### Joint Audit & Compliance Committee

**Agenda**

10:00 am – 10:45 am – Executive Session
10:45 am – 12:00 pm - Public Meeting

**REVISEd**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Proposed Action</th>
<th>Tab</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Executive Session to discuss:</strong></td>
<td>Approval</td>
<td>None</td>
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<tr>
<td>• C.G.S. 1-200(6)[E] – 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. [1-210(b)(1)]</td>
<td>Approval</td>
<td>None</td>
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<tr>
<td>• C.G.S. 1-200(6)[E] – Records or the information contained therein pertaining to strategy and negotiations with respect to pending claims regarding Recovery Audit Contractor (RAC) Audits [1-210(b)(4)]</td>
<td>Approval</td>
<td>None</td>
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<tr>
<td>• C.G.S 1-200(6)(E) – Records, reports and statements privileged by the attorney-client relationship. [1-210(b)(10)]</td>
<td>Approval</td>
<td>None</td>
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<tr>
<td>• C.G.S. 1-200(6)[C] – 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. [1-210(b)(20)]</td>
<td>Approval</td>
<td>None</td>
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</tbody>
</table>

| Opportunity for Public Comment | None |

| Minutes of the May 7, 2015, JACC Meeting | Approval | 1 |

| Storrs & UConn Health Significant Compliance Activities | Update | 2 |

| • Data Exposure in School of Engineering | Update | 2 |
| • Athletics | Update | 2 |
| • ICD-10 - Storrs and UConn Health | Update | 2 |

| Annual Audit & Compliance Plans – Storrs and UConn Health | Approval |   |

*Individual Responsibility, Institutional Success*
<table>
<thead>
<tr>
<th>Issue</th>
<th>Proposed Action</th>
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<tbody>
<tr>
<td>Significant Audit Activities (Storrs &amp; UConn Health)</td>
<td>Update</td>
<td>3</td>
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<tr>
<td>• Status of Audit Assignments</td>
<td></td>
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<tr>
<td>• Audit Follow-up Activity</td>
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<tr>
<td>Auditor of Public Accounts</td>
<td>Presentation</td>
<td>4</td>
</tr>
<tr>
<td>• Auditors’ Report – University of Connecticut for the Fiscal Years</td>
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<tr>
<td>Ended June 30, 2012 and 2013 - Storrs</td>
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<tr>
<td>External Engagements</td>
<td>Approval</td>
<td>5</td>
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<tr>
<td>• Approval to Hire – BKD - Annual Agreed-Upon Procedures to the</td>
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<tr>
<td>Statements of Revenues &amp; Expenses of the UConn’s Athletics Program</td>
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<tr>
<td>• Approval to Hire – McGladrey - Annual Audit and Agreed Upon</td>
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<tr>
<td>Procedures - UCONN 2000 Construction Projects Expenditures</td>
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<tr>
<td>Informational/Educational Items</td>
<td>Information Only</td>
<td>6</td>
</tr>
<tr>
<td>• Compliance Newsletters – Storrs &amp; UConn Health</td>
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<td>• Current Issues in Compliance Newsletters</td>
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<tr>
<td>• Practical Guidance for Health Care Governing Boards on Compliance</td>
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<td>Oversight, April 20, 2015</td>
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<tr>
<td>• JACC Agenda Forecast</td>
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<tr>
<td>Conclusion of Full Meeting</td>
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<tr>
<td>Information Session with OACE’s Chief Audit &amp; Compliance Officer and</td>
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<td>Direct Reports</td>
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The next meeting of the JACC will be held on Tuesday, December 1, 2015 at 10:00 am
Rome Commons Ballroom, Storrs

Individual Responsibility, Institutional Success
TAB 1
The meeting of the Joint Audit and Compliance Committee (JACC) was called to order at 10:02 a.m. by Trustee Nayden.

ON A MOTION made by Trustee Nayden and seconded by Director Holt, THE JACC VOTED to go into executive session to discuss:

• C.G.S. 1-200(6)(E) – A discussion of any matter which would result in the disclosure of public records or the information contained therein pertaining to preliminary drafts or notes that the public agency has determined the public’s interest in withholding outweighs the public’s interest in disclosure. [1-210(b)(1)]

• C.G.S. 1-200(6)(E) - A discussion of any matter which would result in the disclosure of public records or the information contained therein pertaining to strategy and negotiations with respect to pending claims regarding Recovery Audit Contractor (RAC) Audits. [1-210(b)(4)]

• C.G.S. 1-200(6)(E) - A discussion of any matter which would result in the disclosure of public records or the information contained therein pertaining to or communications privileged by the attorney-client relationship. [1-210(b)(10)]

• C.G.S. 1-200(6)(c) – Matters concerning standards, processes and codes not available to the public the disclosure of which would compromise the security of integrity of information technology systems.


The Executive Session ended at 11:17 a.m. and the JACC returned to open session at 11:18 a.m. There were no public comments.
Tab 1 – Minutes of the Meeting

ON A MOTION made by Trustee Nayden and seconded by Trustee Cantor the minutes of the February 10, 2015, JACC meeting were approved.

TAB 2 – Storrs & UConn Health Significant Compliance Activities

K. Fearney provided an update on significant compliance activities.

N. Wallach and W. Byerly presented an overview of Research Compliance for Storrs and UConn Health.

J. Geoghegan updated the committee on ICD-10 initiatives at UConn Health. K. Fearney provided an update for the Storrs campus.

S. Wetstone updated the committee regarding open payment activity at UConn Health.

TAB 3 – Revised Travel and Entertainment Policies and Procedures

C. Eaton provided the committee with a summary of changes made to this policy.

ON A MOTION made by Trustee Carbray and seconded by Director Archambault, the revised Travel and Entertainment Policies and Procedures for Storrs and the regional campuses were approved by the committee.

TAB 4 – Significant Audit Activities

C. Chiaputti provided the JACC with an update on the status of audit assignments (Storrs and UConn Health). OACE completed five audits and had ten audits ongoing during this reporting period. OACE also was working on four special projects.

The JACC accepted four, of the five audits, as follows:

- CLAC Renovations – Review 2,
- Endowed Char Accounts,
- Server Implementation and Security, and
- Faculty Consulting – FY14.

The committee was provided with the status of OACE’s follow-up activities.
**Tab 5 – Auditors of Public Accounts - FY14 Statewide Single Audit Findings and Management Responses**

Auditors of Public Accounts, J. Carroll, N. Freitas, J. Rasimas, G. Slupecki, and W. Felgate presented the Statewide Single Audit for the Fiscal Year Ended June 30, 2014 relative to:

- University of Connecticut Research and Development.
- UConn Health Research and Development.
- University of Connecticut Federal Financial Aid Assistance Programs.


**Tab 6 – External Engagements**

M. Bloom from McGladrey presented the committee with the following FY14 report:

- University of Connecticut – Report to the Board of Trustees and Joint Audit and Compliance Committee.
- University of Connecticut – Agreed Upon Procedures on UConn 2000 Construction Expenditures.

**ON A MOTION** made by Trustee Nayden and seconded by Director Archambault this audit was approved.

**Tab 7 – Informational / Educational Items**

The committee was provided with the following:

- Compliance Newsletters – Storrs and UConn Health,
- Current Issues in Compliance, and
- JACC Agenda Forecast.

There being no further business, **ON A MOTION** made by Trustee Nayden and seconded by Trustee Kruger, the meeting was adjourned at 12:21 p.m.

Respectfully submitted,

Angela Marsh

Angela Marsh
TAB 2
Joint Audit & Compliance Committee
Significant Compliance Activities

Storrs

- **Annual Compliance Training** – 2015 Compliance Training concluded with 100% completion by faculty and staff. This year’s topics included the Code of Conduct, University Guide to the State Code of Ethics, and Health and Safety.

