UCONN
UNIVERSITY OF CONNECTICUT

UCONN
HEALTH

JOINT AUDIT & COMPLIANCE COMMITTEE MEETING

June 23, 2022

PUBLIC SESSION

Meeting held by Telephone

Public Call in # +1-415-655-0002 US Toll
Access Code: 2622 764 1237

Public Access Link: https://ait.uconn.edu/bot

(A recording of the meeting will be posted on the Board website https://boardoftrustees.uconn.edu/ within seven days of the meeting.)

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University of Connecticut & UConn Health

Joint Audit & Compliance Committee Meeting

June 23, 2022

Agenda

10:00 am – 10:30 am - Executive Session / 10:30 am – 12:00 pm - Public Session

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Topic	Proposed Action	Attachment
Executive Session Anticipated	Review	None
1. GENERAL		
• Opportunity for Public Comments*		None
• Minutes of the March 18, 2022 JACC Meeting	Approval	1.1
2. EXTERNAL AUDIT ACTIVITIES		
• Status of External Audit Engagements	Update	2.1
• FY21 UCONN 2000 Infrastructure Program Agreed-Upon Procedures Audit – Mayer Hoffman McCann P.C.	Presentation Audit Report	2.2 2.3
• Annual 340B Drug Pricing Program Audits - Pharmacy Optimization Consultants for the period June 1, 2021-November 30, 2021 as well as Findings and Areas for Improvements for:	Presentation	
◦ John Dempsey Hospital (JDH)	Audit Report	2.4
◦ Division of Infectious Diseases (Ryan White Part A)	Audit Report	2.5
◦ Hemophilia Treatment Center (HTC)	Audit Report	2.6
3. SIGNIFICANT INTERNAL AUDIT ACTIVITIES		
• Status of Audits	Update	3.1
• Status of Audit Findings	Update	3.2
4. COMPLIANCE ACTIVITIES		
• Significant Compliance Activities	Update	4.1
• Required Compliance Training Completion Data	Presentation	4.2
• Informational/Educational Items	Informational	4.3
5. INFORMATION TECHNOLOGY		
• UConn	Update	5.1
• UConn Health	Update	5.2
6. RETIREMENT UPDATES		
• UConn	Presentation	6.1
• UConn Health	Presentation	6.2
7. CLOSING		
• Conclusion of Full Meeting		

***** If members of the public wish to address the Committee during the Public Participation portion of the meeting, you must submit a request in writing 30 minutes prior to the start of the meeting (by 9:30 a.m.) to the following email address: BoardCommittees@uconn.edu. Please indicate your **name, telephone number, and topic** to be discussed. Per the University By-Laws, the Board may limit public comment. As an alternative, you may also submit your comments via email which will be shared with the Board.

ATTACHMENT 1.1

DRAFT

University of Connecticut & UConn Health
Joint Audit & Compliance Committee Meeting
Minutes of the March 18, 2022 Meeting

WebEx Meeting

Attendees	
Trustees/ Directors:	Chair: M. Boxer, A. Dennis-LaVigne, F. Archambault, T. Holt, B. Pollard
Staff:	P. Alpay, O. Andujar, N. Baker, C. Bernard, C. Bianchi, L. Blanchard, J. Blumenthal, L. Brown, A. Buckley, K. Buffkin, W. Byerly, P. Casey, C. Delello, T. Dyer, K. Fearney, M. Frank, N. Fuerst, E. Gallo, N. Gelston, B. Gelston, S. Guralnick, L. Hansen, D. Hook, A. Keilty, M. Kennedy, B. Liang, M. Lucas, R. Maric, C. Murray, L. Neal, G. Perrotti, A. Quaresima, R. Rubin, J. Simpson, D. Swol, D. Toscano, E. Vitullo, R. Wrynn
External Invitees:	M. Delaney, J. Harrison, C. Jackson, A. Phung

1. Opening

The meeting of the Joint Audit and Compliance Committee (JACC) was called to order at 10:04 a.m. by Committee Chair Boxer.

2. Executive Session

ON A MOTION by Trustee Pollard and seconded by Director Archambault, the JACC voted unanimously to go into executive session to discuss:

- C.G.S. 1-210(b)(1)– Preliminary drafts or notes that the public agency has determined that the public's interest in withholding such documents clearly outweighs the public interest in disclosure.
- C.G.S. 1-200(6)(B) – Records or the information contained therein pertaining to strategy and negotiations with respect to pending claims.
- C.G.S. 1-210(b)(10) – Records, reports and statements privileged by the attorney-client relationship.
- C.G.S. 1-210(b)(20)– Records of standards, procedures, processes, software and codes not otherwise available to the public, the disclosure of which would compromise the security and integrity of an information technology system.

The entire executive session was attended by the following: JACC Members: M. Boxer, A. Dennis-LaVigne, F. Archambault, T. Holt, B. Pollard; **President and Senior Staff:** P. Alpay, C. Bianchi, L. Blanchard, J. Blumenthal, L. Brown, T. Casey, C. Delello, N. Fuerst, N. Gelston, A. Keilty, B. Liang, R. Maric, R. Rubin, J. Simpson, D. Toscano, R. Wrynn; **Audit and Management Advisory Services Staff:** T. Dyer, E. Gallo, D. Hook, M. Kennedy, C. Murray, G. Perrotti, A. Quaresima, D. Swol; **University Compliance Staff:** O. Andujar, K. Fearney, B. Gelston, L. Neal, E. Vitullo.

The following were in attendance for part of Executive session: University Information Technology Staff: A. Buckley, C. Bernard, M. Mundrane.

The Executive Session ended at 10:34 a.m.

DRAFT

University of Connecticut & UConn Health

Joint Audit & Compliance Committee Meeting

Minutes of the March 18, 2022 Meeting

WebEx Meeting

OPEN SESSION

The JACC returned to public session at 10:35 a.m.

1. Public Participation

There were no public comments.

ON A MOTION by Trustee Dennis-LaVigne and seconded by Director Archambault, the Minutes of the December 9, 2021, JACC meeting were unanimously approved.

2. External Audit Activities

A. Quaresima provided an update on the status of external audit engagements.

ON A MOTION by Director Holt and seconded by Trustee Pollard, the UConn Health appointment of CliftonLarsonAllen LLP as the independent auditors of the John Dempsey Hospital, University Medical Group, and the UCHC Finance Corporation for the fiscal years 2022, 2023 and 2024 was unanimously approved by the JACC.

M. Delaney provided a presentation on the UConn Health audit of the annual comprehensive financial report for the year ended June 30, 2021.

M. Delaney provided a presentation on the UConn Health departmental audit for fiscal years ended June 30, 2019 and 2020.

C. Jackson provided a presentation on the audits of financial statements for UConn Health's John Dempsey Hospital, University Medical Group and Finance Corporation for the fiscal year ended June 30, 2021.

3. Significant Internal Audit Activities

A. Quaresima provided an update on the status of internal audits.

A. Quaresima provided an update on the status of internal audit findings.

A. Quaresima provided an update on the current Audit and Management Advisory Services staffing.

4. Compliance Activities

K. Fearney provided an update on significant compliance activities.

W. Byerly provided a presentation on the Office of Science and Technology policy implementation guidance related to the national security strategy for U.S. government-supported research and development

K. Fearney informed the JACC that there are informational and educational compliance items included in the materials.

5. Information Technology Update

M. Mundrane provided an update on the UConn information technologies.

A. Buckley provided an update on the UConn Health information technologies.

6. Conclusion of Full Meeting

ON A MOTION by Director Archambault and seconded by Trustee Pollard, the JACC Committee voted unanimously to adjourn the meeting.

There being no further business appearing, the meeting was adjourned at 11:26 a.m.

Respectfully submitted,
Molly Kennedy

ATTACHMENT 2.1

University of Connecticut & UConn Health

Joint Audit & Compliance Committee Meeting

June 23, 2022

Status of External Audit Engagements

Auditor	Area	Scope	Current Status of Audit	Prior Report Issued
CliftonLarsonAllen	UConn Health	Audits of Financial Statements for UConn Health's John Dempsey Hospital, University Medical Group, & Finance Corporation	FY 22 Underway	FY 21 Issued 12/13/21 (Marcum)
James Moore	UConn Athletics	NCAA agreed upon procedures performed on all revenues, expenses, and capital expenditures for the Athletics Program	FY 21 Completed	FY 21 Issued 11/17/21
Mayor Hoffman McCann P.C.	UConn & UConn Health	Annual audit of UCONN 2000 agreed upon procedures	FY 21 Completed	FY 21 Issued 5/18/22
Pharmacy Optimization Consultants	UConn Health	Audit of UConn Health's Covered Entities 340B Drug Pricing Program required by Health Resources and Services Administration	CY 21 3 Audits Completed	CY 21 Issued 1/22, 1/22 & 4/22
State Auditors	UConn	Annual audit of Federal Funds required under the Federal Single Audit Act	FY 21 Underway	FY 20 Issued 7/30/21
State Auditors	UConn Health	Annual audit of Federal Funds required under the Federal Single Audit Act	FY 21 Underway	FY 20 Issued 7/30/21
State Auditors	UConn	Annual audit of financial statements included in the Annual Comprehensive Financial Reports	FY 21 Completed	FY 21 Issued 12/7/21
State Auditors	UConn Health	Annual audit of financial statements included in the Annual Comprehensive Financial Reports	FY 21 Completed	FY 21 Issued 12/15/21
State Auditors	UConn	Departmental Statutory Required Audit (CGS Sec 2-90)	FYs 19, 20 & 21 Underway	FYs 16, 17 & 18 Issued 4/13/21
State Auditors	UConn Health	Departmental Statutory Required Audit (CGS Sec 2-90)	FYs 19 & 20 Completed	FYs 19 & 20 Issued 2/22/22

ATTACHMENT 2.2

University of Connecticut

AGREED-UPON-PROCEDURES RESULTS
FOR YEAR ENDING JUNE 30, 2021

JUNE 23, 2022

CBIZ MHM

Accounting | Tax | Advisory

Agenda

- Your Engagement Leadership Team
- Agreed Upon Procedures Process and Results

Your Engagement Leadership Team

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Agreed-Upon Procedures Process and Results

- As we discussed during the proposal process, in collaboration with management we took a fresh look at the approach to the testing of the UConn 2000 Construction Contracts and expenditures.
- The agreed upon procedures were developed and designed to meet the requirements under Public Act 07-166 which amends Sec. 13 section 10a – 109z of the Connecticut General Statutes.
- We combined all of the work and testing under one Agreed Upon Procedures engagement which allowed for specific and targeted procedures to be performed across the population of contracts and costs resulting in testing a significant portion of the 2021 spend.
- We enhanced certain procedures in response to risks that we see in construction contracts and costs in areas such as contractors' performance bonds and builders risk insurance costs.
- The management team was well prepared and collaborative which helped make for a seamless transition in our first year of completing the procedures.
- We identified one exception which is reported in the expenditure testing, Procedure 6.b.
    - For one of 58 items tested, the builders risk insurance cost that was charged to the contract was based on budgeted amounts instead of actual costs. The difference was subsequently credited back to UConn subsequent to June 30, 2021.

Agreed-Upon Procedures Process and Results

▪ Review of key procedures and the report
▪ Procedures
▪ Appendices

ATTACHMENT 2.3

Agreed-Upon Procedures: UConn 2000 Infrastructure Program as Required by Sec. 10a-109z of the Connecticut General Statutes

University of Connecticut

Year Ended June 30, 2021

UNIVERSITY OF CONNECTICUT

Agreed-Upon Procedures: UConn 2000 Infrastructure Program as Required by Sec. 10a-109z of the Connecticut General Statutes

Table of Contents

Agreed-Upon Procedures: UConn 2000 Infrastructure Program as Required by Sec. 10a-109z of the Connecticut General Statutes:

Independent Accountants' Report on Applying Agreed-Upon Procedures 1

Agreed-Upon Procedures: UConn 2000 Infrastructure Program as Required by Sec. 10a-109z of the Connecticut General Statutes 2-12

Appendix A – University of Connecticut - FY21 UConn 2000 AUP Population: Expenditure and Contract Testing 13-14

Appendix B – University of Connecticut - FY21 UConn 2000 AUP Population: Change Order Testing 15-16

Mayer Hoffman McCann P.C.
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Independent Accountants' Report on Applying Agreed-Upon Procedures

To the Board of Trustees and Joint Audit and Compliance Committee
University of Connecticut
Storrs, Connecticut

We have performed the procedures enumerated below on the UConn 2000 Infrastructure Program as Required by Sec. 109a-109z of the Connecticut General Statutes for the fiscal year ended June 30, 2021 to assist the University of Connecticut (the "University"), the University of Connecticut Health Center ("UConn Health"), its Board of Trustees and the Joint Audit and Compliance Committee (collectively, the "Responsible Parties") with meeting the requirements under Public Act 07-166 which amends Sec. 13 section 10a – 109z of the Connecticut General Statutes (the "Subject Matter"). The University's management is responsible for meeting the aforementioned requirements.

The Responsible Parties have agreed to and acknowledged that the procedures performed are appropriate to meet the intended purpose of meeting the requirements of the Subject Matter. This report may not be suitable for any other purpose. The procedures performed may not address all the items of interest to a user of this report and may not meet the needs of all users of this report and, as such, users are responsible for determining whether the procedures performed are appropriate for their purposes.

The procedures and the associated results are described on pages 2 through 12 of this report.

We were engaged by the University to perform this agreed-upon procedures engagement and conducted our engagement in accordance with attestation standards established by the AICPA. We were not engaged to and did not conduct an examination or review engagement, the objective of which would be the expression of an opinion or conclusion, respectively, on the Subject Matter. Accordingly, we do not express such an opinion or conclusion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

We are required to be independent of the Responsible Parties and to meet our other ethical responsibilities in accordance with the relevant ethical requirements related to our agreed-upon procedures engagement.

This report is intended solely for the information and use of the Board of Trustees, the Joint Audit and Compliance Committee, General Assembly of the Connecticut State Legislature and management of the University and UConn Health and is not intended to be and should not be used by anyone other than these specified parties.

Mayer Hoffman McCann P.C.

May 18, 2022
Boston, Massachusetts

UNIVERSITY OF CONNECTICUT

Agreed-Upon Procedures: UConn 2000 Infrastructure Program as Required by Sec. 10a-109z of the Connecticut General Statutes

Our procedures and results related to UConn 2000 Infrastructure Program as required by Sec. 10a-109z of the Connecticut General Statutes are as follows:

Expenditure Testing:

Procedure:

1. Obtain a report of total UConn 2000 general obligation bond expenditures by project from UConn for Fiscal Year June 30, 2021. To ensure completeness, this report will also include non-UConn 2000 funded expenditures for Fiscal Year June 30, 2021 on projects where any amount of UConn 2000 general obligation bond funded expenditures is present.

Result:

1. We obtained a report of total UConn 2000 general obligation bond expenditures by project from the UConn management team for Fiscal Year June 30, 2021. The report included non-UConn 2000 funded expenditures for Fiscal Year June 30, 2021 on projects where any amount of UConn 2000 general obligation bond fund expenditures were present.

Procedure:

2. From the report obtained in Procedure 1, select all projects, including capital equipment groups/projects, with total fiscal year expenditures greater than $500,000.

Result:

2. From the report we obtained as part of Procedure 1, all projects including capital equipment groups/projects with total fiscal year expenditures greater than $500,000 were selected for testing. See Appendix A for this listing.

Procedure:

3. For projects selected in Procedure 2, aggregate duplicate EDoc numbers per project and select all expenditures greater than $100,000. For projects without any expenditures greater than $100,000, select the highest dollar value expenditure.

Result:

3. For all projects that were selected in Procedure 2, duplicate EDoc numbers per project were aggregated and all expenditures greater than $100,000 were selected. For any projects without any expenditures greater than $100,000, the highest dollar value was selected. There were 196 expenditures that met these parameters.

Procedure:

4. For all expenditures selected in Procedure 3, identify if the expenditure is to an external source supported by a third-party invoice (identified by Kuali Financial System ("KFS") Payment Request ("PREQ")), or an internal/related party source (identified by KFS Internal Billing ("IB") / Distribution of Income and Expense ("DI") / Journal Voucher ("JV") / General Error Correction ("GEC") / General Ledger Transfer ("GLT") and Disbursement Vouchers ("DVCA")).

Result:

4. We identified the expenditures as follows: Of the 196 expenditures that met the parameters of Procedure 3, 172 were PREQ, 4 were IB, 17 were DI, 1 was GLT, and 2 were DVCA. We did not identify any expenditures that were coded as JV or GEC.

Procedures:

5. For all selected expenditures made to external sources that are supported by third-party invoices (PREQ):

    a. Locate the corresponding transaction within the HuskyBuy procurement and payment system.

    b. Inspect the addressee of the supporting invoice for evidence the invoice is addressed to UConn Health, the University of Connecticut or UConn.

    c. Inspect the invoice for the Vendor, Invoice Number or Payment Application Number, Invoice Date, and Invoice Amount, and compare the attributes to the HuskyBuy Invoice for agreement. If vendor names do not agree, determine if the difference is due to a merger, acquisition, DBA or other business combination and is therefore valid. For construction Payment Applications, refer to UConn procedures pertaining to the assignment of invoice numbers and date to AIA Applications for Payment. Invoice amounts can disagree up to $1.00, or by any amount if an intentional short payment occurred.

    d. Obtain a list from UConn identifying approved authorizers and their authorized designees based on UConn authorization thresholds and payment types.

    e. Inspect the Approvals and/or History tabs within the HuskyBuy Invoice and compare authorizations to the list of authorized approvers obtained in Procedure 5.d and determine the electronic approvals match based on authorization guidelines. Approval may alternatively be located in the "Comments" tab of the Invoice if ad-hoc routing was not obtained.

    f. Mathematically check the amount of the supporting invoice.

Results:

a. We located the corresponding transaction within the HuskyBuy procurement and payment system for each of the 172 expenditures that were supported by third-party invoices (PREQ) without exception.

b. We inspected the addressee of the supporting invoice noting that there was evidence that the invoices were addressed to UConn Health, the University of Connecticut or UConn without exception.

c. We inspected the invoices noting vendor, invoice number or payment application, invoice date and invoice amount agreed to the HuskyBuy invoice without exception.

d. We obtained a list from UConn identifying approved authorizers and their authorized designees based on the UConn authorization thresholds and payment types.

e. Using the list obtained in Procedure 5.d, we inspected the approvals and/or history tabs within the HuskyBuy invoice system noting that the approvals agreed to approved authorizers without exception.

f. We mathematically checked the amount of the supporting invoices without exception.

Procedures:

6. For all selected expenditures in Procedure 5 governed by AIA construction contracts that have not been included in prior year audits of completed projects, identify the related purchase order and obtain copies of all current fiscal year construction payment applications from HuskyBuy, regardless of value. Utilizing the construction payment applications:

   a. If applicable, obtain documentation to support the actual costs of the Contractors' performance and payment bonds, noting these undergo a final reconciliation at the end of the project. Compare to the amounts billed, noting any variances from the contract terms.

   b. If applicable, obtain documentation to support the actual costs of insurances charged, and compare to the amounts billed, noting any variances from the contract terms.

Results:

a. We identified 58 expenditures from Procedure 5 that were governed by AIA contracts that had not been included in prior year audits of completed projects.

b. We obtained documentation supporting actual costs of insurances charged and compared to the amounts billed noting one variance in which the builders risk insurance was charged based on budgeted as opposed to actual costs. The amount was credited back to UConn subsequent to June 30, 2021. No other variances were noted.

Procedures:

7. For all selected expenditures made to internal/related party sources that are supported by internal documents (IB/DI/JV/GEC/GLT and DVCA):

    a. Obtain the KFS EDoc.

    b. Obtain a list from UConn identifying approved authorizers and their authorized designees with corresponding approval thresholds for the type of EDoc.

    c. For IB/DI/JV/GEC/GLT transactions, inspect the Route Log approvals in the KFS EDoc and compare authorizations to the list obtained in Procedure 7.b and determine whether the electronic approvals match based on transaction type and authorized dollar thresholds. Approval may alternatively be located in the "Notes" section of the EDoc if ad-hoc routing was not obtained.

        i. Compare the support within the KFS EDoc "attachments" section to the entry in KFS and check for agreement, noting this can take a variety of forms.

    d. For DVCA transactions, locate the corresponding transaction within the HuskyBuy procurement and payment system. Inspect the Approvals and/or History tab within the HuskyBuy Invoice and compare authorizations to the list obtained in Procedure 7.b and determine if the electronic approvals match based on transaction type and authorized dollar thresholds. Approval may alternatively be located in the "Comments" tab of the Invoice if ad-hoc routing was not obtained.

        i. Compare the support within the HuskyBuy "Attachments" tab to the entry in HuskyBuy and check for agreement, noting this can take a variety of forms.

        ii. For DVCA transactions that specify reimbursement to UConn Health in the "Entry Description", review the support within the HuskyBuy "Attachments" tab and verify the reimbursement is properly supported with third-party invoices or authorized internal charges.

Results:

a. For all selected expenditures, which totaled 24, we obtained the corresponding KFS EDoc.

b. We obtained a list from UConn identifying approved authorizers and their authorized designees with corresponding approval thresholds for the applicable type of EDoc.

c. We identified 22 IB/DI/JV/GEC/GLT transactions. For each of those transactions, we inspected the Route Log approvals in the KFS EDoc and compared authorizations to the list obtained in 7.b and determined the electronic approvals matched based on the transaction type and authorized dollar thresholds.

    i. As applicable, we compared the support within the KFS EDoc "attachments" section to the entry in KFS and checked for agreement.

d. For 2 DVCA transactions, we located the corresponding transaction within the HuskyBuy procurement and payment system. We inspected the approvals and/or history tab within the HuskyBuy invoice and compared authorizations to the list obtained in Procedure 7.b. We determined the electronic approvals matched based on the transaction type and authorized dollar thresholds.

   i. We compared the support within the HuskyBuy "Attachments" noting agreement.

   ii. We noted 2 DVCA transactions that specified reimbursement to UConn Health in the "Entry Description" noting no exceptions.

Procedures:

8. For selected expenditures in Procedure 7 supported by a DI EDoc that specify "management fee" or "payroll allocation" in the Explanation field of the DI EDoc:

   a. Inspect the backup documents in the "attachments" section to identify the Project ID of the expenditure selected and compare the Project ID to the report obtained in Procedure 1 for agreement.

   b. Inspect the DI EDoc to identify the Project ID and compare the Project ID to the backup document obtained in Procedure 8.a for agreement, excluding DI EDocs that specify "management fee" or "payroll allocation" for capital equipment as these do not have Project IDs.

   c. Inspect the DI EDoc to identify the amount shown for Project ID selected and compare the amount to the "management fee/payroll" amount shown in the backup document obtained in Procedure 8.a for agreement. Mathematically check the amount of the "management fee" or "payroll allocation" selected by multiplying the percentage and period expenses in the backup document obtained in 8.a.

