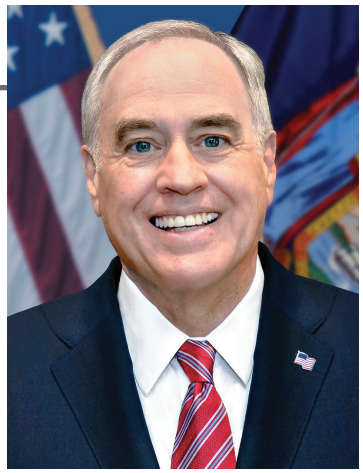
New York State Comptroller
THOMAS P. DiNAPOLI

2024–2025 Annual Report on Audits of State Agencies and Public Authorities

January 2026

Message from the Comptroller



January 2026

One of the chief responsibilities of my office is to audit State agencies, public authorities, and public programs to ensure that the public's money is appropriately protected. The audits conducted by my staff in the Division of State Government Accountability help establish whether our tax dollars are being spent effectively and whether government officials are doing all they can to eliminate waste and prevent and detect fraud. This, in turn, helps promote transparency and accountability in New York State government, which benefits each and every one of us.

State government officials are the stewards of the State's assets and the public's trust. Our audits keep New Yorkers informed on how well agencies and authorities are living up to that responsibility, and sound a call to action when needed. This annual report summarizes the results of the State government audits my staff conducted for the 2024-25 reporting year. This office remains committed to helping officials manage government resources efficiently and to protecting taxpayer assets. I hope that New York public officials and citizens will find this report useful and informative.

Thomas P. DiNapoli
State Comptroller

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About the Annual Report

As required by law, this annual report summarizes the results of all the State agency and public authority audit reports issued by the Office of the State Comptroller from October 1, 2024 through September 30, 2025. It does not include audits of New York City agencies, local governments, or other entities, as these are not included in the statutory requirements. The audit summaries in this report are divided into nine areas: Health and Human Services; Education; Transportation; Government Support; Criminal Justice and Judicial Administration; Economic Development and Housing; Other State Agencies and Public Authorities; Cross-Agency Programs; and Special Reports. An accompanying volume lists, by State agency or public authority, the audit reports issued from October 1, 2019 through September 30, 2025.

To obtain any of the audits cited in this report, visit osc.ny.gov or contact the State Comptroller's Press Office at (518) 474-4015.

Introduction

The New York State Constitution designates the State Comptroller as the State's Auditor. Within the Office of the State Comptroller (OSC), the Office of State and Local Government Accountability (SLGA) is the primary office that carries out the State Comptroller's functions as State Auditor. The Division of State Government Accountability (SGA) is a component of SLGA and conducts audits of New York State and New York City agencies and public authorities.

Audits of New York City agencies, while not included in this report, are accessible at www.osc.ny.gov/state-agencies/audits/by-agency.

SGA employs more than 250 professional auditors, many of whom hold advanced degrees and professional certifications in the auditing field, including Certified Internal Auditors, Certified Fraud Examiners, Certified Information Systems Auditors, and Certified Public Accountants. SGA also employs staff with other professional expertise, including in health, computer science, data analytics, and the social sciences. OSC is dedicated to protecting the public interest and promoting government accountability.

Fiscal Impact

For the reporting year 2024-25 (October 1 through September 30), SGA issued 71 reports addressing the operations of State agencies and public authorities. Auditors identified over $429 million in actual cost savings at these agencies and authorities. These savings have already been achieved, or will be achieved, with the implementation of audit recommendations. Auditors also identified nearly $2.5 billion in potential savings. In these cases, more action is usually required to realize the savings (e.g., legislative action or agency follow-up investigations with vendors to determine exact amounts).

The following table provides an overall summary of the fiscal impact associated with certain findings from the reports issued in reporting year 2024-25. Auditors estimate that if the agencies and authorities implement the recommendations contained in these reports, they could realize substantial monetary benefits, potentially more than $17.8 billion (which includes non-recoverable overpayments that, once corrective actions are taken, can be avoided in the future).

Audit Cost Savings for Reporting Year 2024-25

Fiscal Category	Actual	Potential	Totals
Cost Recovery	$429,334,585	$2,446,565,190	$2,875,899,775
Cost Avoidance	–	7,444,634	7,444,634
Revenue Enhancement	–	232,062	232,062
Subtotals	**$429,334,585**	**$2,454,241,886**	**$2,883,576,471**
Non-Recoverable Overpayments & Questionable Transactions			**14,923,472,348**
Total Fiscal Impact			**$17,807,048,819**

Agency Accountability

According to Section 170 of the Executive Law, when a State entity is audited by the State Comptroller, the executive of that entity must report to the Governor, the State Comptroller, and the leaders of the Legislature and the legislative fiscal committees, advising them on steps taken to implement the State Comptroller's recommendations and, where any particular recommendations were not implemented, explaining the reasons why. (Section 170 is not applicable to audits of New York City agencies.) The State Comptroller also performs follow-ups to assess auditees' progress in implementing prior audit recommendations.

In reporting year 2024-25, SGA issued 30 follow-ups, reviewing progress on a total of 163 recommendations. Of these recommendations, 114 (70%) have been fully or partially implemented, as detailed in the following table. See the Appendix – Status of Recommendations for a complete list of audit recommendations and their implementation status at the time of follow-up.

Agency	Total Number of Follow-Ups	Status of Recommendations		
		Total	Implemented	Percentage
Health and Human Services				
Department of Health	6	**37**	**20**	**54%**
Office for People With Developmental Disabilities	1	**4**	**4**	**100%**
Office of Addiction Services and Supports	2	**6**	**1**	**16%**
Office of Temporary Disability and Assistance	2	**15**	**10**	**67%**
Education				
State University of New York	2	**8**	**7***	**88%**
Transportation				
Metropolitan Transportation Authority	2	**24**	**13**	**54%**
Government Support				
Department of Civil Service	4	**20**	**17**	**85%**
Office of Information Technology Services	1	**1**	**1**	**100%**
Criminal Justice and Judicial Administration				
Department of Corrections and Community Supervision	1	**7**	**4**	**57%**
Economic Development and Housing				
Empire State Development	1	**3**	**3**	**100%**
Homes and Community Renewal	2	**13**	**11***	**85%**
Other State Agencies and Public Authorities				
Department of Labor	1	**4**	**4**	**100%**
Department of Motor Vehicles	1	**5**	**5**	**100%**
Hudson River–Black River Regulating District	1	**1**	**1**	**100%**
Cross-Agency Programs and Special Reports				
Department of Financial Services Department of State New York State Office for the Aging Office of Temporary and Disability Assistance State University of New York	1	**5**	**4**	**80%**
Department of Agriculture and Markets Department of Health	1	**5**	**5**	**100%**
Department of Health Division of Homeland Security and Emergency Services	1	**5**	**4**	**80%**
Totals	**30**	**163**	**114**	**70%**

*Includes one recommendation that was found to be no longer applicable at follow-up.

Audits Impairments and Impediments

State agency and public authority officials have a responsibility to the public to provide access to information to those who oversee their actions, such as OSC. Transparency and accountability are essential cornerstones of good government. When public officials are not transparent about and accountable for their actions, there is an increased risk that internal controls will not function properly—and less assurance that program goals and objectives will be accomplished efficiently and effectively. Denial of, or excessive delay in, auditors' access—or refusal of their direct access—to relevant documents or key individuals leads to incomplete, inaccurate, or significantly delayed findings or recommendations. This, in turn, may prevent agencies from promptly addressing serious problems and deprives decision makers and the public of timely critical information regarding the agency's performance.

In accordance with professional standards, OSC auditors are required to report instances where management's refusal to share all available, relevant evidence constitutes an impairment of audit work. For the reporting year 2024-25, one agency significantly delayed, obstructed, or otherwise impaired the scope of audits.

- **Office of Information Technology Services (ITS): Inventory Controls** (2023-S-17). ITS officials demonstrated a lack of cooperation during the first seven months of the audit. They took months to fulfill requests for information, and when documents were provided, they were often heavily redacted, making them unusable. Additionally, ITS required the auditors to review documents on-site instead of sharing them through a secure document transfer, which hindered the audit team's ability to perform their duties in accordance with GAGAS standards. However, after the audit team issued a scope impairment preliminary report for access to data and key personnel, there was substantial improvement for the remainder of the audit.

Audits of Special Significance

Fiscal

- **Medicaid Program**. Medicaid is a federal, State, and locally funded government program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. Thirteen Medicaid reports were issued during the period and, collectively, they identified more than $2.8 billion in actual and potential cost savings, including over $2.6 billion in payments on behalf of people who may have been residing outside of New York. These audits also identified more than $14.9 billion in questionable and non-recoverable payments, including nearly $14.6 billion in payments for personal care and home health care services that were not supported by required electronic visit verification records.

Housing

- **Division of Human Rights: Investigation of Housing Discrimination Complaints** (2023-S-26). The Division of Human Rights (DHR) is responsible for investigating,

prosecuting, and adjudicating discrimination cases—including housing discrimination complaints—in a timely manner and in accordance with its policies and procedures and related laws. However, DHR's weak controls, including inadequate monitoring, lack of written policies and procedures, and improper training of investigators, undermined this goal. DHR's complicated and poorly managed intake system resulted in claims being lost, unrecorded and unprocessed, or mislabeled as defective without follow-up. DHR also hadn't developed procedures to ensure complaints were processed and investigated in a timely manner. Lengthy case-processing times negatively impacted the quality and efficiency of DHR's investigations, as it lost touch with certain complainants and some complainants were no longer interested in cooperating with the investigation. Also, DHR investigators were not properly trained and supervised, resulting in no assurance that they followed investigation requirements before closing complaints. In addition, housing discrimination cases covered by the U.S. Department of Housing and Urban Development (HUD) (cases with federal status) were prioritized over cases reported directly to DHR by alleged victims because of federal reimbursement. In response to the audit, DHR said the agency made "major" changes to its executive leadership, brought on more investigators, and will conduct internal audits, increase training, and overhaul its case management system and intake process.

Health

- **Department of Health: Oversight of Adult Care Facilities** (2023-S-34). Adult care facilities provide residential care to adults who are substantially unable to live independently because of physical or other limitations associated with age, disabilities, or other factors, but who need a less intensive level of care than residents in nursing homes. The Department of Health (DOH) is responsible for the oversight of the State's 534 adult care facilities, serving 37,547 residents, primarily through regular inspections every 12 to 18 months and complaint investigations. However, the audit found that DOH failed to conduct timely inspections of facilities—in some cases up to five years overdue—and often lacked documentation to show critical problems had been corrected; did not conduct follow-up activities at facilities that received citations during the prior full inspection; and failed to fully investigate some complaints or had no evidence that an investigation was conducted at all. These complaints included allegations of poor care, residents being confined to their rooms or waiting in hallways for assistance for long periods, lack of resident supervision, medication mismanagement, and dirty or poorly maintained facilities. Auditors' site visits to 20 facilities identified concerning conditions at nine, including a half-empty bottle of vodka in a medical room, marijuana paraphernalia in an administrator's office, crumbling stairs/walkways, and kitchen appliances that did not operate at the correct temperature, which could affect food safety.

- **Department of Health and Office of General Services: State Public Health Emergency Medical Stockpile** (2023-S-14). The Department of Health's (DOH) Office of Health Emergency Preparedness (OHEP) is responsible for coordinating and managing all activities for public health and health care facility emergency preparedness, including purchasing, receiving, maintaining, and managing DOH's Medical Emergency

Response Cache (MERC), which includes pharmaceuticals and medical supplies, durable medical equipment (DME) such as X-ray machines and ventilators, and personal protective equipment. During the onset of COVID-19, unlike normal procurement circumstances, DOH was not involved in decisions regarding the ordering of supplies and DME. Rather, the former Executive Chamber, with direction from a consultant, made procurement decisions. Consequently, when the MERC received procured DME, OHEP was often unaware of and unable to account for what had been purchased. Auditors found that a significant amount of DME (247,391 items) was acquired during the pandemic. Of the total DME available for use (including pre-COVID-19 inventory), only 324 items were distributed during the public health emergency, only three of which were from the 247,343 DME purchased at the onset of COVID-19 at an estimated cost of $452.8 million. This leaves a significant amount of DME purchased during the pandemic (247,340 items) still unused in boxes at MERC or Department of Homeland Security and Emergency Services (DHSES) warehouses. DOH has taken limited action to address the surplus DME stockpile, for which the State continues to incur contracted warehouse management costs.

Extreme Weather/Disaster Planning

Two audits of Metropolitan Transportation Authority (MTA) agencies found weaknesses in oversight of inspections and maintenance of resiliency equipment that could leave portions of the transportation system unprepared for the next weather emergency, with the potential for adverse impacts on MTA's vital infrastructure, operations, and revenue streams.

- In Report 2023-S-4, auditors found Bridges & Tunnels (B&T) and MTA Bus (Bus Operations) did not conduct a system-wide risk assessment to identify the potential for damage to their transportation systems. Overall, B&T's lack of regular, timely inspections and maintenance could put its storm mitigation infrastructure at risk. For instance, at two B&T tunnels with 12 flood doors, there was no documentation that the doors had been inspected. During visits, auditors noted broken gasket seals on three doors that could potentially allow water to leak through. At four of six bus depots, auditors also determined inspections were not being done as required. Although there should have been 336 inspections of the large trucks used for snow removal over a year and a half, only 59 were documented. At two depots, there was no evidence that employees had been trained to inspect flood mitigation equipment.

- In another report (2023-S-5), auditors similarly found Metro-North did not perform a system-wide risk assessment, and equipment designed to be deployed during severe weather events, such as snow melters and snow-fighting machines, was not always inspected, tested, or maintained in compliance with Metro-North procedures and plans.

Technology

- **Division of Homeland Security and Emergency Services and Office of Information Technology Services: Next Generation 911 Services** (2023-S-40). The 911 emergency communications system dates back to the late 1960s, and its legacy analog infrastructure is still used in many areas in the State. Limitations in its capabilities have

been addressed with newer Next Generation 911 (NG911) technology, with enhanced capabilities that include voice, photos, videos, and text messages and allow emergency calls to be rerouted to other counties' call centers. The Division of Homeland Security and Emergency Services (DHSES) is the primary agency responsible for overseeing the State's transition to NG911; ITS maintains the statewide authoritative street and address point databases that support NG911. The audit found that DHSES is years behind schedule on adopting the required transition plans and has fallen short in providing counties with needed guidance on moving forward with implementing statewide interoperable communications. DHSES and its partners began developing a State 911 Plan to achieve statewide communication interoperability through NG911. However, efforts to bring a State 911 Plan to fruition have been beset with numerous, lengthy delays—including a three-year suspension of operations during the COVID-19 pandemic—and the plan was still in draft form as of January 2025. Without this plan, an NG911 Strategic Plan, and an NG911 Transition Plan, it will be more challenging for counties to move forward with NG911 implementation. Further, the prolonged implementation of NG911 increases the risk that the current, aging infrastructure will not function properly, particularly during natural disasters or other large-scale emergency events, and the public will not receive vital emergency services when needed.

- **Office of Information Technology Services, Office for the Aging, Department of Corrections and Community Supervision, Department of Motor Vehicles, and Department of Transportation: New York State Artificial Intelligence Governance** (2023-S-50). With their ability to process and analyze large amounts of data, artificial intelligence (AI)-powered tools have an increasingly significant role in industry operations, including New York State government. However, as use and sophistication of AI systems have been growing, they are also giving rise to a host of unintended consequences. Governance over AI systems, including transparency, is essential to promote accountability and responsible use. The Office of Information Technology Services (ITS), the State's technology authority, issued its Acceptable Use of Artificial Intelligence Technologies policy (AI Policy) providing guidelines and requirements for the acceptable use of AI technologies by State agencies. Auditors found that New York State does not have an effective governance framework. While the AI Policy gives an overview of responsible AI use, it lacks adequate guidance and procedures on how agencies can meet these expectations. Among a sample of four agencies, auditors found the AI governance varied significantly. Some agencies identified key risks and took steps to address those risks, while others had not created any AI-specific policies or taken other steps toward effective AI governance. These incomplete approaches to AI governance create a lack of assurance that the State's use of AI is transparent, accurate, and unbiased and avoids disparate impacts. Several factors contributed to the inconsistent and inadequate AI governance and compliance with the AI Policy, including lack of statewide guidance, poor identification of AI technology, and non-existent training.

Audit Summaries

Health and Human Services

Department of Health
(DOH)

DOH promotes and protects the health of New Yorkers through prevention, science, and the assurance of quality health care delivery, and administers a wide range of public health programs, including the State's Medicaid Program.

Audits of the Medicaid Program

The New York State Medicaid program is a federal, State, and local government-funded program that provides a wide range of medical services to individuals who are economically disadvantaged and/or have special health care needs. The Medicaid Program pays health providers through the fee-for-service (FFS) method or through managed care. Under FFS, DOH makes Medicaid payments directly to health care providers for services rendered to Medicaid members. Under managed care, DOH pays managed care organizations (MCOs) a monthly premium payment for each Medicaid member enrolled in the MCOs. The MCOs are then responsible for ensuring members have access to a comprehensive range of health services. The MCOs make payments to health care providers for the services rendered to members and are required to submit encounter claims to inform DOH about each medical service or drug provided. DOH's eMedNY computer system processes Medicaid FFS claims submitted by providers for services rendered to Medicaid-eligible members, and it generates payments to reimburse providers for their claims. Many of the State's Medicaid members are also enrolled in Medicare (referred to as "dual-eligibles") or other third-party health insurance (TPHI). In these cases, Medicare or TPHI is the primary payer for items and services, and Medicaid is the secondary payer. The Office of the Medicaid Inspector General (OMIG) is an independent office that works with DOH to prevent and detect fraudulent, abusive, and wasteful practices and recover improper Medicaid payments. DOH also developed NY State of Health (NYSOH), the online marketplace where individuals can apply for and enroll in Medicaid and health insurance plans such as the Essential Plan, which provides coverage to lower-income people who may not qualify for Medicaid. For the 2024–25 reporting year, OSC issued 13 Medicaid program reports.

