also establishes roles and responsibilities for processing requests for services. According to the guidebook, a formal decision must be made, documented, and communicated to both the veteran and the community provider within three business days of the date the request is received by the VA medical facility. Roles and responsibilities include the following:

- **Provider submissions.** Each VA medical facility should maintain at least one dedicated electronic fax line to receive requests. Facility community care staff must regularly monitor all submission platforms for requests for services to ensure timely processing.

[8] VHA Directive 1232, *Consult Management*, November 22, 2024, states the use of the term "consult" is meant to also include "referral." IVC, "National Return to Clinic Order" (standard operating procedure), September 7, 2022.

[9] IVC, "How to Coordinate Care in the Community."

- **Submission requirements.** A complete request for services must be signed, clearly identify the service, and include required supporting clinical documentation. If the request is incomplete, staff should notify the community provider about the missing items so they can correct the request.
- **VHA community care staff receiving requests.** When a complete request for services is received by the facility, staff must ensure timely distribution of the request for processing by entering it into the Consult Toolbox. This is the first step in the formal documentation process. The staff member who receives the request must also scan it into the veteran's medical record and create a request for services note.
- **Entering the request in the Consult Toolbox.** Community care staff must enter complete submissions, including the date the request was received by the facility, referred to as the "date submitted by community provider" (receipt date), in the Consult Toolbox.
- **Routing to the delegated clinician and tracking the handoff date.** Community care staff route the request to the delegated clinician—authorized to approve or disapprove the request—to determine whether additional care is appropriate and medically necessary. The date this decision is made is referred to as the "delegation of authority decision date" (decision date). The delegated clinician must make a formal decision and document it in the Consult Toolbox.
- **Timely processing standard.** Once the delegated clinician approves or denies the request, community care staff document the decision in the original consult in the Consult Toolbox. In addition, both the veteran and the community care provider should be notified of the decision to approve or disapprove the request for services. According to VHA officials, the Consult Toolbox includes fields for the veteran notification date and provider notification date.

Oversight of the Request for Services Process

VHA Directive 1232 establishes consult management policy and responsibilities at the program office and VA medical facility levels. At the time of this audit, IVC was responsible for consult policy development, training, and monitoring nationally.[10] On July 13, 2026, VHA announced the establishment of the VHA Office of Veterans Community Care, to replace IVC and unify community care programs and operations.

VHA Directive 1232 also assigns VA medical facility directors the responsibility for overseeing consult processes and ensuring adherence to national consult policies; it also identifies

[10] VHA Directive 1232.

governance mechanisms that facilities may use to support oversight. According to the directive, clinical and administrative staff should use VHA's Consult Toolbox to document receipt of the requests for services and the decisions made by the delegated clinician.

Results and Recommendations

Finding: VHA Could Improve Its Processing of Requests for Services

The OIG team found that VA medical facilities met the three-business-day standard established in the VHA *Community Care Field Guidebook* for making decisions on and notifying veterans and providers about requests for services only 17 percent of the time. During the audit period—October 1, 2024, through January 31, 2026—medical facilities processed almost 2.6 million requests.[11] Although close to 1.2 million of those requests (45 percent) had decisions made within three business days, only about 445,000 (17 percent) had documented notifications within the three-business-day standard. Overall, about 46 percent of all requests from the audit period had no documentation of the required notification ever being made to the veteran or provider.

During site visits to four medical facilities—selected because they had high volumes of requests for services and either a high or low number of requests taking more than three business days to process—the OIG team identified several systemic barriers that hindered staff from consistently meeting the three-business-day processing standard. At each facility, leaders and staff reported that backlogs were driven in part by staff having to manually enter data into the Consult Toolbox. Additionally, facility leaders and staff said the delays were further compounded by staffing shortages and by staff having to navigate multiple systems and steps to complete each request. Based on interviews with VHA officials and facility staff, the OIG also found limited oversight of the request for services process, resulting in inconsistent data entry, ineffective processing practices, and inappropriate notification procedures across facilities. The limited oversight contributed to unreliable data and discrepancies in calculating processing times, leaving VHA officials without the information needed to accurately assess timeliness or overall facility performance. Until VHA addresses these challenges, backlogs in processing requests for services are likely to continue, which increases the risk of delayed or unauthorized care for veterans.