Results:

8. We identified 14 expenditures in Procedure 7 that were supported by a DI EDoc that specify "management fee" or "payroll allocation" was included in the explanation field of the DI EDoc.

   a. We inspected the backup documents in the "attachments" section and identified the Project ID of the expenditure selected and compared the Project ID to the report obtained in Procedure 1 noting agreement.

   b. We inspected the DI EDoc identifying the Project ID and compared the Project ID to the backup document obtained in Procedure 8.a noting agreement. DI EDocs that specified "management fee" or "payroll allocation" for capital equipment were excluded.

   c. We inspected the DI EDoc identifying the amount shown for Project ID selected and compared the amount to the "management fee/payroll" amount shown in the backup document obtained in Procedure 8.a noting agreement. We mathematically checked the amount of the "management fee" or "payroll allocation" selected by multiplying the percentage and period expenses in the backup document that was obtained in 8.a.

UNIVERSITY OF CONNECTICUT

Agreed-Upon Procedures: UConn 2000 Infrastructure Program as Required by Sec. 10a-109z of the Connecticut General Statutes

Contract Testing

Procedure:

1. Obtain a report of total UConn 2000 general obligation bond expenditures by project for Fiscal Year June 30, 2021 from UConn. To ensure completeness, this report will also include non-UConn 2000 funded expenditures for Fiscal Year June 30, 2021 on projects where any amount of UConn 2000 general obligation bond funded expenditures are present.

Result:

1. We obtained a report of total UConn 2000 general obligation bond expenditures by project for Fiscal Year 2021 from UConn. This report included non-UConn 2000 funded expenditures for Fiscal Year June 30, 2021 on projects where any amount of UConn 2000 general obligation bond funded expenditures were present.

Procedure:

2. From the report obtained in Procedure 1, select all projects, including capital equipment groups/projects, with total fiscal year expenditures greater than $500,000 that were not audited or examined in a prior fiscal year.

Result:

2. Using the report obtained in Contracts Procedure 1, all projects including capital equipment groups/projects with total fiscal expenditures greater than $500,000 that were not audited or examined in a prior fiscal year were selected. See Appendix A for further detail of the projects selected.

Procedure:

3. For construction projects selected in Procedure 2, obtain the Board of Trustees (“BoT”) budget approval from UConn.

Result:

3. For the projects selected in Contracts Procedure 2, we obtained evidence of the BoT budget approval from UConn.

Procedure:

4. For projects selected in Procedure 2, identify those where a construction contractor has been engaged, and obtain the Contract Approval Request Form (“CAR”) or Approval of Change to Original Contract, Workplan, or Purchase Order Request Form (“ACR” - a.k.a. “Greensheet”) or electronic workflow ACR or Unifier Requisition / Unifier Purchase Order Amendment (collectively, “Electronic Workflow Approval” or “EWA”) for construction services.

Result:

4. For each of the projects identified in Procedure 2, we obtained a CAR or POA noting no exceptions.

Procedure:

5. Obtain a list of approved authorizers or their authorized designees based on project type and contract value and the associated approval dollar thresholds.

Result:

5. We obtained from management a list of approved authorizers or their authorized designees based on project type and contract value and the associated approval dollar thresholds.

Procedure:

6. Inspect the CAR, ACR or EWA for the Vendor, Project Name, and Project ID and compare the attributes to the report obtained in Procedure 1 for agreement. In limited instances, projects may have sub-projects and the Project Name and/or Project ID of the sub-project may differ from the report; these are not exceptions.

Result:

6. We inspected the CAR, ACR or EWA for the Vendor, Project Name and Project ID and compared the attributes to the report obtained in Contracts Procedure 1 for agreement without exception.

Procedure:

7. Inspect the CAR, ACR or EWA for authorizations and compare to the list of approved authorizers or their authorized designees provided by UConn for agreement based on approval dollar thresholds.

Result:

7. We inspected the CAR, ACR or EWA for authorizations and compared the authorizations to the list of approved authorizers or their authorized designees provided by UConn for agreement based on approval dollar thresholds without exception.

Procedure:

8. Obtain the executed contract and President's Contract Signing Authority Delegation letter. For projects selected in Procedure 4, inspect the executed contract to identify the title of the person who signed the owner's authorization and compare it to the President's Contract Signing Authority Delegation letter for agreement based on approval dollar thresholds. Inspect the executed contract to identify the Contractor signature line has been signed by the Contractor.

Results:

8. We obtained the executed contract and President's Contract Signing Authority Delegation letter. For projects selected in Contracts Procedure 4 we performed the following:

    a. Inspected the executed contract and identified the title of the person who signed the owner's authorization and compared that signature to the President's Contract Signing Authority Delegation letter for agreement based on approval dollar thresholds without exception.

    b. Inspected the executed contract observing the Contractor signature line had been signed by the Contractor without exception.

Procedures:

9. Inspect executed contract to identify the initial contract amount and compare the amount to the initial KFS purchase order (or increase if pre-existing purchase order) for agreement.

    a. If amounts do not match by more than $5.00, then inspect the CAR/ACR/EWA and/or Unifier Unfunded Commits document and/or the Notes section of the KFS PO EDoc for written comments identifying the amounts which are to be designated as "Allocated", "Obligated" and/or "Future Funding".

    b. Mathematically add all amounts designated as "Allocated", "Obligated" and/or "Future Funding" to the PO amount and compare the result to the initial contract amount identified in the executed contract for agreement.

Results:

9. We inspected the executed contracts, identifying the initial contract amount and compared the amount to the initial KFS purchase order noting agreement.

    a. We did not identify any differences in excess of $5.00.

    b. We mathematically added all amounts designated as "Allocated", "Obligated" and/or "Future Funding" to the PO amount and compared the result to the initial contract amount identified in the executed contract without exception.

Procedure:

10. For projects selected in Procedure 4, obtain a Change Order ("CO") Analysis report from UConn, if applicable.

Result:

10. For the projects selected in Contracts Procedure 4, we obtained a CO Analysis report from UConn for the 11 projects.

Procedures:

11. Inspect the CO Analysis to identify the total amount of the contract. Compare the amount identified to the PO total in the Purchase Order screen in KFS as of the date of the analysis. If the identified amount from the CO Analysis exceeds the total from the Purchase Order screen in KFS, proceed to Procedures 11.a and 11.b.

    a. If amounts do not match by more than $5.00, then inspect the CAR/ACR/EWA and/or Unifier Unfunded Commits Document and/or the Notes section of the KFS PO EDoc for written comments identifying the amounts which are to be designated as “Allocated”, “Obligated” and/or “Future Funding”.

    b. Mathematically add all amounts designated as “Allocated”, “Obligated” and/or “Future Funding” and add the total to the PO amount and compare the results to the total on the CO Analysis for agreement.

Result:

11. For the projects selected in Contracts Procedure 10, we inspected the CO Analysis and identified the total amount of the contract. We then compared the amount identified in the CO Analysis to the PO total in the Purchase Order screen in KFS as of the date of the analysis. The identified amount from the CO Analysis did not exceed the total from the Purchase Order screen, therefore Procedures 11.a and 11.b were not required.

Procedure:

12. From the CO Analysis, select all change orders greater than $100,000 where the Purchase Order Revision within HuskyBuy was fully approved in the fiscal year under review. For projects without any change orders greater than $100,000, select the highest dollar value change order fully approved within HuskyBuy in the fiscal year under review.

Result:

12. From the CO Analysis, we selected all change orders greater than $100,000 where the Purchase Order Revision within HuskyBuy was fully approved in the fiscal year under review. For projects without any change orders greater than $100,000, we selected the highest dollar value change order that was fully approved within HuskyBuy for the fiscal year ended June 30, 2021 resulting in 52 change orders. No exceptions noted. See Appendix B for listing of change orders selected.

Procedure:

13. For change orders selected in Procedure 12, obtain the ACR and/or EWA and execute change order documents from KFS, HuskyBuy and/or Unifier.

Result:

13. For change orders selected in Procedure 12, we obtained the ACR and/or EWA and executed change order documents from KFS, HuskyBuy and/or Unifier without exception.

Procedure:

14. Inspect executed change order to identify the Vendor, Project Name, Project ID and Amount and compare the attributes to the ACR and/or EWA for agreement within $5.00. In limited instances, projects may have sub-projects and the Project Name and/or Project ID of the sub-project may differ from the ACR, EWA and CO Analysis; these are not exceptions.

Result:

14. We inspected executed change orders to identify the Vendor, Project Name, Project ID and Amount and compared the attributes to the ACR and/or EWA for agreement noting no exceptions in excess of $5.00.

For Procedures 15 through 19, if the selected change order is comprised of Unifier bundled Potential Change Order (PCO) and/or Construction Change Directive (CCD) transactions, obtain at least 75% coverage of the total change order value and include all individual PCO and/or CCD transactions greater than $50,000; otherwise obtain 100% coverage of the total change order value.

Procedure:

15. Inspect the executed change order documentation to identify the prime contractor markups used for insurance, bonds, and overhead and profit, if applicable, and compare the percentages to the executed contract for agreement.

Result:

15. We inspected the executed change order documentation and identified the prime contractor markups used for insurance, bonds, and overhead and profit (if applicable), and compared the percentages to the executed contract for agreement. No exceptions noted.

Procedure:

16. Inspect the executed change order documentation to identify the subcontractor markups used for insurance, bonds, and overhead and profit, if applicable, and compare the percentages to the executed contract for agreement.

Result:

16. We inspected the executed change order documentation to identify the subcontractor markups for insurance, bonds and overhead and profit (if applicable) and compared the percentages to the executed contract for agreement. No exceptions noted.

Procedure:

17. Inspect the executed change order documentation to identify the labor rates utilized within the change order and compare to the approved rates.

Result:

17. We inspected the executed change order documentation and identified the labor rates utilized within the change order and compared to the approved rates.

Procedure:

18. Inspect the ACR and/or EWA for authorizations and compare them to the list of approved authorizers or their authorized designees provided by UConn and determine authorizations agree based on approval dollar thresholds.

Result:

18. We inspected the ACR and/or EWA for authorizations and compared them to the list of approved authorizers or their authorized designees provided by UConn and determined authorizations agreed based on approval dollar thresholds.

Procedure:

19. Mathematically check the amount of the change orders.

Result:

19. We mathematically checked the amount of the change orders for accuracy and no exceptions were noted.

Appendix A

University of Connecticut - FY21 UConn 2000 AUP Population: Expenditure and Contract Testing

UConn 2000 Construction Projects (Storrs, Regionals and UConn Health Named Projects) With Over $500K In Expenditures

Project Name	UConn 2000 Expenditures in Defined Population	UConn 2000 Tested Expenditures	Contract Testing - Initial Contract
Academic & Research Facilities - Gant Building Renovations - STEM	$ 38,433,117	**$ 36,261,313**	Tested in FY21
Academic & Research Facilities - Homer Babbidge Library Renovation	3,396,774	**3,087,936**	Tested in FY21
Academic & Research Facilities - STEM Research Center Science 1	30,493,142	**28,906,912**	Tested in FY21
Boiler Plant Equipment Replacement and Utility Tunnel Connection	7,765,410	**6,425,671**	Tested in FY21
CUP Equipment Replacement and Pumping Improvements	1,252,248	**1,029,522**	Tested in Prior Year
Fine Arts Phase II - Renovation & Improvements	3,119,262	**2,969,334**	Tested in Prior Year
Northwest Quad - Science 1 - Site Improvements & Tunnel Phase II	15,470,916	**14,077,799**	Tested in FY21
Northwest Science Quad Supplemental Utility Plant	15,551,017	**13,964,071**	Tested in FY21
Public Safety Building Improvements	931,969	**804,223**	Tested in FY21
Res Life Facilities - Hicks and Grange Student Room Renovation	1,095,216	**943,276**	Tested in FY21
South Campus Commons Landscape & Pedestrian Improvement Plan	2,460,293	**2,135,124**	Tested in FY21*
South East Campus Infrastructure	523,896	**368,140**	Tested in Prior Year
Stamford Campus Garage - Demolition	702,758	**518,746**	Tested in Prior Year
Stamford Campus Surface Parking Lot	610,979	**411,151**	Tested in Prior Year
UCHC New Construction & Renovation - Clinic Building	2,254,927	**2,165,451**	Tested in Prior Year
UConn 2000 Code Remed - Stamford Downtown Relocation	1,292,694	**362,150**	Tested in FY21
University Athletic District Development (a.k.a. Stadia)	8,605,209	**7,246,469**	Tested in FY21
	$ 133,959,828	**$ 121,677,289**	

* Project had two phases: Phase 1 was completed in FY17 and Phase 2 was completed in FY21. The Phase 1 contract was tested in FY17; therefore, FY21 contract testing was limited to the Phase 2 contract.

UConn 2000 Capital Equipment Initiatives (Storrs and Regionals) and UConn Health Capital Equipment Initiatives & Deferred Maintenance Projects With Over $500K In Expenditures

Project Name	UConn 2000 Expenditures in Defined Population	UConn 2000 Tested Expenditures	Note: Equipment Not Subject to AUP Contract Testing
Academic Capital Equipment	$ 3,141,487	**$ 2,293,868**	
ITS Capital Equipment	2,758,277	**697,761**	
Public Safety Capital Equipment	581,456	**47,348**	
UCH Capital Equipment	786,938	**786,938**	
UCH Deferred Maintenance	507,671	**507,671**	Not in Scope for FY21
Wired Access Layer (ITS) - Phase 2	2,133,856	**1,357,286**	
Wired Access Layer (ITS) - Phase I	1,162,512	**407,941**	
	$ 11,072,196	**$ 6,098,813**	

Appendix A

University of Connecticut - FY21 UConn 2000 AUP Population: Expenditure and Contract Testing

Summary of FY21 UConn 2000 AUP Testing		
Total UConn 2000 FY21 Expenditures:	**$**	**152,817,711**
UConn 2000 Expenditures in Defined Population:	**$**	**145,032,023**
UConn 2000 Expenditures Excluded from Defined Population:**	**$**	**7,785,688**
UConn 2000 Expenditures Tested:	**$**	**127,776,102**
Percent of UConn 2000 Expenditures Tested of the Total UConn 2000 FY21 Expenditures:		**84%**
Percent of UConn 2000 Expenditures Tested of the UConn 2000 Defined Population:		**88%**
Number of Expenditure Transactions Tested - UConn 2000 Funded:		**183**
Number of Expenditure Transactions Tested - All Fund Sources:		**196**
Number of UConn 2000 Initial Contracts Tested:		**11**

** Value represents aggregated costs on projects with less than $500,000 of current fiscal year expenditures. Population for AUP expenditure testing is defined in Expenditure Testing Procedures 1-3.

Appendix B

University of Connecticut - FY21 UConn 2000 AUP Population: Change Order Testing

UConn 2000 Construction Projects (Storrs, Regionals and UConn Health Named Projects): FY21 Change Orders Tested In Accordance With Contract Testing Procedure 12

Project Name	Contractor Name	Original Contract Value	Change Order Number	Change Order Value
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Pre-Con)	$ 199,254	4	$ 91,019
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Phase 1 GMP)	54,232,023	44	120,973
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Phase 1 GMP)	54,232,023	50	185,771
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Phase 1 GMP)	54,232,023	52	176,602
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Phase 1 GMP)	54,232,023	55	260,697
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Phase 1 GMP)	54,232,023	57	363,173
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Phase 1 GMP)	54,232,023	58	287,092
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Phase 1 GMP)	54,232,023	62	191,832
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Phase 1 GMP)	54,232,023	67	126,330
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Phase 1 GMP)	54,232,023	68	121,411
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Phase 2 GMP)	51,138,753	5	288,181
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Phase 2 GMP)	51,138,753	11	103,529
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Phase 2 GMP)	51,138,753	17	137,457
Academic & Research Facilities - Gant Building Renovations - STEM	Whiting-Turner Contracting (Phase 2 GMP)	51,138,753	25	125,676
Academic & Research Facilities - Homer Babbidge Library Renovation	Downes Construction Co, LLC	3,692,379	3	103,012
Academic & Research Facilities - STEM Research Center Science 1	Dimeo Construction Company	134,475,210	3	163,600
Beach Hall Lab Renovations	Sarazin General Contractors	3,181,500	7	19,726
Boiler Plant Equipment Replacement and Utility Tunnel Connection	Bond Brothers Inc. (Pre-Con)	588,097	1	108,027
Boiler Plant Equipment Replacement and Utility Tunnel Connection	Bond Brothers Inc (GMP Pkg 1)	9,200,050	2	1,526,846
Boiler Plant Equipment Replacement and Utility Tunnel Connection	Bond Brothers Inc (GMP Pkg 1)	9,200,050	4	114,924
Campus Wayfinding Improvements	Sign Pro Inc	800,000	3	12,500
CUP Equipment Replacement and Pumping Improvements	Bond Brothers Inc (GMP)	13,579,339	6	112,711
Exigent Repair - Replacement of Steam & Cond Piping	Bond Brothers Inc	1,508,322	2	37,635
Exigent Repair - Replacement of Steam & Cond Piping	Environmental Systems Corp	244,980	1	65,087
Fine Arts Phase II - Renovation & Improvements	Whiting-Turner Contracting Co	25,981,811	19	67,293
Fine Arts Phase II - Renovation & Improvements	Whiting-Turner Contracting Co (GMP Amend)	1,887,767	4	(100,666)
Gampel Pavilion Dome Ceiling and Roof Repair	Downes Construction (GMP)	7,523,870	6	(162,344)
Main Campus Parking Replacements	CJ Fucci Inc	6,070,357	17	14,889
Northwest Quad - Science 1 - Site Improvements & Tunnel Phase II	Dimeo (GMP)	35,124,612	2	273,316
Northwest Science Quad Supplemental Utility Plant	Bond Brothers Inc. (GMP)	51,377,284	2	196,090
Public Safety Building Improvements	Sarazin General Contractors, Inc.	5,546,000	1	(70,000)
Res Life Facilities - Hicks and Grange Student Room Renovation	Scope Construction Co/ In.	1,339,000	1	5,422
School of Business - Roof Repairs	Silktown Roofing Inc.	333,055	3	35,255
South Campus Commons Landscape & Pedestrian Improvement Plan	Milton C Beebe & Sons Inc	2,516,623	6	(107,292)
South East Campus Infrastructure	Whiting-Turner Construction Co	3,940,933	10	(75,428)
Stamford Campus Garage - Demolition	Standard Demo Services Inc	4,137,500	6	491,897
Stamford Campus Surface Parking Lot	Giordano Construction Co Inc	2,990,000	3	186,928
Student Recreation Center	Turner Contracting Co	299,000	51	46,075
UCHC New Construction & Renovation - Clinic Building	Fusco Corp (GMP)	66,137,795	32	240,063

Appendix B

University of Connecticut - FY21 UConn 2000 AUP Population: Change Order Testing

UConn 2000 Construction Projects (Storrs, Regionals and UConn Health Named Projects): FY21 Change Orders Tested In Accordance With Contract Testing Procedure 12

Project Name	Contractor Name	Original Contract Value	Change Order Number	Change Order Value
UConn 2000 Code Remed - Northwest Residence Halls	Zlotnick Construction, Inc.	268,324	1	18,166
UConn 2000 Code Remed - Stamford Downtown Relocation	Daniel O'Connells Sons Inc (Phase 1)	522,856	3	(71,999)
University Athletic District Development (a.k.a. Stadia)	Daniel O'Connells Sons Inc (GMP)	64,051,329	16	234,411
University Athletic District Development (a.k.a. Stadia)	Daniel O'Connells Sons Inc (GMP)	64,051,329	18	163,264
University Athletic District Development (a.k.a. Stadia)	Daniel O'Connells Sons Inc (GMP)	64,051,329	20	303,392
University Athletic District Development (a.k.a. Stadia)	Daniel O'Connells Sons Inc (GMP)	64,051,329	21	204,422
University Athletic District Development (a.k.a. Stadia)	Daniel O'Connells Sons Inc (GMP)	64,051,329	22	529,485
University Athletic District Development (a.k.a. Stadia)	Daniel O'Connells Sons Inc (GMP)	64,051,329	24	209,120
University Athletic District Development (a.k.a. Stadia)	Daniel O'Connells Sons Inc (GMP)	64,051,329	25	110,096
University Athletic District Development (a.k.a. Stadia)	Daniel O'Connells Sons Inc (GMP)	64,051,329	26	162,900
University Athletic District Development (a.k.a. Stadia)	Daniel O'Connells Sons Inc (GMP)	64,051,329	27	105,457
University Dams Evaluation and Restoration	Milton C Beebe & Sons, Inc.	133,222	1	(5,256)
Wired Access Layer (UPDC) - Phase I	Sarazin General Contractors, Inc.	174,500	1	1,429
			Number of Change Orders Tested:	**52**

ATTACHMENT 2.4

UConn Health John Dempsey Hospital (DSH070036)

340B Program and Sample Data Analysis of
June 1, 2021 – November 30, 2021

Detailed Internal Work Plan

340B Program

340B COMPLIANCE PARTNERS

Pharmacy Consultants, Inc.
Roaring Spring, PA 16673

Background

UConn Health John Dempsey Hospital is located in Farmington, CT and is registered as a Disproportionate Share Hospital on the OPAIS database as DSH070036 with a start date of April 1, 2009, and last recertification date of September 7, 2021. UConn Health John Dempsey Hospital has mixed-use, clinics, entity-owned pharmacies, and registered contract pharmacies. Currently, Wellpartner, Walgreens, and Verity serve as TPAs for the Covered Entity. UConn Health John Dempsey Hospital contracted with 340B Compliance Partners to conduct the annual independent external audit of mixed-use and contract pharmacy settings for analysis of program compliance. This audit was conducted with a kick-off, pre-audit conference call on January 14th, 2022, and audit portion was on April 5th -7th, 2022. Auditors were Sherri Faber, Joshua Gue and Steven Carter.