Provider Compliance With the Electronic Visit Verification (EVV) Program (2022-S-31)

Objective: Determine whether Medicaid made payments for personal care (PC) and home health care (HHC) services that were not supported by required EVV records.

Audit Period: Paid PC services with service dates from January 2021–March 2023 and paid HHC services with service dates from January 2023–March 2023

Medicaid members may be eligible for in-home PC and HHC services (e.g., housekeeping, meal preparation, bathing, toileting, personal grooming) provided to promote, maintain, or restore health or lessen the effects of illness and disability and help individuals stay in their own homes and communities rather than live in institutional settings. The federal

21st Century Cures Act requires states to implement an EVV system for all Medicaid PC and HHC services, whereby providers must submit detailed information about the services delivered, including service type, member, provider, service date and begin and end times, and location of service delivery. States can validate the delivery of services by matching Medicaid reimbursement claims with EVV records to identify unsupported and improper services charged to the Medicaid program. In addition, up until January 2024, PC and HHC providers with Medicaid reimbursements exceeding $15 million a year were required to use a verification organization (VO) to verify services on claims before submitting the claims to Medicaid. OMIG was required to develop a list of providers that met the VO requirement and notify them of the requirements.

Auditors determined that Medicaid paid $14.5 billion for 82 million PC services and $97.6 million for 400,557 HHC services that were not supported by required EVV records; $11.6 million for 54,833 PC services where the matching EVV record showed a service duration of less than 8 minutes—which does not indicate valid services; and $9.7 million for 65,626 PC and HHC services provided to 19,935 members while they were hospitalized—when these in-home services should have been suspended.

Key Recommendations:

- Review the $14.5 billion in PC services and $97.6 million in HHC services with no matching EVV records and take steps to ensure these services are properly supported with EVV data.
- Improve oversight of the EVV program and establish key controls to ensure EVV compliance, including developing controls that prevent payment of claims for PC and HHC services that lack supporting EVV records.
- Review the $11.6 million for PC services under 8 minutes and the $9.7 million for PC and HHC services provided during hospital stays and recover overpayments, as appropriate.

Improper Premium Payments Made on Behalf of Managed Care Members Residing Outside the State (2022-S-42)

Objective: Determine if DOH improperly paid Medicaid managed care premiums on behalf of members who resided outside of New York.

Audit Period: July 2017–October 2024

Individuals enroll in Medicaid through NYSOH or through Local Departments of Social Services. Medicaid eligibility determination systems are required to routinely provide data to be sent through the federal Public Assistance Reporting Information System (PARIS). PARIS conducts matches on the enrollment data of public assistance programs, including Medicaid, to determine if an individual is receiving duplicate benefits in more than one location. Auditors found issues that indicated Medicaid paid almost $1.2 billion in managed care premiums for Medicaid members who may have resided outside of New York. Among the issues, auditors identified additional data sources DOH could use to complement the PARIS match and certain review processes for PARIS matches that needed improvement. Additionally, most Medicaid members are enrolled through NYSOH, yet auditors found DOH did not start submitting NYSOH-enrolled member data for PARIS matching until May 2017 (nearly three years after NYSOH started). Further, improper premiums were not recovered for members

whose eligibility was ended due to PARIS matches or whose eligibility was flagged to be closed but not officially ended and premiums continued to be made.

Key Recommendations:

- Verify the residency of members identified by a PARIS match who were not reviewed, as well as members identified as potentially residing outside of the State by data sources other than PARIS, and recover improper premium payments, as appropriate.
- Review the $299 million in premium payments for members whose eligibility was closed or not properly closed, and make recoveries, as appropriate.
- Enhance processes used to identify members living outside of the State and recover improper premium payments.

Impact of Rejected Encounters on the Collection of Drug Rebates (2023-S-2)

Objective: Determine whether DOH did not collect Medicaid drug rebates due to encounter system rejections of pharmacy encounter claims.

Audit Period: January 2018–March 2023

The Medicaid Drug Rebate Program helps offset the costs of covered outpatient drugs dispensed to Medicaid members through rebates received from drug manufacturers. MCOs are required to send DOH detailed information about each drug dispensed to managed care members. DOH and its rebate contractor use this information (received on encounter claims) to submit rebate invoices to drug manufacturers. From January 2018 through March 2023, auditors identified 453,706 pharmacy encounter claims totaling $59.1 million in payments that were rejected by DOH's encounter system. As a result of these rejections, DOH missed an estimated total of $31.2 million in drug rebates. The encounter system rejected these claims because they could not be validated by system controls. Auditors found that DOH does not have a process for performing detailed reviews of rejected encounter claim data.

Key Recommendation:

- Review the 453,706 encounter claims totaling an estimated $31.2 million in missed drug rebates and recover the corresponding missed rebates, as appropriate.

Overpayments for Medicare Part C Claims (2023-S-13)

Objective: Determine whether Medicaid made improper payments on Medicare Part C claims for recipients covered by Medicare Advantage Plans.

Audit Period: May 2018–April 2023

When a Medicare Advantage Plan denies a claim or pays a different amount than what a provider billed, the plan must communicate those actions to providers on the Explanation of Benefits using Claim Adjustment Reason Codes (CARCs). Providers can submit claims for these unpaid amounts to Medicaid, and are required to include the plan-reported CARCs. The eMedNY system uses the CARCs to determine whether a billed service is eligible for payment as well as the correct payment amount. For a judgmental sample of 89 high-risk Part C claims totaling $1,325,452 from five hospitals, auditors determined Medicaid improperly paid 49 claims (55%) totaling $881,233 because hospitals misinterpreted State regulations and billing guidelines, did not properly submit CARCs on claims, or indicated the Medicare Advantage

Plans did not cover services when they actually did. Auditors also found improvements are needed to DOH's automated claims processing and payment system to prevent incorrect payments.

Key Recommendations:

- Review the improperly billed claims sampled and recover overpayments, as appropriate.
- Develop an ongoing process, using a risk-based approach, to identify and review hospitals that bill questionable Part C claims, including the hospitals identified in this report, and ensure corrective steps are taken.
- Enhance controls to help ensure Medicaid accurately pays Part C claims.

Managed Care Payments for Services Not Coordinated Through Recipient Restriction Program Providers (2023-S-18)

Objective: Determine whether DOH provided adequate oversight to ensure managed care recipients in the Recipient Restriction Program (Restriction Program) received services from the appropriate providers.

Audit Period: July 2018–May 2023

The Restriction Program was created to reduce the cost of inappropriate utilization of health care by identifying Medicaid recipients who demonstrate a pattern of misusing and abusing the Medicaid program. Medicaid recipients in the Restriction Program must receive certain care through only their designated health care providers or via referral from those providers.

Due to a lack of oversight by DOH and OMIG, MCOs paid approximately $117 million for clinic, inpatient, practitioner, laboratory, and durable medical equipment services on behalf of Medicaid recipients who had designated Restriction Program providers on file in eMedNY, yet received services that were not furnished or referred by the designated providers. MCOs did not consistently implement Restriction Program requirements and did not have effective mechanisms in place to ensure recipients received restricted services from designated providers or that designated providers made referrals as required.

Key Recommendations:

- Review the identified $117 million in payments on behalf of restricted recipients and determine whether any recoveries should be made or any penalties assessed.
- Take steps to ensure MCOs consistently and appropriately enforce Restriction Program policies and regulations, including monitoring claims and determining whether any recoveries should be made or any penalties assessed.

Claims Processing Activity October 1, 2023 Through March 31, 2024 (2023-S-41)

Objective: Determine whether DOH's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to providers.

Audit Period: October 2023–March 2024 and certain claims outside this period when trends in the claims were observed that warranted follow-up.

The audit identified over $16.2 million in improper Medicaid payments. Among them were payments of $11.8 million for managed care premiums on behalf of Medicaid members who

had other concurrent comprehensive TPHI; $2 million for FFS inpatient claims that should have been paid by managed care; $1.3 million for newborn birth and maternity claims that contained inaccurate information, such as low newborn birth weights that increased reimbursements; and $964,333 for inpatient, pharmacy, referred ambulatory, and clinic claims that did not comply with Medicaid policies. As a result of the audit, more than $2.8 million of the improper payments identified was recovered. Auditors also identified 10 Medicaid providers who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs. DOH removed nine from the Medicaid program; by the end of the audit, the program status of the remaining provider had not yet been resolved.

Key Recommendations:

- Auditors made 10 recommendations to DOH to recover the remaining inappropriate Medicaid payments and improve claims processing controls.

Claims Processing Activity April 1, 2024 Through September 30, 2024 (2024-S-5)

Objective: Determine whether DOH's eMedNY system reasonably ensured that Medicaid claims were submitted by approved providers, were processed in accordance with Medicaid requirements, and resulted in correct payments to providers.

Audit Period: April 2024–September 2024, and certain claims going back to January 2022.

The audit determined eMedNY reasonably ensured Medicaid claims were submitted by approved providers, were processed in accordance with requirements, and resulted in correct payments to providers. However, the audit also identified the need for improvement in the processing of certain types of claims as it found over $11.5 million in improper Medicaid payments. Among them were payments of $8.3 million for managed care premiums on behalf of Medicaid members who had other concurrent comprehensive TPHI; $1.6 million for FFS inpatient claims that should have been paid by managed care; $1.3 million for newborn birth and maternity claims that contained inaccurate information, such as low newborn birth weights that increased reimbursements; and $222,220 for inpatient, clinic, and referred ambulatory claims that did not comply with Medicaid policies. As a result of the audit, more than $2.6 million of the improper payments was recovered. Auditors also identified 14 Medicaid providers who were charged with or found guilty of crimes that violated laws or regulations governing certain health care programs.

Key Recommendations:

- Auditors made seven recommendations to DOH to recover the remaining inappropriate Medicaid payments and improve controls.

Follow-Up Reports

Maximizing Drug Rebates Under the Federal Medicaid Drug Rebate Program (2024-F-14)

Objective: Determine the extent of implementation of the 12 recommendations from Report 2021-S-11, which assessed whether DOH took appropriate steps to collect all available drug rebates under the federal Medicaid Drug Rebate Program.

Initial Audit Key Findings: Auditors identified uncollected drug rebates totaling $183.7 million due to errors in DOH's claim extraction procedures, inaccurate or incomplete claim information submitted by MCOs and providers, exclusions of Program of All-Inclusive Care for the Elderly managed care claims from the rebate process, and claim processing errors made by DOH and the rebate contractor.

Recommendation Status: 2 implemented, 8 partially implemented, 2 not implemented

Excessive Payments for Durable Medical Equipment (DME) Rentals (2024-F-18)

Objective: Determine the extent of implementation of the seven recommendations from Report 2021-S-36, which assessed whether Medicaid MCOs inappropriately paid for DME beyond allowed rental limits, and whether the Medicaid program could achieve cost savings by implementation of a rental cap on oxygen equipment.

Initial Audit Key Findings: The audit found about $1.5 million in overpayments and $503,619 in questionable payments for DME rentals. Auditors also estimated a potential cost avoidance for the Medicaid program of $8.6 million if DOH had adopted a similar policy to Medicare's 36-month cap on oxygen equipment rental payments.

Recommendation Status: 1 partially implemented, 6 not implemented

Improper Fee-for-Service Pharmacy Payments for Recipients With Third-Party Health Insurance (2024-F-25)

Objective: To assess the extent of implementation of the eight recommendations from Report 2021-S-20, which assessed whether Medicaid made inappropriate FFS payments to pharmacies on behalf of recipients who had TPHI and, if so, whether appropriate recoveries were made.

Initial Audit Key Findings: OMIG contracted with Gainwell Technologies (Gainwell) to identify and recover Medicaid payments made for services that should have been paid for by a recipient's TPHI. However, the audit found DOH and OMIG lacked adequate oversight of Gainwell's recovery process to ensure all available recoveries on FFS pharmacy payments were made. The audit also found claim processing improvements could be made to prevent TPHI overpayments from occurring.

Recommendation Status: 1 Implemented, 2 partially implemented, 5 not implemented

Improper Medicaid Payments for Outpatient Services Billed as Inpatient Claims (2024-F-26)

Objective: Determine the extent of implementation of the five recommendations from Report 2022-S-16, which assessed whether Medicaid made improper payments to hospitals for outpatient services that were erroneously billed as inpatient claims.

Initial Audit Key Findings: Outpatient services are generally less expensive than inpatient treatments because they are less involved and do not require a patient's continued presence in a facility. The audit identified 34,264 FFS inpatient claims, totaling $360.6 million, where hospitals reported Medicaid recipients were discharged within 24 hours of admission—an

indicator that these claims possibly should have been billed as outpatient. For a judgmental sample of 190 of these high-risk claims totaling $4,261,428 from six hospitals, auditors determined that 91 claims (48%) totaling $1,577,821 were billed improperly.

Recommendation Status: 3 partially implemented, 2 not implemented

Improper Medicaid Payments During Permissible Overlapping Medicaid and Essential Plan Coverage (2024-F-40)

Objective: Determine the extent of implementation of the two recommendations from Report 2022-S-35, which assessed whether Medicaid made improper payments on behalf of members with DOH-authorized overlapping Medicaid and Essential Plan coverage.

Initial Audit Key Findings: During periods of authorized overlapping Medicaid and Essential Plan coverage, the Essential Plan should be the primary payer and Medicaid, as secondary payer, should pay any remaining liabilities, such as deductibles and coinsurance. The audit found that Medicaid improperly paid $93.7 million in claims during periods of overlapping coverage because DOH did not account for the Essential Plan as a liable TPHI (i.e., primary payer). Despite administering both programs and having enrollment information for both in its systems, DOH never applied payment controls and, consequently, Medicaid had been improperly paying the full amount for services as the primary payer since the inception of the Essential Plan (January 2016).

Recommendation Status: 1 partially implemented, 1 not implemented

Reducing Medicaid Costs for Recipients Who Are Eligible for Medicare (2025-F-8)

Objective: Determine the extent of implementation of the three recommendations included in Report 2021-S-16, which assessed whether DOH took sufficient steps to control the Medicaid costs of recipients who were eligible for Medicare based on age but were not enrolled in Medicare.

Initial Audit Key Findings: When Medicaid recipients are also enrolled in Medicare, Medicare becomes the primary payer and Medicaid the secondary, which allows for a significant cost avoidance for the Medicaid program. Local Departments of Social Services (Local Districts) are required to identify Medicaid recipients who are at least 65 years of age, or will be turning 65 within three months, and have them apply for Medicare. Auditors identified 13,318 Medicaid recipients who appeared eligible for Medicare based on age but were not enrolled in Medicare. Medicaid could have potentially saved $294.4 million on behalf of these recipients for clinic, inpatient, and practitioner claims that could have been covered by Medicare. Although DOH issued guidance to Local Districts regarding the requirement for Medicaid recipients reaching age 65 to apply for Medicare, DOH did not ensure Local Districts complied. Since the initial audit, auditors determined Medicaid could have potentially saved $190.3 million on behalf of 17,818 recipients for clinic, inpatient, and practitioner claims that could have been covered by Medicare as the primary payer if they were enrolled in Medicare when they first became eligible at age 65.

Recommendation Status: 1 implemented, 1 partially implemented, 1 not implemented

Other Audits of DOH Oversight

Oversight of Adult Care Facilities (2023-S-34)

Objective: Determine whether DOH had adequately overseen adult care facilities to ensure quality of care and safety for residents.

Audit Period: January 2018–October 2024

Adult care facilities provide residential care to adults who are substantially unable to live independently because of physical or other limitations associated with age, disabilities, or other factors, but who need a less intensive level of care than residents in nursing homes. In 2023, there were 534 adult care facilities with 37,547 residents in New York State. Auditors found DOH is not adequately overseeing adult care facilities to ensure quality of care and safety for residents. DOH did not inspect facilities within the required time frames or conduct follow-up activities at facilities that received citations during the prior full inspections, including for violations that represent harm or risks to residents and quality of life. Further, DOH did not have evidence it investigated certain complaints or fully documented its investigation of others, did not issue investigation reports to facilities on time or at all in some cases, and did not issue investigation result letters to complainants.

Key Recommendations:

- Review current procedures, guidance, and training and implement changes to ensure full inspections are completed on time and in accordance with laws and regulations and that facilities correct all violations in a timely manner.
- Establish and implement formal procedures to ensure that complaints are fully investigated and properly documented, and ensure monitoring procedures are followed so complaint investigation results are communicated to facilities within the required 30-day time period.
- Ensure DOH staff collect all required information from complainants who do not specifically request anonymity, and establish and document time frames for issuing investigation result letters to complainants.