What the OIG Did

The OIG team analyzed national data from VA's Corporate Data Warehouse using Palantir (a web application that allows for real-time access to data across systems) for requests for services processed at 132 VA medical facilities from October 1, 2024, through January 31, 2026 (the audit period). These requests for services were defined as having a decision date in the Consult Toolbox.[12] For this population of data, the team also analyzed veteran and provider notification dates to determine whether staff met the requirement to notify veterans and providers of

[11] All results are rounded.

[12] The OIG did not include requests for services for dental procedures in this analysis because how they are processed and documented differs from other requests.

decisions within the timeliness standard of three business days. Before May 2025, VHA's Consult Toolbox did not have a way to distinguish between letters sent to veterans or providers. Therefore, the team used the earliest date a letter was sent to either a veteran or provider for this analysis. During the team's analysis, any identified cases where delays could have affected patient care were referred to the OIG's Office of Healthcare Inspections for further review.[13]

The team visited VA healthcare facilities in New Mexico, Texas, South Carolina, and Florida. At each location, the team interviewed staff responsible for managing workflows for these requests and discussed operational challenges, timeliness metrics, and notifications. Additional information on the selected facilities can be found in appendix A.

The team also interviewed VHA and IVC leaders and officials responsible for overseeing veterans' access to community care and the processing of requests for services at medical facilities. Throughout the audit, the team met with leaders from VHA and IVC to discuss the project's methodology, preliminary findings, and proposed recommendations. During a briefing in February 2026 and through follow-up, officials told the team about several actions that IVC had previously taken in response to challenges with processing requests for services. For example, IVC initiated a national review of these requests on July 16, 2025, to address the backlog of requests for services. This initiative required all facilities to collect requests that did not have an associated decision and submit an inventory reduction plan, starting from oldest to newest.[14] This initiative resulted in older requests without decisions being closed. In addition, VHA issued an update to the request for services response letters in September 2025, to standardize the process and content of decision letters sent to providers and veterans. In August 2025, VHA also developed and presented a briefing on the request for services process that was used during calls with the facilities to reinforce expectations about this process. However, during the OIG's February 2026 briefing, VHA leaders confirmed that the issues identified in this report that led to the backlog, such as multiple intake methods, were still present.

Timeliness of Decision-Making

Once a request for services is entered into the Consult Toolbox, the first formal step is for a delegated clinician to review the request and either approve or deny it. The date of this decision is recorded in the Consult Toolbox as the "decision date." To evaluate whether facilities made decisions in a timely manner—thereby enabling them to meet the three-business-day standard for

[13] The team referred three cases involving delays in care associated with the processing of requests for services to the VA OIG Office of Healthcare Inspections to assess for clinical impact of the delays. One case was referred to the local VA medical facility for review of potential impact on patient care.

[14] Acting assistant under secretary for health for IVC, "For Action: National Requests for Services (RFS) Review, (VIEWS #13282481)," memorandum to Veterans Integrated Service Network (VISN) directors and medical center directors, July 16, 2025.

notifying veterans and providers—the OIG team analyzed how long it took medical facilities to render decisions on requests processed during the audit period.

The team found that facilities made decisions within three business days for about 1.2 million of the 2.6 million requests (45 percent) processed during the audit period. For the remaining 55 percent of requests, the timeliness of decision-making varied widely, as shown in table 1.

Table 1. Range of Days from Receipt to Decision for Requests for Services (October 1, 2024–January 31, 2026)

Days from receipt to decision	Count of requests for services	Percent
0 to 3 days	1,200,000	45
4 to 10 days	958,000	36
11 to 20 days	273,000	10
21 to 30 days	93,800	4
Over 30 days	118,000	4

Source: Data from VA's Corporate Data Warehouse obtained from Palantir (October 1, 2024–January 31, 2026).

Note: Numbers and percentages may not sum due to rounding.

Nationally, the average time to make a decision was about eight business days. These findings indicate substantial delays in the decision-making process, which hinder facilities' ability to meet required notification standards and could contribute to delays in veterans' care.