- **Protection of Minors Program** – Storrs Compliance was given responsibility for establishing a Protection of Minors Program at the Storrs, Regional and UConn Health Campuses. A Minor Protection Coordinator will be hired to assist with managing the program. Implementation will require establishing policy, procedures, screening, training, supervision and monitoring.

- **Records and Information Management** - Working with Stamford Campus to ensure proper records management systems in place campus-wide. Educational efforts include records retention schedules, records and privacy concerns, etc.

- **Policy Development** – Policies recently adopted include the Policy for Education Abroad and Related Activities in Sites with a U.S. Department of State Travel Warning/Travel Alert and the Student International Travel Policy.
Joint Audit & Compliance Committee
Significant Compliance Activities

UConn Health

• **Drug Free Schools and Workplace Compliance** – A coordinator and committee with an approved charter have been established to lead activities assuring review and assessment of UConn Health’s compliance with these two federal regulations.

• **Privacy Taskforce** – A short-term task force, reporting to the Executive Vice President for Health Affairs, has been authorized to evaluate the current UConn Health privacy function, benchmark with other institutions, and then identify and recommend an appropriate privacy function that would best fit the institution’s needs.

• **National Government Services Post Pay Probe** – On May 19, 2015, NGS reviewed ten records of patients with three to five day hospital stays. All records were found to be in compliance with Medicare requirements.

• **Hemophilia Treatment Center (HTC) 340 B program compliance** – A self review of eligibility criteria determined that this program was not in compliance with necessary elements to purchase 304B drugs for the CT Children’s Hospital HTC location. UConn Health has sent a self-disclosure letter to the Department of Health and Human Services, Health Resources and Services Administration Office of Pharmacy Affairs to include remediation actions.

• **John Dempsey Hospital (JDH) 340B program compliance review** – A review was conducted by the Department of Health and Human Services, Health Resources and Services Administration Office of Pharmacy Affairs to evaluate the hospital’s program for compliance with the rules. The hospital’s program was found to be mostly compliant, with a minor corrective action plan (CAP) required. JDH’s CAP has been submitted.

• **Compliance Program Change** – The Documentation and Coding Program previously reporting to the UConn Health OACE is now reporting through University Medical Group administration. It is expected that the program staff will continue to provide expert education and guidance to our providers regarding proper documentation and coding practices to assure proper billing of professional services.

• **Overpayment Refunds** –
  - Inpatient Admission orders lacking timely authentication
  - Physical Therapy services provided in physician office but billed with hospital outpatient site-of-service
  - Drugs billed with incorrect units/administration units

• **Executive Compliance Committee** – The UConn Health Executive Compliance Committee (ECC) is being reviewed with plans to restructure the committee to better meet the needs of the institution.
TAB 3
<table>
<thead>
<tr>
<th>Audit Project</th>
<th>Storrs Or UConn Health (UH)</th>
<th>Planning</th>
<th>Fieldwork</th>
<th>Pre-Draft/Draft Report</th>
<th>Final Draft Report Issued</th>
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</thead>
<tbody>
<tr>
<td>Cash Handling</td>
<td>UH</td>
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<tr>
<td>Medical Device Security</td>
<td>UH</td>
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<td>Health Information Management (HIM) – Patient Record Management JDH UMG</td>
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<td>UConn Health Electronic Health Record (eHims)</td>
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<td>General University Fee (GUF) Funded Activity – Marching Band</td>
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<td>Firewall Security Audit</td>
<td>UH</td>
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<td>NCAA Compliance – Academic Performance Program</td>
<td>Storrs</td>
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<tr>
<td>Student Health Services Clinical Systems</td>
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<tr>
<td>Project Commissioning / Closeout Process</td>
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<td>2nd Change Order Monitoring Review (on hold)</td>
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<td>NCAA Compliance - Extra Benefits, and Camps &amp; Clinics</td>
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<td>Student Health Services</td>
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<td>Cash Receipts / Cash Handling</td>
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<td>Compensatory Time, Vacation and other Leave Accruals</td>
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<td>Health Information Management (HIM) – Dental</td>
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<td>Dental Systems</td>
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<td>Storrs</td>
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<td>Grants – Cash Management</td>
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### Joint Audit & Compliance Committee
#### Status of Audit Assignments

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<tr>
<th>Audit Project</th>
<th>Storrs or UConn Health (UH)</th>
<th>Planning</th>
<th>Fieldwork</th>
<th>Pre-Draft/Draft Report</th>
<th>Final Draft Report Issued</th>
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<tr>
<td>Foundation Receipts and Disbursements – FY 15</td>
<td>Storrs and UH</td>
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<td>Lab Safety</td>
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<td>Bioscience CT Initiative – Phase II – New Hospital</td>
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<td>Payment Card Industry Data Security Projects (PCI DSS)</td>
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<td>Innovation Partnership Building (IPB)</td>
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<td>Human Subject Incentive Payments</td>
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<td>Clinical Contracts</td>
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<td>Total Audits (25)</td>
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<tr>
<th>Special Projects/Consulting/Follow-up</th>
<th>Storrs or UConn Health</th>
<th>Planning</th>
<th>Fieldwork</th>
<th>Review Pre-draft</th>
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<td>Athletics</td>
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<td>Radiology</td>
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<td>SHS Special Project</td>
<td>Storrs</td>
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<td>Total Special Projects/Consulting (05)</td>
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Open Overdue Items by Audit - Based on Original Due Date

Audit Name

- 07-18 Storrs Disaster Recovery and Business Continuity
- 07-51 UITS Active Directory
- 07-70 HIPAA Security Storrs
- 09-22 CLAS IT
- 09-44 Library Central Services
- 10-11 UCHC Human Subjects Research
- 11-05 PeopleSoft - Student Administration
- 11-09 Purchasing Card Program
- 11-20 Grant Expenditures & Cost Transfers
- 11-39 NextGen Systems
- 12-01 UCHC Banner
- 12-04 CT Health Information Network (CHIN)
- 12-30 Change Order Monitoring - Storrs
- 12-32 Diagnostic Imaging
- 12-37 Anatomical Donations
- 12-38 Stamford Business Operations and IT
- 12-42 University Server Physical Security
- 12-45 Daily Campus
- 12-49 UConn Health Asset Management
- 12-50 Library Business Process
- 13-01 Emergency Preparedness
- 13-07 Export Controls
- 13-09 Endowed Chairs and Professorships
- 13-12 American Disability Act (ADA)
- 13-13 User Authentication and Account Administration
- 13-21a Tuition Fees - Student Accounts Receivable and Financial Aid
- 13-21b Student Administration Systems - Jenzabar
- 13-22 Lab Safety
- 13-31b JDH Pharmacy Charge Capture
- 13-32 International Faculty and Students
- 13-37 Meaningful Use - Hospital
- 13-38 Medicare Enrollment - Provider Data
- 13-39 Krono's System
- 13-40 Clery Act Compliance
- 14-05 Real Estate Center, School of Business
- 14-06 Law School Foundation
- 14-09 Federal Grants - Cost Sharing
- 14-11 Server Implementation and Security
- 14-12 Husky One Card Office
- 14-14 Advanced Beneficiary Notices
- 14-16 UConn Foundation - FY 14
- 14-17 Avery Point Information Technology
- 14-32 Faculty Consulting - FY14

Number of Open Overdue Items

0 5 10 15 20 25 30 35 40 45 50 55 60
Implemented

- High: 5
- Medium: 32
- Low: 50

Open OverDue Items by Risk Level

- High: 15
- Low: 48
- Medium: 139
Joint Audit & Compliance Committee
Audit Finding Rating Definitions

**Low**

Meaningful reportable issue for client consideration that in the Auditor’s judgment should be communicated in writing. The finding results in minimal exposure to the University or UConn Health and has little or no impact on the University’s or UConn Health’s compliance with laws and regulations. The issues related to this control weakness will typically not lead to a material error.