Office for People With Developmental Disabilities *(OPWDD)*

OPWDD is responsible for coordinating services for individuals with intellectual and developmental disabilities, including employment, day services, and housing. OPWDD oversees several residential service options, which allow clients to live in a community home setting with others and be as independent as possible. Two such community residence types—Individualized Residential Alternatives (IRAs) and Intermediate Care Facilities (ICFs)—serve the majority of clients. OPWDD provides these services directly through State-operated programs and through a network of private non-profit agencies (voluntary agencies).

Follow-Up Report

Pandemic Planning and Care for Vulnerable Populations (2024-F-23)

Objective: Determine the extent of implementation of the four recommendations from Report 2021-S-9, which assessed whether OPWDD adequately addressed the needs of the vulnerable population it serves in its emergency plans and took appropriate actions to care for this vulnerable population during the COVID-19 pandemic.

Initial Audit Key Findings: One component of OPWDD's mission is providing a safe environment for all staff, people receiving services, and families served in homes and programs operated and/or certified by OPWDD, including disaster preparedness. Auditors found OPWDD did not provide consistent oversight and guidance to all homes to ensure they were adequately prepared to manage public health emergencies. For example, OPWDD developed and issued specific COVID-19 plans to only State-operated ICFs, which accounted for less than 1% of OPWDD's residential clients. The remaining facilities, which collectively accounted for 34,048 clients (99%), were required to create their own emergency plans. Additionally, while OPWDD's emergency management and overarching emergency planning documents considered pandemics as a risk even before the COVID-19 pandemic, OPWDD did not take proactive steps to ensure that all homes—both State- and voluntary agency-operated—had followed suit in their own emergency plans. Further, COVID-19 reviews did not adequately provide assurance that homes were following OPWDD guidance.

Recommendation Status: 4 partially implemented

Office of Addiction Services and Supports
(OASAS)

OASAS oversees one of the nation's largest substance use disorder systems of care. Its approximately 1,700 prevention, treatment, and recovery programs serve over 730,000 individuals each year, including inpatient and residential services for about 8,000.

Follow-Up Reports

Oversight of Contract Expenditures of Palladia, Inc. (2024-F-29)

Objective: Determine the extent of implementation of the three recommendations from Report 2020-S-5, which assessed whether OASAS was effectively monitoring its contract with Palladia to ensure reimbursed claims are allowable, supported, and program-related.

Initial Audit Key Findings: OASAS was not effectively monitoring the expenses reported by Palladia to ensure that its reimbursed claims related to its contracted drug and alcohol addiction treatment services were allowable, supported, and program-related. For the three fiscal years ended June 30, 2018, Palladia claimed $2,508,682 in expenses that did not comply with the requirements in the Consolidated Fiscal Reporting and Claiming Manual, OASAS' Administrative and Fiscal Guidelines for OASAS-Funded Providers, and the contract.

Recommendation Status: 1 partially implemented, 2 not implemented

Addiction Support Services During Emergencies (2024-F-39)

Objective: Determine the extent of implementation of the three recommendations from Report 2021-S-35, which assessed whether OASAS offered adequate guidance to providers to help ensure they are able to deliver addiction support services during emergency situations.

Initial Audit Key Findings: Certain providers, including residential treatment and inpatient rehabilitation providers, are required to develop, maintain, and update an Emergency Preparedness Plan to help them prepare for, respond to, and/or recover from an internal or external emergency that may present an immediate danger to personnel, patients, their substance use disorder and problem gambling treatment and prevention programs, and/or property. Auditors found OASAS needed to improve the extent and clarity of its guidance to providers, to include strategies to manage and mitigate prolonged service disruptions, as well as its monitoring of providers' Emergency Preparedness Plans. OASAS personnel reviewed plans only at initial certification despite guidance indicating they would review them during later site visits. Further, OASAS needed to do more to ensure that providers have access to and use the New York State Evacuation of Facilities in Disasters System application to track individuals when relocation occurs during an emergency and improve the accuracy and usefulness of its waiting lists.

Recommendation Status: 3 not implemented

Office of Children and Family Services
(OCFS)

OCFS is charged with promoting the safety, permanency, and well-being of children, youth, families, and vulnerable populations in New York State. Its responsibilities encompass a wide range of social services programs, including foster care and adoption and child and vulnerable adult protective services. Through its Division of Juvenile Justice and Opportunities for Youth, OCFS is responsible for the operation and oversight of nine State-run residential juvenile justice facilities—three secure facilities, five limited secure facilities, and one non-secure facility—that serve court-placed youth. OCFS programs are administered by 58 Local Departments of Social Services (Local Districts) throughout the State.

Child Care Stabilization Grants (2022-S-44)

Objective: Determine whether OCFS established and maintained adequate internal controls to enable it to oversee and monitor child care stabilization grantees to ensure proper use of child care stabilization grant funds, and whether the grants met their intended purpose to stabilize child care operations to maintain care.

Audit Period: January 2020–November 2023

Between May and June 2021, OCFS received $1.8 billion from the American Rescue Plan Act and an additional $469 million from the Coronavirus Response and Relief Supplemental Appropriations Act. OCFS used over $1.4 billion to fund child care stabilization grant programs in two rounds: Stabilization 1.0 focused primarily on stabilizing the child care sector while Stabilization 2.0 focused on stabilizing the child care workforce. Auditors found that

OCFS did not sufficiently monitor grantee expenses claimed under the programs to provide assurance that funds were used in alignment with program goals and for allowable expenses. For example, of $2.6 million in expenses reviewed from 39 non-special education providers, $373,182 (14%) reported to OCFS by 20 providers was either inadequately supported or not supported at all. Also, OCFS' methodology relied heavily on providers' established capacity to determine the amount of grant funding awarded. However, auditors found there were stark differences between the licensed capacity information OCFS used to determine grant awards and child care providers' actual enrollment, especially for special education providers.

Key Recommendations:

- Develop and implement enhanced controls and monitoring practices for child care grants administered by OCFS. This may include, but not be limited to, reviewing supporting documentation for grant expenditures using a risk-based approach.
- Continue efforts to identify and recover unspent or inappropriately spent grant funds from providers.
- Align providers' grant awards to best meet the goals of the program, which may include, but not be limited to: obtaining additional information and increasing communication with providers; coordinating and sharing information with State Education Department regarding special education providers; and evaluating whether additional factors should be considered when awarding grants.

Oversight of Juvenile Detention Facilities (Outside New York City) (2023-S-15)

Objective: Determine whether OCFS adequately oversaw juvenile justice facilities for youth placed in local detention facilities to ensure they meet State regulations for the health and safety of juveniles and staff.

Audit Period: October 2018–January 2024

OCFS is responsible for the operation and oversight of nine State-run residential juvenile justice facilities, ensuring that these facilities are operated in good condition and in compliance with its established policy and procedures, conduct regular fire safety inspections, have an emergency plan, maintain sanitary conditions, and provide health screenings upon admission. Further, OCFS must ensure that facility staff are properly trained and that, when incidents (e.g., assault, contraband possession, youth restraint) occur, facilities log and report them as required. While facilities are meeting State regulations for health, safety, and physical conditions, OCFS was not providing sufficient oversight to ensure they were complying with other requirements. For example, certain admission assessments and screenings, including health-related assessments, were not completed and documented as required or within the required time frames, creating the risk of missed or delayed opportunities to provide care for physical health or mental health issues youth may have upon admission. Also, some restraint incidents lacked sufficient support that a complete review of the events had been conducted. OCFS also did not ensure that all direct care staff were current with the training requirements.

Key Recommendation:

- Clarify, communicate, and, where practicable, standardize procedures for oversight of local juvenile detention facilities to increase assurance that facilities: comply with

regulations related to completing required assessments, documentation, and staff training; adhere to policies and procedures for documenting and reviewing incidents involving restraints; and implement corrective actions as directed in the performance improvement plan.

Office of Temporary and Disability Assistance
(OTDA)

OTDA's mission is to help vulnerable New Yorkers meet their essential needs and advance economically by providing opportunities for stable employment, housing, and nutrition. OTDA provides support to Local Departments of Social Services (Local Districts)—comprising the New York City Department of Homeless Services and 57 county offices throughout the rest of the State—in the operation of these programs.

Response to Human Trafficking (2023-S-31)

Objective: Determine whether OTDA was overseeing contracted providers and Local Districts to ensure adequate services are being provided to victims of human trafficking (survivors).

Audit Period: January 2019–May 2024

OTDA's Response to Human Trafficking Program (RHTP) is designed to support the New York State Human Trafficking Law in improving the capacity of the human services sector to address human trafficking and increasing trafficking survivors' access to quality services to address their physical, emotional, and financial trauma. The audit identified communication, data collection, and documentation weaknesses that undermine OTDA's oversight of RHTP and efforts to ensure that the highest possible number of survivors are receiving services designed to address the trauma resulting from human trafficking. For example, OTDA does not have an effective system for tracking whether human trafficking survivors referred to providers are engaging in RHTP and what services they are receiving. Auditors also found that providers did not collect required documentation that would help OTDA ensure they understand and are meeting Program goals.

Key Recommendations:

- Improve data collection and monitoring efforts to more effectively evaluate RHTP outcomes and success, including obtaining data through the Local Districts and providers.
- Develop and implement policies and procedures regarding the documentation that should be retained to support pauses in the confirmation time frame.
- Enhance guidance, including documentation such as standardized forms, and communicate more frequently to providers to ensure RHTP goals are met.
- Ensure liaisons' duties and responsibilities are effectively communicated so they understand their role in the RHTP.

Monitoring of Homeless Data (2023-S-38)

Objective: Determine if OTDA monitored data on the State's homeless population to better understand the nature and scope of homelessness across the State, and if OTDA's programs were using all available data to best address the needs of those experiencing or at risk of homelessness.

Audit Period: January 2018–July 2024

To assist OTDA in supervising homeless shelters and administering related programs, Local Districts are required to submit Homeless Services Outcome Reports, which contain aggregate data on the number of sheltered and unsheltered homeless individuals and families identified in the last point-in-time count, the number of individuals and families for whom the Local Districts provided temporary housing assistance, and strategies and plans for addressing individuals' housing and service needs. In addition, Local Districts typically collect and submit client-level data on the populations they serve to a computer system compliant with HUD's Homeless Management Information System (HMIS) Data Standards; this data is used by 24 federally funded regional or local planning bodies—Continuums of Care (CoCs)—to coordinate housing and services funding. These CoCs control access to the HMIS-compliant systems but are not required to share this data with OTDA or provide open access to the Local Districts that submit this data. Auditors found that OTDA does not have permission to access all the client-level data collected in the various HMIS-compliant systems, which hinders its ability to better understand the nature and scope of homelessness across the State. Seeing the value of this data, OTDA requested access to HMIS data but received permission from only seven of 24 CoCs during the audit scope, representing about 7% of the State's homeless population. (In its response to the draft report, OTDA stated it had received permission to access data from eight additional CoCs.) Further, of the 579 shelters listed by OTDA, 174 (30%) were not entering any data into an HMIS—and the information provided to OTDA is incomplete.

Key Recommendations:

- Take steps to obtain access to homeless client-level data for OTDA and Local Districts.
- Analyze homeless client-level data to help monitor and manage the statewide homeless shelter system, the services it provides, and the outcomes of those services.
- Pursue a comprehensive data warehouse as stated in the initial goals of the New York State Data Warehouse Environment initiative.
- Survey Local Districts to determine best practices for managing client-level data and employ these strategies statewide where appropriate.

Follow-Up Reports

Oversight of Homeless Shelters (2024-F-31)

Objective: Determine the extent of implementation of the eight recommendations from Report 2018-S-52, which assessed whether OTDA had adequately overseen homeless shelters to ensure they were operating in compliance with applicable laws, rules, and regulations.

Initial Audit Key Findings: OTDA was not providing adequate oversight of homeless shelters to ensure that conditions were safe. Serious violations noted during visits included structural damage, mold, vermin, bug infestations, excessive garbage in rooms, and missing or malfunctioning smoke detectors. Auditors also determined OTDA's oversight could be improved through better risk assessment, more effective information tracking or monitoring of corrective actions, and enforcement of existing consequences for violations.

Recommendation Status: 5 implemented, 1 partially implemented, 2 not implemented

Homeless Services Housing Needs Assessment (2024-F-36)

Objective: Determine the extent of implementation of the seven recommendations from Report 2021-S-23, which assessed whether OTDA's initial Needs Assessments and Individual Living Plans (ILPs) were completed timely and if clients were receiving services needed to transition to permanent housing.

Initial Audit Key Findings: OTDA was not adequately ensuring that assessments and ILPs were completed in a timely manner and that all client support services were being provided. Assessments were either missing or late 40% of the time, and ILPs were either missing or late 38% of the time, impacting the timeliness of services and support to clients aimed at helping them exit the shelter and return to self-sufficiency. Auditors found no evidence that support services listed in the ILPs were delivered for a sample of cases, and 70% of clients in the sample did not exit the shelter and transition to permanent housing. Further, OTDA did not collect and analyze aggregate data that would allow it to identify primary causes for clients not achieving permanent housing and to address these issues.

Recommendation Status: 1 implemented, 3 partially implemented, 3 not implemented

Education

State Education Department
(SED)

SED is responsible for the oversight of more than 700 school districts, with 2.5 million students in pre-kindergarten through 12th-grade programs. It also oversees all public and private schools approved to serve preschool students with disabilities, including schools' compliance with federal and State laws and policies pertaining to the delivery of special education programs and services to preschool students with disabilities.

Access to Preschool Special Education Services (2023-S-1)

Objective: Determine whether SED was effectively overseeing preschool special education in compliance with all applicable laws and regulations to promote timely access to services for children across New York State.

Audit Period: July 2018–January 2024

Preschool special education services for children 3 to 5 years of age can include but are not limited to: speech pathology and language therapy, occupational therapy, physical therapy,

specialized instruction, parent training, and counseling. State laws and regulations establish certain requirements and time frames within the preschool special education evaluation process (e.g., obtaining parental consent, conducting an initial evaluation, developing an Individualized Education Program [IEP]) to ensure students are identified for and receive needed services in a timely manner. Auditors found that preschool special education students may not be receiving all required services within required time frames and, in some cases, may not be receiving them at all. Some school districts had to place students on waitlists for services due to a lack of provider availability. However, SED does not collect data on waitlists and is unaware of the current number of students enrolled in the preschool special education program, the services they are receiving in real time, or the number of districts using waitlists. It is also not aware of the regional need for preschool special education providers across the State. Further, while SED monitors the timing of some steps of the special education process, it does not monitor all steps, including IEP development, or whether students are actually receiving all services to which they are entitled.

Key Recommendations:

- Develop a strategy to address the statewide shortage of preschool special education service providers and work with school districts to identify ways to obtain the necessary services.
- Increase monitoring of school districts, including but not limited to: timeliness of preschool special education events (i.e., evaluations), resolutions of potential non-compliance (i.e., waitlists and ensuring IEP implementation for all students), and determining regional need for providers on a real-time basis.
- Develop and implement a risk-based method to identify school districts that warrant immediate review.
- Develop data integrity controls to provide greater assurance of the accuracy and completeness of data.

Preschool Special Education Program Audits

Objective: Determine if costs reported by special education program providers on their Consolidated Fiscal Reports (CFRs) were reasonable, necessary, directly related to the special education program, and sufficiently documented pursuant to SED's Reimbursable Cost Manual (RCM) and Consolidated Fiscal Reporting and Claiming Manual (CFR Manual).

Private special education providers must be approved by SED to deliver special education services, such as Special Education Itinerant Teacher, Special Class, and Special Class in an Integrated Setting programs, to children in New York. SED annually develops rates for these programs based on actual personal service and other than personal service costs reported to SED on annual CFRs. These rates are used to reimburse providers for eligible costs, which must comply with comprehensive instructions and guidelines set forth in SED's CFR Manual and RCM. Chapter 545 of the Laws of 2013 requires the State Comptroller to audit the expenses reported to SED by every program provider of special education services for preschool children with a disability, subject to the funding made available by the Legislature for such purpose. In the 2024-25 reporting year, OSC issued five such reports, as detailed below. For these providers, auditors identified a total of about $7.8 million in

reported costs that were ineligible for reimbursement. Generally, auditors recommended that, in each case, SED review the disallowances identified and make the necessary adjustments to the costs reported on the provider's CFRs and to the provider's tuition reimbursement rates, as warranted, and remind providers of the pertinent SED requirements that relate to the deficiencies identified; and that the provider ensure that costs reported on annual CFRs fully comply with SED's requirements, and communicate with SED to obtain clarification, as needed.

Jackson Child Development Center, Inc. (2022-S-21)

Audit scope: expenses claimed for fiscal year ended June 30, 2020 and certain expenses claimed for the two fiscal years ended June 30, 2019

Amount of reimbursable costs reported: approximately $24 million

Amount identified as ineligible for reimbursement: $3,020,800

Adaptive Solutions Multi Services, PLLC (2022-S-48)

Audit scope: expenses claimed for fiscal year ended June 30, 2018 and certain expenses claimed for the two fiscal years ended June 30, 2017

Amount of reimbursable costs reported: approximately $11.2 million

Amount identified as ineligible for reimbursement: $803,921

New York Institute for Special Education (2023-S-29)

Audit scope: expenses claimed for fiscal year ended June 30, 2020 and certain expenses claimed for the two fiscal years ended June 30, 2019

Amount of reimbursable costs reported: approximately $17.5 million

Amount identified as ineligible for reimbursement: $3,256,007

UCPA of Cayuga County d.b.a. E. John Gavras Center (2024-S-10)

Audit scope: expenses claimed for fiscal year ended June 30, 2021 and certain expenses claimed for the two fiscal years ended June 30, 2020

Amount of reimbursable costs reported: approximately $4.3 million

Amount identified as ineligible for reimbursement: $625,534

Arc Franklin-Hamilton d.b.a. The Adirondack Arc (2024-S-32)

Audit scope: expenses claimed for fiscal year ended June 30, 2021 and certain expenses claimed for two fiscal years ended June 30, 2020

Amount of reimbursable costs reported: approximately $3.9 million

Amount identified as ineligible for reimbursement: $76,812

State University of New York
(SUNY)

SUNY, the largest comprehensive system of public education in the nation, comprises 64 institutions, including research universities, academic medical centers, liberal arts colleges, community colleges, colleges of technology, and an online learning network. In the fall 2024 semester, SUNY served nearly 377,000 students.