Representation from the Covered Entity included:

Entity Participant's name	Participant's Title
Kimberly Metcalf	AO/ Assoc. VP Pharm & Ancillary Services
Bahar Matusik	PC/ Associate Director, Pharmacy
Joseph Palomba	Pharmacy Clin Coordinator
Mary Delude	Adm Program Coordinator
Kaylee Goodrich-Tomaso	Business System Analyst
Savitri Appiah	

Scope and Methodology

340B Compliance Partners has completed the procedures related to the compliance with the 340B Drug Pricing Program in accordance with the Health Resources and Services Administration's (HRSA's) guidance for Covered Entities as of April 5th, 2022. These procedures were agreed to by Senior Management and the Department of Pharmacy of UConn Health John Dempsey Hospital. The primary areas of analysis for a DSH Covered Entity are meeting eligibility requirements to be in the 340B program with proper recertification, avoiding diversion by establishing and maintaining eligible patient definitions and only counting 340B drugs for those patients, accurate information on Medicaid Exclusion file with processes in place to avoid duplicate discounts, robust Policies and Procedures, and proper oversight of contract pharmacies. Contract pharmacy agreements should include 12 elements identified by HRSA as deemed necessary for compliance. The six months of data analyzed included dispenses from June 1, 2021 through November 30, 2021, with a selection of #130 samples to test for eligibility.

Analysis of the following has been completed:

A. Knowledge during pre-audit conference call

B. Accuracy of 340B Database

C. Verification of Eligibility (Local Government Agreement, MCR, registered on OPAIS)

D. Medicaid Carve In/ Carve Out Status

E. Policy and Procedure Review

F. Sample of Dispensations tested for eligibility for 340B

G. Accumulator review for eligibility and replenishment records where applicable

H. GPO Prohibition Compliance

I. Contract Pharmacy Registration Compliance (dates of contract vs registration on HRSA database)

J. Provider File review

K. Test staff knowledge of program (ordering process, eligibility, if applicable)

L. Internal audit process

M. Multi-disciplinary committee meetings

N. Contract Pharmacy Agreements content complete with 12 elements identified by HRSA

Evidence guides

Three types of audit activities may be used to assess the level of conformance against each criterion:

1. Conducting interviews with the 340B personnel, pharmacy staff, credentialing staff, financial staff, IT/IS staff, authorizing official and primary contact.
2. Review of documentation and records. Previous audits and any required corrective actions will also be reviewed, and actions validated.
3. Observations while on site e.g., patient areas, pharmacy space, contract pharmacy (if applicable), EMR, financial records, billing records, TPA software, wholesaler invoices.

Audit assessment & rating methodology for table below:

Compliance	"Yes"	This criterion has been deemed to have been met, demonstrated and verified. Full implementation and application of the relevant components of the 340B Program are present.
Partial compliance	"Part"	Partial implementation and application of the relevant components of the 340B Program are present.
Non-compliance	"No"	An absence of evidence to verify the implementation and application of the relevant components of the 340B Program for the specific area observed.
Best Practice Recommendation	"BP"	This does not warrant a "finding" but is recommended to meet best practice and a recommendation for improvement

OBSERVATIONS

As part of the review process, 340B Compliance Partners shares observations that are both intended to highlight strengths of the program as well as opportunities that may not fall cleanly into a "finding" or "area for improvement" but may benefit the organization to review.

- Dedicated team for program. Clearly striving for ultimate compliance.
- Team well-versed in audit process
- Items of concern but due to short staffing issues: noted in Wellpartner (for mixed-use) 55 unmapped CDMs, 83 unmapped NDCs and one unrecognized dispense location will create more WAC purchasing
- JG modifier is applied to all K status medications without consideration of purchasing at 340B. Coordination with pharmacy to only apply to 340B purchased meds will limit the cuts in reimbursement to the mandated list.
- Additional access is needed for frontline 340B staff to see actual UB04 and history in patient accounts

FINDINGS SUMMARY

- OPAIS error for CVS 01903
- Five samples were not ordered by an eligible provider
- Sample 82 failed to show responsibility of care with CE

AFIS (Areas for Improvement)

- Address how MCO Medicaid is handled in PSAs
- Improve explanation of out-of-state Medicaid in P&P
- Include reverse distribution process in P&P
- Review process for appending Medicare Advantage claims with modifiers (JG/TB), not consistent today across plans.
- Ensure OPAIS crosswalk to active PSAs is accurate (Ex: Optum location with PSA, but no registration).
- Ensure all prescriptions originate from an eligible location and document this on the prescription as well as in EMR
- Education (and potentially additional access) is needed to the 340B team to correctly demonstrate patient status at the time of medication administration
- Ensure most up-to-date documents are provided in data request packet (i.e., current PSA addendum not provided for ONCO360 & CVS/Caremark).

DETAIL OF 340B ANALYSIS

	Criteria Requirement	Rating Yes/Part/No/NA	Observations	Recommendations/Comment
A	Knowledge during pre-audit conference call- appropriately answer questions and ask questions related to audit	Yes	Stakeholders participated on call on January 14, 2022. The Bizzell Group's pre-audit conference call agenda was followed. Good participation.	Continue to educate all staff and stakeholders so when HRSA audit is announced, everyone will be prepared
B	Accuracy of OPAIS database	Part	ACCREDO / EXPRESS SCRIPTS OPAIS — PSA 2040 W RIO SALADO PKWY STE 101B — 2040 W. Rio Salado Pkwy Suite 101B 2 BOULDEN CIR STE1 — 2 Boulden Circle, Suite 1 4750 E 450 S SUITE A — 4750 East 450 South Suite A 7909 S HARDY DR STE 106 — 7909 South Hardy DR STE 106 CVS/CAREMARK 800 BIERMANN CT STE B — 800 BIERMANN COURT SUITE B 1307 ALLEN DR STE H — 1307-H ALLEN DR 400 METACOM AVENUE — 400 METACOM AVE 110 ROUTE 6A — 110 RTE 6A 327 MAIN AVENUE — 327 MAIN AVE 26 DAVIS STREET — 26 DAVIS ST 891 NORTH COLONY RD. — 891 N COLONY RD 410 LONGMEADOW STREET — 410 LONGMEADOW ST 137 FEDERAL STREET — 137 FEDERAL ST 905 SOUTH MAIN ST — 905 S MAIN ST 790 CHIEF JUSTICE CUSHING HWY — 790 JUSTICE CUSHING WAY, RTE 3A 17 WEST MAIN STREET — 17 W MAIN ST 511 MONROE TURNPIKE, RT 111 — 511 MONROE TURNPIKE 108 RT 44 — 108 RTE 44	The minor address discrepancies could be addressed on any amendment upcoming and may not be an issue. Just want to point out any discrepancy at all. The addresses that are incorrect and highlighted should potentially be corrected with an amendment.

			266 WEST STREET, ROUTE 202	266 WEST ST, RTE 202	
			330 MAIN STREET	330 MAIN ST	
			142 TALCOTTVILLE ROAD	142 TALCOTTVILLE RD	
			839 FARMINGTON AVE	839 FARMINGTON AVE, RTE 6, BRISTOL S/C	
			978 FARMINGTON AVENUE	978 FARMINGTON AVE	
			1078 SILAS DEANE HIGHWAY	1078 SILAS DEAN HWY	
			484 WINDSOR AVENUE	484 WINDSOR AVE	
			566 FARMINGTON AVENUE	566 FARMINGTON AVE	
			308 MAIN STREET EXTENSION	308 MAIN ST EXTENSION	
			2639 MAIN STREET	2639 MAIN ST	
			1099 NEW BRITAIN AVENUE	1099 NEW BRITAIN AVE	
			1181 MAIN STREET	1181 MAIN ST	
			713 WEST MAIN STREET	713 W MAIN ST	
			632 MIDDLE TURNPIKE STORRS MANSFIELD	632 MIDDLE TURNPIKE STORRS	
			14 FARMINGTON AVENUE	14 FARMINGTON AVE	
			908-910 MAPLE AVENUE	908-910 MAPLE AVE	
			839 EAST MAIN STREET	839 E MAIN ST	
			1200 MAIN STREET	1200 MAIN ST	
			45 SOUTH MAIN ST	45 S MAIN ST	
			372 WEST MAIN STREET	372 W MAIN ST	
			1044 BOULEVARD	1044 BLVD	
			326 MAIN STREET	326 MAIN ST	
			90 MAIN STREET	90 MAIN ST	
			20 BURNSIDE AVENUE	20 BURNSIDE AVE	
			661 MAIN STREET	661 MAIN ST	

			464 REIDVILLE DRIVE	464 REIDVILLE DR	
			1240 FARMINGTON AVENUE	1240 FARMINGTON AVE	
			219 BROAD STREET	219 BROAD ST	
			777 MAIN STREET	777 MAIN ST	
			26 WATERBURY ROAD	26 WATERBURY RD	
			81 NORTH STREET	81 NORTH ST	
			6 QUEEN STREET	6 QUEEN ST	
			824 PARK AVE	796 PARK AVE (STORE 01903)	
			260 NORTH MAIN STREET	260 N MAIN ST	
			1279 WEST MAIN STREET	1279 W MAIN ST	
			1057 BOSTON POST ROAD, ROUTE 1	1057 BOSTON POST RD RT #1	
			540 WEST MAIN STREET	540 W MAIN ST	
			118 NORTHAMPTON ST	118 NORTHAMPTON ST, RTE 10	
			22 WINDSOR AVE	22 WINDSOR AVE, RTE 83	
			1055 FARMINGTON AVENUE	1055 FARMINGTON AVE	
			526 MERIDEN ROAD	526 MERIDEN RD	
			150 SOUTH MAIN STREET	150 S MAIN ST	
			2427 MAIN STREET	2427 MAIN ST	
			986 MAIN STREET	986 MAIN ST	
			35 KNEELAND STREET	35 KNEELAND ST	
			323 CROMWELL AVENUE	323 CROMWELL AVE	
			675 WASHINGTON STREET	675 WASHINGTON ST	
			54 EAST HIGH ST	54 E HIGH ST	
			241 MIDDLE TURNPIKE WEST	241 MIDDLE TURNPIKE W	
			150 WASHINGTON STREET	150 WASHINGTON ST	
			153 BROAD STREET	153 BROAD ST	

			110 MAIN STREET 110 MAIN ST 1221 MAIN STREET 1221 MAIN ST 8 ROYCE CIRCLE 8 ROYCE CIRCLE (TS-3) 37 WEST MAIN STREET 37 W MAIN ST 1 GREAT VALLEY BOULEVARD NO PSA PROVIDED WILKES BARRE, PA 18706 1780 WALL ST NO PSA PROVIDED MT PROSPECT, IL 60056-5790 HARTFORD HOSPITAL 85 SEYMOUR STREET 85 SEYMOUR ST ONCO 360 SINA DRUG LLC at 1985 MARCUS AVE STE 120, NEW HYDE PARK NY 11042 registered on OPAIS, but not listed in most recent PSA addendum. Sina Drug, LLC at 225 Community Drive Suite 100 Great Neck, NY 11021 is a listed location in most recent PSA addendum but is not registered to OPAIS. SINA DRUG LLC at 1981 MARCUS AVE STE 225, NEW HYDE PARK NY was a listed location in previous addendum but is not registered to OPAIS. OPTUM 1050 PATROL RD 1050 PATROL ROAD NOT REGISTERED 8350 BRIOVA DR LAS VEGAS, NV 89113 UCONN HEALTH PHARMACY SERVICES INC 270 FARMINGTON AVE STE 108 270 FARMINGTON AVENUE SUITE 108	Included CE locations should ideally state parent “and all registered child sites on HRSA database” to avoid amendments in the future. PSA is missing date of signature for each party.
C	Verification of eligibility	Yes	Recertification completed timely. DSH percentage is 14.24.	
D	Medicaid Carve-In, Carve-Out Status		Carved-in for FFS Medicaid.	

E	Policy & Procedure Review	Part	HRSA is looking for very detailed policies and procedures. Minimum guidance may be found in the self-audit for P&P by Apexus. For DRL#1 A. Original registration process and recertification are addressed. B. OPAIS database review is stated annually with changes as needed C. Location eligibility addressed including locations deemed eligible but not yet appearing on the MCR. D. Procurement is addressed for mixed use as well as contract pharmacy arrangements. E. GPO prohibition is addressed via TPA and 3 purchasing accounts. F. Bundled services called out as NCOD, and then a reference to an exclusion list maintained by the pharmacy dept. G. QA for both mixed-use and contract pharmacy arrangements are addressed. H. Both mixed-use and contract pharmacy arrangement inventory/accumulation are addressed. I. Site eligibility, patient medical record, patient eligibility, provider eligibility is addressed. Referrals are not currently part of the UCONN JDH 340B program. J. All elements addressed besides referral capture K. CT Medicaid relies on the MEF process, which is described in P&P. JDF excludes other state Medicaid programs. L. Recent HRSA audits are asking for both Medicaid FFS and MCO processes to avoid duplicate discounts. MEF is FFS – specific, but CE is still responsible to know process for avoiding duplicate discounts with MCO Medicaid, as applicable. M. Material breach is addressed but defined as reviewed on a case-by-case basis in consultation with JDH Compliance/legal. N. Mentioned above regarding eligible child sites.	Recommend additional language around initial registration. Child sites and CP covered well in P&P. Recommend including full NCOD list as an appendix to P&P. Recommend including sampling quantity/methodology and elements reviewed (especially for mixed-use) Recommend including process for drug waste not administered to the patient. Recommend defining material breach in either dollar amount or percentage of 340B spend, and to also define what is being considered to meet that threshold (i.e., expense of medication, or delta between 340B and WAC, etc.).

			Reverse distribution only mentioned in responsibilities for Purchasing/Inventory Specialist. Recommend including process for this and if 340B is included in this program. Program savings only addressed in the responsibilities of the Associate Pharmacy Director. Recommend verbiage around intent of savings. Conflict between date issue (20-Jan-17) and date effective (1-Oct-13) Recommend including that non-CT Medicaid is carved out.	
F	Samples tested	Part	See details as follows:	
	❖ Provider Eligible? ❖ Referral but no documentation or incomplete documentation found. Would also be a finding of ineligible provider and therefore diversion.	Part N/A	Samples #1, 31, 39, 81, and 106 did not have an eligible provider. None in audit	
	❖ Location Eligible?	Part	Sample #55 prescribed from an ineligible location (per hardcopy)	
	❖ Responsibility of care with Covered Entity?	Part	Sample #82, eligible visit outside 13-month window defined in P&P	
	❖ Mixed-Use (Clinic)- administration date/time documented or ❖ Mixed-Use- Medication administered when patient in an inpatient status	Yes Part	Samples #5 and #10 were administered while patient status = INPATIENT	

	❖ documentation of prescription sent to pharmacy in chart or EMR	Yes		Must have documentation in chart for all prescriptions sent to a pharmacy
	❖ 340B drugs are line-item billed with appropriate modifiers as necessary for Physician Administered Drugs. ❖ Medicaid Carved out in Contract Pharmacy ❖ Medicare requires JG for DSH for K and TB for G **OR** TB modifier for G and K status drugs if a DSH is treated as a SCH	Yes Yes Yes	Secondary Medicaid is the concern. Need to have something in writing from all contract pharmacies that they either do not bill anything beyond primary or that you would have visibility into secondary billing.	This needs to be monitored and updated quarterly. Right now, missed opportunity by adding to all K status instead of only ones purchased at 340B.
G	Accumulator and replenishment verified	Yes		
H	GPO Prohibition Compliance	Yes		

I	Contract Pharmacy /Entity-owned pharmacy registration compliance	Part	See OPAIS findings	
J	Provider File Review	Part	This is a manual process today for the 340B, that did lead to some samples falling out.	
K	Test Staff Knowledge of program (ordering, etc.)	Yes	Knowledgeable front line purchasing staff, engaged in good discussion.	
L	Internal Audit Process	Yes	Discussed process and QA templates provided by team.	
M	Multi-disciplinary Committee Meetings	Yes	It appears the 340B staff members are covered in the P&P and have minutes to demonstrate meetings	
N.	12 Essential Elements in contracts for Contract Pharmacy	Yes		As indicated in the Federal Register from March 2010, there are 12 essential elements the pharmacy services agreement with contract pharmacies should contain.

This report is intended solely for the information and use of UConn Health John Dempsey Hospital senior management, JDH 340B Oversight Committee, and JDH pharmacy personnel and is not intended to be and should not be used by another, other than those specified parties.

Any questions related to this report may be directed to 340B Compliance Partners at:
sfaber@rxconsultantsinc.com or (304) 964-3903

Summary of site observations

Site observation conducted by:	**Sherri D. Faber, RPh, MHA Joshua Gue, CPhT Steven Carter, PharmD**		
Site observation report attached:	**Yes: See above**	**No:**	**Date: 04/25/2022**

Comments:

We enjoyed working with this great group of conscientious leaders responsible for the 340B program at UConn Health John Dempsey Hospital.

To further mimic the HRSA audit experience, you would have 30 days to dispute any of the findings presented in the final report. If no disputes in the next 60 days from report receipt, you would create your Corrective Action Plan (CAP) and have 6 months after it is approved by HRSA to fully implement and attest to the completion of the CAP. The CAP would address all Findings and AFIs; however, Findings may be the only request for CAP from HRSA.

FINDINGS AND AREAS FOR IMPROVEMENT OF THE INDEPENDENT OUTSIDE AUDIT FOR JDH 340B PROGRAM

The JDH 340B program underwent an outside independent mock audit as required by Health Resources and Services Administration (HRSA) for the period of June 1, 2021 – November 30, 2021. This audit was conducted by 340B Compliance Partners with a kick-off, pre-audit, conference call on January 14, 2022, and the audit took place on-site on April 5-7, 2022. 340B Compliance Partners completed the procedures, related to compliance with the 340B Drug Pricing Program, in accordance with the HRSA's guidance for Covered Entities.

FINDINGS:

1. Finding: "*OPAIS error for CVS 01903.*"

HRSA's Office of Pharmacy Affairs (OPA) administers the 340B Drug Pricing Program. The database is a comprehensive search engine for covered entities, contract pharmacies, and manufacturers and the data provided needs to be kept up to date.

JDH 340B Management Response:
The JDH 340B Management team agree with this finding. The discrepancy between the OPAIS database and the Pharmacy Service Agreement will be corrected through a contract amendment. In addition, the 340B team has amended its Policy and Procedures for reviewing the OPAIS database from annual to quarterly.

Completion Date: 8/31/2022

2. Finding: "*Five samples were not ordered by an eligible provider.*"

An eligible provider is a provider either employed by the covered entity or provides health care under contractual or other arrangements (i.e., referral for consultation), such that responsibility for the care provided remains with the Covered Entity.

JDH 340B Management Response:
The JDH 340B Management do not agree with the finding because all the providers associated with the five samples were active within the medical staff office database as having had privileges during the audit period.

The 340B team previously attempted to maintain an active provider file but replicating a database that is continuously fluid is not feasible and therefore the medical staff office provider database is the source of truth for our determination of provider status. The administrative staff of the 340B have been re-educated and therefore since the providers associated with the five samples always remained active, the 340B team disagrees with the auditors rating of a "finding".

Completion Date: 5/12/2022

3. Finding: "*Sample 82 failed to show responsibility of care with CE.*"

The 340B law prohibits Covered Entities from diverting 340B drugs to individuals who are not their patients. Per JDH CE Policy & Procedures, patient eligibility requires that an episode of care has occurred within 13 months of a qualified claim.

JDH 340B Management Response:
JDH 340B Management agrees with the finding identifying that this patient did not physically visit their physician within the defined period before the date this prescription was written. However, the patient had a documented 'Medical

Question' telephone encounter with their physician within 12 months of this sample. This oversight of our internal quality assurance process was identified in September of 2021 and subsequently corrected so that no future fills for this patient qualifies without a visit to their physician.

Completion Date: 5/12/2022

AREAS FOR IMPROVEMENT:

1. AFI: "*Address how MCO Medicaid is handled in PSAs.*"

The 340B law prohibits duplicate discounts. Purchasing a drug at a discount under 340B and the claim also being subject to a rebate under a state Medicaid program delivered by a managed care organization would subject the manufacturer to 'two' discounts.

JDH 340B Management Response:
JDH 340B Management agrees with the auditor's concern for prevention of duplicate discounts however disagrees with the assessment and recommendation regarding this AFI. Avoiding duplicate discount billing has become more complex due to the increase in the number of Medicaid managed care organizations, and is a multi-pronged approach. The JDH CE addresses MCO Medicaid by monitoring for Medicaid BIN/PCN through its Third Party Administrators and providing claims level data to manufacturers.

Completion Date: 5/12/2022

2. AFI: "*Improve explanation of out-of-state Medicaid in P&P.*"

HRSA expects Covered Entities to have detailed policies and procedures as related to their 340B programs. This should include explaining the CE's process for ensuring how duplicate discounts are avoided with out of state Medicaid.

JDH 340B Management Response:
JDH 340B Management agrees with the auditor's assessment and recommendation regarding this AFI. JDH 340B Management expanded its Policy and Procedures by adding language specific to this. The updated policy will be presented to the 340B Oversight Committee for approval.

Completion Date: 5/31/2022

3. AFI: "*Include reverse distribution process in P&P.*"

HRSA expects Covered Entities to have detailed policies and procedures as related to their 340B programs. A 'Reverse Distributor' is a company which receives pharmaceuticals from a healthcare facility for the purpose of returning unwanted, unusable, or outdated pharmaceuticals to the manufacturer or to another entity that can reuse the medicine.

JDH 340B Management Response:
JDH 340B Management agrees with the auditor's assessment and recommendation regarding this AFI. UConn Health JDH Pharmacy Department does not use a reverse distributor. JDH 340B Management has expanded its Policy and Procedures by adding specific language regarding this. The updated policy will be presented to the 340B Oversight Committee for approval.

Completion Date: 5/31/2022

4. AFI: *"Review process for appending Medicare Advantage claims with modifiers (JG/TB), not consistent today across plans."*

CMS CY2018 OPPS Final Rule established two modifiers to identify 340B drugs – the "JG" and "TB" modifiers. The "JG" modifier triggers a reimbursement reduction, while the "TB" modifier is used for informational purposes. As of January 1, 2018, affected CEs are required to report these modifiers on OPPS claims for certain separately payable drugs or biologicals that are acquired through the 340B program and administered or dispensed to a Medicare patient.

JDH 340B Management Response:
JDH 340B Management does not agree with the auditor's assessment and recommendation regarding this AFI. While the modifiers were not shown in Epic EMR, three out of the four claims reviewed by the auditors had the appropriate modifier on the UB-04 form and the fourth claim's UB-04 was previously corrected by Revenue Integrity as part of a quality assurance project. The CE has appropriate safety nets in place to catch these.

Completion Date: 5/12/2022

5. AFI: *"Ensure OPAIS crosswalk to active PSAs is accurate (Ex: Optum location with PSA, but no registration)."*

The 340B registration and pricing databases are collectively known as the 340B Office of Pharmacy Affairs Information System (340B OPAIS). Authorized users of 340B OPAIS must have a user account with appropriate roles while keeping the database up-to-date and accurate.