The team found that some services with average decision times greater than three business days were those for which timely action is particularly important for veterans receiving ongoing or critical care:

- Requests related to mental health services took an average of 10 days for clinicians to decide. Of about 94,500 mental health requests processed during the audit period, about 63,800 (68 percent) were not decided within three business days.
- Neurosurgery request decisions took an average of 9 days. Of about 55,300 requests processed during the audit period, more than 27,200 (49 percent) exceeded three business days.
- Cardiology requests averaged 6 days to decision. Of about 182,000 requests processed during the audit period, about 91,700 (50 percent) were not decided within three business days.

VHA is supposed to process requests for services, from initial receipt to final notification, within three business days. The national average of 8 days from receipt to decision indicates systemic

delays, which can contribute to interruptions in needed care for veterans. According to the guidebook, until requests are reviewed and approved and notification is made to the veteran and provider, no additional veteran care should be provided or paid for.

Documentation and Timeliness of Notifications

Of the almost 2.6 million requests processed during the audit period, only about 1.4 million (54 percent) had a recorded veteran or provider notification date in the Consult Toolbox. The other roughly 1.2 million requests (46 percent) had no documented notification, leaving no way to verify whether the required notifications were made. Facility staff who the OIG interviewed reported that, without timely notifications of denied requests, providers may continue providing care that is not authorized.

For the roughly 1.4 million requests with documented notifications, the OIG team assessed whether veterans and providers had been notified within three business days of the request being received by the facility. Nationally, across all 132 facilities, about 445,000 notifications (17 percent of the almost 2.6 million requests and about 31 percent of the 1.4 million requests with a notification date) were issued within three business days. For the remaining 83 percent of requests, the timeliness of notifications varied widely, as shown in table 2.

Table 2. Range of Days from Receipt to Notification for Requests for Services (October 1, 2024–January 31, 2026)

Days from receipt to notification	Count of requests for services	Percent
No notification documented	1,200,000	46
0 to 3 days	445,000	17
4 to 10 days	611,000	23
11 to 20 days	200,000	8
21 to 30 days	61,200	2
Over 30 days	96,700	4

Source: Data from VA's Corporate Data Warehouse obtained from Palantir (October 1, 2024–January 31, 2026).

Note: Numbers and percentages may not sum due to rounding.

On average, veterans and providers were notified around 12 days after the facility received the request. It took VHA almost 8 days to make a decision, and then almost 6 more days, on average, to send the decision letter.

As a result, community care staff processed 1.2 million requests without notification documented in the Consult Toolbox and allowed approximately 968,000 requests to exceed the three-business-day processing standard, which delayed veterans' scheduling and receipt of

community care and may have reduced their opportunities for earlier diagnoses or necessary treatment. Further, facility staff reported that if veterans and providers are not informed about denied requests, there is a risk that providers will continue to give care to veterans that will ultimately not be authorized—potentially leaving the veteran or provider liable for the cost of the care. These findings highlight opportunities for VHA to strengthen processes and oversight to make sure that requests are acted on promptly and that veterans and providers receive timely, accurate communication.

Challenges in the Request for Services Process

The OIG team identified significant challenges in VHA's receiving and processing of requests for services. Based on interviews with VHA officials and facility staff, the OIG found that limited national oversight of the request for services process contributed to inconsistent data entry, processing, and notification practices. Additionally, VHA lacked reliable national metrics to reinforce accountability and support corrective action.

Receiving Requests for Services

During site visits, community care staff at all four medical facilities reported that most requests arrived by electronic fax and required manual sorting, identification, labeling, and data entry into the Consult Toolbox. According to facility leaders and staff, this manual process, combined with staffing shortages, resulted in substantial backlogs in entering new requests into the system.

At the four facilities visited, backlogs related to electronic faxes were a barrier to timely processing. For example, at one site, community care staff explained that delays in receiving and manually preparing requests caused the fax queue to fall several weeks behind. Facility staff reported that about 1,800 requests were waiting in the queue to be entered into the Consult Toolbox, delaying clinicians' ability to review and approve or deny additional care for veterans.