Oversight of the Educational Opportunity Program (2024-S-2)

Objectives: Determine whether SUNY was adequately monitoring the Educational Opportunity program (EOP) and if SUNY and the campuses were using EOP funding for allowed purposes.

Audit Period: July 2019–December 2024

SUNY's EOP provides access, support, and financial aid for disadvantaged students who show the potential to succeed despite poor academic preparation and limited financial resources. The audit found that SUNY was monitoring EOP, and campuses were generally using the funds for allowed purposes. However, auditors identified opportunities for SUNY to improve its oversight of the campuses' use of EOP funds and maintenance of adequate documentation for program-related expenses and services.

Key Recommendations:

- Ensure that campuses participating in EOP are using EOP funds for allowable purposes under the summer program guidance and the Guidelines.
- Ensure that campuses maintain documentation to adequately support EOP expenditures and services and retain that documentation as appropriate.

Follow-Up Reports

Determination of Residency for Tuition Purposes (2023-F-45)

Objective: Determine the extent of implementation of the four recommendations from Report 2019-S-58, which assessed whether SUNY had adequate assurance that campuses were making accurate residency determinations for students and thus charging the correct tuition rates.

Initial Audit Key Findings: SUNY did not have adequate assurance that, at the graduate level, campuses were making accurate residency determinations for students and that students were being charged the appropriate tuition rate. Having greater autonomy in graduate application processing, each of the seven SUNY campuses reviewed applied its own interpretation of the Residency Policy requirements. In many cases, the campuses relied solely on the residency status self-reported by students and did not obtain the proper supporting documentation to verify domicile. Moreover, auditors found potential undercharges totaling $1,343,051 for students who were charged the in-state rate as well as potential overcharges totaling $44,171 for students charged the out-of-state rate. Further, based on a random statistical sample of 1,207 graduate student tuition assessments of the 150,116 total assessments for these seven campuses alone, auditors identified 421 assessments with

either no or inadequate documentation of domicile. Projecting the results of these findings to the total enrollment for each of these campuses, auditors estimated that at least 52,484 graduate student tuition assessments had unsupported residency determinations.

Recommendation Status: 1 implemented, 1 partially implemented, 1 not implemented, 1 not applicable

Oversight of Disability Services (2025-F-7)

Objective: Determine the extent of implementation of the four recommendations from Report 2021-S-42, which assessed whether SUNY adequately provided access to campuses, programs, and services to students with disabilities.

Initial Audit Key Findings: The six campuses reviewed (Binghamton University, Maritime College, Stony Brook University, SUNY Morrisville, SUNY Cobleskill, and SUNY Oneonta) provided academic accommodations, outreach, and training to students and staff about their services and received no complaints regarding discrimination based on a student's disability. However, SUNY Morrisville failed to adequately document that some students didn't complete the disability self-reporting process and there were inconsistencies in how campuses reported students with disabilities within the Higher Education Data System, which is used to collect and distribute information annually on the status of higher education in New York State. Additionally, while the six campuses were ADA-compliant, auditors identified 170 areas where accessibility could be improved.

Recommendation Status: 4 implemented

Transportation

Metropolitan Transportation Authority
(MTA)

The MTA is a public benefit corporation, overseen by a 23-member Board of Directors (Board), providing transportation services in and around the New York City metropolitan area. The MTA has six agencies: New York City Transit (Transit), which operates bus and subway service; MTA Bus Company (MTA Bus), which provides bus services in the Bronx, Brooklyn, and Queens; the Long Island Rail Road (LIRR) commuter railroad; Metro-North Railroad; Triborough Bridge and Tunnel Authority (B&T), which operates seven toll bridges and two tunnels that interconnect parts of New York City; and MTA Construction & Development.

Transformation of the MTA (2022-S-5)

Objective: Determine whether the MTA established a working plan for implementing Transformation with completion dates and the savings to be achieved, and had implemented any aspect of the Transformation Plan (Plan) that resulted in improved service levels for the customer, process efficiencies, and cost reductions.

Audit Period: January 2017–October 2022

In April 2019, the New York State Legislature enacted changes in the Public Authorities Law requiring the MTA and its affiliated entities to develop and complete a personnel and reorganization plan. The legislation expected to transform the organization—through elimination of redundancies, streamlining processes, and greater collaboration—to improve customer service, achieve greater efficiency, and realize cost savings. Auditors found the MTA did not have a working plan for Transformation that identified the tasks to be completed and included specific dates and cost savings. Full Transformation and delivery of the goals the Plan promised—improved customer service, process efficiencies, and cost reductions—were not supported by the work completed or based on documentation provided by the six departments reviewed. Savings called for under the Plan were achieved by eliminating both administrative and operational positions that had been vacant due to a 2018 hiring freeze. No further savings were identified during the audit beyond the removal from the MTA budget of the costs related to the positions that were already vacant.

Key Recommendations:

- Ensure that future projects have a detailed working plan that includes specific dates, activities, and cost savings.
- Ensure that future projects document the status of goals.
- Ensure that future projects document what cost savings are achieved.

MTA Bridges & Tunnels, MTA Bus Company, and New York City Transit - Department of Buses: Risk Assessment and Implementation of Measures to Address Extreme Weather Conditions (2023-S-4)

Objectives: Determine whether the MTA—B&T, MTA Bus, and Transit Bus—identified the potential damage to its transportation systems and developed plans to mitigate the effect of extreme weather conditions and flooding; and whether the plans were tested/updated and the weather-related equipment was inspected/maintained to ensure it can be deployed when needed.

Audit Period: April 2009–July 2023

Inspection and maintenance of B&T and Bus Operations (Transit Bus and MTA Bus) equipment is critical to ensure the system is prepared for future extreme weather events. Both B&T and Bus Operations are required to conduct inspections of their storm equipment and vehicles periodically. Preventive maintenance (PM) is performed to detect or prevent the degradation of vehicles and equipment in order to sustain or extend their useful life. Auditors found that B&T and Bus Operations did not conduct a system-wide risk assessment to identify the potential for damage to their transportation systems. However, both had developed and carried out projects to mitigate the effects of coastal storms and related flooding. Of nine capital projects reviewed, auditors determined that five projects (three B&T and two Bus Operations) spent more than the contract award amount, ranging from $26,558 to $1.6 million over the contract award amount. Of the same nine projects, six did not meet their substantial completion time frame, ranging from one to six months behind schedule. Auditors also determined inspections, PM, and corrective maintenance tasks were not completed as required or were not documented for flood mitigation equipment. Additionally, issues reflected in inspection reports, such as cracks in crash barriers for a portal flood

gate, were not corrected promptly, and subsequent inspection reports indicated worsening damage over time. Auditors also found that vehicle inspections were either not sufficiently documented or were not conducted in accordance with Bus Operations' Winter Operations Plan requirements.

Key Recommendations:

- Periodically update the system-wide assessment, document progress made, and report on any new conditions requiring mitigation.
- Monitor projects to ensure costs do not markedly exceed the contract award amount.
- Maintain and inspect equipment regularly and in a timely manner as required.
- Improve the vehicle PM by recording each PM task completed on the work order and ensuring mileage is recorded and accurate for each vehicle for use in determining required maintenance.
- Clarify in the Winter Operations Plan the responsibility for performing weekly/monthly inspections of snow fighter equipment.

Metro-North Railroad: Mitigation for Extreme Weather Conditions and Flooding (2023-S-5)

Objectives: Determine whether Metro-North performed a system-wide risk assessment to identify potential risks to its system from extreme weather conditions and flooding and developed plans to mitigate their effects; and whether Metro-North tested and updated the plans and inspected/maintained the equipment to ensure they can be deployed when needed.

Audit Period: April 2009–May 2023

Severe winter weather can create hazardous travel conditions throughout the Metro-North region and possibly hamper Metro-North's ability to provide regular train services. Metro-North developed a Winter Storm Plan and a Coastal Storm and Hurricane Plan, which include standard operating procedures to be implemented prior to a storm's arrival, during the storm, and for recovery and post-recovery. Auditors found that Metro-North did not perform a system-wide risk assessment. Further, Metro-North did not have procedures to address all types of severe weather events and did not perform an assessment of its Harlem Line related to flooding due to heavy rains. In addition, its Winter Storm Plan and Coastal Storm and Hurricane Plan do not account for weather conditions such as extreme cold/heat, tornadoes, heavy rains, and lightning. Auditors also found that equipment designed to be deployed during severe weather events—such as snow melters, snow-fighting equipment, snow tractors, snow blowers, and snow brooms—was not always inspected, tested, or maintained in compliance with Metro-North procedures and plans.

Key Recommendations:

- Conduct periodic system-wide assessments of the Metro-North system to observe new or possible increased weather-related risks that could affect the system.
- Revise or develop weather plans that include lightning, extreme heat/cold, heavy rains, and tornadoes.

- Ensure that all required PM events are completed, and update and review the equipment database to ensure equipment maintenance, testing, and inspections are recorded.

Transforming the Procurement Function (2023-S-6)

Objective: Determine whether the MTA took action to comply with the MTA Board-approved Transformation Plan, resulting in improved service levels for the customer, process efficiencies, and reduced costs.

Audit Period: January 2017–August 2023

The MTA was required to "develop and complete a personnel and reorganization plan" (Transformation), and in July 2019, the Board approved a plan to merge all support functions to drive higher service levels at lower costs. The result would be one Procurement Function for MTA's five operating agencies, MTA Construction & Development (formerly MTA Capital Construction), and MTA Headquarters. Auditors found that, while making some improvements, the Procurement Function has not demonstrated that it achieved the objectives of improved service levels for the customer, process efficiencies, and cost reductions. Although the effective date of Procurement Function consolidation was October 2021, it was mostly operating under the same practices in September 2023—almost two years later. While Procurement Operations reported cost savings of $152 million for calendar year 2022, auditors concluded that none of the $37.3 million in savings sampled could be attributed to Transformation or consolidation actions.

Key Recommendations:

- Define and distinguish Transformation-related from non-Transformation-related initiatives required to achieve Transformation goals, and formally monitor the progress toward their completion.
- Clearly define cost savings and cost avoidance for the Procurement Function, and maintain documentation to support the basis for reporting cost savings and cost avoidance.
- Develop and issue new procedures that can be used by all agencies, where appropriate.

LIRR: Implementation of Train Service to Grand Central Madison (2023-S-28)

Objectives: Determine whether LIRR implemented train service to Grand Central Madison (GCM) terminal in a manner that addressed customer needs, and whether LIRR addressed passenger concerns in General Order #202 effective September 5, 2023.

Audit Period: January 2021—November 2023

GCM was built to extend LIRR service to the east side of Manhattan and was projected to cut commute time by as much as 40 minutes per day (round-trip) for some customers and ease overcrowding at Penn Station. Despite LIRR's claims of 41% more train service—adding 271 trains for a total of 936 trains—auditors found only a 23% increase in service across all branches. Of the 271 trains added, only 153 trains represented increases in branch service. The remaining 118 trains were shuttle trains to Brooklyn and did not provide additional branch service. Further, while LIRR stated it takes passenger concerns into account when making changes to the schedule, the changes implemented may not support customer needs, as some passengers may have been required to change their travel times, increasing wait

times and adding more steps to their trips where direct service was eliminated. LIRR also did not document and could not support that changes made adequately factored in passenger feedback.

Key Recommendations:

- Develop a formal mechanism for documenting the receipt and assessment of comments from the public regarding proposed train schedules or other service-planning issues.
- Document actions taken to revise or adjust service and/or the decision not to take action in response to customer feedback.
- Revisit the process to identify the feedback essential to service-planning decisions and document all essential decisions to ensure the efficiency of future decision-making.
- Document the practices used by Service Planning to prepare the timetables to establish policies and procedures.

Follow-Up Reports

Transit and MTA Bus: Management and Maintenance of Non-Revenue Service Vehicles (2024-F-16)

Objective: Determine the extent of implementation of the 11 recommendations from Report 2020-S-31, which assessed whether Transit and MTA Bus maintained an accurate and complete inventory of non-revenue service vehicles, and whether the non-revenue service vehicles received scheduled preventive maintenance (PM), were safeguarded, and were properly disposed of at the end of their useful life.

Initial Audit Key Findings: Transit and MTA Bus did not always adhere to their own guidance or practice to provide light and annual service operations as part of PM on its fleet of vehicles. Vehicles that do not receive recommended maintenance may invalidate the warranty, have a shortened useful life, or be subject to more repairs, resulting in higher costs. In addition, Transit and MTA Bus did not have an inventory system or maintain an accurate and up-to-date inventory of parts purchased to be used to maintain its vehicles. Auditors noted that maintenance costs were $50.5 million, or 21%, over the $41.8 million budgeted.

Recommendation Status: 4 implemented, 2 partially implemented, 5 not implemented

LIRR: Non-Revenue Service Vehicles and On-Rail Equipment (2024-F-17)

Objective: Determine the extent of implementation of the 13 recommendations from Report 2020-S-29, which assessed whether LIRR maintained an asset inventory, performed preventive maintenance (PM), and maintained an accurate inventory of parts required to repair the on-rail equipment.

Initial Audit Key Findings: LIRR lacked formal policies and procedures for maintaining accurate inventories, performing PM, and managing non-revenue vehicle fleet and on-rail equipment, leading to missing documentation, late or incomplete maintenance, and discrepancies in inventory records. Additionally, cost-benefit analysis for vehicle leasing and purchasing was often incomplete, and parts inventory management lacked sufficient controls, increasing the likelihood of asset loss as well as other operational issues.

Recommendation Status: 3 implemented, 4 partially implemented, 6 not implemented

New York State Thruway Authority
(NYSTA)

NYSTA operates the New York State Thruway (Thruway), a 570-mile superhighway that connects the State's principal cities, rural areas, and tourist destinations. The Thruway comprises 496 miles including the mainline from the New York City line at Yonkers to Buffalo and the Erie Section. There are an additional five segments: Niagara Section, Berkshire Section, New England Section, Garden State Parkway Connector, and Cross Westchester Expressway. It has 817 bridges, 137 interchanges, and 27 travel plazas. NYSTA is vested by New York State laws and regulations to assess and collect toll revenues for use of the Thruway.

Selected Aspects of Toll Collections (2023-S-25)

Objective: Determine whether NYSTA ensured that Thruway users are accurately billed for the correct amounts and that customer billing issues are addressed.

Audit Period: January 2019–October 2023

In November 2020, NYSTA completed a system-wide conversion to cashless tolling using the E-ZPass system. Tolls may be charged through NY E-ZPass, Non-NY E-ZPass, or Tolls By Mail. NYSTA also offers discounts or non-revenue plans to specific categories of customers, allowing them to travel on the Thruway at a lower cost or without paying tolls. While NYSTA generally ensured accurate billing, auditors found exceptions that highlight the need for error monitoring and corrective actions. NYSTA also lacks thorough documentation to support fee reductions, eligibility verification for certain toll discounts for residents, and non-revenue E-ZPass tags, as well as effective procedures for handling undeliverable mail containing invoices and past due notices.

Key Recommendations:

- Periodically review transactions to ensure tolls were correctly charged, identify the cause of incorrect charges, take appropriate action to prevent it from recurring, and document those where no action is deemed necessary.
- Follow NYSTA policies for violation fee reductions and waivers. If exceptions are warranted, document the reasons why.
- Maintain documents to support the initial and continued eligibility for non-revenue and resident discount tags, and periodically recertify the eligibility of these customers.
- Establish a system to internally flag undeliverable mail to owners of New York and Massachusetts registered vehicles and notify the Department of Motor Vehicles of returned correspondence.

Government Support

Department of Civil Service
(Civil Service)

Civil Service is the principal human resources provider for the Executive Branch of State Government, serving approximately 150,000 employees. It also administers the New York State Health Insurance Program (NYSHIP), which covers more than 1.1 million current and retired State and local government employees and their family members. NYSHIP's primary health insurance program is the Empire Plan, which costs the State and local governments about $13.1 billion each year. Civil Service contracts with several companies to administer different coverage components, including Empire BlueCross (now Anthem Blue Cross) to administer the Hospital Program of the Empire Plan and UnitedHealthcare Insurance Company of New York (United) to administer the Medical/Surgical Program. It also contracts with CVS Caremark (a subsidiary of CVS Health) to administer the Prescription Drug Program. The Prescription Drug Program includes a Commercial Plan for members and their dependents who do not qualify for Medicare and the Empire Plan Medicare Rx drug plan (Medicare Rx Plan) for retired members and their dependents who do qualify for Medicare.