JDH 340B Management Response:
JDH 340B Management agrees with the auditor's concern to maintain an OPAIS crosswalk however disagrees with the assessment and recommendation referencing the Optum location. Shortly after this specific PSA was executed, one of the contract pharmacies listed within the PSA closed. The CE never registered this pharmacy and never processed any claims through it. Of note, the 340B team has amended its Policy and Procedures on the review of the OPAIS database from annual to quarterly.

Completion Date: 5/31/2022

6. AFI: *"Ensure all prescriptions originate from an eligible location and document this on the prescription as well as in EMR"*

A 340B-eligible patient is an individual who receives health care services such that responsibility for the care provided remains with the covered entity. Most prescriptions for the CE's patients are e-prescribed while some are faxed or hand-written. Once a prescription reaches a pharmacy, it may be marked up with internal notes of the pharmacy.

JDH 340B Management Response:
JDH 340B Management does not agree with the auditor's assessment and recommendation regarding this AFI. During the 340B Compliance Partners external audit review of our program the auditor noticed the CP's hard copy had the incorrect address for the provider. This was a notation made by the pharmacy on the faxed prescription and not by the CE. It was clearly documented in the CE's electronic medical record (EMR) that the care was provided by an eligible prescriber and at an eligible location demonstrating continuity of care. The CE is not responsible for internal documentations made on the hard copy of the CP.

Completion Date: 5/12/2022

7. AFI: *"Education (and potentially additional access) is needed to the 340B team to correctly demonstrate patient status at the time of medication administration."*

During an audit, a 340B CE must be able to demonstrate program integrity and records documenting compliance with 340B Program requirements. This includes being able to navigate the EMR.

JDH 340B Management Response:
JDH 340B Management agrees with the auditor's assessment and recommendation regarding this AFI. During the 340B Compliance Partners external audit review of our program, the 340B team was unable to demonstrate within Epic, specifically, patients' status change during their admission. The team will receive additional access and training to be able to navigate this within Epic.

Completion Date: 5/31/2022

8. AFI: *"Ensure most up-to-date documents are provided in data request packet (i.e., current PSA addendum not provided for ONCO360 & CVS/Caremark)."*

Covered entities selected for a HRSA audit receive an engagement letter along with a data request list which asks, among many items, for copies of Pharmacy Services Agreements (PSAs).

JDH 340B Management Response:
JDH 340B Management agrees with the auditor's assessment and recommendation regarding this AFI. During the 340B Compliance Partners external audit review data request period, the 340B team did not submit the most current PSAs on file. In the future, the 340B team will utilize a double check system when submitting data requested by the auditors.

Completion Date: 5/12/2022

ATTACHMENT 2.5

University of Connecticut Division of Infectious Diseases Ryan White Part A (RWI06030)

340B Program and Sample Data Analysis of
June 1, 2021 – November 30, 2021

Detailed Internal Work Plan

340B Program

340B COMPLIANCE PARTNERS

Pharmacy Consultants, Inc.
Roaring Spring, PA 16673

Background

University of Connecticut Ryan White Part A is located in Farmington, Connecticut and is registered as a Ryan White Part A on the OPAIS database as RWI06030 with a start date of January 1, 2012, and last recertification date of February 23, 2021. University of Connecticut Ryan White Part A has registered contract pharmacies. Currently, Wellpartner, Walgreens, Verity and Curant serve as TPAs for the Covered Entity. University of Connecticut Ryan White Part A contracted with 340B Compliance Partners to conduct the annual independent external audit of contract pharmacy settings for analysis of program compliance. This audit was conducted with a kick-off, pre-audit conference call on January 4th, 2022, and virtual audit portion was on January 19th, 2022. Auditors were Sherri Faber, Jami Dean and Michelle Jackson.

Representation from the Covered Entity included:

Entity Participant's name	Participant's Title
Kim Metcalf	AO/ Assoc VP, Pharm & Ancillary Services
Bahar Matusik	PC/Assoc Director, Pharmacy
Dr. Kevin Dieckaus	Chief, Division of Infectious Diseases
Joe Palomba	Pharmacy Clinical Coordinator
Mary Delude	Adm Program Coordinator for 340B
Kaylee Goodrich-Tomaso	Business System Analyst
John Canelli	Credentialing

Scope and Methodology

340B Compliance Partners has completed the procedures related to the compliance with the 340B Drug Pricing Program in accordance with the Health Resources and Services Administration's (HRSA's) guidance for Covered Entities as of January 19th of 2022. These procedures were agreed to by Senior Management and the Department of Pharmacy of University of Connecticut Ryan White Part A. The primary areas of analysis for a Ryan White Part A Covered Entity are meeting eligibility requirements to be in the 340B program with proper recertification, avoiding diversion by establishing and maintaining eligible patient definitions and only counting 340B drugs for those patients, accurate information on Medicaid Exclusion file with processes in place to avoid duplicate discounts, robust Policies and Procedures, and proper oversight of contract pharmacies. Contract pharmacy agreements should include 12 elements identified by HRSA as deemed necessary for compliance. The six months of data analyzed included dispenses from June 1, 2021 through November 30, 2021 with a selection of #60 samples to test for eligibility.

Analysis of the following has been completed:

A. Knowledge during pre-audit conference call

B. Accuracy of 340B Database

C. Verification of Eligibility (grant awarded, registered on OPAIS)

D. Medicaid Carve In/ Carve Out Status

E. Policy and Procedure Review

F. Sample of Dispensations tested for eligibility for 340B

G. Accumulator review for eligibility and replenishment records where applicable

H. Diversion tests

I. Contract Pharmacy Compliance (dates of contract vs registration on HRSA database)

J. Provider File review

K. Test staff knowledge of program (ordering process, eligibility, if applicable)

L. Internal audit process

M. Multi-disciplinary committee meetings

N. Contract Pharmacy Agreements content complete with 12 elements identified by HRSA

Evidence guides

Three types of audit activities may be used to assess the level of conformance against each criterion:

1. Conducting interviews with the 340B personnel, pharmacy staff, credentialing staff, financial staff, IT/IS staff, authorizing official and primary contact.
2. Review of documentation and records. Previous audits and any required corrective actions will also be reviewed and actions validated.
3. Observations while on site e.g., patient areas, pharmacy space, contract pharmacy (if applicable), EMR, financial records, billing records, TPA software, wholesaler invoices.

Audit assessment & rating methodology for table below:

Compliance	"Yes"	This criterion has been deemed to have been met, demonstrated and verified. Full implementation and application of the relevant components of the 340B Program are present.
Partial compliance	"Part"	Partial implementation and application of the relevant components of the 340B Program are present.
Non-compliance	"No"	An absence of evidence to verify the implementation and application of the relevant components of the 340B Program for the specific area observed.
Best Practice Recommendation	"BP"	This does not warrant a "finding" but is recommended to meet best practice and a recommendation for improvement

OBSERVATIONS

As part of the review process, 340B Compliance Partners shares observations that are both intended to highlight strengths of the program as well as opportunities that may not fall cleanly into a "finding" or "area for improvement" but may benefit the organization to review.

- Dedicated team for program. Clearly striving for ultimate compliance.
- Team well-versed in audit process
- Overall, each year represents improvement in oversight of program
- According to 340B Health Conference sessions and with Apexus, the encounter must be associated with the proper diagnosis for the grant. However, other medications that result from those visits may also count as 340B eligible.

FINDINGS SUMMARY

- Diversion Finding for no eligible encounter found within timeframe set forth by the Covered Entity of 13 months. Samples #29, #52, #53

AFIS (Areas for Improvement)

- Potential for Duplicate Discounts with secondary medicaid coverage. Need documentation from all pharmacies/TPAs that they show secondary billing or do not bill secondary at all. Samples #28, 29, 30, 31 all have secondary Medicaid in EMR. While this does not mean it was billed at the pharmacy, it represents risk until confirmation at each pharmacy of process for both primary and secondary Medicaid. Verity – continue investigation into secondary Medicaid billing
- Samples #33, #36 written dates were off by one day when comparing TPA with chart notes and hard copies.
- Need to verify action completed when reversals or true ups are requested. Some samples were still in data that were requested to be corrected.
- Potential issue with contracted providers or fellows/residents leaving.

DETAIL OF 340B ANALYSIS

	Criteria Requirement	Rating Yes/Part/No/NA	Observations	Recommendations/Comment
A	Knowledge during pre-audit conference call- appropriately answer questions and ask questions related to audit	Yes	Stakeholders participated on call on January 4, 2022. The Bizzell Group's pre-audit conference call agenda was followed. Good participation.	Continue to educate all staff and stakeholders so when HRSA audit is announced, everyone will be prepared
B	Accuracy of OPAIS database	Part	**Accredo Health Group Inc** OPAIS / Contract Cir / Circle STE / Suite **ESI Mail Pharmacy Service** OPAIS / Contract S / South 85284-1112 / 85284 **Curant Health Florida, LLC** OPAIS / Contract STE / Suite 33716-2338 / 33716 approved 4/4/16 / signed begin 7/1/16* / 12/22/16 **Curant Health Georgia LLC** OPAIS / Contract 200 Technology CT / 200 SE BLDG 200 SUITE B / Technology *also has Curant / Court, SE, Suite	The minor address discrepancies could be addressed on any amendment upcoming and may not be an issue. Just want to point out any discrepancy at all. The addresses that are incorrect and highlighted should potentially be corrected with an amendment.

				Health in address field*	B, Building 200	
				30082-5250 approved 4/4/16 begin 7/1/16*	30082 signed 12/22/16	
				CVS Pharmacy LLC. 01156		
				OPAIS	Contract	
				Avenue	Ave	
				CVS Pharmacy LLC. 02119		
				OPAIS	Contract	
				Avenue	Ave	
				CVS Pharmacy LLC. 04436		
				OPAIS	Contract	
				West	W	
				CVS Pharmacy LLC. 00085		
				OPAIS	Contract	
				#85	00085	
				CVS Pharmacy LLC. 00145		
				OPAIS	Contract	
				Street	ST	
				CVS Pharmacy LLC. 00288		

				OPAIS	Contract
				839 Farmington Ave	839 Farmington Ave, RTE 6, Bristol S/C
				Grand St. Paul CVS, LLC. 05788	
				OPAIS	Contract
				6905 York Avenue	6905 York Ave, S
				CVS Pharmacy LLC 00348	
				OPAIS	Contract
				1078 Silas Deane Highway	1078 Silas Dean HWY
				CVS Pharmacy LLC 00349	
				OPAIS	Contract
				Avenue	Ave
				CVS Pharmacy LLC 00350	
				OPAIS	Contract
				Avenue	Ave
				CVS Pharmacy LLC. 00671	
				OPAIS	Contract
				Avenue	Ave

				CVS Pharmacy LLC 00691	
				OPAIS	Contract
				Street	ST
				CVS Pharmacy LLC 00839	
				OPAIS	Contract
				Avenue	Ave
				CVS Pharmacy LLC 00840	
				OPAIS	Contract
				Avenue	Ave
				CVS Pharmacy LLC 00953	
				OPAIS	Contract
				45 South Main St Farmington Plaza	45 S Main St
				CVS Pharmacy LLC 01038	
				OPAIS	Contract
				Boulevard	Blvd
				CVS Pharmacy LLC 01060	
				OPAIS	Contract
				Street	St
				CVS Pharmacy LLC 01089	

				OPAIS Avenue	Contract Ave	
				CVS Pharmacy LLC 01166 OPAIS Street	 Contract St	
				CVS Pharmacy LLC 01183 OPAIS Street	 Contract St	
				CVS Pharmacy LLC 01213 OPAIS Street	 Contract St	
				CVS Pharmacy LLC 01242 OPAIS 714 Hopmeadow St. Dracut Mall	 Contract 714 Hopmeadow St	
				CVS Pharmacy LLC 01276 OPAIS Street	 Contract St	
				CVS Pharmacy LLC 01903 OPAIS 824 Park Ave	 Contract 796 Park Ave	

				CVS Pharmacy LLC 02109		
				OPAIS	Contract	
				22 Windsor Ave Vernon Rockville	22 Windsor Ave, RTE 83 Rockville	
				CVS Pharmacy LLC 02153		
				OPAIS	Contract	
				150 South Main Street	150 S Main St	
				CVS Pharmacy LLC 02919/CarePlus		
				OPAIS	Contract	
				Procare Pharmacy LLC	0219/CarePlus	
				CVS Pharmacy LLC 05263		
				OPAIS	Contract	
				Street	St	
				CVS Pharmacy LLC 10008		
				OPAIS	Contract	
				6265 East 2nd St.	6265 E 2nd St. #101	
				CVS Pharmacy LLC 10316		

				OPAIS Street	Contract St	
				CVS Specialty Illinois OPAIS 800 Biermann Ct. STE B 60056-2151	Contract 800 Biermann Court Suite B 60056	
				CVS Specialty Michigan OPAIS 1307 Allen Dr. STE H	Contract 1307-H Allen Dr	
				Aetna Specialty Pharmacy OPAIS LN 06032-1572	Contract Lane 6032	
				Hartford Hospital OPAIS DBA Hartford Healthcare Retail Pharmacy	Contract DBA Hartford Healthcare Community Pharmacy	
				Walgreens 03827 **OPAIS** 06106	****changed on Amen.3**** **Contract** 06106-2464	

				Walgreens 07585 OPAIS Street	****changed on Amen.2** Contract** St	
				Walgreens 07750 OPAIS 06110	changed on Amen.3 Contract 06110-1458	
				Walgreens 15207 OPAIS 06119	**Orig. & amen. 1(different address) Changed on Amen.2 & 3 Contract** 06119-1810	
				Walgreens 17298 OPAIS 06002	**changed on Amen. 3 Contract** 06002-2469	
				Walgreens 18243 OPAIS 06053	**changed on Amen. 3 Contract** 06053-3224	
				Walgreens 18969 OPAIS 06112	**changed on Amen. 3 Contract** 06112-2198	

				Walgreens 19842 **OPAIS** 06111	**changed on Amen. 3** **Contract** 06111-2613	
				Prime Therapeutics Specialty/Walgreens 16568 **OPAIS** 32819-9992	 **Contract** 32819	
				Walgreens 05134 **OPAIS** 06070-2925	 **Contract** 06070	
				Walgreens 05407 **OPAIS** Street 06040	 **Contract** St. 06040-4128	
				Walgreens 05949 **OPAIS** 28 East Elm St 06790	 **Contract** 28 E Elm St 06790-5016	
				Walgreens 07566 **OPAIS** Lane 06118	 **Contract** LN 06118-1248	
				Walgreens 11825		

			OPAIS Avenue 06010 **Contract** Ave 06010-3931 **UCONN Health** **OPAIS** 270 Farmington Ave STE 108 **Contract** 270 Farmington Avenue	
C	Verification of eligibility	Yes	Grant provided. Recertification completed timely	
D	Medicaid Carve-In, Carve-Out Status	Yes	Carved-out for FFS Medicaid	
E	Policy & Procedure Review	Yes	HRSA is looking for very detailed policies and procedures. Minimum guidance may be found in the self-audit for P&P by Apexus. For DRL#1 A. Original registration process and recertification are addressed. Likely need to include portion about the grantee being operational in the HRSA Electronic Handbook. B. OPAIS database review is stated annually. C. OK- scope of grant addressed. D. Procurement is addressed for contract pharmacies. E. N/A GPO Prohibition F. None listed G. Need more detail as to what you are auditing in terms of quantities or as mentioned in audit- all first fills. H. OK- inventory explained. I. N/A Mixed-Use is under DSH registration. J. This portion is addressed.	

			K. N/A L. Recent HRSA audits are asking for both Medicaid FFS and MCO processes to avoid duplicate discounts. MEF is FFS – specific, but CE is still responsible to know process for avoiding duplicate discounts with MCO Medicaid, as applicable. M. Material Breach is mentioned case by case but likely need some sort of criteria examined to make determination. No mention of material breach discussion as part of oversight committee minutes. Of minutes submitted, no findings for RWI. All designations are reported together but no mention of material breach analysis on other areas that were not 100% compliant. N. N/A	
F	Samples tested	Part	See details as follows:	
	❖ Provider Eligible? ❖ Referral but no documentation or incomplete documentation found. Would also be a finding of ineligible provider and therefore diversion.	Yes		
	❖ Location Eligible?	Yes		
	❖ Responsibility of care with Covered Entity?	Part	Samples #29, #52, #53 had no eligible encounter within time frame established by CE	

	❖ Mixed-Use (Clinic)- administration date/time documented or ❖ Mixed-Use- Medication administered when patient in an inpatient status ❖ Mixed-Use- Medication order not documented so ordering provider unavailable ❖ documentation of prescription sent to pharmacy in chart or EMR	N/A N/A N/A Yes		Must have documentation in chart for all prescriptions sent to a pharmacy
	❖ Insurance Coverage is MCO Medicaid so proper billing and modifiers in the in-clinic. ❖ 340B drugs are line-item billed with appropriate modifiers as necessary for Physician Administered Drugs.	N/A N/A	Carve-Out Medicaid	

	❖ Medicaid Carved out in Contract Pharmacy ❖ Medicare requires JG for DSH or TB modifier for G and K status drugs if a DSH is treated as a SCH	Part N/A	Medicaid is secondary in EMR so potential duplicate discount in retail pharmacy Samples: #28, #29, #30, #31. Need to verify that secondary is not billed and keep that documentation for future audits.	
G	Accumulator and replenishment verified	Part		
H	Diversion tests i.e. location, not meeting patient definition, ineligible provider	Part	Diversion would be the finding for any above that did not meet patient definition for 340B Samples #29, #52, #53	
I	Contract Pharmacy /Entity-owned pharmacy compliance	Part	With ongoing audits ensure that TPA is functioning as intended. Ensure requested reversals/true ups/credits have been processed	
J	Provider File Review	Part	Nice provider file. A few ordering providers were not on file.	List is being updated timely.
K	GPO Prohibition	N/A		
L	Internal Audit Process	Yes		These are being completed
M	Multi-disciplinary Committee Meetings	Yes	It appears the 340B staff members are covered in the P&P and have minutes to demonstrate meetings	
N.	12 Essential Elements in contracts for Contract Pharmacy	Yes		As indicated in the Federal Register from March 2010, there are 12 essential elements the pharmacy services agreement with contract pharmacies should contain.

This report is intended solely for the information and use of UConn senior management, UConn 340B Oversight Committee, and UConn pharmacy personnel and is not intended to be and should not be used by another, other than those specified parties.

Any questions related to this report may be directed to 340B Compliance Partners at:
sfaber@rxconsultantsinc.com or (304) 964-3903

Summary of site observations

Site observation conducted by:	**Sherri D. Faber, RPh, MHA Jami Dean, CPhT Michelle Jackson, CPhT**		
Site observation report attached:	**Yes: See above**	**No:**	**Date: 02/27/2022**

Comments:

We enjoyed working with this great group of conscientious leaders responsible for the 340B program at University of Connecticut, Ryan White Program.

To further mimic the HRSA audit experience, you would have 30 days to dispute any of the findings presented in the final report. If no disputes in the next 60 days from report receipt, you would create your Corrective Action Plan (CAP) and have 6 months after it is approved by HRSA to fully implement and attest to the completion of the CAP. The CAP would address all Findings and AFIs; however, Findings may be the only request for CAP from HRSA.

FINDINGS AND AREAS FOR IMPROVEMENT OF THE INDEPENDENT OUTSIDE AUDIT FOR RYAN WHITE 340B PROGRAM

The Ryan White 340B program underwent an outside independent mock audit as required by Health Resources and Services Administration (HRSA) for the period of June 1, 2021 – November 30, 2021. This audit was conducted by 340B Compliance Partners with a kick-off, pre-audit conference call on January 4, 2022 and the virtual audit taking place on January 19, 2022. 340B Compliance Partners completed the procedures related to the compliance with the 340B Drug Pricing Program in accordance with the HRSA's guidance for Covered Entities.

FINDINGS:

1. *Finding: "Diversion Finding for no eligible encounter found within timeframe set forth by the Covered Entity of 13 months. Samples #29, #52, #53"*
   Section 340B of the Public Health Service Act prohibits diversion – the resale or other transfer of a 340B drug to ineligible patients. To adhere to this requirement, a covered entity is responsible for the tracking and accountability of its 340B drugs to ensure that diversion has not occurred. It is the covered CE's responsibility to prevent diversion.

   RWI 340B Management Response:
   The Ryan White 340B Management do not agree with the finding.
   - Sample 29 was already identified as not being eligible and had been submitted for reversal on December 27, 2021, which was prior to the audit.
   - Sample #52 & #53 were telephone-encounter refill approval of maintenance medications knowing the patient has a future scheduled annual appointment for their chronic condition. In 2021, patients were postponing or canceling doctor's appointments due to COVID-19 concerns. These refills were approved for a patient of the CE who was unable to keep their appointment in July of 2021. The patient subsequently was out of refills for their HIV medication and had a new prescription called in by the RWI provider in August of 2021. These set of events were clearly documented in the Electronic Medical Record (EMR).

   Completion Date: 3/15/2022

AREAS FOR IMPROVEMENT:

1. *AFI: "Potential for Duplicate Discounts with secondary Medicaid coverage. Need documentation from all pharmacies/TPAs that they show secondary billing or do not bill secondary at all. Samples #28, 29, 30, 31 all have secondary Medicaid in EMR. While this does not mean it was billed at the pharmacy, it represents risk until confirmation at each pharmacy of process for both primary and secondary Medicaid. Verity – continue investigation into secondary Medicaid billing."*
   The 340B statute prohibits duplicate discounts which occur when a covered entity obtains a 340B discount on a medication and a Medicaid agency obtains a discount in the form of a rebate from the manufacturer for the same medication. Covered entities must have mechanisms in place to prevent duplicate discounts.

   RWI 340B Management Response:
   The Ryan White 340B Management do not agree with this area for improvement. All BIN/PCN that are tied to Medicaid are excluded from contract pharmacy billing. Samples #28, 29, 30, 31 were all excluded from Medicaid. The management disagrees with the auditors interpretation that the medical benefit insurance coverage within their medical record will be used and or apply to the patient's pharmacy benefit. What is applied to those patients' pharmacy benefit is the BIN/PCN group numbers which the contract pharmacy submits when filling the prescription. In addition, as stated previously none of the samples were billed to Medicaid nor do we feel there is a risk in our process.

   Completion Date: 3/15/2022

2. *AFI: "Samples #33, #36 written dates were off by one day when comparing TPA with chart notes and hard copies."*

   RWI 340B Management Response:
   The Ryan White 340B Management do not agree with this area for improvement. This would not be considered diversion because the visit occurred before the prescriptions were filled. The qualified visit and the subsequent prescription fill were clearly documented in the EMR which was true for both samples.