Officials at all four facilities reported insufficient staffing levels to manage their overall workload. Because sorting and labeling incoming requests is labor-intensive, vacancies among community care staff involved in tasks associated with the processing of requests for services contributed to delays in task processing. For example, staffing information provided by officials showed that, in fiscal year 2025, one of the sites had 10 vacancies in positions that involved processing requests, while another site had four. By March 2026, these vacancies had grown to 13 (12 percent) and 29 (16 percent), respectively, and each of these sites had more than 1,700 requests that had not yet been documented by the facilities as formally received. Once a request has been formally received, it still has to be entered into the Consult Toolbox and reviewed by a delegated clinician, and then the veteran or provider has to be notified. At a third facility, a community care nurse and scheduling staff reported that staffing shortages led managers to halt the entry of new requests for services into the Consult Toolbox. Staff were redirected to focus exclusively on processing already approved new community care

authorizations. Facility staff reported that this shift resulted in a backlog of more than 3,700 unentered requests for services as of September 2025.

According to the chiefs of community care, two of the four facilities had recently implemented two automation tools that use artificial intelligence to sort and label requests received via electronic fax, eliminating two manual steps in the process. The tools have helped sort and identify requests for services and their associated documents more quickly, reduce workload, improve processing times, and identify duplicate requests, demonstrating that technology solutions can meaningfully mitigate delays. The community care chiefs stated that the tools are approved for use by VA.

Community care staff at most facilities said that because they still manually receive and process requests, many veterans experienced extended delays—sometimes more than 60 days—before care decisions were made. These delays, according to facility leaders and staff, increased the risk of adverse health outcomes and placed some veterans at risk of out-of-pocket costs if they received additional services before their requests were formally processed and approved.

Recommendation 1 calls on VHA to assess options to expand and optimize automation tools, including artificial intelligence–based solutions, for processing requests for services to reduce manual steps and promote efficiency.

Processing Requests for Services

The OIG team found that VA medical facilities relied on multiple systems to process requests for services and that limitations within these systems, along with ineffective review practices, contributed to delays. The Computerized Patient Record System is used to track consult actions in veterans' medical records; however, VA clinicians and the OIG team's review of selected records confirmed that the system does not clearly differentiate actions related to requests for services from other consult activities, such as determining VA appointment availability for new consults. This lack of distinction made it difficult for community care staff and delegated clinicians to identify requests and prioritize them for timely review. At one facility, a physician serving as a delegated clinician explained that alerts generated when a clinical decision was required were routed through the same channels as other consult workflows and clinical tasks. According to clinical staff, this increased the likelihood that requests for services could be missed amid competing priorities. This lack of distinction, according to a community care nurse and a physician serving as a delegated clinician, made it difficult to identify these requests and prioritize them for timely review.

Another limitation in both the Computerized Patient Record System and the Consult Toolbox that was noted by community care staff was the inability to automatically track unresolved requests for services. For example, at one facility, community care staff reported that after requests were assigned to delegated clinicians, community care nurses had to manually track their status because neither system automatically notified staff when a request was completed or

remained unresolved. To manage this challenge, the community care staff said the facility's 30 community care nurses each maintained individual spreadsheets to monitor request statuses, resulting in 30 separate tracking systems within the same facility and increasing the risk of delays and ineffective follow-up.

The OIG team also found considerable variation in how delegated clinicians approached and documented their reviews, which affected the time required to complete them. At one facility, community care staff reported that all requests were first routed to a primary care clinician who was expected to approve or deny the request. A delegated primary care clinician told the OIG team that he routinely forwarded requests for specialty care to the appropriate specialty clinician because he lacked the expertise to determine whether specialized services were warranted. This approach increased the number of clinicians involved and added more time to the review process for delegated clinicians to review and approve the request. Additionally, a delegated primary care clinician and a delegated specialty care clinician said they believed they each had three days to complete their respective reviews, rather than understanding that the full review process, from initial receipt through final notification, should be completed within three business days. In contrast, community care staff at other facilities reported different routing practices that reduced the number of review steps.

Without improvements to system functionality and greater consistency in review practices, VHA will continue to face barriers to timely routing, review, and approval of requests for services—ultimately increasing wait times for community care appointments.

Recommendation 2 calls on VHA to address system limitations that prevent identification of whether actions specific to requests for services have been taken or are pending, such as the delegated clinician review.

Recommendation 3 calls on VHA to review and update national standard operating procedures for processing requests for services to clarify roles and responsibilities, which will help address inappropriate practices and reduce processing delays.

Oversight of the Request for Services Process

The OIG team determined that VHA has limited oversight to make sure facility community care staff and delegated clinicians follow the request for services procedures outlined in VHA's *Community Care Field Guidebook*. As a result, VHA does not have assurance that the data available on requests for services are accurate or that these requests are being processed on time.