**Medium**

Significant exposure to the area under review within the scope of the audit. The finding results in the potential violation of laws and regulations and should be addressed as a priority to ensure compliance with University’s or UConn Health’s policies and procedures. The significance of the potential errors related to this control weakness makes it important to correct.

**High**

Significant exposure to the University or UConn Health that could include systemic University or UConn Health wide exposure. The finding could result in a significant violation of laws and regulations and should be viewed as a highest priority which the University or UConn Health must address immediately.
AUDITORS' REPORT
UNIVERSITY OF CONNECTICUT
FOR THE FISCAL YEARS ENDED JUNE 30, 2012 AND 2013

AUDITORS OF PUBLIC ACCOUNTS
JOHN C. GERAGOSIAN  ROBERT M. WARD
We have audited certain operations of the University of Connecticut (UConn) in fulfillment of our duties under Section 2-90 of the Connecticut General Statutes. The University of Connecticut is a component unit of the University of Connecticut system, which includes UConn, the University of Connecticut Health Center (UConn Health Center) and the University of Connecticut Foundation, Inc. We also audit the financial statements of UConn and the UConn Health Center and report on those audits separately. The scope of our audit included, but was not necessarily limited to, the fiscal years ended June 30, 2012 and 2013. The objectives of our audit were to:

1. Evaluate UConn’s internal controls over significant management and financial functions.

2. Evaluate UConn’s compliance with policies and procedures internal to the university or promulgated by other state agencies, as well as certain legal provisions.

3. Evaluate the economy and efficiency of certain management practices and operations, including certain financial transactions.

Our methodology included reviewing written policies and procedures, financial records, minutes of meetings, and other pertinent documents; interviewing various personnel of the university, as well as certain external parties; and testing selected transactions. We obtained an understanding of internal controls that we deemed significant within the context of the audit objectives and assessed whether such controls have been properly designed and placed in operation. We tested certain of those controls to obtain evidence regarding the effectiveness of their design and operation. We also obtained an understanding of legal provisions that are significant within the context of the audit objectives, and we assessed the risk that illegal acts, including fraud, and violations of contract, grant agreement, or other legal provisions, could occur. Based on that risk assessment, we designed and performed procedures to provide reasonable assurance of detecting instances of noncompliance significant to those provisions.
We conducted our audit in accordance with the standards applicable to performance audits contained in Government Auditing Standards, issued by the Comptroller General of the United States. Those standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides such a basis.

The accompanying Résumé of Operations is presented for informational purposes. This information was obtained from the university's management and was not subjected to the procedures applied in our audit of the university. For the areas audited, we identified:

1. Deficiencies in internal controls;
2. Apparent noncompliance with legal provisions; and
3. Need for improvement in management practices and procedures that we deemed to be reportable.

The State Auditors’ Findings and Recommendations in the accompanying report presents any findings arising from our audit of UConn.

COMMENTS

FOREWORD

The University of Connecticut, a constituent unit of the state system of higher education, operates generally under the provisions of Title 10a, Chapter 185b, Part III, of the General Statutes. UConn is governed by the Board of Trustees of the University of Connecticut, consisting of 21 members appointed or elected under the provisions of Section 10a-103 of the General Statutes. The board makes rules for the governance of the university and sets policies for administration of the university pursuant to duties set forth in Section 10a-104 of the General Statutes. The members of the board as of June 30, 2013 were:

Ex officio members:

Dannel P. Malloy, Governor
Sanford Cloud Jr., Chairperson of the UConn Health Center Board of Directors
Stefan Pryor, Commissioner of Education
Steven K. Reviczky, Commissioner of Agriculture
Catherine Smith, Commissioner of Economic and Community Development

Appointed by the Governor:

Lawrence D. McHugh, Middletown, Chair
Louise M. Bailey, West Hartford, Secretary
Peter S. Drotch, Framingham, Massachusetts
Lenworth M. Jacobs, M.D., West Hartford
Rebecca Lobo, Granby
Auditors of Public Accounts

Denis J. Nayden, Stamford
Thomas D. Ritter, Hartford
Juanita T. James, Stamford
Wayne J. Shepperd, Danbury
Richard Treibick, Greenwich
Marilda L. Gandara, Hartford
Thomas E. Kruger, Stamford

Elected by alumni:

Francis X. Archambault, Jr., Storrs
Richard T. Carbray Jr., Rocky Hill

Elected by students:

Brien T. Buckman, Storrs
Rose A. Barham, Storrs

Dannel P. Malloy served as Governor during the audited period.

Cory Schmitt of Storrs, Michael A. Bozzuto of Avon and Michael J. Martinez of East Lyme completed their terms June 30, 2011; they were succeeded by Brien T. Buckman of Stamford, Marilda L. Gandara of Hartford and Thomas E. Kruger of Stamford, effective July 1, 2011.

Andrea Dennis-LaVigne completed her term on August 31, 2011 and was succeeded by Richard T. Carbray Jr., effective September 1, 2011.

George A. Coleman served as Acting Commissioner of Education until he was succeeded by Stefan Pryor, effective September 7, 2011 and Gerard N. Burrow, M.D., served as chairman of the UConn Health Center’s Board of Directors until he was succeeded by Sanford Cloud, Jr., effective September 1, 2011.

Adam Scianna completed his term on June 30, 2012 and was succeeded by Rose A. Barham, effective July 1, 2012.

Lenworth M. Jacobs, Rickhard Treibick, Peter S. Drotch, Wayne J. Shepperd, and Brien T. Buckman completed their terms June 30, 2013. They were succeeded by Andy F. Besette, Charles F. Bunnell, Shari G. Cantor, Michael K. Daniels, and Andrea Dennis-LaVigne, effective July 1, 2013.

Pursuant to Section 10a-108 of the General Statutes, the board of trustees is to appoint a president of UConn to be the chief executive and administrative officer of the university and the board. Susan Herbst was appointed on December 20, 2010 and serves as the 15th president of the university.
UConn’s main campus is located at Storrs, Connecticut. The university maintains additional facilities and carries out programs at locations across the state. These facilities and programs include:

Avery Point:

- University of Connecticut at Avery Point
- Connecticut Sea Grant College Program
- National Underwater Research, Technology & Education Center

Farmington:

- University of Connecticut Health Center

Greater Hartford:

- University of Connecticut at Hartford
- Graduate Programs at Hartford
- University of Connecticut School of Law
- School of Social Work
- Graduate Business Learning Center

Stamford:

- University of Connecticut at Stamford
- Graduate Programs at Stamford

Torrington:

- University of Connecticut at Torrington

Waterbury:

- University of Connecticut at Waterbury
- Graduate Programs at Waterbury

Operations of the UConn Health Center are examined and reported upon separately by the Auditors of Public Accounts.

**Autonomy**

Statutes governing the state’s constituent institutions of higher education provide the University of Connecticut notable autonomy and flexibility. The most significant changes were effectuated by Public Act 91-256, which greatly expanded certain limited authorities granted by Public Act 90-201. Subsequent legislation increased the degree of independence granted the institutions.
This independence is most notable with respect to procurement. Institutions of higher education may, under Section 10a-151b of the General Statutes, purchase equipment, supplies and contractual services, execute personal service agreements or lease personal property without the approval of the Comptroller, the Secretary of the Office of Policy and Management or the Commissioner of the Department of Administrative Services. Personal service agreements are not subject to the restrictions codified under Sections 4-212 through 4-219. As a compensating measure, personal service agreements executed by institutions of higher education must satisfy the same requirements generally applicable to other procurement actions.