New York State Health Insurance Program

CVS Caremark: Accuracy of Empire Plan Commercial Rebate Revenue Remitted to the Department of Civil Service (2023-S-42)

Objective: Determine if CVS Caremark appropriately invoiced drug manufacturers and remitted corresponding rebate revenue to Civil Service for prescription drugs provided under the Empire Plan.

Audit Period: January 2019–December 2022

During the audit period, CVS Caremark processed and paid over 126 million pharmacy claims totaling over $13.1 billion. CVS Caremark was contractually required to utilize the Empire Plan's significant enrollment to maximize savings to the Prescription Drug Program by negotiating agreements with drug manufacturers for rebates, discounts, and other consideration (collectively, "rebates") and remit the rebate revenue to Civil Service. The audit found that CVS Caremark did not always invoice drug manufacturers for rebates or collect and remit all rebate revenue to Civil Service. Based on judgmental samples of 10 manufacturers and 25 drugs, auditors identified $1,160,286 in rebate revenue that is due to Civil Service from CVS Caremark.

Key Recommendations:

- Review the $1,160,286 in drug rebate revenue identified as due to Civil Service, and remit as warranted.
- Take corrective steps to ensure all the Empire Plan's rebate-eligible drug utilization is invoiced, collected from the drug manufacturers, and remitted in a timely manner to Civil Service.

Follow-Up Reports

CVS Health: Accuracy of Empire Plan Medicare Rx Drug Rebate Revenue Remitted to the Department of Civil Service (2024-F-24)

Objective: Determine the extent of implementation of the two recommendations included in Report 2022-S-1, which assessed if CVS Health appropriately invoiced drug manufacturers and remitted corresponding rebate revenue to Civil Service for prescription drugs provided under the Empire Plan Medicare Rx drug benefit.

Initial Audit Key Findings: Auditors found that CVS Health did not always invoice drug manufacturers for rebates, collect rebates from the manufacturers, or remit all rebate revenue to Civil Service. They identified $10,723,916 in rebates that is due Civil Service from CVS Health.

Recommendation Status: 1 partially implemented, 1 not implemented

Empire BlueCross: Overpayments for Physician-Administered Drugs (2024-F-34)

Objective: Determine the extent of implementation of the seven recommendations from Report 2021-S-33, which assessed whether Empire BlueCross (now Anthem Blue Cross) appropriately reimbursed physician-administered drugs.

Initial Audit Key Findings: Auditors identified over $2.7 million in actual and potential overpayments for physician-administered drugs: $1,690,853 was paid under both the Hospital Program and the Prescription Drug Program, and $45,546 in related payments were incorrectly processed when Empire BlueCross paid the full price even though facilities billed $0.01 (no-cost drugs); and $1,040,111 was paid for drugs that were billed out of compliance with guidelines (such as billing for more drug units than allowed and inadequate supporting documentation).

Recommendation Status: 2 implemented, 4 partially implemented, 1 not implemented

UnitedHealthcare Insurance Company of New York: Overpayments for Physician-Administered Drugs (2024-F-35)

Objective: Determine the extent of implementation of the eight recommendations from Report 2021-S-32, which assessed whether United appropriately reimbursed physician-administered drugs.

Initial Audit Key Findings: Auditors identified over $5.5 million in actual and potential overpayments for physician-administered drugs, including $4,019,329 paid under both the Medical/Surgical and Prescription Drug Programs; $1,194,719 paid in excess of provider-contracted rates; $179,190 paid for drugs in excess of maximum allowable dosage limits; and $143,299 in duplicate payments.

Recommendation Status: 1 implemented, 6 partially implemented, 1 not implemented

Incorrect Payments by CVS Caremark for Medicare Rx Drug Claims That Were Improperly Paid Under the Commercial Plan (2025-F-1)

Objective: Determine the extent of implementation of the three recommendations included in Report 2022-S-24, which assessed whether CVS Caremark paid claims under the correct prescription drug plan.

Initial Audit Key Findings: Claims paid under the Medicare Rx Plan are eligible for enhanced drug manufacturer discounts and federal subsidies that are not available for claims paid under the Commercial Plan. For the period January 2015 through March 2022, auditors identified claims totaling $12,358,531 that were incorrectly paid under the Commercial Plan instead of the Medicare Rx Plan.

Recommendation Status: 3 partially implemented

Office of Information Technology Services
(ITS)

As the State's centralized technology agency, ITS provides statewide IT strategic direction, directs IT policy, and delivers centralized IT products, services, and solutions, including the procurement, distribution, and maintenance of technical equipment for State employees.

Inventory Controls (2023-S-17)

Objective: Determine whether ITS had adequate controls to ensure the accuracy and completeness of inventory records, accountability for inventory transactions, and safeguarding of inventory.

Audit Period: March 2020–August 2024

ITS is responsible for maintaining an accurate inventory of all information assets, including all workstations (desktop and laptop computers), virtual desktops, printers, scanners, mobile devices, and additional specialized equipment, as well as any digital programs or systems needed to support various job functions. To manage the vast inventory, ITS utilizes Information Technology Service Management (ITSM) software as its centralized system of record. The audit found that ITS did not have the necessary controls in place to accurately and completely account for all workstations and other hardware assets for which it is responsible. Auditors also found significant weaknesses related to ITSM accuracy, as well as missing devices, and a lack of security over equipment and the information stored on devices at ITS stockrooms.

Key Recommendations:

- Conduct a comprehensive review and cleanup of ITSM data to ensure accuracy and completeness, and implement ongoing quality reviews of ITSM data to maintain integrity.
- Improve oversight and monitoring of stockrooms.
- Maintain an accurate and complete inventory of workstations and other equipment available to ensure efficient use of resources and prevent waste of equipment and taxpayer money.

- Formally evaluate the current practice of destroying new and lightly used equipment, and determine if these devices could be resold or donated.
- Implement the recommendation detailed in our preliminary findings to strengthen technical controls over the selected systems reviewed.
- Continue to improve the timeliness of cooperation with authorized State oversight inquiries to ensure transparent and accountable agency operations.

Follow-Up Report

Windows Domain Administration and Management (2024-F-12)

Objective: Determine the extent of implementation of the six confidential recommendations from Report 2022-S-19, which assessed whether ITS had security controls in place to ensure appropriate management and monitoring of its Active Directory environment.

Initial Audit Key Findings: ITS did not have certain security controls in place, according to several ITS policies and standards, to ensure appropriate management and monitoring of its Active Directory environment. Due to the confidential nature of the audit findings, auditors communicated the details of these findings with six recommendations in a separate, confidential report to ITS for review and comment.

Recommendation Status: 3 implemented, 2 partially implemented, 1 not implemented

Criminal Justice and Judicial Administration

Department of Corrections and Community Supervision
(DOCCS)

DOCCS is responsible for the confinement and rehabilitation of approximately 31,000 individuals under custody held at 44 State facilities and the supervision of over 27,000 parolees throughout seven regional offices statewide.

Follow-Up Report

Controls Over Tablet and Kiosk Usage by Incarcerated Individuals (2024-F-28)

Objective: Determine the extent of implementation of the seven recommendations from Report 2022-S-8, which assessed whether DOCCS provided sufficient oversight to ensure that the independent network, kiosks, and tablets used by Incarcerated Individuals (Individuals) were secure, and whether secure messaging accessed by them complied with DOCCS directives.

Initial Audit Key Findings: Due to inadequate oversight, DOCCS had limited assurance of compliance with its directives. Specifically, DOCCS did not know how many Individuals opted in/out of the tablet program and did not internally monitor the number of active tablets at its facilities. Additionally, DOCCS did not verify the identity of community members in correspondence with Individuals through secure messaging, and its secure message content

screening process did not adequately capture all the risks to Individuals and others. Further, DOCCS was not adequately overseeing the security and configurations of certain assets and did not ensure systems were maintained at vendor-supported levels required to preserve the accuracy and integrity of DOCCS information.

Recommendation Status: 1 implemented, 3 partially implemented, 3 not implemented

Economic Development and Housing

Empire State Development
(ESD)

ESD promotes the State's economy, encourages business investment and job creation, and supports local economies through the efficient use of loans, grants, tax credits, real estate development, marketing, and other forms of assistance.

COVID-19 Pandemic Small Business Recovery Grant Program (2023-S-10)

Objectives: Determine whether ESD awarded funds according to COVID-19 Pandemic Small Business Recovery Grant Program (Program) eligibility requirements, and whether ESD established performance measures to assess the impact of the awards.

Audit Period: April 2021–January 2023

The Program was intended to support small businesses or for-profit independent arts and cultural organizations impacted by the COVID-19 pandemic that either did not qualify for federal assistance programs or that received inadequate federal COVID-19 support. ESD reported receiving over 168,000 applications, with just over 75,200 being fully completed and submitted. ESD awarded the entirety of the $760 million allocated for small businesses ($40 million was allocated for administrative expenses) to 40,842 applicants, with an average grant amount of $18,608. Auditors found ESD needed to improve controls for monitoring eligibility of grant recipients and enhance practices for award distribution. Among other findings, almost $4.1 million was awarded to 101 businesses that were ineligible because they had already received assistance from federal business assistance programs. Further, ESD did not consider business type, need, or factors established in the original goals of the Program when awarding grants, instead favoring a first-come, first-served methodology, with little consideration of other factors to ensure the funds were going to businesses or industries most impacted by the pandemic. As a result, almost 50% of the awarded businesses (19,752) were sole proprietor transportation businesses without employees (ride share drivers), and they received a combined grant amount of $184,493,238. Additionally, while the Program encouraged participation from micro-businesses, socially and economically disadvantaged business owners, minority- and/or women-owned businesses, and small businesses that did not receive adequate federal COVID-19 support, women-owned businesses accounted for only 19% of funded businesses but represented 39% of the unfunded businesses, and low–middle income applicants accounted for 30% of the funded recipients but represented 70% of the unfunded population. Further, ESD did not establish a process to meaningfully measure whether the Program achieved its intended goals or its impact on businesses, and

there is limited assurance that the Program met its goals outside of distributing funds to businesses.

Key Recommendations:

- Develop and implement enhanced application review and award practices for grants administered by ESD. This may include, but not be limited to: utilizing relevant publicly available data sources; working with federal or other applicable government partners to obtain relevant information on eligibility criteria; and incorporating relevant elements into award selection methodology, including, but not limited to, areas outlined in the Program's goals.
- Establish a process or practice to measure performance of grants administered by ESD.
- Recover Program funds that were awarded to ineligible businesses as appropriate.

Follow-Up Report

Oversight of Select High-Technology Projects (2024-F-19)

Objective: Determine the extent of implementation of the three recommendations from Report 2017-S-60, which assessed whether ESD adequately monitored selected high-tech economic development programs and projects it oversees and whether these projects were achieving the intended employment goals.

Initial Audit Key Findings: ESD provided millions of dollars to private companies in high-tech sectors with the ultimate goal of creating jobs and increasing private investment. While ESD had effective practices for monitoring specific programs, it did not adequately monitor high-tech projects within the SUNY Polytechnic and/or Buffalo Billion portfolio to ensure that taxpayer money was effectively spent and was producing the intended results. Despite millions of dollars of State funding, selected high-tech projects had yet to create the expected number of jobs.

Recommendation Status: 1 implemented, 2 partially implemented

Division of Human Rights
(DHR)

DHR enforces the New York State Human Rights Law (Law) through investigation, prosecution, and adjudication of discrimination cases; educates the public about their rights and responsibilities; and proposes policy and legislation. Each year, DHR handles thousands of active cases and reaches more than 5 million New Yorkers across the State with information on their rights and protections.

Investigation of Housing Discrimination Complaints (2023-S-26)

Objective: Determine whether DHR reviewed and addressed housing discrimination complaints timely and in accordance with its policies and procedures and the related laws.

Audit Period: April 2019–February 2024

DHR is responsible for investigating, prosecuting, and adjudicating discrimination cases—including housing discrimination complaints—in a timely manner and in accordance with its policies and procedures and related laws. The audit found that DHR did not have adequate controls over the intake of housing discrimination complaints, resulting in lost and unprocessed complaints as well as some complaints inappropriately being deemed defective. DHR also hadn't developed procedures to ensure complaints were processed and investigated in a timely manner. DHR also failed to develop adequate policies, training, and guidelines for handling submitted complaints. Also, DHR investigators were not properly trained and supervised, resulting in no assurance that investigators followed investigation requirements before closing complaints. Additionally, DHR improperly prioritized U.S. Department of Housing and Urban Development cases, for which it received reimbursement, over non-federal cases.

Key Recommendations:

- Establish adequate internal controls over the handling, processing, and investigation of all complaints—including those deemed defective—and ensure that all complaints are handled on time and appropriately, including: developing and implementing comprehensive written procedures that include a streamlined process for handling and tracking all incoming housing discrimination complaints in a timely and consistent manner; monitoring and segregating the duties of the staff responsible for logging, tracking, and completing the initial review of complaints; conducting ongoing reconciliations of DHR's various intake logs with Case Management System records; providing adequate training for all staff involved in the complaint intake, processing, and investigation process; and actively monitoring DHR's intake and investigation procedures to ensure that complaints—including those marked as defective and as non-federal cases—are handled on time and appropriately.
- Improve oversight of the investigation process to identify reasons for delays in case processing times and ensure case determinations are consistent and accurate.
- Investigate complaints in the order in which they were filed, regardless of federal status, to ensure all investigations are initiated within 30 days.

Homes and Community Renewal
(HCR)

HCR is New York's affordable housing agency, with a mission to build, preserve, and protect affordable housing and increase homeownership throughout the State. HCR is composed of several different offices and agencies, including: the Division of Housing and Community Renewal (DHCR), which oversees Mitchell-Lama developments, and the Housing Trust Fund Corporation (HTFC), through which HCR receives funding from the U.S. Department of Housing and Urban Development (HUD).

Internal Controls Over the Governor's Office of Storm Recovery's (GOSR) Federally Funded Programs (2022-S-37)

Objective: Determine whether HCR established and maintained adequate internal controls to oversee and monitor GOSR's federally funded programs to ensure they meet grant requirements.

Audit Period: April 2017–December 2022 and April 2017–January 2023, respectively, for the two programs audited and agency actions through August 2023.

GOSR, which operates within the HTFC, was established as a temporary agency to coordinate and direct statewide administration of federal Community Development Block Grant Disaster Recovery Program funds for recovery and rebuilding efforts in storm-affected municipalities across the State. Auditors identified potential weaknesses in GOSR's methods for determining applicant eligibility to receive assistance and in determining award amounts. There were also delays in the redevelopment of some properties and weaknesses in GOSR's practices related to both recapturing funds and handling uncollectible accounts. The implications and significance of the findings warrant prompt and appropriate action to better manage the remaining open projects and to inform other HCR housing programs.

Key Recommendations:

- Revise practices, which could include amending policies and procedures, to provide greater assurance that GOSR Disaster Recovery program funds are awarded only to eligible applicants and for eligible properties and are accurately calculated, including making appropriate adjustments for duplication of benefits.
- Take steps to prevent potential losses of federal funds, including proactively addressing project delays that may lead to undeveloped properties and subsequent recapture efforts and uncollectibility determinations.

HTFC: Oversight of the Rural Rental Assistance Program (RRAP) (2023-S-53)

Objective: Determine whether project owners were receiving RRAP payments only for eligible units and were properly maintaining the units for which they received RRAP payments, and whether HTFC was engaging in adequate outreach activities to make sure the program was reaching rural areas throughout the State.

Audit Period: April 2019–June 2024

The RRAP, which HTFC administers in partnership with the U.S. Department of Agriculture (USDA), provides rental subsidies for low-income elderly and family tenants residing in multi-family properties in rural areas of the State. Overall, auditors determined that HTFC is making program payments to property owners for the correct number of units and that units and projects were maintained properly by project owners. However, there were opportunities for HTFC to better ensure it receives all the information it should from USDA that would allow HTFC to sufficiently monitor individual projects.

Key Recommendations:

- Obtain and continue to receive the results of USDA triennial supervisory reviews in accordance with the memorandum of understanding.

- Work with USDA to clarify language in the memorandum of understanding to reflect current practices, including but not limited to, providing HTFC with the results of reviews conducted by USDA's contractor.

Follow-Up Reports

HTFC: Internal Controls Over and Maximization of Federal Funding for Various Section 8 Housing Programs and the COVID Rent Relief Program (2024-F-21)

Objective: Determine the extent of implementation of the four recommendations from Report 2022-S-28, which assessed whether HCR had established and maintained adequate internal controls to oversee and monitor the federally funded Section 8 Housing Choice Voucher (HCV) Program, Section 8 Performance-Based Contract Administration Program, and COVID Rent Relief Program to ensure they meet requirements; and whether HCR was obtaining federal reimbursements on time and in a manner that recovers all eligible costs.

Initial Audit Key Findings: HCR was not fully utilizing its HUD-authorized HCV vouchers or budget to help families in need of housing assistance. HCR did not meet HUD's voucher utilization threshold during any year covered by the initial audit scope, despite having significant reserves available to improve utilization. Further, HCR could not fully reconcile its HCV financial figures, including funding available, reserves, and spending. Further, auditors found several areas that HCR could improve to better address health and safety concerns, which could otherwise potentially result in injury to tenants and in HUD recouping excess reserves or reducing allocations for future award years.