Inconsistent Data Entry

The OIG team found that limited oversight contributed to unreliable data for requests for services. The VHA *Community Care Field Guidebook* instructs facilities to make a formal decision on a request, document that decision, and notify both the veteran and the community provider within three business days of receiving the request. However, community care staff at

all four facilities interpreted the guidance inconsistently and did not uniformly enter the "receipt date" into the Consult Toolbox. Staff entered the receipt date as the date the provider signed the request, the fax transmission date showing when VA received the request, or the date staff entered the request into the Consult Toolbox.

To assess the reliability of the recorded dates, the OIG reviewed a sample of 124 requests for the audit period for the four sites the team visited. About 22 percent included receipt dates that did not match the actual transmission date shown on the fax cover sheets in veterans' medical records—the date that should have been used. For one request, community care staff incorrectly recorded the receipt date, resulting in a calculated processing time of 13 days. When the OIG team corrected the receipt date based on documentation, the actual processing time was 35 days. In another case, staff calculated a processing time of 7 days using the Consult Toolbox receipt date, but the OIG team determined the true processing time was 21 days based on the date shown on the faxed request. These discrepancies stemmed from inconsistent data entry practices across facilities. As a result, timeliness metrics were distorted to undercount or overcount processing time, compromising the accuracy and integrity of facility reporting and potentially masking delays in care. Community care staff told the audit team that requests for services can remain in fax queues for up to two months before staff enter them into the Consult Toolbox. When facilities use the entry date rather than the date the fax was received by the facility, processing times are understated by the length of the delay in the fax queue.

VHA officials acknowledged that the Consult Toolbox cannot automatically capture the actual date a request for services is received. An official further stated that there is no established national procedure for verifying the correctness of receipt dates entered by staff. Without improved oversight and system safeguards, data inaccuracies will continue to hinder the reliable measurement of timeliness and may delay veterans' access to needed community care services.

Recommendation 4 calls on VHA to develop processes or controls to help improve the accuracy and consistency of using the actual receipt date as the official date VHA received the request for services to maintain accurate timeliness tracking.

Inappropriate Processing and Notification

Limited oversight also led to inappropriate processing of requests for services and did not ensure veterans and community providers were notified about the outcomes of those requests. At one facility the team visited, community care staff did not follow required procedures for processing requests. Community care staff told the audit team that, instead of waiting for delegated clinicians to formally approve or deny the requests and then issuing the appropriate notifications, staff were instructed by managers to close requests on the fourth day after the request was entered into the Consult Toolbox, even if the delegated clinician had not made a decision. Further, the staff said they notified community providers of the request's status regardless of whether the required clinical review had occurred. According to a community care nurse, the provider would be sent a denial letter stating that the request was still under review, and the

veteran would be advised to follow up with their primary care team. The community care staff explained that this deviation from VHA *Community Care Field Guidebook* policy was due to an existing backlog that delayed processing.

Community care staff told the OIG team that staff were directed to do this because the facility is supposed to make some type of notification to the submitting provider within three business days. Staff were instructed to use a "needs more time" option in the request for services notification template. However, two staff members reported that this option was no longer available. According to them, only "approval" and "denial" selections remained, and one of the staff interpreted that as meaning they needed to select "denial" and add a comment stating "still under provider review" on the fourth day, then notify the provider accordingly. The community care chief from this facility confirmed that this practice was still in effect as of April 2026.

As noted earlier in this report, the OIG team found that facilities did not consistently notify veterans and providers of decisions on requests for services, and when notifications did occur, they often did not meet the three-business-day requirement. The VHA *Community Care Field Guidebook* states that both the veteran and the community provider should be notified unless the request is denied for incompleteness, in which case only the provider needs to be contacted so that the request can be corrected. However, at one facility, a nurse reported that staff were told to fax notifications only to providers and not to notify veterans. The lack of consistent practices and documentation of notifications—both to veterans and to providers—further limits VHA's ability to oversee the timeliness and accuracy of request for services processing. Without reliable notification data, facility leaders cannot determine how long veterans and providers wait for decisions or whether requests are being finalized within required time frames.

Recommendation 5 calls on VHA to make sure staff provide accurate notifications to community providers and notify veterans at key processing stages.