Under Section 3-25 of the General Statutes, higher education institutions may, subject to the approval of the Comptroller, pay most non-payroll expenditures (those funded from the proceeds of state bond issuances being an exception) directly instead of through the State Comptroller. UConn issues checks that are drawn on a zero balance checking account controlled by the State Treasurer. Under the approved procedures, funds are advanced from the university’s civil list funds to the Treasurer’s cash management account. The Treasurer transfers funds from the cash management account to the zero balance checking account on a daily basis, as needed to satisfy checks that have cleared.

Although Section 3-25 clearly states that “payments for payroll…shall be made solely by the Treasurer…,” UConn does pay the majority of its food service employees directly. This arrangement is discussed in more detail in the Condition of Records section of this report.

UConn also enjoys a significant degree of autonomy with respect to personnel matters. Section 10a-108 of the General Statutes grants the board of trustees the authority to employ professional employees and establish the terms and conditions of employment. Section 10a-154b allows institutions of higher education to establish positions and approve the filling of vacancies within the limits of available funds.

**UConn 2000**

Public Act 95-230, known as The University of Connecticut 2000 Act, authorized a massive infrastructure improvement program to be managed by UConn. Although subsection (c) of Section 7 of the act provided that the securities issued to fund this program are to be issued as general obligations of UConn (see Section 10a-109g subsection (c) of the General Statutes), it also committed the state to fund the debt service, both principle and interest, on these securities, for the most part, from the resources of the General Fund. Per subsection (c) of Section 5 of the act, codified as Section 10a-109e subsection (c) of the General Statutes, “As part of the contract of the state with the holders of the securities secured by the state debt service commitment and pursuant to section 21 of this act, appropriation of all amounts of the state debt service commitment is hereby made out of the resources of the general fund and the treasurer shall pay such amount in each fiscal year, to the paying agent on the securities secured by the state debt service commitment or otherwise as the treasurer shall provide.”

These securities are not considered to be a state bond issue as referred to in Section 3-25 of the General Statutes. Therefore, UConn is able to make payments related to the program directly, rather than process them through the State Comptroller.
Subdivision (1) of subsection (b) of Section 9 of Public Act 95-230 established a permanent endowment fund, the net earnings on the principal of which are to be dedicated and made available for endowed professorships, scholarships and programmatic enhancements. To encourage donations, subparagraph (A) of subdivision (2) of subsection (b) of Section 9 of the act provided for state matching funds for eligible donations deposited into the fund, limiting the total amount matched to $10,000,000 in any one year and to $20,000,000 in the aggregate. It specified that the match, which was to be financed from the General Fund, would be paid into the fund during the fiscal years ending June 30, 1998, 1999 and 2000.

Effective July 1, 1998, Section 28 of Public Act 98-252 authorized the deposit of state matching funds in the university, or in a foundation operating pursuant to Sections 4-37e and 4-37f, consistent with the deposit of endowment fund eligible gifts. This provision was made to clarify the issue of whether state matching funds could become foundation assets or must be deemed assets of the associated constituent unit of higher education.

The enabling legislation for this program was subsequently amended to extend it through the fiscal year ending June 30, 2014. The state’s maximum commitment was set as an amount not exceeding ten million dollars for the fiscal year ending June 30, 1999; seven million five hundred thousand dollars for each of the fiscal years ending June 30, 2000, June 30, 2002, June 30, 2003, June 30, 2004, and June 30, 2005; five million dollars for the fiscal year ending June 30, 2001; ten million dollars for the fiscal years ending June 30, 2006 and June 30, 2007; and fifteen million dollars for the fiscal years ending June 30, 2008 to June 30, 2014, inclusive, per Section 10a-109c of the General Statutes.

Furthermore, the amending legislation, codified in Section 10a-109i of the General Statutes, reduced the state match from a one-to-one ratio to a one-to-two ratio (one state dollar for two private dollars) beginning with the fiscal year ended June 30, 1999, except for eligible gift amounts certified for the fiscal years ended June 30, 1999 and 2000, for which written commitments were made prior to July 1, 1997. The ratio was further reduced to a one-to-four ratio beginning with the fiscal year ended June 30, 2008; similar caveats were established providing for a one-to-two match for gifts made during the period from January 1, 2005 to June 30, 2005, and multi-year commitments for periods beginning prior to December 31, 2004, but ending before December 31, 2012.

However, in accordance with the provisions of Section 10a-8c of the General Statutes, the timing of the state match payment is affected by the state’s financial condition. Funds are not to be disbursed unless the state’s budget reserve (rainy day fund) exceeds ten percent of the net General Fund appropriation for the fiscal year in progress. That requirement has not been met since it was established by Public Act 05-3, in the June Special Session. As a result, as of June 30, 2013, approximately $24,778,000 in state match has been earned by UConn and the UConn Health Center, but not yet disbursed.

In the past, the state match has been deposited in the University of Connecticut Foundation, Inc. when received, as permitted by subsection (b) of Section 10a-109i of the General Statutes. The University of Connecticut Foundation, Inc. has not recognized the outstanding amount as
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revenue or as an asset, as it does not meet the standards established for recognition under generally accepted accounting principles.

Recent Legislation

Noteworthy legislation affecting UConn and the UConn Health Center that became effective during the period under review and thereafter is presented below:

- Public Act 11-2, of the October Special Session, established the Connecticut Bioscience Collaboration Program within Connecticut Innovations, Incorporated, to support the establishment of a bioscience cluster anchored by a research laboratory housed at the UConn Health Center. It directed the State Bond Commission to authorize up to $290,685,000 for the program.

- Public Act 11-6, Section 42, provided for the funding of the UConn Health Center hospital fringe rate differential from the resources appropriated to the State Comptroller in an amount not to exceed $13,500,000 per year for fiscal years 2011-2012 and 2012-2013. Section 44 capped expenditures for institutional administration at 3.13 percent and 3.1 percent of the annual General Fund appropriation plus operating fund expenditures, for fiscal years 2011-2012 and 2012-2013, respectively. Section 56 required the president of UConn to submit recommendations for cost savings to the General Assembly by January 1, 2012.

- Public Act 11-48 eliminated the Board of Governors of Higher Education, removing the requirement for UConn to comply with statewide policy and guidelines of constituent units of the state system of higher education and providing for the university to submit its budget directly to the Office of Policy and Management. Certain responsibilities of the Board of Governors of Higher Education regarding the university, most notably the responsibility for approving new academic programs, were transferred to the newly established Board of Regents for Higher Education. The act also requires the constituent units of the state system of higher education to use their best efforts to fully utilize Core-CT and to initiate the process of determining consistent classification and compensation for employees not represented by an employee organization, as defined in Section 5-270 of the General Statutes.

- Public Act 11-57, Section 92, gave the State Bond Commission the authority to authorize up to $172,500,000 for the development of a technology park at UConn.

- Public Act 11-75 modified the UConn Health Center initiative established by Public Act 10-104, increasing the authorized amount of bond funding for UConn Health Center renovations by $262,900,000. It removed the requirement to obtain $100,000,000 in grant or other funding before expending state bond funds for the project, replacing it with the requirement
that the UConn Health Center contribute not less than $69,000,000 from operations, special eligible gifts or other sources and provide for construction of a new ambulatory care center through debt or equity financing obtained from one or more private developers.

- Public Act 12-97 amended Section 10a-151b of the General Statutes to allow for non-competitive purchases for the purpose of testing any technology, product or process.

- Public Act 12-129 removed certain responsibilities of the Board of Regents for Higher Education regarding UConn, but left intact the responsibility for approving new academic programs.