   Completion Date: 3/15/2022

3. *AFI: "Need to verify action completed when reversals or true ups are requested. Some samples were still in data that were requested to be corrected."*

   RWI 340B Management Response:
   The Ryan White 340B Management agree that the reversal did not fully complete by the time of the audit. The 340B team is incorporating reversal follow up measures into their QA process. Of note, if claim reversals occur before the HRSA engagement letter, then the claim is taken out of the samples and replaced with a spare sample. If reversal occurs after the engagement letter then HRSA tests the reversal.

   Completion Date: 5/31/2022

4. *AFI: "Potential issue with contracted providers or fellows/residents leaving.*"

   A CE is responsible for maintaining a complete list of its physician providers, including fellows and residents. The CE needs to demonstrate the 340B-eligible patient definition is fulfilled where the individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the covered entity.

   RWI 340B Management Response:
   The Ryan White 340B Management do not agree with this area for improvement. The Medical Staff Office of UConn John Dempsey Hospital keeps the complete list, which will now be the source of truth, and the manual version maintained by the 340B team will no longer be submitted. If the report extraction is missing elements, HRSA allows this information to be submitted after.

   Completion Date: 3/15/2022

ATTACHMENT 2.6

Pharmacy Consultants, Inc.

DBA: 340B Compliance Partners

Annual 340B Independent Audit Team 2022

Sherri D. Faber, Jami Dean, Michelle Jackson

sfaber@rxconsultantsinc.com

(304) 964-3903

University of Connecticut

Hemophilia Treatment Center (HM06030)

340B Audit Detailed Report

Number: 012022	**Title:340B Detailed Internal Work Plan**
Scope: HTC Contract Pharmacy	**Sample period of June 2021 through November 2021**
Date: January 20, 2022	**Duration: 1 day virtually**
Location: virtual University of Connecticut Hemophilia Treatment Center	**Key contacts: April Mansi**
Auditor: Sherri Faber	**Contact details: sfaber@rxconsultantsinc.com**
Auditor: Jami Dean **Auditor: Michelle Jackson**	**jdean@rxconsultantsinc.com** **mjackson@rxconsultantsinc.com**

Entity Participant's name:	**Participant's title:**	**Entity Participant's name:**	**Title:**
Andy Kucia	Admin Director of Finance/Business	April Mansi	Admin Program Director/PC
Genise Nelson	Program Director HTC	Kimberly Metcalf	AO/ Associate VP for Pharmacy and Ancillary Services
Biree Andemariam	HTC Director/ Associate Professor of Medicine		

Background

University of Connecticut Hemophilia Treatment Center (RMH) is located in Farmington, Connecticut and is registered as a Comprehensive Hemophilia Treatment Center (HM) on the OPAIS database as HM06030 with a start date of April 1, 2012, and last recertification date of February 3, 2022. University of Connecticut Hemophilia Treatment Center has registered contract pharmacies. EMR is Epic. Currently, Red Chip contract pharmacy uses its own system to function as a TPA for the Covered Entity, Verity is the TPA used for Accredo, and Optum Pharmacy is a manual process.

University of Connecticut Hemophilia Treatment Center contracted with 340B Compliance Partners to conduct the annual independent external audit of contract pharmacy for analysis of program compliance. This audit was conducted with a kick-off, pre-audit conference call on January 12th, 2022, and virtual audit portion was on January 20, 2022. Auditors were Sherri Faber, Jami Dean, and Michelle Jackson.

Scope and methodology

340B Compliance Partners has completed the procedures related to the compliance with the 340B Drug Pricing Program in accordance with the Health Resources and Services Administration's (HRSA's) guidance for Covered Entities as of January 20th of 2022. These procedures were agreed to by Senior Management and the leadership of Connecticut Hemophilia Treatment Center. The primary areas of analysis for a Hemophilia Treatment Center Covered Entity are meeting eligibility requirements to be in the 340B program with proper recertification, avoiding diversion by establishing and maintaining eligible patient definitions and only counting 340B drugs for those patients, accurate information on Medicaid Exclusion file with processes in place to avoid duplicate discounts, robust Policies and Procedures, and proper oversight of contract pharmacies. Contract pharmacy agreements should include 12 elements identified by HRSA as deemed necessary for compliance. The six months of data analyzed included dispenses from June 1, 2021 through November 30, 2021 with a selection of #36 samples to test for eligibility. There were only thirty-six 340B medications presented as being captured during this 6-month period; so, 100% were audited.

Analysis of the following has been completed:

A. Knowledge during pre-audit conference call
B. Accuracy of 340B Database
C. Verification of Eligibility (grant, registered on OPAIS)
D. Medicaid Carve In/ Carve Out Status
E. Policy and Procedure Review
F. Sample of Dispensations tested for eligibility for 340B
G. Accumulator review for eligibility and replenishment records where applicable
H. Diversion tests
I. Contract Pharmacy Compliance (dates of contract vs registration on HRSA database)
J. Provider File review
K. Test staff knowledge of program (ordering process, eligibility)
L. Internal audit process
M. Multi-disciplinary committee meetings
N. Contract Pharmacy Agreements content complete with 12 elements identified by HRSA

Observations

- Addresses on prescriptions do not match registrations on OPAIS. May want to address this in Policies and Procedures
- Optum needs to send eRx, not compounding labels when hard copies are requested

- Need to provide actual subaward agreement for DRL 2 for eligibility.
- Ask for training from Accredo/Verity to better monitor dispenses for accumulation and replenishment to 11-digit NDC.
- No contract submitted for UCONN Health Pharmacy Services, Inc. and no samples provided.
- There were no findings for the sample review in that all met appropriate criteria for patient eligibility; however, issues with quantities on Rx versus quantities dispensed and unable to prove proper accumulation and replenishment within Verity for Accredo.
- Great job in keeping the P&P updated with most recent expectations from HRSA regarding telehealth, etc.

Findings Summary

- Multiple issues with NDCs used/replenished across the board. Unable to match prescriptions easily to samples provided. NDC on RX of 00944284310 from Accredo. None of the Accredo samples have that NDC nor do any invoices provided for purchase history for six months. Lack of program oversight would be a finding in no visibility into accumulations and replenishments currently- need training.
- Not all purchase history provided compared to samples. Some duplicate invoices were provided. Unable to verify NDCs ordered compared to usage.
- No NDC on Genentech invoice to know which product. They differ if preservative free or not. Both NDCs listed on samples. Not enough invoices to match dispenses.
- Contract pharmacies registered without a fully executed agreement in place. Contract provided for Red Chip was signed by both parties in 2017 (not provided in this year's data); yet registrations 4/1/2016 for Suite F. No mention of Suite F prior.
- Incorrect written dates on sample when compared with EMR.
- Hard copies provided had different RX numbers listed than in sample. Ex. Sample 23 Rx listed as 28273938 but hard copy saved as a pdf RX 9148 20201103.
- Some dispenses are for greater amount than prescription is written above the +10% as indicated. This would result in accumulation issues in Rx does not match dispense/accumulation/purchases.

AFIs (Areas for Improvement)

- Educational opportunities for pharmacy staff and other stakeholders.
- Provider file- recommend adding a start date and termination date column.
- Material Breach is simply mentioned but there is no indication of what would constitute this or even what factors would be considered if it is to be addressed on a case-by-case basis. Should at least see in minutes that it was discussed when QA is presented in the event of any errors that it was determined it did not reach the committee's view of material breach if the decision is to keep definition as is.
- Difficult to follow NDCs purchased and dispensed when two or more NDCs are used for a prescription and quantities are unclear.

Evidence guides

Three types of audit activities may be used to assess the level of conformance against each criterion:	
1.	Conducting interviews with the 340B personnel, pharmacy staff, credentialing staff, financial staff, IT/IS staff, authorizing official and primary contact.
2.	Review of documentation and records. Previous audits and any required corrective actions will also be reviewed, and actions validated.
3.	Observations while on site e.g., patient areas, pharmacy space, contract pharmacy (if applicable), EMR, financial records, billing records, TPA software, wholesaler invoices.

Audit assessment & rating methodology for table below:

Compliance:	"Yes"	This criterion has been deemed to have been met, demonstrated and verified. Full implementation and application of the relevant components of the 340B Program are present.
Partial compliance	"Part"	Partial implementation and application of the relevant components of the 340B Program are present.
Non-compliance	"No"	An absence of evidence to verify the implementation and application of the relevant components of the 340B Program for the specific area observed.
Best Practice Recommendation	"BP"	This does not warrant a "finding" but is recommended to meet best practice and a recommendation for improvement.

Audit Detail

	Criteria Requirement	Rating Yes/Part/No/NA	Observations	Recommendations/Comment
A	Knowledge during pre-audit conference call- appropriately answer questions and ask questions related to audit	Part	Stakeholders participated in call on March 22, 2021. Followed the Bizzell pre-audit conference call agenda and answered questions to prepare for a HRSA audit in the future.	Continue to educate all staff and stakeholders so when HRSA audit is announced, everyone will be prepared. Staff goal is to become comfortable with questions regarding their 340B program.

B	Accuracy of OPAIS database	No	Double checked addresses and dates of contracts vs registrations. Discrepancies on address abbreviations: **Accredo IN** OPAIS — Contract RD — Road **Accredo KS** OPAIS — Contract Strang Line Rd — Strang Line STE A — Suite A **Option Care CT** OPAIS — Contract 06484 — 06484-4846 **Optum Infusion** OPAIS — Contract OPTUM Infusion — Diplomat Specialty DR — Drive STE — Suite **Optum Infusion FL** OPAIS — Contract CT — Court STE — Suite 32765-3400 — 32765 Other issues within contracts: No registration for OPTUM in Havertown, PA from original contract. Unclear if amendments deleted it or not. Red Chip Suite F registration is 4/1/2016 – no	Get amendments for all contract pharmacy agreements to update addresses to exactly match the OPAIS database. Best to update these whenever establishing an amendment for another reason. Important to have signatures on dates on the contracts to compare with registration dates on OPAIS. Need to find REDCHIP agreement that was fully executed PRIOR to the registrations in 2015 and 2016.

			contract with that address prior to that date. Reference 2017 agreement also in 2021, but not provided in contracts.	
C	Verification of eligibility	Part	Provide copy of subgrant for HRSA grant	
D	Medicaid Carve-In, Carve-Out Status	Yes	Carve-Out but also do not use 340B under HTC for in-clinic medications	Hospital carves-in and provides medications for HTC use
E	Policy & Procedure Review	Yes	HRSA is looking for very detailed policies and procedures. Already added telemedicine as eligible encounter. Look back for eligible visit is 365 and that had been updated in P&P. Reviewed and approved within past year as indicated in P&P.	Weak area with Material Breach definition. If it is determined to keep it on a case-by-case basis, there should be documentation in committee minutes that committee did not decide any errors met their threshold for material breach.
F	Sample tested		See details as follows:	
	❖ Provider Eligible?	Yes	All samples had eligible providers.	Keep provider list up to date and current with TPA/Contract Pharmacy Best practice is to keep a list of providers with NPI, contracted/ employed and start and term dates.
	❖ Location Eligible?	Yes		
	❖ Responsibility of care with Covered Entity?	Yes	All had eligible encounter	Ensure that patients' care remains with Covered Entity and have an eligible encounter in past # days as part of ongoing audits or within whatever parameters are set forth for patient eligibility in your P&P-
	❖ Mixed-Use- administration date/time documented, or documentation of prescription sent to pharmacy in chart or EMR	N/A	No samples provided for in-clinic administration	
	❖ Insurance Coverage is Medicaid so proper billing and modifiers in mixed-use. 340B drugs are line-item billed with appropriate modifiers as necessary ❖ Medicaid carved-out in contract pharmacy	N/A Yes/BP	Best to have an email or something to produce to show your comfort level that dual eligible patients do not pose a duplicate discount risk because secondary is not billed in a particular contract pharmacy.	Ensure that patient with Secondary Medicaid coverage do not pose a duplicate discount issue. Check with contract pharmacies to see if they bill secondary Medicaid. Be aware of how often TPA updates

				BIN/PCN of Medicaid to blacklist these in contract pharmacy, including MCOs
G	Accumulator and replenishment verified	No	This is more of a separate physical inventory process currently with Red Chip. Verity (Accredo) was unclear as to accumulations- quantities had to be calculated and compared to prescription. The second NDC listed on some of the samples for Accredo did not appear on any of the invoices during that time period.	
H	Diversion tests i.e., Inpatient status, location, not meeting patient definition, no documentation	Yes	All documentation found in EMR	
I	Contract pharmacy compliance	Part	Great work in clinics and discharge prescriptions of them being charted or recorded. Best Practice to document all data elements are present on sample reviews. Should be able to review all elements including accumulation and replenishment ongoing.	Complete ongoing audits of contract pharmacy and review TPA functionality and adherence to contract agreement with accumulations and replenishments Recommend creating a spreadsheet for quality assurance with data elements to review across top. HRSA audits request a blank one of these to determine what is being tested as part of your ongoing quality assurance.
J	Provider File Review	Yes	List appears to be accurate. Consider adding start dates and a column for termination dates	Continue to keep updated provider list and dates from active to terminated.
K	Test Staff Knowledge of Program	BP	Continue to educate about the program	Excellent staff who are interested in learning- opportunity to expand their knowledge about program
L	Internal Audit Process	Yes	100% audited.	
M	Multi-disciplinary committee meetings	Yes	These are being held routinely in line with P&P with minutes as a joint committee with DSH and RWI. Specific line has been added on agenda for QA report out from HTC	Keep this going

N	Contract Pharmacy agreement content complete with 12 elements identified by HRSA	Yes	Ensure 12 essential elements expected in Pharmacy Services Agreements are present in all contracts. Red Chip: There is language in the contract about sharing the agreement with a manufacturer but no indication there is an understanding that upon written request the copy of the service agreement will be provided to OPA/HRSA.	

This report is intended solely for the information and use of UConn HTC senior management, UConn HTC Oversight Committee, and UConn HTC pharmacy personnel and is not intended to be and should not be used by another other than those specified parties.

Any questions related to this report may be directed to 340B Compliance Partners at: sfaber@rxconsultantsinc.com

or (304) 964-3903

Summary of site observations

Site observation conducted by:	**Sherri Faber, RPh, MHA; Jami Dean, CPhT; Michelle Jackson, CPhT**		
Site observation report attached:	**Yes: See above**	**No:**	**Date: 2/11/2022**
Comments:			
We enjoyed working with this great group of conscientious leaders responsible for the 340B program at University of Connecticut Hemophilia Treatment Center.			
To further mimic the HRSA audit experience, you would have 30 days to dispute any of the findings presented in the final report. Afterward, you would create your Corrective Action Plan (CAP) within 60 days and have 6 months after it is approved by HRSA to fully implement and attest to the completion of the CAP. The CAP would address all Findings and AFIs.			

Date when Corrective Action Plan (CAP) Created:

Date when all actions completed:

Name:

Role:

FINDINGS AND AREAS FOR IMPROVEMENT OF THE INDEPENDENT OUTSIDE AUDIT FOR HEMOPHILIA TREATMENT CENTER (HTC) 340B PROGRAM

The Hemophilia Treatment Center 340B program underwent an outside independent mock audit as required by Health Resources and Services Administration (HRSA). This audit was conducted by 340B Compliance Partners with a kick-off, pre-audit conference call on January 12, 2022 and "onsite" portion which took place virtually on January 20th, 2022. 340B Compliance Partners completed the procedures related to the compliance with the 340B Drug Pricing Program in accordance with the Health Resources and Services Administration's (HRSA's) guidance for Covered Entities.

FINDINGS

1. Multiple issues with NDCs used/replenished across the board. Unable to match prescriptions easily to samples provided. NDC on RX of 00944284310 from Accredo. None of the Accredo samples have that NDC nor do any invoices provided for purchase history for six months. Lack of program oversight would be a finding in no visibility into accumulations and replenishments currently- need training.

   HTC 340B Management Response
   The HTC 340B Management agrees with the finding. The program was replenishing drug for drug within the same manufacturer as provided by the dispensing pharmacy. The 340B HTC program was unfamiliar with 340B virtual inventory processes, qualified prescription dispensed quantities, and the requirement of an 11-digit NDC match. The program recognizes the need to align with the pharmacy department and adopt their virtual inventory replenishment processes and QA metrics going forward to ensure the program's ability to demonstrate prevention of diversion and duplicate discounts In addition to incorporating pharmacy into the HTC 340B program, the HTC 340B Management is evaluating Third Party Administrators to assist in meeting virtual inventory replenishment metrics, reports, and identifying new and additional HTC 340B opportunities.

   Estimated Date of Completion: 08/01/2022

2. Not all purchase history provided compared to samples. Some duplicate invoices were provided. Unable to verify NDCs ordered compared to usage.

   HTC 340B Management Response
   The HTC 340B Management group agrees with the finding, and the provision of the HTC's purchase histories to the mock auditor were inaccurate, therefore the auditor was not able to measure and test replenishment of audit samples. The 340B HTC Management staff reviewed the samples after completion and were able to complete 11 digit NDC matches from contract pharmacy dispense history to HTC purchase history. The alignment of the 340B HTC program with pharmacy staff will help alleviate this audit discrepancy going forward as well as provide QA practices to ensure replenishment was conducted accurately.

   Estimated Date of Completion: 5/1/2022

3. No NDC on Genentech invoice to know which product. They differ if preservative free or not. Both NDCs listed on samples. Not enough invoices to match dispenses.

HTC 340B Management Response
The HTC 340B Management agrees with the finding and was not aware that the auditor was requiring this level of detail on the invoice. Genentech provides the NDC level detail on the corresponding matching packing slip which the auditor did not request. The 340B HTC team has been able to match all packing slips with contract pharmacy dispensations, but the alignment of the HTC 340B team with pharmacy 340B processes will alleviate this missing information in future audits.

Estimated Date of Completion: 3/15/2022

4. Contract pharmacies registered without a fully executed agreement in place. Contract provided for Red Chip was signed by both parties in 2017 (not provided in this year's data); yet registrations 4/1/2016 for Suite F. No mention of Suite F prior.

   HTC 340B Management Response
   The 340B HTC Management do not agree with the finding and the staff were able to locate the agreement which is in March 2016 that lists the suite F location. We have requested from this auditor o remove the finding.

   Estimated Date of Completion: 3/1/2022

5. Incorrect written dates on sample when compared with EMR

   HTC 340B Management Response
   The HTC 340BManagement agrees with the finding and provided the auditor incorrect sample prescription written dates. These incorrect submissions resulted in the auditor not being able to test eligibility of the prescription. At the completion of the audit, the 340B HTC staff reviewed the EMR and sample data and were able to trace all sample data of prescription written dates to be just prior to the prescription being dispensed. The alignment of pharmacy staff within the 340B HTC staff has also provided the necessary expertise to correctly pull data and reports of written prescription dates to support future audits.

   Estimated Date of Completion: 3/15/2022

6. Hard copies provided had different RX numbers listed than in sample. Ex. Sample 23 Rx listed as 28273938 but hard copy saved as a pdf RX 9148 20201103.

   HTC 340B Management Response
   The HTC 340B Management agrees with the finding, and agrees that the prescription numbers provided in the audit samples were derived from the covered entity EMR and not the auditors requested data which are the prescription numbers assigned by the contract pharmacy. This incorrect submission was identified in two out of the three pharmacies audited. The alignment of pharmacy staff within the 340B HTC staff has also provided the necessary expertise to correctly pull data and reports of written prescription dates to support future audits.

   Estimated Date of Completion: 3/15/2022

7. Some dispenses are for greater amount than prescription is written above the +10% as indicated. This would result in accumulation issues in Rx does not match dispense/accumulation/purchases.

   HTC 340B Management Response
   The HTC 340B staff agree with the finding and recognize that the QA procedures did not include oversight of prescription/ordered quantity to be at or below the 340B replenished quantity. The alignment of pharmacy staff within the 340B HTC staff will provide the necessary expertise to correctly evaluate and monitor prescription filling compliance amongst contract pharmacies to ensure the 340B HTC does not over replenish on 340B.

   Estimated Date of Completion: 08/01/2022

AREAS FOR IMPROVEMENT:

1. Educational opportunities for pharmacy staff and other stakeholders.

   HTC 340B Management Response
   The 340B HTC staff are now a part of the UConn Health 340B program which is overseen by pharmacy.
   Estimated Date of Completion: 03/01/2022

2. Provider file- recommend adding a start date and termination date column.

   HTC 340B Management Response
   The 340B HTC staff agree with this area of improvement and has created a provider file listing the start date and termination date column.

   Estimated Date of Completion: 3/1/2022

3. Material Breach is simply mentioned but there is no indication of what would constitute this or even what factors would be considered if it is to be addressed on a case-by-case basis. Should at least see in minutes that it was discussed when QA is presented in the event of any errors that it was determined it did not reach the committee's view of material breach if the decision is to keep definition as is.

   HTC 340B Management Response
   The HTC 340B staff agrees with this finding and will revise its policies to quantify what constitutes a material breach. This policy revision will be presented to the 340B Oversight Committee for review and approval.

   Estimated Date of Completion: 6/1/2022

4. Difficult to follow NDCs purchased and dispensed when two or more NDCs are used for a prescription and quantities are unclear.

   HTC 340B Management Response

The HTC 340B staff agrees with this area of improvement. The HTC 340B staff is working with the pharmacy staff to create improved tracking tools that provide the 11 digit NDC match which is necessary for virtual inventory and replenishment monitoring. In addition the 340B HTC staff are reviewing potential options for a Third Party Administrator to screen, track accumulations, and replenishments based on an 11 digit NDC match.