Lack of a National Performance Report

The OIG team found that VHA lacks a functioning national performance report to monitor the processing of requests for services. Although a national report previously existed, VHA officials told the team that the report had not been used since February 2025 after they determined that the underlying data were unreliable. VHA officials told the OIG team that, as of March 2026, VHA had not implemented a replacement reporting tool, although they were in the process of building a new report, with a projected implementation date of September 2026. Without a national mechanism to track timeliness and notification practices, VHA has limited visibility into how facilities are performing and whether veterans and community providers are receiving decisions within required time frames.

The absence of reliable, systemwide data also hinders VHA's ability to identify systemic issues and develop improvements. Without accurate performance information, VHA leaders cannot effectively assess compliance, address operational inefficiencies, or make sure that veterans

receive timely decisions regarding their community care needs or that all care is authorized. This lack of oversight increases the risk of inappropriate processing of requests and noncompliance with timeliness requirements, ultimately affecting veterans' access to needed care.

Recommendation 6 calls on VHA to implement mechanisms to provide routine oversight of the request for services process, including assessing data accuracy and the timeliness of request processing, to reinforce accountability and support corrective action.

Conclusion

VHA community care staff at medical facilities are not consistently meeting the three-business-day processing standard for requests for services. For 83 percent of all requests during the audit period, processing time did not meet the three-business-day limit, and at some facilities, facility staff reported that the combined processes of delegated clinician review and subsequent notification to veterans and providers took weeks. This may result in delayed care or in veterans receiving care that is ultimately unauthorized when requests are denied. Breakdowns in timely notification further exacerbate these risks. Site visits revealed that manual workflows, staffing shortages, system limitations, and limited oversight all contribute to backlogs and unreliable data, leaving VHA without an accurate understanding of timeliness or facility performance. Without sustained attention to these operational and oversight challenges, backlogs will persist, and veterans will continue to face delayed access to essential care.

Recommendations 1–6

In accordance with the OIG's statutory responsibility to improve the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, and to better align with the requirements, roles, and responsibilities outlined in VHA Directive 1232 and the *Community Care Field Guidebook*, the OIG made the following recommendations to the under secretary for health:[15]

1. Assess options to expand and optimize automation tools, including artificial intelligence–based solutions, for request for services processing to reduce manual steps and promote efficiency.
2. Address system limitations that prevent identification of whether actions specific to requests for services have been taken or are pending, such as the delegated clinician review.

[15] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

3. Review and update national standard operating procedures for request for services processing to clarify roles and responsibilities, address inappropriate practices, and reduce processing delays.
4. Develop processes or controls to help improve the accuracy and consistency of the use of the actual receipt date as the official date the Veterans Health Administration received the request for services to maintain accurate timeliness tracking.
5. Make sure facilities provide accurate notifications to community providers and notify veterans at key processing stages.
6. Implement mechanisms to provide routine oversight of the request for services process, including assessing data accuracy and the timeliness of request processing, to reinforce accountability and support corrective action.

VA Management Comments

The acting under secretary for health concurred with recommendations 1 through 6 and provided corrective action plans in August 2026. The full text of the management comments is provided in appendix B.

In response to recommendation 1, the acting under secretary said that VHA will evaluate existing and emerging automation and artificial intelligence–based tools to identify viable options for expanded use to reduce manual steps and promote efficiency. For recommendation 2, he reported that VHA will assess current system capabilities and limitations across platforms used to document and track requests for services. Based on this assessment, VHA will then identify and implement enhancements to improve visibility into the status of pending and completed actions for requests for services.

In response to recommendation 3, the acting under secretary noted that VHA will review existing national guidance and standard operating procedures. This review will include assessing how to clarify the three-business-day processing standard, better delineate review responsibilities and time frames among delegated clinicians, and update guidance to reduce inconsistent local practices. VHA will then update national guidance for requests for services. Regarding recommendation 4, he said that VHA will develop and implement processes to help improve the accuracy and consistency of using the actual receipt date for requests for services.

For recommendation 5, the acting under secretary said VHA will reinforce national training and guidance on notification requirements and procedures for requests for services, including appropriate use of decision status designations. He also said that VHA will evaluate reporting capabilities to improve visibility into whether required notifications have been completed. Finally, to address recommendation 6, VHA will develop and implement a national reporting mechanism to support routine oversight of the request for services process, including monitoring data accuracy and processing timeliness.