- Public Act 13-118 removed the responsibility of the Board of Regents for Higher Education to approve new academic programs at UConn, leaving the authority to approve new academic programs to the Board of Trustees of the University of Connecticut.

- Public Act 13-143 requires a report from the Board of Regents for Higher Education and the Board of Trustees for the University of Connecticut regarding administrative salaries and the ratio of administrators to faculty and students.

- Public Act 13-177 established a process for the awarding of design-build contracts by UConn and amended Section 10a-151b of the General Statutes to allow for noncompetitive purchases of agricultural products in an amount of $50,000 or less.

- Public Act 13-233 established the Next Generation Connecticut initiative as part of the UConn 2000 program, increasing the authorized amount of state bond funding by $1,551,000,000.

- Public Act 14-98 authorizes the issuance of state bonds to the State Comptroller for enhancements and upgrades to the Core-CT human resources system at UConn, not exceeding $7,000,000. It also reduces the amount authorized for the development of a technology park at UConn from $172,500,000 to $169,500,000.

- Public Act 14-112 clarified the university’s authority to acquire and dispose of land.
UConn 2000 Authorizations

As of June 30, 2013, projects totaling $4,619,300,000 were authorized by the legislature under the enabling legislation for the UConn 2000 program.

<table>
<thead>
<tr>
<th>Authorizing Legislation</th>
<th>Cumulative Project Authorizations</th>
<th>Cumulative Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UConn Bonds</td>
<td>State Bonds [a]</td>
</tr>
<tr>
<td>PA 95-230</td>
<td>$1,250,000,000</td>
<td>$962,000,000</td>
</tr>
<tr>
<td>PA 02-3</td>
<td>2,598,400,000</td>
<td>2,262,000,000</td>
</tr>
<tr>
<td>PA 10-104</td>
<td>2,805,400,000</td>
<td>2,469,000,000</td>
</tr>
<tr>
<td>PA 11-75</td>
<td>3,068,300,000</td>
<td>2,731,900,000</td>
</tr>
<tr>
<td>PA 13-233</td>
<td>4,619,300,000</td>
<td>4,282,900,000</td>
</tr>
</tbody>
</table>

[a] Under Section 5 subsection (b) of Public Act 95-230, the funding for UConn 2000 included $18,000,000 in state general obligation bonds authorized under Section 1 of Public Act 95-270 and $962,000,000 in UConn bonds authorized under Section 4 subsection (a) of Public Act 95-230.

The legislature authorized additional funding through the issuance of state general obligation bonds. These bonds are obligations of the state and are not included as debt in the UConn financial statements. Several projects were funded in this manner; the most significant was the provision, under Public Act 11-57, as amended by Public Act 14-98, of up to $169,500,000 for the development of a technology park at the university.

Enrollment Statistics

Statistics compiled by the UConn registrar present the following enrollments in the university’s credit programs during the audited period.

<table>
<thead>
<tr>
<th>Student Status</th>
<th>2011-2012</th>
<th>2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall</td>
<td>Spring</td>
</tr>
<tr>
<td>Undergraduates</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22,472</td>
<td>21,630</td>
</tr>
<tr>
<td>Graduates</td>
<td>6,662</td>
<td>6,261</td>
</tr>
<tr>
<td>Professional (School of Law and Doctor of Pharmacy)</td>
<td>860</td>
<td>834</td>
</tr>
<tr>
<td>Medicine – Students</td>
<td>355</td>
<td>355</td>
</tr>
<tr>
<td>Medicine – Other (1)</td>
<td>611</td>
<td>611</td>
</tr>
<tr>
<td>Dental – Students</td>
<td>176</td>
<td>176</td>
</tr>
<tr>
<td>Dental – Other (1)</td>
<td>112</td>
<td>112</td>
</tr>
<tr>
<td>Totals</td>
<td>31,248</td>
<td>29,979</td>
</tr>
</tbody>
</table>

(1) Other includes residents, interns and post-graduate clinical enrollment.
Résumé of Operations

Under the provisions of Section 10a-105 subsection (a) of the General Statutes, fees for tuition are fixed by the board of trustees. The following summary presents annual tuition charges during the audited period.

<table>
<thead>
<tr>
<th>Student Status</th>
<th>2011-2012</th>
<th>2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-State</td>
<td>Out-of-State</td>
</tr>
<tr>
<td>Undergraduates</td>
<td>$8,256</td>
<td>$25,152</td>
</tr>
<tr>
<td>Graduates</td>
<td>10,224</td>
<td>26,532</td>
</tr>
<tr>
<td>School of Law</td>
<td>21,240</td>
<td>44,736</td>
</tr>
</tbody>
</table>

Generally, the State Comptroller accounts for UConn operations in:

- General Fund appropriation accounts.
- The University of Connecticut Operating Fund.
- The University of Connecticut Research Foundation Fund.
- The University Bond Liquidation Fund.
- Accounts established in capital project and special revenue funds for appropriations financed primarily with bond proceeds.

UConn maintains additional accounts that are not reflected in the state’s civil list financial system. The most significant relate to the UConn 2000 infrastructure improvement program. They are used to account for the revenue from the issuance of UConn 2000 bonds and related expenditures.

UConn also maintains a special local fund that is used to account for endowments, scholarships and designated funds, loans, agency funds and miscellaneous unrestricted balances. The special local fund was authorized by Governor William A. O'Neill under Section 4-31a subsection (b) of the General Statutes in 1987 to encompass existing local funds which had traditionally been under university control.

Additionally, there are certain trust accounts associated with UConn which, while legally controlled by the university, are not considered part of the University of Connecticut system reporting entity. These include the following university trust accounts:

- Graduate Student Senate Activity Fund
- Storrs Associated Student Government Activity Fund
- Connecticut Daily Campus Activity Fund
- WHUS Radio Station Activity Fund
- Student Organizations Activity Fund
- UConn PIRG (Storrs) Activity Fund
- Student Bar Association Activity Fund
- Legal Clinic Activity Fund
- Law Review Activity Fund
- School of Social Work Activity Fund
- Hartford Associated Student Government Activity Fund
- UConn Public Interest Research Group (Hartford) Activity Fund
- Torrington Associated Student Government Activity Fund
- Stamford Associated Student Government Activity Fund
- Southeastern (Avery Point) Associated Student Government Activity Fund
- Waterbury Associated Student Government Activity Fund
- Student Television Activity Fund

The UConn financial statements are prepared in accordance with all relevant Governmental Accounting Standards Board (GASB) pronouncements. The university utilizes the proprietary fund method of accounting whereby revenue and expenses are recognized on the accrual basis. All revenues and expenses are subject to accrual.

The UConn financial statements are adjusted as necessary and incorporated into the state’s Comprehensive Annual Financial Report. The financial balances and activity of the university are combined with those of the UConn Health Center, including the John Dempsey Hospital, and presented as an enterprise fund.

UConn employment grew slightly during the audited period. The university reported 4,510, 4,624 and 4,757 full and part-time faculty and staff (excluding graduate assistants, dining services employees and student labor) as of the Fall 2011, 2012 and 2013 semesters, respectively.

UConn’s total net position increased by $93,747,396 from $1,395,355,409 as of June 30, 2011, to $1,489,102,805 as of June 30, 2012. It then decreased by $37,050,053 to $1,452,052,752 as of June 30, 2013. These changes did not accurately reflect fluctuations in the results of operations. Rather, they were caused by the timing of the provision of state capital appropriation support to the university.

UConn received $115,400,000 in state capital appropriations in the form of the state debt service commitment for principle attendant on the sale of bonds in connection with the UConn 2000 infrastructure improvement program in the fiscal year ended June 30, 2012. No bonds were sold in the fiscal year ended June 30, 2013.