Recommendation Status: 2 implemented, 1 partially implemented, 1 no longer applicable

Physical and Financial Conditions at Selected Mitchell-Lama Developments in New York City (2024-F-30)

Objective: To assess the extent of implementation of the nine recommendations from Report 2022-S-9, which assessed whether tenants living in Mitchell-Lama developments supervised by DHCR were provided safe and clean living conditions, and whether funds were properly accounted for and used for intended purposes.

Initial Audit Key Findings: DHCR did not adequately oversee the physical and financial conditions at four sampled developments, likely causing management at those developments to misspend funds and fail to provide a safe and clean living environment for their residents. Auditors observed hazardous conditions at the four developments; DHCR also identified hazardous conditions during its own visits but often did not share its findings with the developments in a timely manner. All four developments misspent funds under DHCR's watch. Additionally, DHCR reported inaccurate information to the Legislature, State Comptroller, and Attorney General in the required Annual Report on Mitchell-Lama Housing Companies in New York State.

Recommendation Status: 1 implemented, 6 partially implemented, 2 not implemented

Other State Agencies and Public Authorities

Department of Agriculture and Markets
(AGM)

AGM promotes New York State agriculture and its high-quality and diverse products; fosters agricultural environmental stewardship; and safeguards the State's food supply, land, and livestock to ensure the viability and growth of New York's agriculture industries.

Farmland Protection Program (2023-S-19)

Objective: Determine whether AGM was adequately administering and promoting the Farmland Protection Program (Program) to protect agriculturally viable farmland in the State.

Audit Period: April 2019–April 2024 and preserved acre data going back to April 2005.

Farmland Protection Implementation Grants account for over 98% of all funds awarded through the Program and provide financial assistance to eligible entities (counties, municipalities, soil and water conservation districts, and land trusts) to enable them to implement farmland protection activities. Grants awarded by AGM have helped preserve approximately 114,000 acres of farmland, involving almost 400 farms between 2005 and 2023. While regions vary significantly in grant eligibility, land values, farmland availability, and Program participation, the audit found initially allocating funds equally across regions, without considering these regional factors, may contribute to delays in awarding grant funds for farmland preservation. Additionally, the $2 million cap, set by AGM in 2014, has a greater impact on regions with higher land values and greater development pressures. Lastly, rising land values and funding constraints make it increasingly challenging for the Program to compete with other developmental pressures.

Key Recommendations:

- Evaluate the Farmland Protection Implementation Grant allocation and funding methodology and determine whether changes should be made in the distribution of funds and Program participation. The evaluation should include, but not be limited to, considering: revising the regional allocation methodology; increasing grant funding caps; and incorporating relevant data, such as the U.S. Department of Agriculture Census and AGM historical data, into grant decisions.
- Work with various stakeholders to tailor outreach and administrative support activities to best serve their needs and promote participation in the Program.

Department of Environmental Conservation
(DEC)

As the State's environmental regulatory agency, DEC's mission is to conserve, improve, and protect New York's natural resources and environment and to prevent, abate, and control water, land, and air pollution.

Brownfield Cleanup Program (2022-S-26)

Objective: Determine if DEC was effectively administering and monitoring the Brownfield Cleanup Program in accordance with requirements.

Audit Period: January 2019—January 2025

DEC's Brownfield Cleanup Program (Brownfield Program) was established to encourage and accelerate voluntary private-sector cleanup and redevelopment of brownfield sites through incentives including technical assistance, tax credits, and liability relief to assist developers in cleanup efforts. DEC formalizes program participation with applicants by entering into a Brownfield Cleanup Agreement (Agreement) outlining site investigation and cleanup objectives. Distinct from the voluntary Brownfield Program, the Inactive Hazardous Waste Disposal Site Program (Superfund Program) is DEC's enforcement program, with a goal of ensuring that hazardous waste sites that pose a significant threat to public health or the environment are properly addressed. While time needed to complete remediation varies based on the type, scope, and severity of contamination, auditors identified some sites in the Brownfield Program that posed significant threats to health and the environment where delays did not appear to be reasonable. Auditors reviewed 518 active Brownfield Program sites and determined 86 (17%) have been active for more than 10 years. Of the 25 sites reviewed that had been in the program between 17 and 19.5 years, DEC indicated that four (16%) posed a significant threat to the public health or environment and had significant delays. Additionally, between September 2018 and July 2024, auditors identified 27 sites that entered the Brownfield Program and had remedial activity that could have possibly been remediated through the Superfund Program, but whose owners chose to apply for the Brownfield Program after receiving notification from DEC of the option to do so.

Key Recommendation:

- Develop policies or guidance that communicate to project managers more specific criteria and time frames for determining appropriate progress and possible actions to ensure effective and timely cleanup for sites that pose a significant threat to health and the environment. The policies or guidance should include direction on when program termination should be considered and what circumstances might constitute lack of progress, especially in cases where DEC determines the applicant is not acting in good faith to adhere to the Agreement.

Oversight of Dam Safety (2023-S-16)

Objective: Determine if DEC was adequately regulating dam owners across the State to ensure their compliance with safety requirements.

Audit Period: January 2020–October 2024

DEC is entrusted with the regulatory power over approximately 6,500 dams located throughout the State. Auditors found DEC could increase compliance and improve enforcement against dam owners that fail to submit required documentation used for identifying deficiencies and corrective actions and that facilitates DEC's review of dam owners' emergency response procedures. Further, DEC's enforcement procedures did not include steps to act against owners that did not comply with these regulatory requirements.

Although DEC implemented a process to assign condition ratings (indicating the condition of a dam based on structural safety) to Hazard Class B and C dams (dams that pose the greatest risks in the event of dam failure) as of March 2024, 220 of the 843 (26%) Hazard Class B and C dams had not been assigned a rating. Although assigning condition ratings is not a prerequisite to enforcement, these ratings better enable DEC's efforts to implement enforcement actions because certain condition ratings require the dam owner to act. Lastly, DEC could improve the timeliness of inspections and establish time frames for the completion of inspection reports to ensure that inspection results are communicated in a timely manner.

Key Recommendation:

- Improve regulation of dam owners in New York State, which may include but not be limited to: completing and implementing enforcement procedures for dam owners that fail to operate and maintain a dam in a safe condition and fail to submit required documents to DEC as necessary; assigning condition ratings to Hazard Class B and C dams and updating DEC's database accordingly; increasing the number of timely inspections in alignment with DEC's goals for Hazard Class B and C dams; and establishing time frames for the completion of inspection reports.

Department of Labor
(DOL)

DOL enforces New York Labor Laws that protect workers, assists the unemployed, and helps connect job seekers with jobs.

Oversight of Registered Apprenticeship Programs (2023-S-33)

Objective: Determine whether DOL was providing adequate oversight of registered apprenticeship programs.

Audit Period: Programs active April 2019–August 2024 and activities related to those Programs through March 2025.

DOL oversees registered apprenticeship programs (Programs), which are formal training relationships between an employer and employee (apprentice), during which the apprentice learns a trade. Entities that offer Programs are referred to as Sponsors. According to regulations issued by DOL, all Program applications are subject to a due diligence review, including determination of the applicant's compliance with State and federal laws and regulations; provision for equal opportunity in employment; and ability to employ, train, and instruct apprentices. DOL will also conduct a review of the applicant's history of liens and judgments to determine if it has shown the fiscal responsibility necessary to continue the Program through to graduation. Programs are monitored by DOL Apprenticeship Training Representatives (ATRs), who conduct and report on monitoring visits. Certain approved employers are eligible for the Empire State Apprenticeship Tax Credit (ESATC) program, which provides refundable tax credits against New York State income or franchise tax to eligible employers who register qualified apprentices with an approved Program. Auditors identified that DOL's time to approve some Program applications submitted during the audit period was excessive, ranging from one to more than three years. For some approved

applications, DOL couldn't provide documentation that the required due diligence review was done; for others, where the due diligence review identified issues, DOL couldn't provide sufficient evidence to support that the issues were resolved. Additionally, DOL issued ESATC certificates to some employers that may not have been eligible for them and ATRs didn't conduct monitoring visits as frequently as called for in DOL guidance. Auditors also found database weaknesses that hinder DOL's effective oversight of Programs.

Key Recommendations:

- Reduce the time to approve apprenticeship Program applications.
- Incorporate regular communication about new trades and the ESATC program into ATR monitoring practices and document relevant results to inform decision-making.
- Improve practices for conducting monitoring visits and completing monitoring reports.
- Enhance practices to improve apprenticeship data collection and reliability, which could include collecting estimated completion dates and reasons for deregistration and improving the accuracy of apprentice status data (e.g., active, exited).
- Develop and implement a mechanism to identify Programs with low completion rates.

Follow-Up Report

Services to Workers Under the Worker Adjustment and Retraining Notification (WARN) Act (2024-F-22)

Objective: Determine the extent of implementation of the four recommendations from Report 2022-S-11, which assessed whether DOL was providing appropriate and timely services to workers affected by closings and layoffs that are covered under the WARN Act, and whether it was effectively overseeing employer compliance with the Act.

Initial Audit Key Findings: Auditors identified several areas that DOL could improve to better meet its obligations under the WARN Act. Specifically, there were weaknesses in DOL's oversight of employer compliance with the advance warning requirement. The audit also identified examples of WARN Notices that were not entered into the system DOL used to record related services to employers and affected employees. Further, DOL staff were often late in attempting initial outreach to employers that submitted WARN Notices and to affected employees, and in some cases, there was no record of any outreach.

Recommendation Status: 3 implemented, 1 partially implemented

Department of Motor Vehicles
(DMV)

DMV is responsible for issuing secure identity documents, delivering essential motor vehicle and driver-related services, and administering motor vehicle laws enacted to promote safety and protect consumers.

Assessable Expenses of Administering the Motor Vehicle Financial Security Act and the Motor Vehicle Safety Responsibility Act for the State Fiscal Year Ended March 31, 2024 (2024-M-2)

Objective: Ascertain the total expenses incurred in administering the Motor Vehicle Financial Security Act and the Motor Vehicle Safety Responsibility Act (collectively, Acts).

Audit Period: April 1, 2023–March 31, 2024

The Acts help ensure that operators of motor vehicles driven in New York State possess adequate insurance coverage, or are financially secure, to compensate those persons they might injure or whose property they might damage as a result of an accident. The DMV is responsible for tracking the expenses of administering the Acts and assessing these expenses on insurance carriers that issue policies or contracts of automotive bodily injury insurance. Auditors performed certain procedures, which were agreed to by DMV, to ascertain the expenses incurred in administering the Acts for the State Fiscal Year ended March 31, 2024. Expenses to administer the Acts for the State Fiscal Year totaled $33.2 million.

Key Recommendations: None

Follow-Up Report

Language Access Services (2024-F-33)

Objective: Determine the extent of implementation of the five recommendations from Report 2022-S-38, which assessed whether DMV was adequately serving the needs of individuals with Limited English Proficiency (LEP), including complying with Executive Order 26.1 and New York State Executive Law Chapter 18, Article 10, Section 202-A.

Initial Audit Key Findings: Pursuant to Executive Law, DMV published a Language Access Plan (Plan) that sets forth DMV's planned actions to ensure meaningful access to their services for LEP New Yorkers. However, the audit found that State and county DMVs were not following aspects of DMV's Plan, including not using the contracted vendor (Language Line) for interpretation services. Further, due to gaps in the law, DMV did not have sufficient authority to enforce its language access policies at county DMVs despite these offices accounting for over 75% of the total customer-facing DMV offices. Also, DMV relied only on Language Line data to assess additional language needs and did not track any statistics of LEP customers served outside of those Language Line calls.

Recommendation Status: 2 implemented, 3 partially implemented

Erie County Medical Center Corporation
(ECMCC)

ECMCC, a health care provider and academic medical center in Western New York, specializes in services including oncology, transplantation, behavioral health, primary care, and more than 30 outpatient specialty services. ECMCC is recognized as a verified Level 1 Adult Trauma Center and serves as a regional hub for burn care and rehabilitation. ECMCC is also a teaching facility affiliated with the University at Buffalo.

Security Over Critical Systems (2023-S-48)

Objective: To determine whether the security over ECMCC's critical systems was sufficient to minimize the various risks associated with unauthorized access to systems and data.

Audit Period: December 2023–December 2024

ECMCC's Healthcare Information Security Officer (HISO) oversees the daily management of the Information Security Program and is responsible for developing and implementing its long-term strategy. In 2024, the HISO identified eight critical systems and 24 essential applications vital for its core operations, consisting of electronic medical records for both primary and outpatient care, employee location tracking, imaging systems, medication, and dosage platforms as well as various databases and laboratory services. Auditors identified areas where ECMCC could improve certain security controls to minimize the various risks associated with unauthorized access to its systems and data. Due to the confidential nature of the audit findings, the details of these findings with eight recommendations were communicated in a separate, confidential report to ECMCC.

Key Recommendation:

- Implement the eight recommendations included in the confidential draft report.

Hudson River-Black River Regulating District *(HRBRRD)*

HRBRRD constructs, maintains, and operates reservoirs in the upper Hudson River and Black River watershed, including the Sacandaga, Indian, Black, Moose, and Beaver rivers, for the purpose of regulating the flow of streams or rivers when required by public welfare, including public health and safety.

Follow-Up Report

Security Over Critical Systems (2025-F-5)

Objective: Determine the extent of implementation of the one recommendation from Report 2023-S-24, which assessed whether security over HRBRRD's critical systems was sufficient to minimize the various risks associated with unauthorized access to systems and data.

Initial Audit Key Findings: Auditors found HRBRRD demonstrated effort and timeliness in addressing security issues as they arose. Further, HRBRRD had generally taken appropriate steps to secure processes and systems used to accept credit card payments. However, auditors identified areas where HRBRRD could improve to better meet Payment Card Industry Data Security Standards requirements, including documenting certain policies and procedures.

Recommendation Status: 1 implemented

Workers' Compensation Board
(WCB)

The WCB's mission is to protect the rights of employees by ensuring the proper delivery of benefits and by promoting compliance with the Workers' Compensation Law.

Assessment of Costs to Administer the Workers' Compensation Program for the Three State Fiscal Years Ended March 31, 2023 (2024-M-1)

Objective: Ascertain the total expenses that the WCB incurred in administering the Workers' Compensation Program (Program).

Audit Period: Three State Fiscal Years ended March 31, 2023

Auditors performed certain procedures, which were agreed to by the WCB, to ascertain the WCB's expenses to administer the Program for the three State Fiscal Years ended March 31, 2023. Annual expenses to administer the Program averaged about $214.1 million.

Key Recommendations: None

Cross-Agency Programs

State Public Health Emergency Medical Stockpile (2023-S-14)

Agencies: Department of Health (DOH), Office of General Services (OGS)

Objective: Determine what steps DOH and OGS took during the procurement process for medical equipment for public health emergencies to ensure usability of the equipment purchased and whether DOH and OGS managed and maintained—in functioning condition—the inventory of the State's medical stockpile.

Audit Period: January 2020–June 2024

DOH's Office of Health Emergency Preparedness (OHEP) is responsible for coordinating and managing all activities for public health and health care facility emergency preparedness, including purchasing, receiving, maintaining, and managing DOH's Medical Emergency Response Cache (MERC), which includes pharmaceuticals and medical supplies, beds, ventilators, and other durable medical equipment (DME), and personal protective equipment. OGS, as the State's centralized procurement office, has established Procurement Guidelines to guide agencies in procurement decision-making. To compete for the purchase of medical equipment to protect the public health and prepare health care facilities during the onset of the pandemic, the State took steps to expedite its procurement process, out of alignment with OGS' guiding principles, with the former executive chamber dictating the procurement orders. As a result, OHEP was often unaware of and unable to account for what had been purchased. Auditors determined that, of 247,394 items DOH either procured (247,343 items at a cost of $452.8 million) or acquired, only 324 items were distributed during the public health emergency, including only three of the 247,343 DME that DOH purchased. Auditors also found a significant amount of DME purchased during the pandemic (247,340 items) still unused in boxes at MERC or other warehouses, for which the State continues to incur contracted warehouse management costs.

Key Recommendations:

DOH:

- Maintain basic internal controls during emergency scenarios to ensure stewardship over State assets that address concepts such as conducting transactions in an ordinary manner, recording transactions, effective communication, and documenting receipt of purchases.
- Document and preserve the process and/or key factors used when making significant decisions, and keep documentation of key events, such as the Steering Committee's recommendation of DME to be retained and to receive preventive maintenance.
- Develop and implement a statewide public health strategic plan to utilize surplus DME.
- Develop and implement a strategic plan for DME preventive maintenance so that it is ready and reliable for use during public health emergencies.

OGS:

- Develop and issue statewide guidance for State agency procurements during declared State emergency disasters in conjunction with the State Procurement Council.

Next Generation 911 (NG911) Services (2023-S-40)

Agencies: Division of Homeland Security and Emergency Services (DHSES), Office of Information Technology Services (ITS)

Objective: Determine if DHSES was effectively overseeing the development and implementation of New York State's Next Generation 911 plan, and whether ITS had controls in place to ensure that data used by 911 systems is adequately secured and conforms with the format and standard for Next Generation 911.

Audit Period: January 2021–December 2024, State Interoperable and Emergency Communication Board (Board) meeting minutes dating back to 2018, and the 2019 New York Statewide Communication Interoperability Plan.