OIG Response

VHA's corrective action plans are responsive to the intent of the recommendations. The OIG will monitor VHA's progress in addressing the recommendations and will close them when VHA provides sufficient evidence that the action plans have been completed.

Appendix A: Scope and Methodology

Scope

The VA Office of Inspector General (OIG) team conducted its work from November 2025 through July 2026. The scope of the audit included requests for services with dates recorded in the Consult Toolbox from October 1, 2024, through January 31, 2026.

Methodology

To address the audit objective, the team completed the following actions:

- Obtained community care consult data from VA's Corporate Data Warehouse through Palantir and applied exclusion criteria to avoid any outliers
- Tested the data to determine to what extent Veterans Health Administration (VHA) medical facilities met the timeliness standards for requests for services to be completed in accordance with VHA guidelines for decisions on approval or denial, and to notify veterans and providers of the decisions once made
- Reviewed veterans' community care medical records
- Interviewed officials from the Office of Integrated Veteran Care, VA medical facility leaders, staff (both clinical and administrative) involved with implementing the Community Care Program at the facility level, and medical support assistants
- Visited four medical facilities (the New Mexico VA Health Care System in Albuquerque, New Mexico; the VA South Texas Health Care System in San Antonio, Texas; the Ralph H. Johnson VA Health Care System in Charleston, South Carolina; and the North Florida/South Georgia Veterans Health Care System in Gainesville, Florida)

These sites were selected based on the high volume of requests for services during the audit period and included sites that had lower and higher volumes of requests that took longer than three business days to process. At each location, the team interviewed staff responsible for managing workflows for these requests. While on-site, the team discussed operational challenges, timeliness metrics, and notifications. Table A.1 presents the volume of requests during the audit period for the four sites, including the number of requests exceeding three business days from receipt to decision dates and the average number of days it took to approve or deny the request.

Table A.1. Average Days from Receipt to Decision for Services at Selected Sites (October 1, 2024–January 31, 2026)

VA medical facility	Average processing rate (days)	Total count	Requests that took more than three business days	Percentage exceeding three business days
Gainesville, Florida	15	57,292	54,526	95
Albuquerque, New Mexico	15	42,337	29,924	71
Charleston, South Carolina	12	50,078	23,074	46
San Antonio, Texas	10	53,220	35,819	67

Source: Data obtained from VA's Corporate Data Warehouse through Palantir (October 1, 2024–January 31, 2026).

Internal Controls

The team assessed internal controls to determine whether they were significant to the audit objective. Consistent with the Government Accountability Office's *Standards for Internal Control in the Federal Government*, the team considered the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.[16] Based on this assessment, the team identified two internal control components and two principles as significant to the audit objective and the conditions discussed in the Results and Recommendations section.[17] The team identified internal control deficiencies during this audit and proposed recommendations to address those listed in table A.2.

[16] Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-25-107721, May 2025.

[17] Because this audit focused on the internal control components and principles identified as significant, it may not have disclosed all internal control deficiencies that could have existed at the time of the audit.

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 designs control activities to achieve objectives and respond to risks.	VHA facilities relied on labor-intensive, manual, and fax-dependent receipt and processing steps with multiple handoffs, which contributed to backlogs and delayed processing; facilities also used ineffective local procedures and, in some cases, deviated from national expectations (for example, prematurely closing requests or issuing decision letters before a formal decision). These conditions indicate that control activities were not consistently designed or operating to respond to workload risks and to support timely processing of requests for services.
Information and communication	13. Management uses quality information to achieve objectives.	VHA's ability to oversee timeliness and workload was weakened because facilities inconsistently recorded receipt dates (often using processing dates rather than actual receipt/provider submission dates) and did not consistently close completed requests in the Consult Toolbox; national performance reporting was unreliable; and the primary national report was discontinued due to data reliability concerns. These conditions indicate that information supporting timeliness tracking, backlog aging, and outcomes was not consistently complete, accurate, or timely, limiting effective communication and oversight.