The net increase in total net position during the audited period was primarily attributable to an increase in the amount of net position restricted for investment in capital assets from $1,144,923,350 as of June 30, 2011, to $1,222,167,483 as of June 30, 2013. UConn’s unrestricted net position balance decreased by $21,155,808 from $175,373,890 as of June 30, 2011, to $154,218,082 as of June 30, 2013. The university’s cash and cash equivalents balance decreased by $9,690,367 from $276,484,964 as of June 30, 2011, to $266,794,597 as of June 30, 2012, and again by $22,008,793 during the following fiscal year to $244,785,804 as of June 30, 2013.
UConn revenues, operating and non-operating, and other additions, totaled $1,099,832,476 and $1,007,306,672 for the fiscal years ended June 30, 2012 and 2013, respectively. General Fund support, primarily in the form of annual appropriations for operating expenses, in-kind fringe benefit support and the state debt service commitment for principle and interest on UConn 2000 related bonds, was the university’s largest source of revenue. It totaled $455,525,330 (41 percent) and $349,026,963 (35 percent) of total revenues and other additions for the fiscal years ended June 30, 2012 and 2013, respectively. The decrease in the second year of the audited period was primarily attributable to the timing of the provision of state capital appropriation support in the form of the state debt service commitment for principle.

Other significant sources of revenue included student tuition and fees, sales and services of auxiliary enterprises, and grant and contract revenues. Student tuition and fees were $251,016,679 and $261,641,000 for the fiscal years ended June 30, 2012 and 2013, respectively. Sales and services of auxiliary enterprises were $181,974,163 and $185,240,404 for the fiscal years ended June 30, 2012 and 2013, respectively. Grant and contract revenues totaled $159,696,741 and $159,825,151 for the fiscal years ended June 30, 2012 and 2013, respectively.

UConn expenses, operating and non-operating, and other deductions totaled $1,006,085,080 and $1,044,356,727 for the fiscal years ended June 30, 2012 and 2013, respectively. Most were classified as operating expenses. A schedule of operating expenses by functional classification, as presented in the university’s financial statements for the audited period follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>2011-2012</th>
<th>2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instruction</td>
<td>$291,370,499</td>
<td>$302,201,568</td>
</tr>
<tr>
<td>Research</td>
<td>73,508,341</td>
<td>74,948,222</td>
</tr>
<tr>
<td>Public Service</td>
<td>35,477,844</td>
<td>39,067,856</td>
</tr>
<tr>
<td>Academic Support</td>
<td>108,339,599</td>
<td>117,678,945</td>
</tr>
<tr>
<td>Student Services</td>
<td>35,255,666</td>
<td>33,315,154</td>
</tr>
<tr>
<td>Institutional Support</td>
<td>53,465,323</td>
<td>63,301,666</td>
</tr>
<tr>
<td>Operations and Maintenance of Plant</td>
<td>100,401,506</td>
<td>101,661,524</td>
</tr>
<tr>
<td>Depreciation</td>
<td>88,478,214</td>
<td>91,712,989</td>
</tr>
<tr>
<td>Student Aid</td>
<td>6,107,357</td>
<td>7,153,704</td>
</tr>
<tr>
<td>Auxiliary Enterprises</td>
<td>164,388,850</td>
<td>167,473,719</td>
</tr>
<tr>
<td>Total Operating Expenses</td>
<td>956,793,199</td>
<td>998,515,347</td>
</tr>
</tbody>
</table>

The non-operating expenses during the audited period consisted primarily of interest payments. Interest expense was $47,117,080 and $45,401,894 for the fiscal years ended June 30, 2012 and 2013, respectively. This expense was, for the most part, offset by transfers from the state General Fund. The state debt service commitment for interest was $39,755,112 and $40,571,126 for the fiscal years ended June 30, 2012 and 2013, respectively.

UConn did not hold significant endowment and similar fund balances during the audited period, as it has been the university’s longstanding practice to deposit funds raised with the University of Connecticut Foundation, Inc. or the University of Connecticut Law School Foundation, Inc. The University of Connecticut Foundation, Inc. provides support for UConn and the UConn Health Center. Its financial statements reflect balances and transactions.
associated with both entities, not only those exclusive to the university. A summary of the two foundations’ assets, liabilities, net position, revenue and support, and expenses, as per those audited financial statements, follows:

<table>
<thead>
<tr>
<th></th>
<th>University of Connecticut Foundation, Inc.</th>
<th>Law School Foundation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fiscal Year Ended</td>
<td>Fiscal Year Ended</td>
</tr>
<tr>
<td>Assets</td>
<td>$408,861,000</td>
<td>$459,101,000</td>
</tr>
<tr>
<td>Liabilities</td>
<td>24,921,000</td>
<td>45,632,000</td>
</tr>
<tr>
<td>Net position</td>
<td>383,940,000</td>
<td>413,469,000</td>
</tr>
<tr>
<td>Revenue and Support</td>
<td>50,489,000</td>
<td>79,574,000</td>
</tr>
<tr>
<td>Expenses</td>
<td>44,656,000</td>
<td>50,045,000</td>
</tr>
</tbody>
</table>
STATE AUDITORS’ FINDINGS AND RECOMMENDATIONS

Our review of the financial records of the University of Connecticut disclosed certain areas requiring attention, as discussed in this section of the report.

OUTPATIENT PAVILION

Background: Section 10a-109e subsection (f) of the General Statues provides that “The University of Connecticut Health Center shall … (2) provide for construction of a new ambulatory care center through debt or equity financing obtained from one or more private developers who contract with the university to construct such new ambulatory care center.” It appears that the legislature intended that this project be pursued as a public-private partnership. Typically, a public-private partnership involves the assumption of a significant degree of risk by the private partner. Additionally, it can provide the public partner with off-balance-sheet financing.

Criteria: In its Guidelines for Public Debt Management, the International Monetary Fund clearly articulates the main objective of public debt management. It is to ensure that the government's financing needs and its payment obligations are met at the lowest possible cost over the medium to long term, consistent with a prudent degree of risk.

Condition: The university determined that it was not feasible to fund the ambulatory care center project through debt or equity financing obtained from one or more private developers, as directed by the legislature. Accordingly, in December 2012, the university, acting through the University of Connecticut Health Center Finance Corporation, secured a $203,000,000 loan from TIAA-CREF to fund the project. The TIAA-CREF loan bears interest at a rate of 4.809 percent. Interest payments over the life of the loan will total $158,595,860. In December 2012, the university issued special revenue refunding bonds with a total interest cost of 2.480 percent. If the TIAA-CREF loan bore the same interest rate, interest payments over the life of the loan would total $81,787,842, or $76,808,018 less.

To provide the lender, TIAA-CREF, with assurance regarding the collectability of this loan, the university asked the Attorney General to “confirm that: (i) the financial obligations of the Health Center under the Lease are not subject to appropriation risk; and (ii) in the extraordinary unlikely event that the Health Center were to default on its Lease obligations, these obligations would become general, unrestricted legal obligations of the State of Connecticut and unrelated to any appropriation to the Health Center.” The Attorney General concluded that “(1) although in the normal course required payments under the Lease will be made...
from available Health Center funds, the Lease payment obligations of the Health Center create legal obligations to the State of Connecticut; and (2) as a legal obligation of the State of Connecticut, required payments under the Lease are not subject to the risk of legislative non-appropriation for the Lease payments. Rather, like any claim against the State, a claim against the Health Center could proceed as provided by law.”

**Effect:**

This transaction will burden the state with significant unnecessary interest costs. As the Attorney General has determined, the promissory note is a general obligation of the state. In practice, it exposes the state to the same level of risk as would a standard bond issuance, but at a far higher interest cost.