Estimated Date of Completion: 6/1/2022

ATTACHMENT 3.1

University of Connecticut & UConn Health
Joint Audit & Compliance Committee Meeting
June 23, 2022

Office of Audit and Management Advisory Services
Status of Open Audits
As of May 31, 2022

Audits Approved in the **FY 2022** Audit Plan	Campus	Current Status	Anticipated JACC Meeting			
			Jun 2022	Sept 2022	Dec 2022	Mar 2023
Approval Authority Review	UC	Fieldwork				▬
Cash Handling	UH	Planning		▬		
Compensatory Time	UC	Fieldwork			▬	
Compensatory Time	UH	Report	▬			
Denials Management - Dental	UH	Report	▬			
Denials Management - JDH & UMG	UH	Draft		▬		
Electronic Prescriptions	UH	Planning		▬		
Radiology	UH	Draft		▬		
Faculty Consulting For the Period Fiscal Year 2021	UC	Report	▬			
Foreign Influence	UC	Planning				▬
Foreign Influence	UH	Planning				▬
IT Application Change Management	UH	Report	▬			
Injections and Infusions	UH	Report	▬			
Indirect Cost Recovery Revenues from Grants	UC/UH	Planning				▬
Memorandum of Understandings	UC/UH	Fieldwork		▬		
Patch Management - College of Liberal Arts & Sciences	UC	Fieldwork		▬		
Planning for the Potential Impact of the Retirements in 2022*	UC/UH					
School of Business Entrepreneurial Programs on Stamford Campus	UC	Fieldwork				▬
Student Health Services Electronic Prescriptions	UC	Planning		▬		
University of Connecticut Foundation Fiscal Year 2021	UC	Fieldwork		▬		

*UC & UH Human Resources retirement presentations in lieu of audit

ATTACHMENT 3.2

University of Connecticut & UConn Health
Joint Audit & Compliance Committee Meeting
June 23, 2022

Status of Audit Findings
Aging of Overdue Management Actions by Functional Area Based on Original Due Date
As of May 31, 2022

Functional Area	Not Due			0-3 Mos			3-6 Mos			6-12 Mos			1-2 Yrs			2-3 Yrs			> 3 Yrs			Total
	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	
UConn:																						
UC Athletics													1									1
UC Controller		2	1		1								1									5
UC Facilities Operations														3			4			1		8
UC Human Resources		1						2											1	1		5
UC OVPR																			1			1
UC Procurement																	1					1
UC Research Compliance Services							2			1												3
UC School of Law																			1			1
UC Student Activities													4									4
UC Student Affairs Administration													1	3		3	2					9
UCH School of Medicine							1															1
UC Enrollment Planning and Management					1																	1
UC Office of Global Affairs	1	3																				4
UC Dean of Students		1																				1
UConn Total	1	7	1		2		3	2		1			7	6		3	7		3	2		45
UConn Health:																						
UCH School of Medicine																2		1				3
UCH Information Technology Services		5									1	3	1	8	6	2	3	1				30
UCH School of Dental Medicine													2	4								6
UCH Human Resources	2															1	1		4	1		9
UCH JDH Administration											5		1	5	2		3	1				17
UCH Controller				2	1												1					4
UCH JDH and UMG Revenue Cycle Management											1					1	4	1				7
UCH Epic														1								1
UCH CEO and EVP for Health Affairs														2								2
UC Office of Institutional Equity													3	2								5
UConn Medical Group											1											1
UCH JDH Quality and Patient Services														1								1
UCH Graduate Medical Education	1																					1
UCH CFO					3																	3
UConn Health Total	3	5		2	4						8	3	7	23	8	6	12	4	4	1		90
Total	4	12	1	2	6		3	2		1	8	3	14	29	8	9	19	4	7	3		135

Note: The net number of management open actions increased by 4 from 131 to 135 from the prior reported quarter due to the issuance of new audit reports.

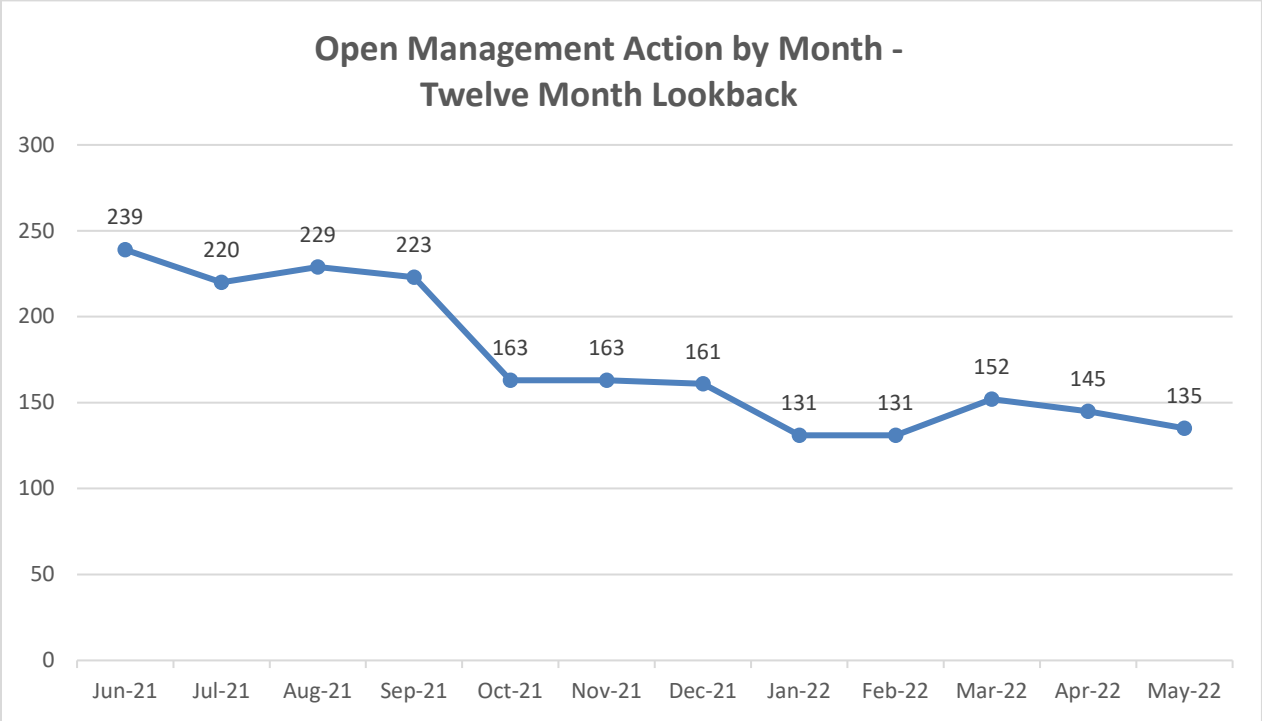
University of Connecticut & UConn Health
Joint Audit & Compliance Committee Meeting
June 23, 2022

Status of Audit Findings
Aging of Overdue Management Actions by Finding Category Based on Original Due Date
As of May 31, 2022

Finding Category	Not Due			0-3 Mos			3-6 Mos			6-12 Mos			1-2 Yrs			2-3 Yrs			> 3 Yrs			Total
	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H	
UConn:																						
Business Process Improvement		2					1	1					5	1			1		1	1		13
Business Purpose																			1			1
Documentation													1									1
Governance														1		2						3
Management Oversight																1						1
Monitoring														1								1
Physical Security of Assets		1															1					2
Policy	1	2			1		1	1									1			1		8
Regulatory Compliance		2	1		1		1			1							1					7
Security														3			3					6
Segregation of Duties													1									1
Use of Resources																			1			1
UConn Total	1	7	1		2		3	2		1			7	6		3	7		3	2		45
UConn Health:																						
Business Process Improvement														2	1	3	2	1	1			10
Documentation											4		1			2	1		1			9
Governance																				1		1
Management Oversight	2													2			2	1				7
Monitoring														3			2		1			6
Physical Security of Assets														1								1
Policy	1												3	4	1	1	2		1			13
Regulatory Compliance				1	3						3		2	2								11
Security		3									1	3		3	1		2	1				14
Segregation of Duties		2																				2
Technology														3	4		1	1				9
Use of Resources				1	1								1	3	1							7
UConn Health Total	3	5		2	4						8	3	7	23	8	6	12	4	4	1		90
Total	4	12	1	2	6		3	2		1	8	3	14	29	8	9	19	4	7	3		135

University of Connecticut & UConn Health
Joint Audit & Compliance Committee Meeting
June 23, 2022

Status of Audit Findings
Trend Analysis of Monthly Balances of Open Management Actions
As of May 31, 2022



Analysis:

A substantial effort was made by UConn and UConn Health to decrease of the number of open actions.

The effective collaboration between UConn and UConn Health and AMAS reflects a continued commitment to resolving outstanding open actions, as depicted in the downward trend in the above line graph minus the upticks for new required management actions.

University of Connecticut & UConn Health
Joint Audit & Compliance Committee Meeting
June 23, 2022

Status of Audit Findings
Management Actions Closed By Functional Areas by Risk Level
For the Period March 1, 2022 to May 31, 2022

Audit Area	Implemented			No Longer Appilcable			Recommendation Moved to / Included in Another Audit			Total
	L	M	H	L	M	H	L	M	H	
UConn:										
UC Information Technology Services	2									2
UC Public Safety		1								1
UC President's Office		2								2
UConn Total	2	3								5
UConn Health:										
UCH Controller	1	1								2
UCH Information Technology Services	1	2	1							4
UCH JDH Administration		2								2
UCH JDH and UMG Revenue Cycle Management		2								2
UCH Procurement	1									1
UCH Human Resources	3									3
UCH JDH Quality and Patient Services		1								1
UCH OVPR						1				1
UCH Epic		1								1
UCH Ambulatory Care		1								1
UConn Health Total	6	10	1			1				18
Total	8	13	1			1				23

University of Connecticut & UConn Health
Joint Audit & Compliance Committee Meeting
June 23, 2022

Status of Audit Findings
Risk Level Descriptions

The description of the risk levels identified in this report is based on the following methodology. Observations are ranked based on an analysis of the likelihood and impact of a control or process failure. Considerable professional judgment is used to determine the risk ratings. Accordingly, others could evaluate the results differently and draw different conclusions. The risk levels provide information about the condition of risks and internal controls at one point in time. Future changes in environmental factors and personnel actions may significantly impact the risk ratings.

Low	Observation has a low probability of occurring. Preventive controls do not exist but detection and mitigating controls exist. Minimal exposure that will not typically lead to a material error and corrective action may lead to improvements in efficiencies and effectiveness. The issues identified may include: • Noncompliance with internal policies • Lack of internal policy that is not mandated by federal and state requirements • Minimal financial losses • Minor operational issues
Moderate	Observation is likely to occur or has occurred. Preventive and detection controls do not exist but mitigating controls exist. Exposure that requires priority attention because the observation has or may result in: • More than minimal financial losses or fraud or theft of resources • Noncompliance with laws and regulations or accreditation standards • Ineffective internal policy or practice • Reputation damage • Negative impact to audit area under review, which includes continuity, security and privacy issues • Safety and health concerns
High	Observation has a high probability of occurring or has occurred at a high rate. Preventive, detection and mitigating controls do not exist. High impact exposure that requires immediate attention because the observation has or may result in: • Substantial financial losses or fraud or theft of resources • Noncompliance with significant laws and regulations • Serious reputation damage • Negative impact to systemwide operations, which includes continuity, security and privacy issues • Significant safety and health concerns

ATTACHMENT 4.1

University of Connecticut & University of Connecticut Health Center
Joint Audit & Compliance Committee Meeting

SIGNIFICANT COMPLIANCE ACTIVITIES

Organizational Update - The Office of University Compliance welcomed Kim Colon on May 27th to fill the Associate Compliance Officer position, which will be primarily responsible for conducting compliance investigations for UConn and UConn Health.

Bruce Gelston will take over as the Privacy Officer for the University, after Laurie Neal leaves the University on June 16.

Training - University Compliance completed the 2022 Annual Compliance and Ethics training season on May 27, 2022. University Compliance provided three live WebEx training sessions as well as one live WebEx training that was facilitated in Spanish.

Education and Awareness - Education and awareness was provided on the following topics since the March meeting:

- Video on Post-State Employment
- UConn's Minor Protection Program
- UConn's Policy on Policies
- Records Management Policy

During the training season, University Compliance has worked to enhance communication and awareness for managers and supervisors to garner mid-level support for compliance training. Additionally, University Compliance used metrics from the training evaluation data to promote and encourage UConn and UConn Health employees to take the training by the established deadline.

Investigations - As of May 25, 2022, University Compliance has received 57 reported concerns, 47% of which have been reviewed and closed. Specific metrics related to reported concerns and compliance investigations are included in the JACC packet for review.

Ethics – By May 1st, Statements of Financial Interests must be filed with the Office of State Ethics by certain designated individuals at both UConn and UConn Health. As in years past, UConn and UConn Health achieved 100% completion by the deadline.

Compliance Monitoring - University Compliance, in collaboration with the Office of Institutional Equity, the Office of Healthcare Compliance and Privacy, IT Security at UConn Health, and Human Resources, has prepared longitudinal data included in the JACC packet regarding required training compliance numbers for UConn and UConn Health.

University of Connecticut & University of Connecticut Health Center
Joint Audit & Compliance Committee Meeting

SIGNIFICANT COMPLIANCE ACTIVITIES

Healthcare Compliance and Privacy Update -

Psychiatry: Healthcare Compliance continues meeting weekly with the Psychiatry Department to assist in addressing risk areas noted in both the Internal Audit and external consultant review.

OIG Work Plan: Healthcare Compliance continues to collaborate with management to address new items added to the Work Plan by the OIG

Privacy Education: Specific training on HIPAA's "Minimum Necessary Rule" was assigned to certain staff to reinforce education.

Privacy Update - Privacy at partnered with the Orientation Office to provide FERPA training for UConn's student orientation leaders.

Policy Update - The UConn Health Policy Migration Team created a benchmarking report outlining policy structures and metrics at other academic medical centers including UC Davis, Penn State Health, and Yale University among others. University Compliance developed a sustainability proposal for the UConn Health policy program that resulted in approval of two new hires: a Policy Software Administrator and a Clinical Policy Coordinator position. Both searches are underway.

University Compliance has begun working with IT to enhance and re-design the current policy website at UConn, which is anticipated to launch by the end of summer.

2022 Compliance Education & Awareness Report

OFFICE OF UNIVERSITY COMPLIANCE
January 1, 2022 - May 25, 2022

Compliance Chatters (Educational Communications)

Total Compliance Chatters

41

Monthly Average: 3.7

Compliance Chatters are e-mail communications on various compliance topics.

Average Open Rate

55%

National Avg: 24%

The "open rate" is the percentage of recipients who opened communications.

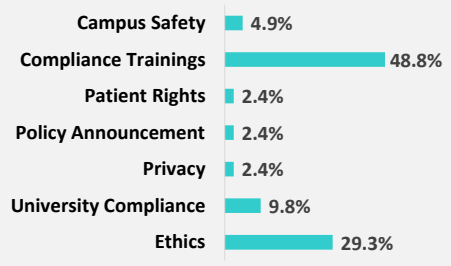
Average Click Rate

4.5%

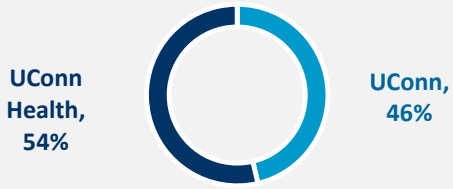
National Avg: 1.3%

The "click rate" is the percentage of recipients who opened communications and clicked on any embedded links.

Compliance Chatters Topic Areas



Compliance Chatters by Campus



Total Compliance Chatters per Month

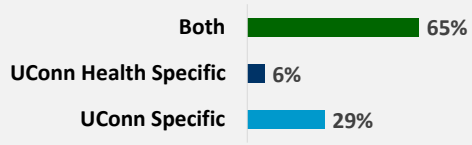
Compliance Clips Views (Informational Videos)

Number of Views
(Lifetime Views)

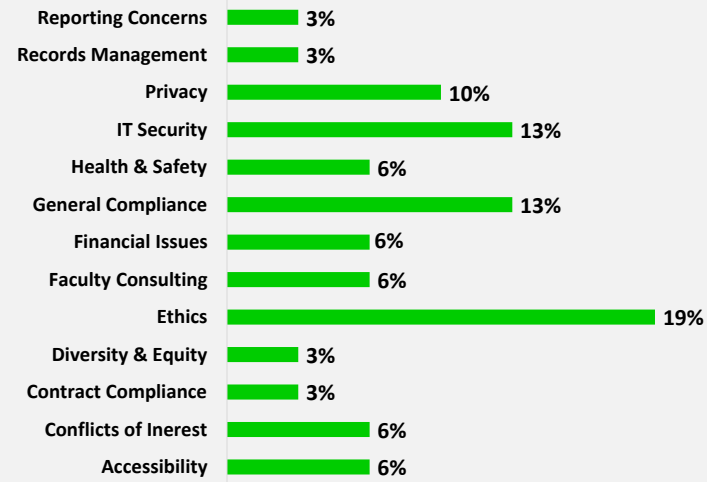
7644

Total Compliance Clips: 31

Compliance Clips by Campus



Compliance Clips Topic Areas



Website Analytics

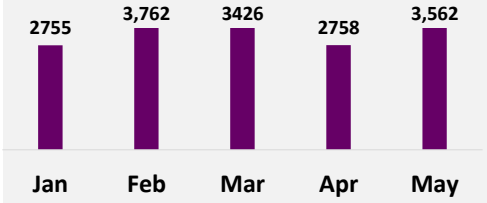
Number of Visits

16236

Unique Pageviews

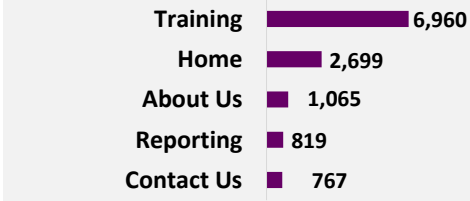
13060

Total Pageviews per Month



Top 5 Visited Webpages in 2022

**Not Unique Users*



2022 Reports and Investigations Data Summary
January 1, 2022 - May 26, 2022

UCONN | UNIVERSITY OF CONNECTICUT
OFFICE OF UNIVERSITY COMPLIANCE

Total Cases

57

UConn - 29
UConn Health - 28

Total Active Cases

21

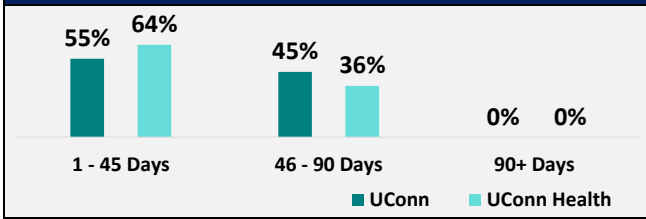
UConn - 10
UConn Health - 11

Reports by Campus

Summary

UConn numbers include Regional Campuses, the School of Law and the School of Social Work. UConn Health numbers include Farmington, Storrs, West Hartford, and Canton locations.

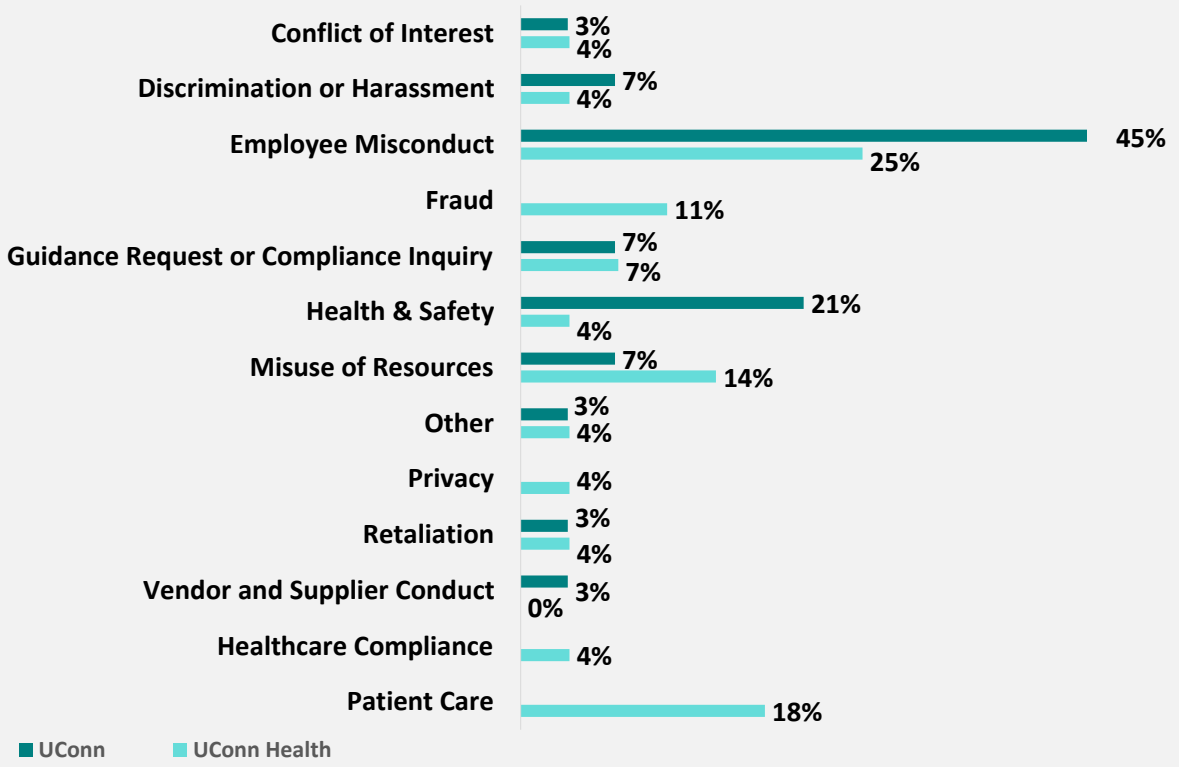
Resolution Times for Closed Cases



Summary

Resolution time speaks to the amount of calendar days from when University Compliance receives a report to the issuance of a final report or closing memo.

Issue Category of Reported Concerns



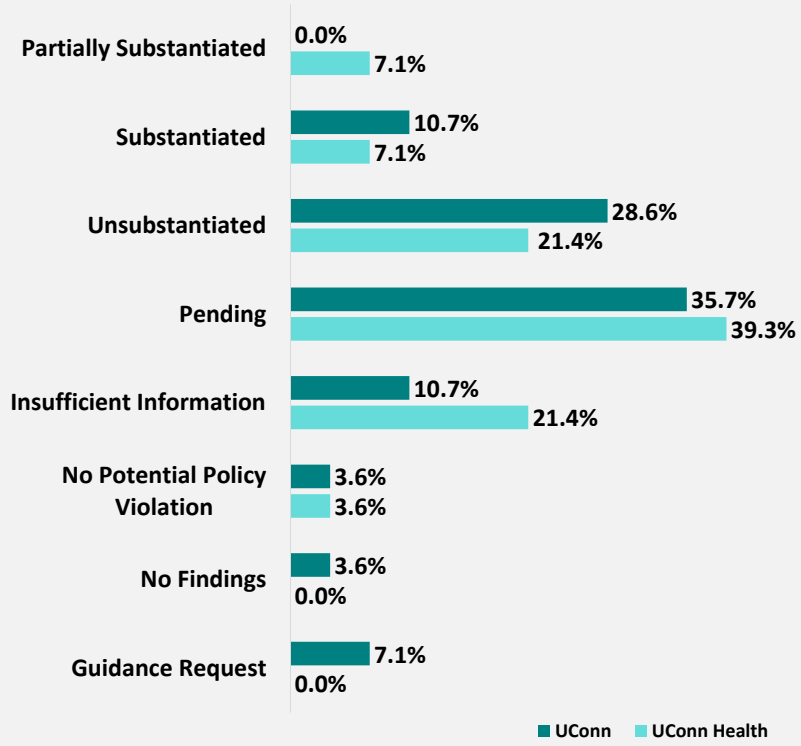
Summary

Categories speak to the overarching issue being reported. University Compliance has identified 18 specific categories and tracks the number of reports it receives related to the issue category. The five issue categories that have not been reported in 2022 thus far are Athletics Compliance, Academic or Scholarly Misconduct, Accounting and Financial Matters, Admissions and Recruitment, and Research Misconduct. University Compliance also tracks departments and units identified by reports in an effort to analyze potential trends or hotspots.