The 911 emergency communications system, which dates back to the late 1960s, is built upon legacy analog infrastructure that is still used in many areas in the State. Limitations in its capabilities have been addressed with newer NG911 technology, with enhanced capabilities that include voice, photos, videos, and text messages and allow emergency calls to be rerouted to other counties' Public Safety Answering Point (call center). In 2018, DHSES began developing a State 911 Plan to achieve statewide communication interoperability through NG911. However, the audit found that DHSES is not effectively overseeing the development and implementation of the State's transition to NG911. Its efforts to bring a State 911 Plan to fruition have been beset with numerous, lengthy delays, and as of January 2025, the plan was still in draft form. Without this plan, an NG911 Strategic Plan, and an NG911 Transition Plan, the implementation of NG911 will be more challenging for counties to move forward. Further, the prolonged implementation of NG911 increases the risk that the current, aging 911 infrastructure will not function properly, particularly during natural disasters or other large-scale emergency events, and the public will not receive vital emergency services when needed. Auditors also identified weaknesses in technical controls that need to be corrected to ensure the ITS information system is not at risk.

Key Recommendations:

DHSES:

- Finalize the State 911 Plan to include NG911.
- Continually monitor counties' progress in implementing NG911 technologies to ensure they meet the goals established.

ITS:

- Implement the recommendations detailed in the preliminary report to strengthen technical controls over the selected systems reviewed.

New York State Artificial Intelligence Governance (2023-S-50)

Agencies: Office of Information Technology Services (ITS), Office for the Aging (NYSOFA), Department of Corrections and Community Supervision (DOCCS), Department of Motor Vehicles (DMV), Department of Transportation (DOT)

Objective: Assess various agencies' progress in establishing an appropriate artificial intelligence (AI) governance structure over the development and use of AI tools and systems.

Audit Period: January 2019–November 2024

With their ability to process and analyze large amounts of data, AI-powered tools have an increasingly significant role in industry operations, including New York State government. However, as use and sophistication of AI systems have been growing, they are also giving rise to a host of unintended consequences. ITS, the State's IT authority, issued its Acceptable Use of Artificial Intelligence Technologies policy (AI Policy) providing guidelines and requirements for the acceptable use of AI technologies by State agencies. The audit found that New York State does not have an effective AI governance framework. While the AI Policy outlines certain requirements or recommendations for agencies to consider, it lacks adequate guidance and procedures on how these agencies can meet these expectations. Auditors found the AI governance at four sampled agencies (NYSOFA, DOCCS, DMV, DOT) varied significantly. Some agencies identified key risks and took steps to address those risks, while others had not created any AI-specific policies or taken other steps toward effective AI governance. These incomplete approaches to AI governance create a lack of assurance that the State's use of AI is transparent, accurate, and unbiased and avoids disparate impacts. Several factors contributed to the inconsistent and inadequate AI governance and compliance with the AI Policy, including lack of statewide guidance, poor identification of AI technology, and non-existent training.

Key Recommendations

ITS:

- Amend the AI Policy and provide additional guidance or procedures to assist State agencies with adopting AI technologies.
- Coordinate with all State agencies to provide support in developing AI governance structures as necessary.
- Develop and coordinate statewide training to ensure key AI risks and risk management options are understood by appropriate staff.

NYSOFA, DOCCS, DMV, and DOT:

- Review ITS' AI Policy to identify areas within the agency that need to be strengthened.
- Implement policies to create an effective AI governance structure.
- Coordinate with ITS on developing AI governance structures as necessary.

DMV:

- Review the facial recognition system with ITS to determine compliance with ITS' AI Policy.

Follow-Up Reports

Selected State Agencies' Roles in Financial Literacy (2024-F-7)

Agencies: Department of Financial Services (DFS), Department of State (DOS), Office for the Aging (NYSOFA), Office of Temporary and Disability Assistance (OTDA), State University of New York (SUNY)

Objective: Determine the extent of implementation of the five recommendations from Report 2020-S-53, which assessed selected State agencies' roles in financial literacy offerings, including how they identify and reach out to the most critical and vulnerable consumer groups, how they measure gains in individuals' knowledge after participating in financial literacy offerings, and what data these agencies use to evaluate and improve financial literacy offerings.

Initial Audit Key Findings: Each of the five agencies selected were involved to some degree in financial literacy efforts and some collaboration existed. However, there didn't appear to be a coherent strategy or plan to coordinate these efforts statewide, nor was there a shared understanding or definition of "financial literacy." Such a plan, if well-implemented, would likely provide a stronger level of service to New Yorkers.

Recommendation Status: 4 (issued to DFS, DOS, NYSOFA, OTDA) implemented, 1 (issued to SUNY) not implemented

Oversight of the Nourish New York Program (2024-F-27)

Agencies: Department of Agriculture and Markets (AGM), Department of Health (DOH)

Objective: Determine the extent of implementation of the five recommendations from Report 2022-S-33, which assessed whether AGM and DOH were ensuring Nourish NY provided adequate access to the program for farmers and connected citizens across the State to surplus agricultural products.

Initial Audit Key Findings: AGM and DOH could strengthen controls in certain areas to ensure only eligible products and expenses are funded by Nourish NY. Specifically, AGM and DOH's processes and the documentation provided by food relief organizations made determining whether expenses were eligible for Nourish NY funding difficult—generally because they lacked sufficient detail. Further, information used by DOH and AGM was not being used effectively together to determine if products purchased with Nourish NY funds were eligible New York food products. The audit also found DOH provided little guidance to

food relief organizations establishing what constitutes an allowable administrative cost, and conducted minimal review to determine if administrative expenses claimed were allowable and, therefore, used to support Nourish NY. Additionally, AGM could have done more to promote participation by vendors and DOH had not submitted the cold storage report to the Executive and Legislature.

Recommendation Status: 4 implemented, 1 partially implemented

Oversight of Water Supply Emergency Plans (2024-F-32)

Agencies: Department of Health (DOH), Division of Homeland Security and Emergency Services (DHSES)

Objective: Determine the extent of implementation of the five recommendations from Report 2021-S-39, which assessed if DOH was providing sufficient guidance and oversight to ensure that Water System operators completed and submitted updated Emergency Response Plan (ERPs) timely, including Vulnerability Assessments (VAs), as required; and whether DOH and DHSES were effectively collaborating to share relevant information regarding the VAs and to ensure that any recommended follow-up actions occur.

Initial Audit Key Findings: Auditors found that Water Supply Emergency Plans for most of the 317 Water Systems that were required to submit them were current and available. However, there were several instances where it had been more than 10 years since the Water System last submitted an ERP or VA, and some Water Systems had never submitted a Cybersecurity Vulnerability Assessment. Further, there was limited participation by local health department staff in calls and site visits where DHSES communicates recommendations to Water Systems. The audit also found little collaboration between DOH and DHSES to follow up on risks identified by DHSES reviews. Finally, the audit found that DOH didn't verify whether Water Systems issued the required public notice of Plan availability, which provides a venue for public comment.

Recommendation Status: 4 implemented, 1 not implemented

Appendix – Status of Recommendations

The following list presents, for each auditee, the initial audit's recommendations and implementation status at the time of follow-up, and a link to the reports detailing auditees' progress in implementing the recommendations.

Recommendations	Status
Health and Human Services	
Department of Health (DOH)	
Maximizing Drug Rebates Under the Federal Medicaid Drug Rebate Program (2024-F-14)	
1. Review the $119 million in missed rebates and invoice manufacturers, as appropriate.	Implemented
2. Review the $44.5 million in missed rebates and invoice manufacturers, as appropriate. Where rebates cannot be sought due to missing NDCs or invalid procedure code and NDC combinations on physician-administered drug claims paid by MCOs, follow up with MCOs for proper drug information or seek recovery directly from MCOs for the missed rebates.	Partially Implemented
3. Ensure the EIS edit is working properly and requires a valid NDC on physician-administered drug encounter claims.	Partially Implemented
4. Add or enhance system edits to ensure all claims include a valid procedure code and NDC combination, where applicable.	Partially Implemented
5. Add or enhance system edits to prevent the use of unclassified drug codes on claims when a procedure code has been assigned.	Partially Implemented
6. Formally determine whether rebates can be sought on physician-administered drug claims where the procedure code and NDC combination is not yet on the crosswalk or the procedure code is an unclassified drug code, either by invoicing claims in a subsequent quarter or by using NDC information on the claims.	Implemented
7. Review the $12.8 million in missed rebates and invoice the manufacturers, as appropriate.	Partially Implemented
8. Ensure all rebate-eligible PACE encounter claims are included in the rebate process and invoiced appropriately.	Partially Implemented
9. Review the $6.4 million in missed rebates and invoice the manufacturers, as appropriate.	Not Implemented
10. Take corrective actions to ensure rebate-eligible claims are not incorrectly rejected by the rebate contractor's system.	Not Implemented
11. Review the $993,207 in missed rebates and invoice the manufacturers, as appropriate.	Partially Implemented
12.Periodically review Magellan's data after it processes claims to ensure drug claims eligible for rebates are not ignored during the invoicing process.	Partially Implemented
Excessive Payments for Durable Medical Equipment Rentals (2024-F-18)	
1. Formally determine whether it is efficient and appropriate under managed care to require a cap on the number of rental payments for oxygen-related equipment. If deemed appropriate, work with stakeholders to implement policy changes.	Not Implemented
2. Formally re-evaluate the existing policies for paying FFS DME rental claims for oxygen-related equipment, including an evaluation of the appropriateness of the uncapped continuous rental policy and the Medicaid reimbursement fees. If deemed appropriate, implement policy and claims processing changes.	Partially Implemented
3. Follow up with the MCO that made payments in excess of its policy limits on oxygen equipment to ensure that the $200,657 is reviewed and recovered, as appropriate.	Not Implemented
4. Review the $1.3 million in overpayments identified for DME rental claims and ensure recoveries are made, as appropriate.	Not Implemented
5. Monitor MCOs' DME rental claims for overpayments, including a review of the $503,619 identified, and take appropriate corrective steps, including ensuring recoveries are made.	Not Implemented

6. Advise MCOs to evaluate the feasibility of developing controls to identify and prevent the types of DME rental overpayments identified by the audit, and take steps to ensure corresponding corrective actions are implemented.	Not Implemented
7. Formally determine the appropriateness of certain MCOs' policies that allow payments for a new rental period whenever there is a 60-day gap in rental payments or a change in provider. If deemed inappropriate, work with stakeholders to implement policy changes.	Not Implemented
Improper Fee-for-Service Pharmacy Payments for Recipients With Third-Party Health Insurance (2024-F-25)	
1. Review the $28.8 million in Medicaid payments for pharmacy services on behalf of recipients with TPHI drug coverage and ensure overpayments are appropriately recovered, prioritizing FFS claims that are approaching the 3-year window for recovery.	Not Implemented
2. Assess the recoverability of the $8.6 million in Medicaid payments for pharmacy claims that were billed to TPHI carriers but did not result in a recovery (due to carrier denials), and ensure all necessary follow-up actions are taken to obtain appropriate recoveries, prioritizing the claims that are approaching the 6-year window for recovery.	Not Implemented
3. Assess the TPL recovery process for FFS pharmacy services to identify all factors that led to exclusions from TPHI carrier billings, and ensure corrective actions are taken where appropriate.	Not Implemented
4. Perform sufficient and ongoing monitoring of the TPHI recovery process for FFS pharmacy claims to ensure the completeness and timeliness of recoveries, including obtaining and reviewing all required reports per the contract, and monitoring FFS pharmacy claims that are not billed to TPHI carriers and FFS pharmacy claims that are billed to TPHI carriers but do not result in a recovery.	Partially Implemented
5. Continue communication with providers to help ensure Medicaid FFS pharmacy providers are aware of all eMedNY policies regarding TPHI with drug coverage.	Implemented
6. Strengthen eMedNY TPHI claims processing controls to address the edit weaknesses identified in the audit report, and require pharmacies to provide supporting documentation from the TPHI when submitting zero-filled pharmacy claims.	Partially Implemented
7. Ensure Gainwell implements processes to initiate recovery efforts directly from pharmacies, where appropriate.	Not Implemented
8. Periodically determine if the FFS pharmacy claim fields provided to Gainwell are sufficient and being appropriately used by the contractor.	Not Implemented
Improper Medicaid Payments for Outpatient Services Billed as Inpatient Claims (2024-F-26)	
1. Develop and provide Medicaid guidance to hospitals to assist them in determining when services should be billed as an inpatient or outpatient claim.	Partially Implemented
2. Advise hospitals to develop controls to verify inpatient billing requirements are met prior to billing Medicaid (e.g., the existence of a valid admission order and room and board).	Partially Implemented
3. Review the improperly billed inpatient claims we sampled that have not yet been voided by hospitals and recover overpayments, as appropriate.	Not Implemented
4. Develop a risk-based approach to review the remaining 34,074 inpatient claims, totaling $356 million, identified in this audit to identify improper payments and make recoveries as appropriate.	Partially Implemented
5. Develop an ongoing process to identify and review the appropriateness of high-risk short-stay inpatient claims, such as the ones identified in this audit.	Not Implemented
Improper Medicaid Payments During Permissible Overlapping Medicaid and Essential Plan Coverage (2024-F-40)	
1. Review the $93.7 million ($83.1 million + $10.6 million) in improper payments and make recoveries as appropriate.	Not Implemented
2. Recognize the Essential Plan as liable third-party health insurance and ensure proper processing of Medicaid claim payments.	Partially Implemented
Reducing Medicaid Costs for Recipients Who Are Eligible for Medicare (2025-F-8)	

1. Follow up with the identified recipients who appeared eligible for Medicare, including those with SSI, and ensure they apply for Medicare, as appropriate.	Partially Implemented
2. Work with Local Districts to develop and implement procedures to ensure that information on file is correct and all recipients, including those with SSI, are asked to apply for Medicare when they appear eligible.	Not Implemented
3. Evaluate the cost-benefit of developing and implementing processes to periodically identify recipients with SSI who appear eligible for Medicare and refer them to SSA for Medicare eligibility determinations.	Implemented
Office for People With Developmental Disabilities (OPWDD)	
Pandemic Planning and Care for Vulnerable Populations (2024-F-23)	
1. Periodically review and update as necessary the EMOP and supplemental documents to ensure all homes implement current policies and procedures in the event of another public health emergency.	Partially Implemented
2. Develop procedures to ensure facility-level emergency plans encompass planning for and responding to public health emergencies.	Partially Implemented
3. Ensure monitoring and review protocols address infection control practices, are well developed, and are consistently applied when conducting reviews at homes.	Partially Implemented
4. Establish effective communication with individuals responsible for infection control policies and procedures when pertinent deficiencies are identified.	Partially Implemented
Office of Addiction Services and Supports (OASAS)	
Oversight of Contract Expenditures of Palladia, Inc. (2024-F-29)	
1. Recover $2,508,682 in unallowable and/or unsupported costs from Palladia, including $1,679,913 in personal service costs, $779,458 in OTPS costs, and $49,311 in parent agency administration costs.	Partially Implemented
2. Establish additional monitoring controls and improve oversight to ensure that Palladia claims only actual expenses and that those expenses are allowable, reasonable, supported, and consistent with the CFR Manual, the Guidelines, and the contract.	Not Implemented
3. Ensure Palladia discloses all expenses and allocation methodologies during its budget process, specifically salary expenses shared between OASAS and non-OASAS programs and the details of those expenses included in parent agency administration costs.	Not Implemented
Addiction Support Services During Emergencies (2024-F-39)	
1. Review and revise the LSBs, site review instruments, and any other guidance, as considered necessary, to: incorporate provisions that address providers' plans to manage and mitigate prolonged disruptions in service; and clearly describe the responsibilities of both providers and OASAS personnel related to Plans, eFINDS readiness, and waiting list requirements.	Not Implemented
2. Implement a risk-based method to: review Plans subsequent to the initial certification; and verify provider access to eFINDS, including verification that assignments to key roles are current.	Not Implemented
3. Improve the use of waiting list information submitted by providers to better support OASAS' decision making and oversight.	Not Implemented
Office of Temporary and Disability Assistance (OTDA)	
Oversight of Homeless Shelters (2024-F-31)	
1. Improve policies and procedures for using inspection checklists, monitoring shelter violations, and ensuring shelter inspections.	Implemented
2. Refine inspection checklists to better document regulatory requirements.	Partially Implemented

3. Take steps to ensure shelter violations are corrected, which may include partially or fully withholding reimbursements for homeless services or reconsidering provider eligibility in the homeless shelter system in accordance with applicable regulations.	Implemented
4. Add hotels/motels to the homeless shelter inventory upon initial resident referral.	Not Implemented
5. Continue to evaluate and develop SMS to ensure it is being used to its full potential in assisting OTDA in monitoring risk at homeless shelters.	Implemented
6. Review required plans to help homeless individuals and families secure permanent housing.	Not Implemented
7. Ensure facilities are aware of the Grant Program, which could help them make needed health and safety improvements.	Implemented
8. Improve transparency and cooperation to maintain good governance.	Implemented
Homeless Services Housing Needs Assessment (2024-F-36)	
1. Work with Local Districts and shelter providers identified through annual inspections that have not prepared or have late or incomplete Assessments and ILPs.	Partially Implemented
2. Reassess the oversight processes and develop new methods to supplement the annual inspections to identify Local Districts and shelter providers that have not prepared or have late or incomplete Assessments and ILPs.	Not Implemented
3. Work with Local Districts and shelter providers identified through annual inspections whose clients are not receiving the needed services identified in their Assessments and the service strategy set forth in the ILP.	Partially Implemented
4. Reassess the oversight processes and develop new methods to supplement the annual inspections to identify Local Districts and shelter providers whose clients are not receiving needed services identified in their Assessments and set forth in the ILP.	Not Implemented
5. Take additional steps to ensure that Local Districts and shelter providers complete treatment plans.	Not Implemented
6. Develop a standardized form for Local Districts and providers to use when documenting client services to be included in the ILP and monitor to ensure ILP implementation.	Implemented
7. Collect and analyze aggregate data that will allow OTDA to identify primary causes for clients not achieving permanent housing and address these issues.	Partially Implemented