Also, the UConn Health Center is subsidized from the state’s General Fund. Any profit or loss related to ancillary operations of the UConn Health Center, such as the ambulatory care center, will affect the amount that must be provided from the General Fund. Therefore, excessive costs incurred by ancillary operations of the UConn Health Center will, in the end, be borne by the state.

Additionally, issuing general obligation debt instruments may fall within the broad powers granted the University of Connecticut Health Center Finance Corporation by Section 10a-254 of the General Statutes. However, in addition to the excessive interest costs involved, the propriety of issuing this promissory note without obtaining specific legislative approval seems questionable, given the existing legislative directive to proceed in a different fashion.

**Cause:**

When it became apparent that it was not feasible to fund the ambulatory care center project through debt or equity financing obtained from one or more private developers, the university sought an alternative financing method. The university determined that the TIAA-CREF loan was the lowest cost alternative it had the authority to pursue. The university sought and obtained the approval of the state’s Office of Policy and Management before it executed the promissory note.

**Recommendation:**

The University of Connecticut should seek legislative authorization for the issuance of state bonds to refinance the TIAA-CREF loan when market conditions are appropriate. The cost savings that can be achieved will vary depending on both the state general obligation bond interest rate and, due to yield maintenance prepayment penalty on the TIAA-CREF loan, current Treasury rates. (See Recommendation 1.)

**Agency Response:**

“Whether State bonds should be issued to refinance the University’s loan is not a University decision to make. The University respectfully offers that the Auditors of Public Accounts should provide its recommendations
to the legislature and executive branch offices with authority over the issuance of State bonds. The University agrees that it is sound policy to achieve savings whenever possible, and will provide a copy of the Auditor’s recommendation to the legislature and the Office of Policy and Management.”

BUSINESS CONTINUITY AND DISASTER RECOVERY

Criteria: A business continuity plan documents the processes and procedures to be carried out to ensure that essential business functions continue to operate in the event of a disaster. It provides a comprehensive framework for actions to be taken in response to disruptive events in order to minimize their effect on operations. Once a determination is made of which systems and business units are essential, disaster recovery plans can be developed. Disaster recovery plans are more detailed technical plans. They involve the identification of all critical systems and detailed plans for recovery.

Condition: Many information technology systems provide mission critical support functions. In our previous report, we noted that University Information Technology Services (UITS), which maintains the university’s core systems, did not have a disaster recovery plan on file.

We followed up on this issue on December 12, 2014. The university had not developed a business continuity plan and UITS was still working towards developing a disaster recovery plan.

Effect: The lack of business continuity and disaster recovery planning will hamper the ability of the university to respond in a timely fashion if a disaster seriously compromises its core information technology systems. If key personnel crucial to the process are unavailable, the university’s ability to recover will be severely limited.

Cause: The cause could not be readily determined.

Recommendation: The University of Connecticut should make business continuity and disaster recovery planning a priority. (See Recommendation 2.)

Agency Response: “The University Information Technology Services (UITS) has contracted with IBM to deliver cold site disaster recovery infrastructure. UITS is currently planning the first test disaster recovery exercise for June, 2015 and is creating disaster recovery documentation to support that activity. The disaster recovery documentation will be updated based on testing results, and considered active by July, 2015. The IBM facility is available now, in the event a disaster is declared.”
SAFEGUARDING CONFIDENTIAL INFORMATION

Criteria: Data maintained by the university includes information that is confidential under the Family Educational Rights and Privacy Act (FERPA), Payment Card Industry Data Security Standard (PCI DSS), Health Insurance Portability and Accountability Act (HIPAA), and Personally Identifiable Information (PII) laws and regulations. Therefore, hard drives need to be securely erased when computers are taken out of service to prevent the inadvertent release of confidential information.

Condition: When university departments transfer computers to Central Stores for redistribution, sale, or disposal, the departments are required to remove all data from the hard drives prior to transfer. It is a good practice to remove all confidential data before computers leave the user department.

Securely erasing hard drives is not a regular departmental level procedure and some department personnel may lack sufficient expertise with this aspect of computer maintenance. A supplementary erasure should be performed by Central Stores when computers are received to safeguard confidential information.

Effect: The lack of a centralized process carried out by experienced personnel increases the risk of the inadvertent release of confidential information.

Cause: The university has classified this task as a department level responsibility.

Recommendation: The University of Connecticut should ensure that computer hard drives are securely erased by experienced personnel after they are transferred to Central Stores. (See Recommendation 3.)

Agency Response: “Departments are required to remove all confidential data from hard drives prior to removing personal computers or servers from service. The University ‘Confidential Data, Information Technology’ policy specifies that the data on any device containing confidential data must be destroyed when a device is removed from service. University Central Stores provides the capability to physically destroy or degauss hard drives and the aforementioned policy makes reference to central stores drive destruction capabilities and procedures. Since the finding was issued it has become standard practice that Central Stores destroys all drives for any desktop, laptop or server it receives, regardless of data classification.”
PERFORMANCE BONUSES

Criteria: Performance bonuses should be awarded in accordance with a structured plan with pre-established criteria. The plan should be properly documented and the criteria applied objectively.

Condition: The university normally processes salary payments through its own payroll system, which functions as a front end to the state payroll system. In some instances, unusual salary payments are initiated directly in the state payroll system. When we reviewed a sample of such payments, we noted that performance bonuses in the aggregate amount of $93,268 were paid to six Finance and Budget Division employees.

We asked for documentation supporting these performance bonuses. We were told that they were one time payments based on the employees’ current salaries and their work on the Kuali financial system implementation. The only documentation we were able to obtain supporting these payments consisted of payroll authorizations specifying the amounts to be paid. We were told that no plan existed.

Effect: The lack of a structured plan with pre-established criteria gives the impression that the payments were determined in an arbitrary and subjective manner.

Cause: We were unable to readily determine why these payments were made in an arbitrary and subjective manner.

Recommendation: The University of Connecticut should not pay performance bonuses without first developing a structured plan with criteria for determining when bonuses should be awarded and the amounts to be paid. (See Recommendation 4.)

Agency Response: “Performance bonuses were paid to select management-exempt Finance and Budget employees, who were not paid for overtime or comp time for their efforts in the successful implementation of the Kuali Financial Systems (the University’s general ledger and financial system). During the project these individuals spent a significant amount of time in addition to their normal work schedule on this implementation. Their efforts contributed significantly to this project being implemented on time and under budget. In the future, if senior management decides to award performance-based pay for successful delivery of major projects, a formal plan will be developed.”
FOOD SERVICES EMPLOYEES

**Background:**

The Associated Student Commissaries was an association of student-operated commissaries occupying UConn residences that was formed to provide central administrative services for the member commissaries. It operated as an activity fund established under the authority of Section 4-53 of the General Statutes, in accordance with procedures established by the State Comptroller.

In 1979, the Connecticut State Board of Labor Relations was asked to determine whether the employer of cooks and kitchen assistants in the member commissaries was the Associated Student Commissaries or the individual member commissaries. The Board of Labor Relations concluded that they were employed by the individual student commissaries, as the power to hire, discharge and discipline the kitchen employees, as well as to control the wages, hours, and other conditions of employment, was vested in the individual commissaries, not in the Associated Student Commissaries.

Employees of the member commissaries comprised only a portion of the UConn food service employees at that time. Employees serving in the large dining halls were state employees paid through the State Comptroller.

The degree of independence and authority possessed by the member commissaries gradually eroded over time. Eventually, the smaller dining halls formerly controlled by the member commissaries closed and the Associated Student Commissaries activity fund effectively ceased operations.

Currently, students are served by several large dining halls operated by the Department of Dining Services of the Division of Student Affairs. The power to hire, discharge and discipline staff and to control the wages, hours, and other conditions of employment rests with UConn administrators. However, most of the food service operations employees staffing these large dining halls are now paid directly by the university in a manner similar to the way the former employees of the member commissaries were compensated.