2022 Reports and Investigations Data Summary
January 1, 2022 - May 26, 2022

UCONN | UNIVERSITY OF CONNECTICUT
OFFICE OF UNIVERSITY COMPLIANCE

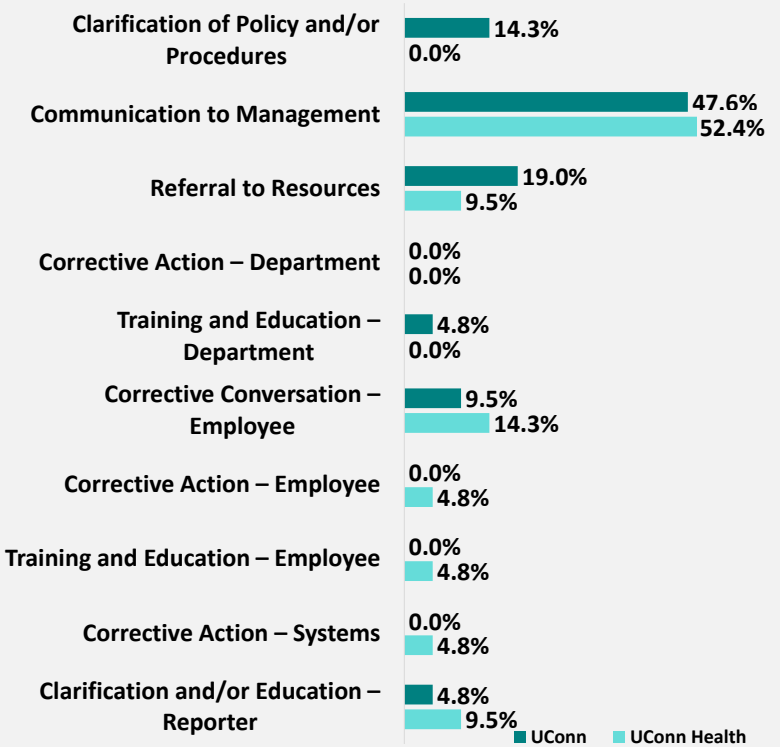
Investigation Findings



Summary

Investigation findings speak to whether or not a policy violation was determined to have taken place. "No findings" is when a review does not determine a finding of a policy violation, but where the managing office institutes corrective action or education immediately. "No Potential Policy Violation" is when a report is submitted, and even if determined to be factually accurate would not constitute a policy violation. "Insufficient Information" is when the report does not include key information needed to conduct a thorough investigation, despite requesting additional information from the reporting party. "Pending" means the matter is still currently under review/investigation and a finding has yet to be made.

Investigation Outcomes or Recommendations



Summary

These are outcomes or recommendations that resulted from a review or investigation of a reported concern. These outcomes can be instituted or recommended regardless of whether or not a policy violation was determined to have occurred. Therefore, a reported concern may have not resulted in a substantiated allegation, but still resulted in some sort of outcome. Additionally, one single matter may result in several outcomes or recommendations or none at all. From the 36 closed cases for all campuses, 43 outcomes or recommendations were initiated to address the reported concerns.

ATTACHMENT 4.2

OVERVIEW

The Office of University Compliance (OUC), in collaboration with the Office of Institutional Equity (OIE), the Office of Healthcare Compliance and Privacy (HCCP), IT Security at UConn Health, and Human Resources conducted a review of training data pertaining to nine mandatory compliance trainings for UConn and UConn Health. The scope of this review was to assess training completion rates across the selected mandatory compliance trainings. Below is a summary of the approach used for this review, along with preliminary results.

SUMMARY

Training data for the period of 2019, 2020, and 2021 was reviewed as part of this project. To help ensure a consistent analysis of the requested data, efforts were made to collect the following data fields for each of the trainings listed below.

Trainings included in our scope	Requested data fields
• University Compliance and Ethics Training (UConn and UConn Health) • Sexual Harassment Prevention Training (UConn and UConn Health) • Diversity Awareness Training (UConn and UConn Health) • Healthcare Compliance Training (UConn Health) • HIPAA Privacy Training (UConn Health) • Security Awareness Training (UConn Health)	• Participant Full Name • Unit / Department Name • Course Title • Course Assignment Date • Current Course Completion Status • Course Completion Date (including those after training due date) • Employment Status During Training Period

INCOMPLETE THEMES AND PATTERNS

In addition to looking at the completion status for assigned training participants, completion dates were compared to the established deadlines to identify late training completions. This data was also reviewed to identify whether a pattern of repeat incomplete or overdue completions among departments existed; however, such trends were not identified.

COVID-19 IMPACT

It is worth noting, that the unique circumstances associated with the Covid-19 pandemic appear to have contributed to delays in training completions during the period being reported. For example, prior to the Covid-19 pandemic, one of the trainings at UConn Health was only offered in person. The delivery of that training was temporarily paused in 2020, resulting in higher than usual training incompletions.

OPPORTUNITIES FOR ENHANCEMENT

These preliminary results have been shared with responsible units and there are plans to establish a workgroup to continue to enhance efforts to track and communicate mandatory compliance training efforts. This includes establishing a framework of best practices, self-assessment tools, and the standardization of training follow-up methods to promote accountability and consistency across the compliance program.

University Compliance would like to thank the partnering offices for their collaboration on this project and for their commitment to enhancing required training completion rates.

Summary of Mandatory Compliance Training Data for JACC

<table>
<tr><th>Training Owner</th><th>Training</th><th>Completion Status</th><th>Overdue Status</th></tr>
<tr><td>OUC – UConn</td><td>University Compliance and Ethics Training – UConn</td><td>100% training completion was achieved for the period being reported.
<table><tr><td>2019</td><td>100%</td></tr><tr><td>2020</td><td>100%</td></tr><tr><td>2021</td><td>100%</td></tr></table></td><td>0.6% - 3% of those who completed the training, did so after the established deadline.
<table><tr><td>2019</td><td>0.6%</td></tr><tr><td>2020</td><td>2%</td></tr><tr><td>2021</td><td>3%</td></tr></table></td></tr>
<tr><td>OUC – UConn Health</td><td>University Compliance and Ethics Training – UConn Health</td><td>99.3% - 100% training completion was achieved for the period being reported.
<table><tr><td>2019</td><td>100%</td></tr><tr><td>2020/21</td><td>93.3%</td></tr></table></td><td>7% of those who completed the training after the deadline in 2019. In 2020, the late training completion rate was 1%.
<table><tr><td>2019</td><td>7%%</td></tr><tr><td>2020/21</td><td>1%</td></tr></table></td></tr>
<tr><td>OIE – UConn</td><td>Sexual Harassment Prevention Training – UConn</td><td>99% training completion was achieved in 2019 and 2020. 81% training completion was achieved in 2021.
<table><tr><td>2019</td><td>99%</td></tr><tr><td>2020</td><td>99%</td></tr><tr><td>2021</td><td>81%</td></tr></table></td><td>0.1% - 0.2% of those who completed the training during the period being reported, did so after deadline.
<table><tr><td>2019</td><td>0.2%</td></tr><tr><td>2020</td><td>0.1%</td></tr><tr><td>2021</td><td>0.2%</td></tr></table></td></tr>
<tr><td>OIE – UConn Health</td><td>Sexual Harassment Prevention Training – UConn Health</td><td>94% - 99% listed as new hires or needing the SHPT training completed it for the period being reported.
<table><tr><td>2019</td><td>99%</td></tr><tr><td>2020</td><td>96%</td></tr><tr><td>2021</td><td>94%</td></tr></table></td><td>*21% in 2020 and 6% in 2021 of those who completed the training did so after the deadline.
<table><tr><td>2019</td><td>-</td></tr><tr><td>2020</td><td>*21%</td></tr><tr><td>2021</td><td>6%</td></tr></table></td></tr>
<tr><td>OIE – UConn</td><td>Diversity Awareness Training</td><td>96% - 98% training completion was achieved for the period being reported.
<table><tr><td>2019</td><td>98%</td></tr><tr><td>2020</td><td>98%</td></tr><tr><td>2021</td><td>96%</td></tr></table></td><td>0.8% - 1.5% of those who completed the training did so after the deadline in 2020 and 2021.
<table><tr><td>2019</td><td>-</td></tr><tr><td>2020</td><td>1.5%</td></tr><tr><td>2021</td><td>0.8%</td></tr></table></td></tr>
<tr><td>OIE – UConn Health</td><td>Diversity Awareness Training</td><td>The training completion rate for the period being reported ranged between 63% - 93%.
<table><tr><td>2019</td><td>93%</td></tr><tr><td>2020</td><td>*63%</td></tr><tr><td>2021</td><td>93%</td></tr></table></td><td>5% - 10% of those who completed the training did so after the deadline.
<table><tr><td>2019</td><td>5%</td></tr><tr><td>2020</td><td>11%</td></tr><tr><td>2021</td><td>10%</td></tr></table></td></tr>
<tr><td colspan="4">*In person trainings were put on hold in 2020 due to Covid-19.</td></tr>
</table>

Summary of Mandatory Compliance Training Data for JACC

<table>
<tr><th>Training Owner</th><th>Training</th><th>Completion Status</th><th>Overdue Status</th></tr>
<tr><td>HCCP – UConn Health</td><td>Healthcare Compliance</td><td>98% - 100% training completion was achieved for the period being reported.

<table><tr><td>2019</td><td>100%</td></tr><tr><td>2020</td><td>99.5%</td></tr><tr><td>2021</td><td>98%</td></tr></table></td><td>0.2% - 0.5% who completed the training did so after the deadline in 2019 and 2021. In 2020, the rate of late training completions was 1%.

<table><tr><td>2019</td><td>0.2%</td></tr><tr><td>2020</td><td>1%</td></tr><tr><td>2021</td><td>0.5%</td></tr></table></td></tr>
<tr><td>HCCP – UConn Health</td><td>HIPAA</td><td>94% - 98% training completion was achieved for the period being reported.

<table><tr><td>2019</td><td>97.5%</td></tr><tr><td>2020</td><td>99.5%</td></tr><tr><td>2021</td><td>98%</td></tr></table></td><td>In 2019, the rate of late training completions was 13%. In 2020 and 2021, 0.7% - 2% who completed the training did so after the established deadline.

<table><tr><td>2019</td><td>13%</td></tr><tr><td>2020</td><td>2%</td></tr><tr><td>2021</td><td>0.7%</td></tr></table></td></tr>
<tr><td>ITS – UConn Health</td><td>Security Awareness</td><td>97% - 99% training completion was achieved for the period being reported.

<table><tr><td>2019</td><td>97%</td></tr><tr><td>2020</td><td>99%</td></tr><tr><td>2021</td><td>97%</td></tr></table></td><td>In 2019, the rate of late training completions was 13%. In 2020 and 2021, 1% - 2% who completed the training after the established deadline.

<table><tr><td>2019</td><td>1%</td></tr><tr><td>2020</td><td>2%</td></tr><tr><td>2021</td><td>13%</td></tr></table></td></tr>
</table>

ATTACHMENT 4.3

Who has completed this year's University Compliance and Ethics Training?

UCONN

1 out of every 5 UConn employees

UCONN HEALTH

Nearly 2.5 out of every 5 UConn Health employees

Training Due Date

May 27th

Join your peers!

Already completed the training? Thank you!

What are your peers saying about this year's training?

"It was **easy** to use and complete, yet still had **important information**."

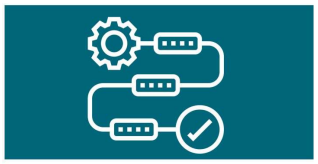
"I appreciate being able to take the training virtually and **at my own pace**."

"I really **enjoyed the scenarios and the mini videos**."

"The scenarios and videos made the training more **relatable and engaging**."

"I appreciate the addition of **training materials and resource guide**. **They were extremely helpful**... please keep this feature for years to come!"

Still need to take the training? You have options!



Online and Live Options

Different people prefer different learning modalities. This year's training is being offered online in Saba or through a live WebEx session.

Go at your own pace

Don't have the time to complete the whole training today? Complete it one module at a time!

Training FAQs

Still have questions related to the 2022 Annual University Compliance and Ethics Training? Click here to view this year's Training FAQ Guide.

ONLINE MODULE

Click below to register for the online training, which should take 60 - 75 minutes to complete.

http://uconn-health.sabacloud.com

LIVE WEBEX SESSIONS

Click below to register for one of our upcoming live web sessions, which take approximately 90 minutes.

Wednesday, April 6: 9:00 - 10:30am

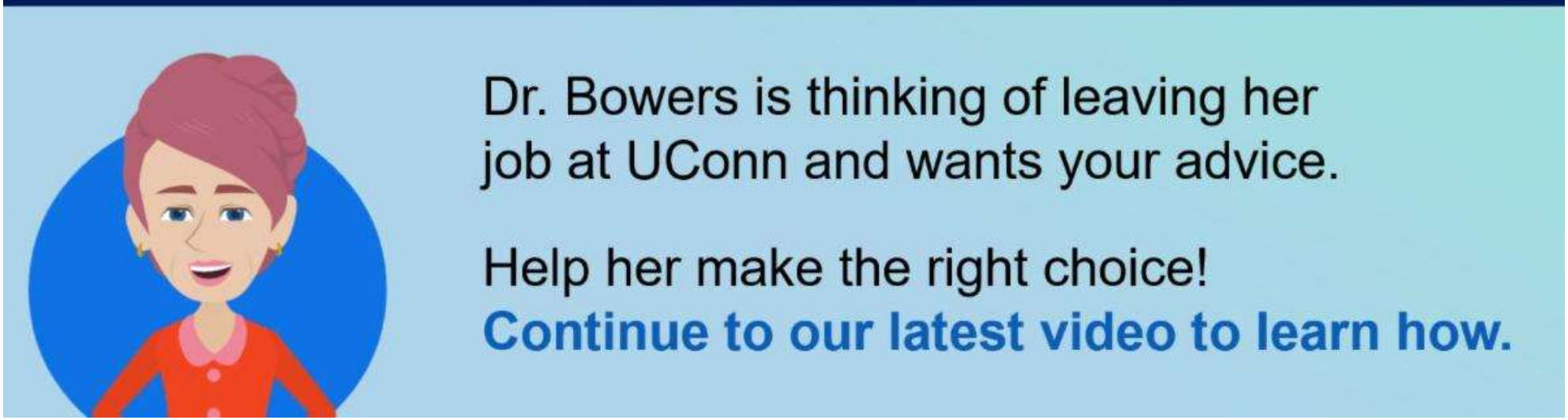
Tuesday, May 24: 1:30 - 3:00pm

For additional information, email the Office of University Compliance at **compliance@uchc.edu**.

Please Note: Special Payroll employees are not required to complete the training unless Department Heads require it.

UCONN
OFFICE OF UNIVERSITY COMPLIANCE

UCONN HEALTH



If you are considering leaving UConn and state service, you should be aware of the State Code of Ethic's guidelines often referred to as the revolving door provisions. Watch this **informative 3 minute video** and read the **accompanying resource** to learn more.

Read our Digital Resource

Watch the Video and Help Dr. Bowers

Test Your Knowledge

UCONN
OFFICE OF UNIVERSITY COMPLIANCE

Introducing UConn's New

POLICY ON POLICIES

Learn More

The University's mission and values are expressed in and supported by its stated Policies. University policies protect the integrity of the University's mission, reputation and operations and guide our workforce.

What is the focus of the University's Policy on Policies?

The Policy on Policies (Policy) explains the policy lifecycle including how new University Policies are developed and approved and how existing policies are revised, decommissioned, and archived.

The Policy allows for a consistent and clear process for all University Policies.

It is intended to be efficient and user-friendly so that the policy process is predictable and consistent.

It defines the difference between a University Policy and related resources such as procedures and guidelines.

Implementation of this Policy ultimately seeks to provide guidance and a roadmap for our faculty, staff, and students when engaging with the policy process.

Interested in Learning More?

Read the Policy

Watch this Video

policy@uconn.edu

Join the Policy Listserv

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Are you retiring or leaving UConn soon? Now may be the time for you to declutter your space by disposing of old records! **Here are some important reminders related to managing records at work.**

As a state agency, UConn follows records disposition rules established by the Office of the Public Records Administrator of the Connecticut State Library.

In most cases, we do not need to keep records "forever." Rather, ask yourself the questions listed below to make decisions about what to keep (and what to toss!)

HER ARE SOME THINGS TO THINK ABOUT

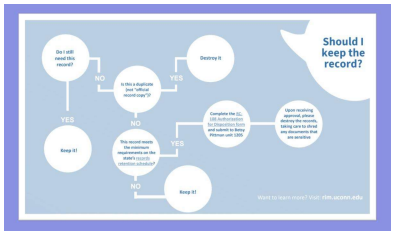
1. **Do I still need this record?** If yes, keep it! If no, go to step 2.

2. **Is this record the "official record copy" or a duplicate?** If it's a duplicate, destroy it. If it's the official record copy, go to step 3.

3. **Does the age of this record meet the minimum requirement on the state's records retention schedule?** If no, retain the record. If yes, go to step 4.

4. **Complete the RC-108 Authorization for Disposition form and submit to Records Management Liaison Officer* on your campus.**
5. **Upon receiving approval, please destroy the records, taking care to shred any documents that are sensitive.** For example, shredding should be the method of destruction for student, patient, payroll, and procard records, just to name a few.

Click on the image to the right to view a decision tree that will help you determine whether or not to keep a record.



At times, the records destruction process can be a bit more involved than the above referenced steps. If at any time you need guidance, please contact the University's Records Management Liaison Officer, **Betsy Pittman**.

Also, if you come across records that you believe may have historical value, please contact Betsy who may decide to transfer the records to University Archives to preserve our history. Below are some additional resources to help guide you through the record destruction process.

ADDITIONAL RESOURCES

Understanding the Official Copy of Record

Record Retention Schedules

RC-108 Records Disposition Authorization Form

Confidential Shredding Options

For more information, go to: **https://rim.uconn.edu/**.

Be sure to also check out the following resource post state employee requirements:

HEALTHCARE COMPLIANCE AND PRIVACY MATTERS

March 2022

Annual Compliance Training Due Tomorrow (3/15)

In consideration of the extraordinary circumstances of the public health crisis and challenges faced by our workforce, the deadline for the compliance training was extended to Tuesday, March 15.

Read More

Office of Healthcare Compliance and Privacy
263 Farmington Avenue, Farmington, CT 06030

Phone: 860.679.4177 **Fax:** 860.679.1016

UCONN HEALTH

HEALTHCARE COMPLIANCE AND PRIVACY MATTERS

Disposal of PHI and ePHI

Do you know the proper protocols for disposing of protected health information (PHI) and electronic protected health information (ePHI)?

Read More

Office of Healthcare Compliance and Privacy
263 Farmington Avenue, Farmington, CT 06030

Phone: 860.679.4177 **Fax:** 860.679.1016

UCONN HEALTH

ATTACHMENT 5.1

University of Connecticut

Joint Audit & Compliance Committee Meeting

Public Session

June 23, 2022

UConn – Information Technology Services

Financials FY2022 Operating

State Appropriation and Tuition Budget and Forecasted Expenditures:

Budget	$40.1M
Forecasted Personal Services and Fringe Benefits	$26.2M
Forecasted Operating Expenses	$ 12.6M
Forecasted Carryforward	$ 1.3M

To date in FY2022 ITS's operating budget was cut by $765K, our deferred maintenance budget remains at $1.7M and our 5-year wired access layer refresh budget was decreased to $4.0M (our original request was 5-years at $6.0M per year and FY2022 is year 3).

Also, in FY2022, ITS received operating budget for the director of high-performance computing position and capital funds for the $1.6M investment in high performance computing hardware.

Information Technology Staffing (as of 5/25/22)

- ITS has twelve new open positions.
- There have been six new hires since March 12, 2022.
- There have been eight new Special Payroll hires since March 12, 2022.
- Since March 12, ITS has had fourteen employees separate or retire.

Major Outages (as of 05/31/22)

Outage Taxonomy	# of Issues	Systems Affected
Network Issue - Hardware	1	Power Outage on Storrs Campus affected multiple systems
Network Issue - Software	0	
Network Issue – Request Flood	0	
System Issue - Hardware	0	
System Issue - Software	0	
Third Party	0	

Total # of Major Outages: 4

UConn – IT Projects Status (as of 05/31/22)

Project Name	Brief Project Description	Planned Budget	Actual Spend	Status	Rational for Yellow and Red Status	Expected Completion Date
WALR FY 2021 Phase 2	Upgrade all network equipment and wired access infrastructure for the University	$4.200M	$3.736M	GREEN	Construction was completed on time, under budget. Completed designs for future phases.	12/31/2022
WALR FY 2022 Phase 3	Upgrade all network equipment and wired access infrastructure for the University	$4.000M	$0.400M	GREEN	On track for planned summer work. A portion of the Phase 3 budget and scope has been shifted into Phase 4.	02/28/2023
Kuali 2022	Migrate university Kuali Financials system from on-prem to Kuali-Co cloud solution.	$1.400M	$0.000	GREEN	Currently in contract development.	TBD

ATTACHMENT 5.2

Joint Audit & Compliance Committee: June 2022
UConn Health Information Technology Services
Public Session Key Takeaways

- **Financials YTD FY 2022: (28,437) due to timing of AP**
- **33 open position: resignations and early retirements**
- **Completed 33 projects Feb – May 2022**
- **New Interim CISO: Dr. Dennis Leber**
- **All projects are green except for: Identity Access Broker; Cloud Access Security Broker; MS 365; DR; Network Segmentation; Vulnerability Remediation:**
  - **Identity Access Broker RFP (RED): was on hold pending placing a CISO and CASB (RED): being pushed to accommodate the Data Loss Prevention project**
  - **MS365 (YELLOW): Released vendor and now augmenting with MS support and new vendor. Planned mail migration July**
  - **DR (portions are yellow) as work is lagging projections**
  - **Network Segmentation (YELLOW): vendor side delay**
  - **Vulnerability Remediation (YELLOW): vendor delay/separation. CISO building program.**
- **Three meetings of IT Governance have occurred to prioritize major projects**
- **Epic focus has been: Projects managed through ITG; Epic for NICU with go live June 28th; June QTR Upgrade; new clinical areas**

University of Connecticut

Joint Audit & Compliance Committee Meeting

Public Session

June 2022

UConn Health – Information Technology Services

Financials FY2022 Operating

FY22 Budget	$ 56,646,099
FY22 Personal Services and Fringe	$36,398,351
FY22 Purchased Services	$19,247,748
FY22 (1 – 3rd Actual)	$41,076,606
FY22 (1 – 3rd Budget)	$41,105,043
FY22 Variance (1- 3rd Bud v Act)	($28,437)

Open Positions, New Positions, Positions on Hold, Terminations and the areas they represent.