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 team relied on computer-processed data to support the findings, conclusions, and recommendations of this audit. The team used electronic data retrieved from VA's Corporate Data Warehouse through Palantir to evaluate requests for services. The team evaluated the completeness and accuracy of the data from this system through an audit of the request for services data and discussions with VHA staff to validate data integrity. The team used several methods to identify unique requests for services and to ensure the validity of the data, due to staff not recording dates or recording them incorrectly in the Consult Toolbox. For example, the team manually reviewed a group of consults to determine how to identify each unique request for service and then created an algorithm combining the "consult sid" and "request for services #." This resulted in one unique identifier for all associated consult activities and services, for each

individual request for service. As another example, the team only included requests that had dates recorded for decisions, and sequential dates for actions taken in the Consult Toolbox, based on the logical order of events, such as decision dates recorded prior to notification dates. The team determined that the electronic data provided a reasonable basis for addressing the audit objectives and supporting this report's findings and conclusions.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards.[18] 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.

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

Appendix B: VA Management Comments

Department of Veterans Affairs Memorandum

Date: August 27, 2026

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Audit of Processing Community Care Requests for Services (VIEWS 15066965).

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

1. Thank you for the opportunity to review and comment on OIG's draft report on Audit of Processing Community Care Requests for Services. The Veterans Health Administration (VHA) concurs with the recommendations made to the Under Secretary for Health and provides an action plan in the attachment.

2. VHA greatly values the OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.

The OIG removed point of contact information prior to publication.

(Original signed by)

John Figueroa

Attachment

VETERANS HEALTH ADMINISTRATION (VHA) Action Plan
OIG Draft Report - Audit of Processing Community Care Requests for Services
(OIG Project Number 2025-03946-AE-0154)

Recommendation 1: Assess options to expand and optimize automation tools, including artificial intelligence–based solutions, for request for services processing to reduce manual steps and promote efficiency.

VHA Comments: Concur. VHA agrees with this recommendation and will evaluate existing and emerging automation and AI-based tools currently in use or in pilot status to identify viable options for expanded deployment to reduce manual steps and promote efficiency.

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

Recommendation 2: Address system limitations that prevent identification of whether actions specific to requests for services have been taken or are pending, such as the delegated clinician review.

VHA Comments: Concur. VHA agrees with this recommendation and will assess current system capabilities and limitations across platforms used to document and track requests for services. Based on this assessment, VHA will identify and implement system or process enhancements to improve visibility into the status of pending and completed actions throughout the request lifecycle.

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

Recommendation 3: Review and update national standard operating procedures for requests for services processing to clarify roles and responsibilities, address inappropriate practices, and reduce processing delays.

VHA Comments: Concur. VHA concurs with this recommendation and will conduct a review of existing national guidance and standard operating procedures related to requests for services. This review will address clarification of the three-business-day processing standard, delineation of review responsibilities and timeframes among delegated clinicians, and updated guidance to reduce inconsistent local practices. VHA will issue updated national guidance and communicate it to facilities through established channels.

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

Recommendation 4: Develop processes or controls to help improve the accuracy and consistency of the use of the actual receipt date as the official date the Veterans Health Administration received the request for services to maintain accurate timeliness tracking.

VHA Comments: Concur. VHA agrees with the recommendation and will develop and implement processes to help improve the accuracy and consistency of receipt dates recorded for requests for services, with the goal of reducing discrepancies between recorded and actual receipt dates over time. Progress will be tracked through appropriate reporting mechanisms.

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

Recommendation 5: Make sure facilities provide accurate notifications to community providers and notify veterans at key processing stages.

VHA Comments: Concur. VHA agrees with the recommendation and will reinforce national training and guidance on notification requirements and procedures for requests for services, including appropriate use of decision status designations. VHA will also evaluate reporting capabilities to improve visibility into

whether required notifications have been completed, to support facility accountability and compliance with notification requirements.

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

Recommendation 6: Implement mechanisms to provide routine oversight of the request for services process, including assessing data accuracy and the timeliness of request processing, to reinforce accountability and support corrective action.

VHA Comments: Concur. VHA agrees with the recommendation and will develop and implement a national reporting mechanism to support routine oversight of the requests for services process. This mechanism will include capabilities to monitor data accuracy and processing timeliness, enabling VHA to identify trends, address facility-level performance issues, and support corrective action on an ongoing basis.

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

The text of VA's management comments is reprinted verbatim as received from the department. 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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