Education

State University of New York (SUNY)	
Determination of Residency for Tuition Purposes (2023-F-45)	
1. SUNY Administration: provide guidance and support to campus officials in interpreting and implementing the Residency Policy to ensure tuition is charged correctly by obtaining sufficient proof of residency for purposes of determining eligibility for in-state tuition.	Partially Implemented
2. SUNY Administration: work with campuses to ensure all student residency documents are maintained for at least 6 years from the time the student separates from the campus.	Implemented
3. SUNY Campuses: ensure tuition is charged correctly by obtaining sufficient proof of residency for purposes of determining eligibility for in-state tuition.	Not Implemented
4. SUNY Campuses: maintain all student residency documents for at least 6 years from the time the student separates from the campus.	No Longer Applicable
Oversight of Disability Services (2025-F-7)	
1. SUNY Administration: continue to work with SED to provide training and education to campuses to accurately and consistently report data on students with disabilities.	Implemented
2. SUNY Campuses: maintain sufficient documentation for students with disabilities who don't follow through with the process to obtain accommodations.	Implemented
3. SUNY Campuses: accurately and consistently report students with disabilities in accordance with SED requirements.	Implemented

4. SUNY Campuses: continue to actively evaluate and improve accessibility and incorporate the potential improvement areas identified where feasible.	Implemented

Transportation

Metropolitan Transportation Authority (MTA)	
Management and Maintenance of Non-Revenue Service Vehicles (2024-F-16)	
1. Work with the user groups to ensure the vehicles are delivered for the scheduled ASOs and LSOs.	Implemented
2. Send reminders to user departments when mileage has not been entered into the SPEAR system on a regular recurring basis.	Implemented
3. Revise inspection forms to reflect changes to LSO intervals.	Implemented
4. Revise inspection forms to reflect the manufacturer-recommended maintenance for electric and hybrid vehicles in the fleet.	Partially Implemented
5. Document reasons when SFS does not follow certain recommended maintenance in owner's manuals.	Not Implemented
6. Formalize procedures to record and account for, in SPEAR, the parts that were replaced on the vehicle during maintenance and repairs.	Not Implemented
7. Train SFS staff on the process to establish consistency when recording parts in SPEAR.	Not Implemented
8. Establish a process for tracking and monitoring maintenance costs.	Not Implemented
9. Establish written policies and procedures and provide training to employees on how to implement this process as part of controlling cost.	Not Implemented
10. Establish written policies and procedures and provide training to staff on record keeping and maintaining an accurate and up-to-date inventory list.	Partially Implemented
11. Evaluate and address the optimal vehicle capacity at the East New York facility to reduce overcrowding. Consider the number of vehicles that East New York can hold, space restrictions, and the daily workload.	Implemented
Non-Revenue Service Vehicles and On-Rail Equipment (2024-F-17)	
1. Verify that all required documents, such as vehicle title, are included in the hard-copy folder and ensure that documentation is periodically confirmed.	Implemented
2. Establish a formal process for vehicle exemption from scheduled PM that includes documented rationale for exemption and formal notification of the department head and executive management.	Not Implemented
3. Ensure that records are backed up in case the maintenance contract vendor's system is compromised.	Not Implemented
4. Revisit the ENG-006 Passenger and Work Vehicle Replacement and Additional Request Procedure to ensure a complete cost-benefit analysis occurs on a timely basis.	Implemented
5. Develop and implement a procedure for visiting shops based on the nature of the repair, which at a minimum requires reporting on the vehicles examined and the expectation for their return to service, and document the visit.	Partially Implemented
6. Ensure that the EAM system under development contains sufficient data to maintain both Track's inventory and maintenance history of on-rail equipment.	Partially Implemented
7. Perform internal periodic reconciliation of Track equipment inventory between the Track Excel listing and the Shop Database.	Not Implemented
8. Ensure that LIRR Corporate Policy and Procedure PL-025 is followed, including all required reconciliations.	Not Implemented
9. Revisit the retention policy for ownership documents to ensure that records are retained until the property is disposed.	Implemented

10. Establish a PM process that documents when maintenance is done or the reasons it was not done.	Not Implemented
11. Ensure that the Daily Reports are completed and distribution procedures are followed.	Partially Implemented
12. Develop and implement formal procedures for removing and returning parts from the MofW warehouse at HSF. Monitor compliance with the procedures.	Not Implemented
13. Enforce the BSC policy for submitting purchase order invoices for operating-funded expenditures	Partially Implemented

Government Support

Department of Civil Service (Civil Service)	
CVS Health: Accuracy of Empire Plan Medicare Rx Drug Rebate Revenue Remitted to the Department of Civil Service (2024-F-24)	
1. Remit $10,723,916 to Civil Service for the rebate revenue identified by our audit.	Partially Implemented
2. Take corrective steps to ensure all of the Empire Plan Medicare Rx rebate-eligible drug utilization is invoiced, collected from the manufacturers, and remitted in a timely manner to Civil Service.	Not Implemented
Empire BlueCross: Overpayments for Physician-Administered Drugs (2024-F-34)	
1. Work with Civil Service to review the remainder of the $1,736,399 ($1,580,240 + $110,613 + $45,546) in physician-administered drugs identified by the audit and make recoveries, as warranted.	Partially Implemented
2. Work with Civil Service to identify physician-administered drugs paid for by both the Hospital and the Prescription Drug Programs and develop a process to prevent future overpayments.	Partially Implemented
3. Remind facility officials on how to properly bill for no-cost drugs (indirect approach).	Partially Implemented
4. Fix claims processing-related controls to ensure claims for no-cost drugs billed in accordance with guidelines are correctly paid.	Implemented
5. Review the remainder of the $1,040,111 ($795,099 + $245,012) in improperly paid physician-administered drugs identified and make recoveries, as warranted.	Partially Implemented
6. Review claims billed for physician-administered drugs in excess of allowed limits to recover overpayments and make necessary changes to the claims processing system to prevent future improper payments.	Implemented
7. Remind facility officials of proper billing and documentation requirements regarding physician-administered drugs.	Not Implemented
UnitedHealthcare Insurance Company of New York: Overpayments for Physician-Administered Drugs (2024-F-35)	
1. Review the $4,019,329 in physician-administered drugs that were paid for by both the Medical/ Surgical and Prescription Drug Programs and make recoveries, as warranted, giving priority to collecting the remaining $169,641 in provider-acknowledged refunds due.	Partially Implemented
2. Work with Civil Service to identify physician-administered drugs paid for by both the Medical/ Surgical and Prescription Drug Programs and develop a process to prevent future overpayments.	Partially Implemented
3. Establish a policy/guidance for billing no-cost drugs and educate providers on how to properly document and bill for no-cost drugs (indirect approach).	Not Implemented
4. Ensure the eight sampled providers correct the billing flaws that caused their improper payments.	Partially Implemented
5. Recover the remaining $1,194,354 ($1,194,719 - $365) in overpayments, as warranted.	Partially Implemented
6. Develop a process for monitoring general service code claims to ensure payments are in accordance with provider contracted rates.	Implemented

7. Recover the remaining $172,062 ($179,190 - $7,128) in overpayments for drugs in excess of dosing allowances, as warranted.	Partially Implemented
8. Recover the remaining $98,964 ($143,299 - $44,335) in duplicate payments, as warranted.	Partially Implemented
New York State Health Insurance Program: Incorrect Payments by CVS Caremark for Medicare Rx Drug Claims That Were Improperly Paid Under the Commercial Plan (2025-F-1)	
1. Civil Service and CVS Caremark: review the $12,358,531 in claims identified in this report as incorrectly paid under the Commercial Plan to determine which claims to reprocess under the Medicare Rx Plan.	Partially Implemented
2. Civil Service and CVS Caremark: consider and evaluate additional controls, as needed, to prevent the processing and payment of claims under the incorrect plan and continue to perform periodic reconciliations.	Partially Implemented
3. CVS Caremark: reprocess under the Medicare Rx Plan those claims that were identified as incorrectly paid under the Commercial Plan, as warranted.	Partially Implemented
Office of Information Technology Services (ITS)	
Windows Domain Administration and Management (2024-F-12)	
1. Implement the six recommendations included in our confidential draft report.	Partially Implemented

Criminal Justice and Judicial Administration

Department of Corrections and Community Supervision (DOCCS)	
Controls Over Tablet and Kiosk Usage by Incarcerated Individuals (2024-F-28)	
1. Strengthen DOCCS's responsibility and role in the relationship between the Provider and Individuals for the tablet program.	Implemented
2. Implement a process to ensure that Individuals' correspondence with community members via secure messaging complies with DOCCS Directives.	Not Implemented
3. Implement a process to ensure compliance with the negative correspondence/telephone list.	Not Implemented
4. Ensure that all kiosks located at facilities are visually inspected in accordance with DOCCS Directives, and facilities are using updated daily Checklists to complete visual inspections of kiosks.	Partially Implemented
5. Develop, implement, and adhere to an internal process to effectively monitor program participation and tablet inventory at both the facility and statewide levels.	Not Implemented
6. Ensure that systems are maintained at vendor-supported levels, including those under the vendor's responsibility. Until then, DOCCS should work with ITS to submit the required exception request form.	Partially Implemented
7. Implement the remaining technical recommendations detailed in the preliminary report.	Partially Implemented

Economic Development and Housing

Empire State Development (ESD)	
Oversight of Select High-Technology Projects (2024-F-19)	
1. Conduct comprehensive assessments of the risks, costs, and economic benefits of projects before funding decisions are made to determine if projects should receive significant State investment.	Implemented
2. Develop standard performance metrics and then evaluate projects to determine their actual economic benefits compared with the State's investment.	Partially Implemented
3. Standardize the public reporting of projects to eliminate discrepancies and provide the public with accurate information on project costs, statuses, and economic benefits using a clear and consistent method.	Partially Implemented

Homes and Community Renewal (HCR)	
Housing Trust Fund Corporation: Internal Controls Over and Maximization of Federal Funding for Various Section 8 Housing Programs and the COVID Rent Relief Program (2024-F-21)	
1. Fully investigate and identify barriers to optimizing HCV vouchers and funding and, based on the results, develop and implement strategies to increase utilization and prevent potential reduction or loss of federal funds. This should include but not be limited to increased use of reserve funds.	No Longer Applicable
2. Develop and implement solutions to financial management systems to improve the reliability and usability of programmatic financial data.	Partially Implemented
3. Improve controls over HQS inspections to ensure that deficiencies identified during inspections are remedied within HUD-prescribed time frames and that inspection standards are consistent across LAs.	Implemented
4. Develop and implement internal controls over the SDA.	Implemented
Physical and Financial Conditions at Selected Mitchell-Lama Developments in New York City (2024-F-30)	
1. Improve monitoring of developments, including but not limited to: verifying that Management Representatives responsible for oversight at the sampled developments review all items on the Field and Office Visit Report and prepare and send those reports to the developments' management promptly, as required; conducting at least one annual site visit to each development; ensuring immediate corrective action is taken when unsafe conditions are identified, and documenting dates of correction; and taking action against managing agents who are non-compliant with Regulations.	Partially Implemented
2. Develop a formal process to obtain and analyze publicly available violations and complaints data, and use the information to enhance monitoring of developments.	Implemented
3. Review expenditures, including all bonus payments, petty cash transactions, and reimbursements, at the sampled developments, and take appropriate action, including recouping funds, for transactions that are inappropriate or unusual.	Partially Implemented
4. Develop and implement policies and procedures related to bonus payments, requirements such as dollar thresholds for contracts, segregation of duties, and internal controls over purchasing at the developments, and monitor compliance with these policies.	Partially Implemented
5. Improve monitoring of financial conditions at the developments by enforcing compliance with Regulations related to the proper use of the developments' funds, competitive analysis and bidding, and DHCR's approval requirements for annual expenditures of $100,000 or more.	Partially Implemented
6. Mandate regular training for management at the developments and Board members to ensure they are aware of good governance and their fiduciary responsibilities.	Partially Implemented
7. Monitor residential and commercial rent arrears, and work with development management to take appropriate steps in line with Regulations to collect outstanding rent.	Partially Implemented
8. Assist management at Cathedral and Findlay House with filling vacancies.	Not Implemented
9. Ensure Program staff maintain a current and accurate list of the DHCR-supervised developments and communicate reliable data to the Legislature, State Comptroller, and Attorney General.	Not Implemented

Other State Agencies and Public Authorities

Department of Labor (DOL)	
Services to Workers Under the Worker Adjustment and Retraining Notification Act (2024-F-22)	
1. Implement a process to: substantiate that employers that file late Notices meet exemption criteria; and verify that employers pay affected employees when they cite past or planned payments in late-filed Notices.	Implemented
2. Follow up on Notices that were not entered in OSOS, including those identified by our audit, and offer and provide Rapid Response services as appropriate.	Implemented
3. Take steps to improve timely outreach to both employers and employees affected by employment changes covered by the WARN Act.	Implemented
4. Assess current and anticipated WARN activity to determine and pursue appropriate WARN staffing levels.	Partially Implemented

Department of Motor Vehicles (DMV)	
Language Access Services (2024-F-33)	
1. Develop procedures to verify that all State DMVs are complying with the requirements of the DMV's Plan, including: utilizing Language Line for interpretation services where applicable; tracking statistics for interpretation services provided; and obtaining waiver forms when customers choose to rely on their family or friends for interpretation services.	Partially Implemented
2. Increase collaboration efforts with County DMVs to provide equal access and consistent services to LEP individuals throughout the State.	Implemented
3. Collect and analyze available language statistics, and collaborate with County DMVs to develop a method to track complete and accurate statistics of non-English languages they serve throughout the State.	Partially Implemented
4. Develop procedures to ensure that RFQ expectations for interpretation services are being met.	Implemented
5. Develop procedures to ensure that charges for interpretation services are accurate and appropriate, and recoup any outstanding overpayments.	Partially Implemented
Hudson River–Black River Regulating District (HRBRRD)	
Security Over Critical Systems (2025-F-5)	
1. Develop relevant policies and procedures as required for PCI DSS.	Implemented

Cross-Agency Projects

Department of Financial Services (DFS), Department of State (DOS), New York State Office for the Aging (NYSOFA), Office of Temporary and Disability Assistance (OTDA), State University of New York (SUNY)	
Selected State Agencies' Roles in Financial Literacy (2024-F-7)	
1. DFS: work with agencies and authorities to help ensure that those that are subject to the law are providing the required information to enhance consumer financial literacy and education and that it's accessible on DFS' website. Such actions could include, for example, establishing and communicating a definition of "financial literacy" to guide agencies' determination of relevant content.	Implemented
2. DOS: work with DFS to ensure that access to information about DOS's financial literacy-related content and efforts is available on DFS' website.	Implemented
3. NYSOFA: identify and pursue ways to enhance financial education and literacy among older New Yorkers.	Implemented
4. OTDA: implement a method to obtain SYEP [Summer Youth Employment Program] participant input to identify potential strengths and weaknesses in financial literacy offerings and share this information with partners as considered appropriate.	Implemented
5. SUNY: in coordination with the Smart Track vendor, where appropriate, use available Smart Track information and user metrics to identify potential areas of focus and improvement.	Not Implemented
Department of Agriculture and Markets (AGM), Department of Health (DOH)	
Oversight of the Nourish New York Program (2024-F-27)	
1. AGM: develop processes and procedures to improve data collection and reliability for information maintained on vendor participation and use the data to build the program's effectiveness and promote enhanced participation.	Implemented
2. DOH: communicate guidance to food relief organizations on eligibility requirements for purchases made under Nourish NY, including but not limited to administrative and non-New York food purchases.	Implemented
3. DOH: issue the overdue report on the unmet need for cold storage equipment to the Executive and Legislature and maintain a timely schedule hereafter.	Partially Implemented
4. AGM and DOH: improve monitoring of Nourish NY, which may include but not be limited to enhancing documentation requirements, and review processes to ensure purchases are from eligible sources.	Implemented

5. AGM and DOH: Collaborate to develop and document criteria for Nourish NY purchases that most effectively balance the needs of its various stakeholders and communicate the criteria to food relief organizations and vendors.	Implemented
Department of Health (DOH), Division of Homeland Security and Emergency Services (DHSES)	
Oversight of Water Supply Emergency Plans (2024-F-32)	
1. DOH: develop and implement a method to monitor the timeliness of Water Systems' Plan submissions and to follow up on requested revisions.	Implemented
2. DOH: develop and communicate guidance regarding LHD participation at site visits and calls with Water Systems that incorporates consideration of the nature and extent of the risks identified.	Implemented
3. DOH: provide guidance to LHDs that addresses both effective use of SDWIS in monitoring Plan compliance and practices for reviewing Assessments.	Implemented
4. DOH: take action to determine, on a sample basis, whether Water Systems issue the required public notice of Plan availability for review and comment.	Not Implemented
5. DOH and DHSES: establish a method to strengthen the follow-up on recommendations that DHSES communicates to Water Systems.	Implemented

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