1. Open Positions: 33
2. New Positions: 3

Outages (02/01/2022 – 04/30/2022)

Outage Taxonomy	# of Issues	Duration	Systems Affected

Total # of Outages: 0

ATTACHMENT 6.1

UConn Storrs & Regional Campuses - Retirement Cliff

JACC: June 23, 2022

UConn Storrs/Regionals : Goals Today

- To understand terms & impact of this summer's Retirement Cliff
- Review UConn Eligibility and Retirement Data
- Review UConn's Impact Action Plans (2018-2022 & beyond)

UConn Storrs/Regionals – What is IT?

Changes for Employees in SERS or ARP for Retirements on or the Cliff:

1. Normal Retirement Age changes for SERS (Tier 2 and 2A, inc. Hybrid)

2. Annual Cost of Living Adjustment (COLA) changes for all SERS plans

3. Increase in Retiree Health Care Costs for Participants Under Age 65

4. Increase in certain Retiree Health Care Costs for participants ≥Ages 65

UConn Storrs/Regionals - IMPACT

- Employees eligible for **Normal Retirement** in **SERS** (age varies by plan) planning to retire before cliff and also worried about **retiree healthcare** costs.

- Employees eligible for **Early Retirement** in **SERS** planning to retire by cliff and also worried about **retiree healthcare** costs

- Some employees in the **Alternate Retirement Plan** worried about mainly **retiree healthcare** costs

WHAT HR IS SEEING: MOST EMPLOYEES PROVIDING THEIR INTENT TO RETIRE OR RETIRING ARE THOSE WHO HAD PLANNED TO RETIRE OVER THE NEXT 12 MONTHS REGARDLESS OF THE CLIFF.

Storrs/Regionals: Planning/Actions Items 2018 -2019

- **AUTOMATION** - HR Selects and Implements **PAGE UP** with **BROADBEAN – Automating Applicant Processing and Hire/Onboarding and Diversity Recruitment** (Goal: Growing and Diversifying Applicant Pools as the Retirement Cliff Approaches and Successful Talent Acquisition Automation).

- **COMPENSATION** - At the request of the University, UConn HR proposes and completes a rigorous overhaul of staff **Compensation Philosophy**, external and internal market assessments and wage increase approval authorizations to support compensation consistency/budgets/market demands.

- **EDUCATION/RISK ASSESSMENT - HR educates and socializes Retirement Cliff** staff and faculty data with Budget, senior leaders and union leadership in multiple meetings.

Storrs/Regionals: Planning/Actions Items 2020-2021

- **Website/Onboarding** - HR Updates Entire HR Website and Bi-Weekly Onboarding of Staff (GOAL: A more user-friendly website for applicants, employees and managers alike cross-referenced to other peer and aspirant institutions of higher education).

- **Client Support -** HR continues to promote institutionalizing staffing audits/organizational design support/successions plan reviews led by HR's Work Force Team with retirement data summaries specific to each of the 60 hiring units.

- **Personalized Education -** COVID changes the Retirement Cliff Landscape and Individual Decision Making. HR begins the UConn/UCH retirement website build outs

- **Talent Pathways -** Implementation of Management and Confidential Employee Talent Pathways Project at UConn Storrs and the Regionals starting with Phase 1: New Performance Management process and annual goal attainments.

- **Retirement Survey** - UConn and UCH HR send out Retirement Interest Survey following Retirement website Go-Live and COVID Vaccine and Testing Implementation.

RETIREMENT SURVEY RESULTS

SURVEY RESULT	UCONN	UCHC
SERS Response	547 (65.58% of 834)	433(71.5% of 605)
Planning to Retire	173	130
- October to December	15	11
- January to March	40	30
- April to July	113	85
- Blank	5	4
Not Planning to Retire	178	112
Undecided	183	184
Blank	13	7
Anticipated Retirements	350 (120 To Be Expected)	300 (100 To Be Expected)
ARP Response	151 (48.2% of 313)	168 (46% of 365)
Planning to Retire	34	33
-October to December	4	6
-January to March	8	9
-April to July	21	18
-Blank	1	0
Not Planning to Retire	80	47
Undecided	34	85
Blank	3	3
Anticipated Retirements	100 (25 To Be Expected)	172 (62 To Be Expected)

Storrs/Regionals: Retirement Data

Retirement Date		UConn SERS/Hybrid/TRS	UConn ARP	UConn Total	
5/1/2020		7	1	8	
6/1/2020		15	3	18	
7/1/2020		8	4	12	
8/1/2020		15	2	17	
9/1/2020		11	1	12	
10/1/2020		14	1	15	
11/1/2020		4	0	4	
12/1/2020		4	0	4	
1/1/2021		18	5	23	
2/1/2021		8	0	8	
3/1/2021		10	1	11	
4/1/2021		18	1	19	
5/1/2021		6	2	8	
6/1/2021		14	4	18	
7/1/2021		14	6	20	
8/1/2021		11	7	18	
9/1/2021		15	3	18	
10/1/2021		20	1	21	
11/1/2021		7	1	8	
12/1/2021		2	1	3	
1/1/2022		20	5	25	
2/1/2022		8	4	12	
3/1/2022		16	2	18	
4/1/2022		41	0	41	
5/1/2022		21	5	16	
6/1/2022		64	14	78	Anticipated
7/1/2022		93	14	107	Anticipated

Storrs/Regionals: Retirement Data Analysis

Retirement Cliff Fact	UConn Storrs and Regionals
Actual Retirements from 7/1/21 to 2/1/2022	125
Actual/Anticipated Retirements from 3/1/22 to 7/1/22	260
Actual from 7/1/2021 to 7/1/2022	385***
Total Regular Payroll as of 3/1/2022	5,145
Total Regular Payroll Eligible for a Retirement Plan as of 7/1/2022*	4,952 (3.3% of this # are anticipated to retire 3/22-7/22)
Total Eligible for a Retirement Plan (and eligible for Retiree Health Insurance) as of 7/1/2022	1,071 (15.4% of this # are anticipated to retire 3/22-7/22)
Total Most Like to Retire as of 7/1/2022**	430

* Excludes post-doctoral scholars and those on VISAs that are ineligible for SERS or ARP at this time.
** Those eligible for Normal Retirement or 1 year or less away (Early Penalty) and who have retiree health care)
*** Average Year would be 150-170 EXPECTED retirements

Storrs/Regionals: Next Steps

- Processing Retirements!
- Organization/Job Functions - *consultative* Assessments with HR Workforce Team and Budget Partnerships
- Continued & Modern Support of Decentralized Labor Planning/Hiring Strategies
- Rollout of HR's Diversity and Inclusion Task Force Outcomes from Application, through Onboarding and into integration within work teams.
- Hiring of Recruiter/Talent "Sourcer"
- "Cluster" OR "Anticipated" Hiring Protocols for Critical Functions
- Elimination of 1:1 Hiring unless Business Needs Require
- Stakeholder Support of HR's Systematic and Modern Compensation and Approval Practices
- Mentorship Possibilities
- Manager/Staff Training and Leadership Development Strategy (Funded and Now In Development)
- Modern HR Workforce Policies (Telecommuting, Work/Life Integration, Talent Pathways Project Phase 2: Succession Planning)
- Turnover Analysis

Storrs/Regionals: Turnover Snapshot

2017	2018	2019	2020	2021	2022*
Retirement Turnover	Retirement Turnover	Retirement Turnover	Retirement Turnover	Retirement Turnover	*YTD Retirement Turnover
191	138	129	119	174	Anticipated 385
3.89%	**2.77%**	**2.56%**	**2.33%**	**3.39%**	**7.46%**

4896	4978.5	5049.5	5092	5151.5	5154
2017	**2018**	**2019**	**2020**	**2021**	**2022***
Total Annual Turnover	**Total Annual Turnover**	**Total Annual Turnover**	**Total Annual Turnover**	**Total Annual Turnover**	**Total *YTD Annual Turnover**
586	554	566	443	555	513
11.97%	**11.13%**	**11.21%**	**8.70%**	**10.77%**	**9.95%**

2017	2018	2019	2020	2021	2022*
Non-Retirement Turnover	Non-Retirement Turnover	Non-Retirement Turnover	Non-Retirement Turnover	Non-Retirement Turnover	*YTD Non-Retirement Turnover
395	416	437	324	381	128
8.05%	**8.35%**	**8.66%**	**6.35%**	**7.43%**	**2.48%**

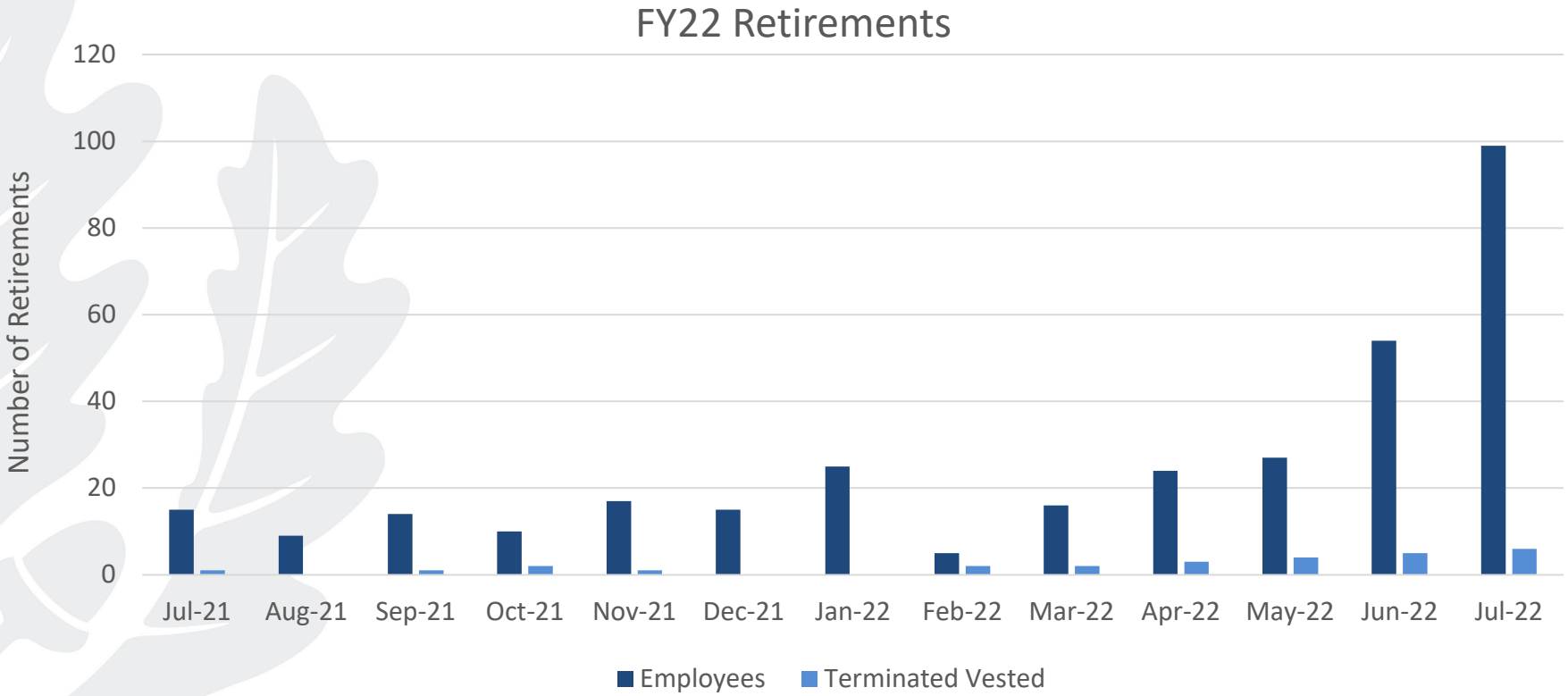
ATTACHMENT 6.2

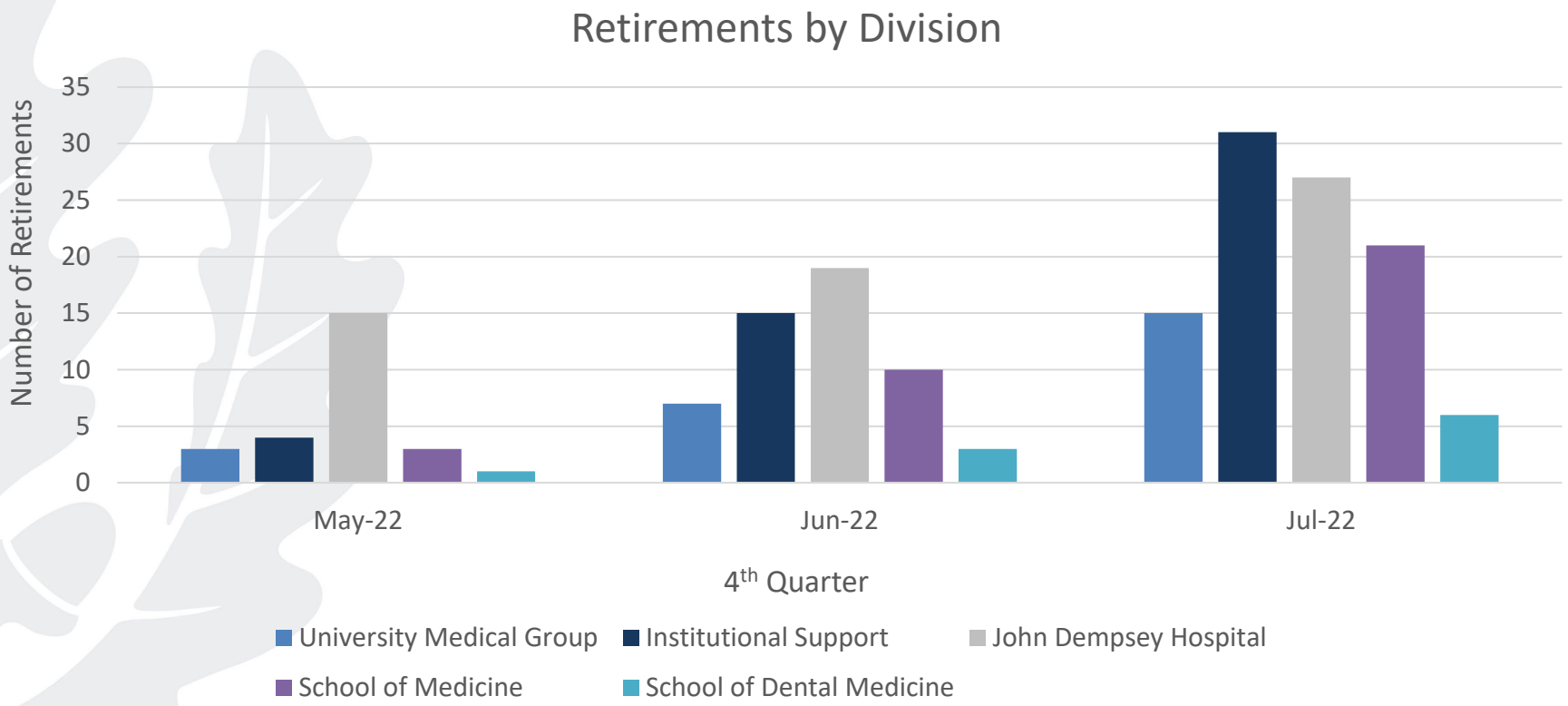
UConn Health Retirement Status Update

Lakeesha Brown, Vice President, Human Resources

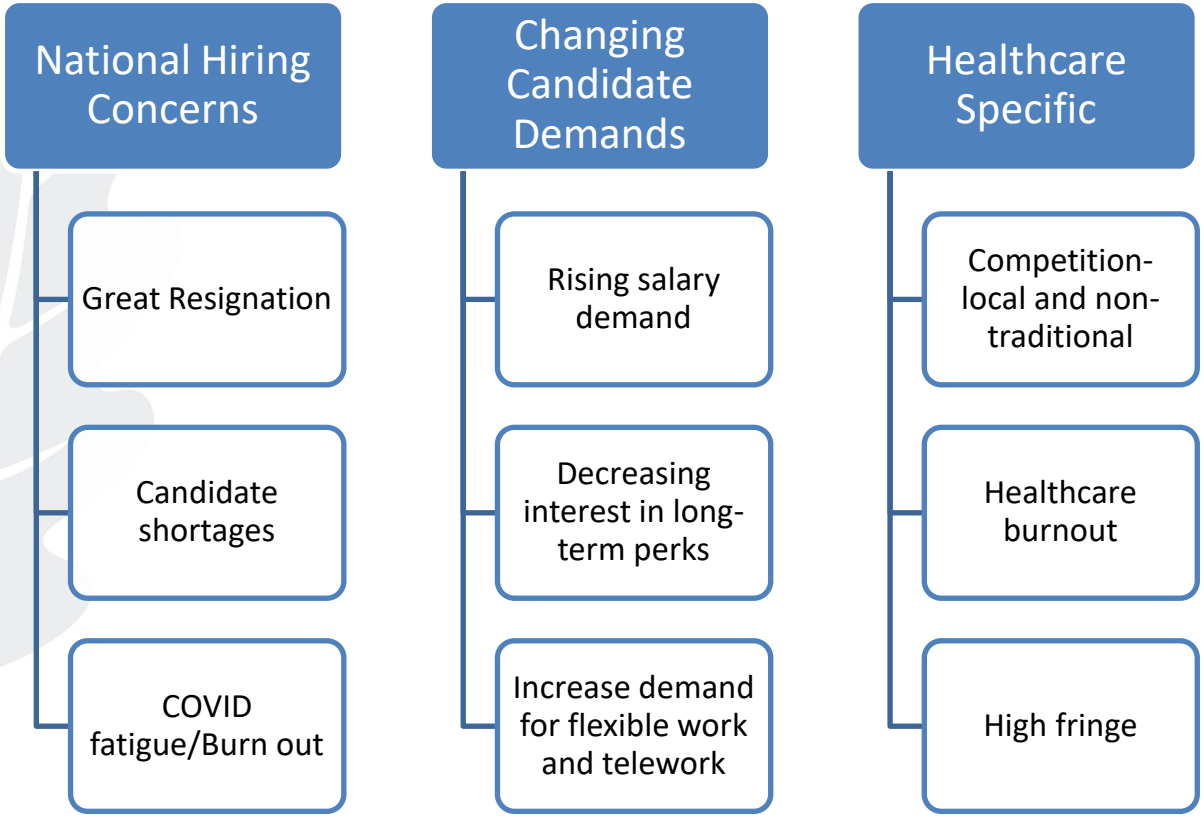
June 23, 2022

UCONN HEALTH


FY22 Retirements
Number of Retirements
120
100
80
60
40
20
0
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Employees
Terminated Vested

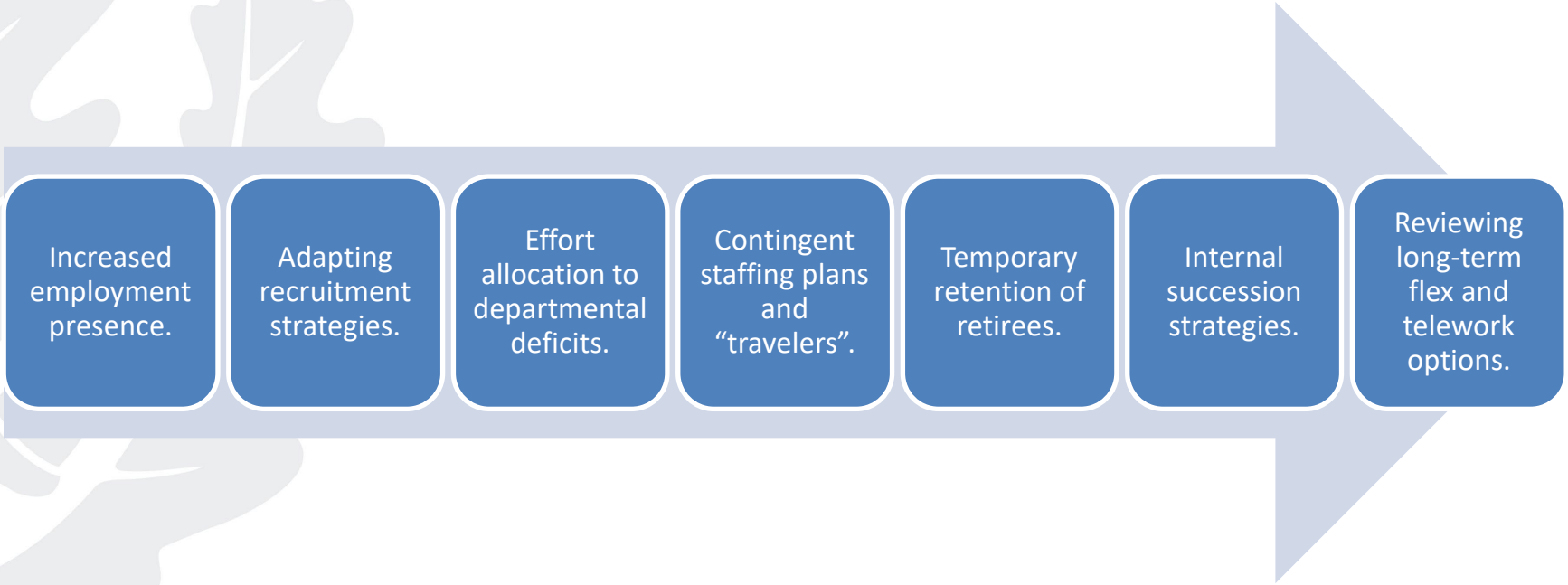

Retirements by Division
Number of Retirements
35
30
25
20
15
10
5
0
May-22
Jun-22
Jul-22
4th Quarter
University Medical Group
Institutional Support
John Dempsey Hospital
School of Medicine
School of Dental Medicine

Other workforce considerations



UCONN HEALTH

Mitigation Strategies



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