Most food service operations employees are not members of the state retirement system. Instead, they are eligible to participate in two other retirement plans, the Department of Dining Services Money Purchase Pension Plan or the University of Connecticut Department of Dining Services 403(b) Retirement Plan.
UConn filed a request for a ruling regarding the status of the Department of Dining Services pension plans on May 17, 1999. In a ruling dated February 24, 2000, the Internal Revenue Service agreed that the food service operations employees are employees of an agency or instrumentality of the state and that the plans are governmental plans.

**Criteria:**
Under Section 10a-108 of the General Statutes, the board of trustees has the authority to “employ the faculty and other personnel needed” and “fix the compensation of such personnel.” The board’s authority to fix compensation does not extend to employees in state classified service. The work done by most food service operations employees appears to be the type typically performed by employees in state classified service. Section 10a-108 does not address participation in retirement plans.

Section 3-25 of the General Statutes authorizes constituent units of the state system of higher education to pay certain claims directly, rather than through the State Comptroller. However, Section 3-25 specifically excludes payments for payroll.

**Condition:**
The approximately 500 food service operations employees at UConn are generally referred to as dining services employees to distinguish them from other university employees. However, the Department of Dining Services is a unit of the university and, therefore, of the state. Accordingly, the employees of the university’s food service operation are employed by the state.

Unlike other UConn employees, they are paid directly by the university instead of through the State Comptroller. Additionally, as noted above, they participate in separate retirement plans.

**Effect:**
Though there are sound operational reasons for the UConn method of compensating its food service operations employees, the legal basis for the direct payment of wages by the university is unclear, as is the participation of these employees in separate retirement plans.

**Cause:**
UConn did not seek clear statutory authority to compensate its dining service operations employees in this manner.

**Recommendation:**
The University of Connecticut should seek clear statutory authority for the direct payment of wages to its food service operations staff and for their participation in separate retirement plans. (See Recommendation 5.)

**Agency Response:**
“In response to the Auditors’ concerns, the University is actively investigating alternatives that will continue to meet the operational needs of Dining Services and will clarify the relationship between the University and this workforce consistent with statutory requirements.”
COST SHARING

Background: Sponsored research projects benefit the universities that carry out the research, providing important educational opportunities for students and professional development for faculty. Since universities benefit from the projects, it is reasonable for them to share in the costs of the projects by funding a portion of those costs from their own unrestricted resources.

Grantors may require universities to commit specified resources to the projects (mandatory cost sharing) and universities may volunteer to assume a share of the cost to give their proposals a competitive advantage (voluntary committed cost sharing). Additionally, faculty may voluntarily devote additional effort over and above what has been committed because of their personal interest in the projects (voluntary uncommitted cost sharing).

Criteria: Cost sharing is commonly achieved by paying researchers out of unrestricted UConn resources (i.e., funding provided to the university from the resources of the state’s General Fund) while they work on sponsored projects. UConn’s default functional classification on faculty effort is instruction. When voluntary uncommitted cost sharing is not broken out, the amount reported as spent on instruction will be overstated and the amount spent on research understated. University administrators, and others with oversight responsibilities, including the legislature, need accurate functional reporting to evaluate if state funds are being used prudently and as intended.

Condition: In our prior report, we noted that UConn tracks mandatory and voluntary committed cost sharing in its time and effort reporting system. It does not track voluntary uncommitted cost sharing. Our prior reviews indicated that there was a significant amount of voluntary uncommitted cost sharing at the university.

Effect: The use of unrestricted UConn resources for sponsored research is in keeping with the university’s goal of recognition as one of the nation’s top-20 public research universities, according to the annual U.S. News and World Report rankings. However, without effective monitoring of the amount of unrestricted university resources directed to sponsored research projects by researchers, the university cannot reasonably estimate the associated costs and determine whether the amount used is appropriate.

Though we acknowledge that, given the UConn environment, time and effort reporting is necessarily imprecise, we believe that tracking voluntary uncommitted cost sharing in the university’s time and effort reporting system would increase the accuracy of the university’s breakdowns of costs incurred by function, especially the breakdown
between instruction and research. This would allow the university to make more informed financial decisions.

**Cause:**

Management believes that the cost of tracking voluntary uncommitted cost sharing would exceed the value of any benefits resulting from the process. We believe that it would not significantly increase costs, as researchers are already required to provide a reasonable breakdown of all their time and effort to document compliance with grantor requirements – it would simply require more accurate reporting of the distribution of their time and effort between instruction and research.

**Recommendation:**

The University of Connecticut should track voluntary uncommitted cost sharing in its time and effort reporting system. (See Recommendation 6.)

**Agency Response:**

“The University disagrees. The University of Connecticut’s mission includes creating and disseminating knowledge for the public good. And, like most research universities, UConn achieves this goal largely through the important research, scholarship, and creative activities of its faculty. Much of the scholarly activity of faculty has limited cost, and faculty carry out this work with time and supporting resources provided by the university. However, there are also research projects and scholarly pursuits where external funding is necessary.

The federal government requires time and effort reporting per OMB Circular A-21 for personnel who have formally committed some level of effort to the government in the grant proposal or who work on the project and charge a portion of their salary to the grant.

However, this has not always been the case. Prior to 2001, Universities had to track all effort on a federal project, even if not directly charged or committed to the project. This tracked effort was required to be counted as cost share to the project. Cost share has the effect of lowering federal reimbursement to the University as it lowers the university indirect cost rate. Many researchers over reported the amount of time they were spending on research projects out of a concern that sponsors must be monitoring how much they were voluntarily contributing to the project. After extensive work by Universities and University Associations during the 1990s to reduce the administrative burden of effort reporting and streamline the requirements for cost shared effort, the Office of Management and Budget (OMB) clarified the treatment of voluntary uncommitted cost sharing in a memorandum dated January 5, 2001 which states that voluntary uncommitted effort (above what is committed in the proposal or charged to the grant) is excluded from the effort reporting requirements of OMB Circular A-21. UConn is consistent with other
universities in excluding the specific tracking of voluntary uncommitted effort through effort reporting.

The University is opposed to collecting voluntary uncommitted effort as part of the effort reporting process:

- Universities were successful in making the case to the OMB that the collection of voluntary effort through effort reporting was burdensome and nearly impossible to gather accurately given the role of faculty and the mission of a research University. The University does not want to take steps to undermine this position.

- If the University was able to collect voluntary uncommitted effort, we may run the risk of having the government require us to count the effort as cost share and apply it to the calculation of our indirect cost rate which would cost the university significantly in terms of facilities and administrative revenue collected from the federal government.

- Some faculty members get limited or no external funding for their research and therefore do not complete effort reports.

UConn’s treatment of these costs is consistent with other research universities and with the guidance in OMB Circular A-21 section J.8.b (1).c, "Payroll Distribution," that a precise documentation of faculty effort is not always feasible, nor is it expected, because of the inextricably intermingled functions performed by the faculty in an academic setting (i.e., teaching, research, service and administration).”

While the University disagrees with capturing voluntary uncommitted effort through effort reporting, we have contacted the Council on Government Relations to inquire about what studies may have been prepared which explain the full costs of research. We also believe that academic leadership is already in a position to manage the voluntary efforts of their faculty by other means - such as annual activity reports, scholarly publications, courses taught and students advised as a few examples.”

**Auditors’ Concluding Comment:**

We believe that the university needs to know the total (required and voluntary) percentage of effort faculty are devoting to research in order to make more informed financial decisions. We are recommending that the university track voluntary uncommitted cost sharing in its time and effort reporting system, as this is a system for tracking faculty effort that is already in place. If the university believes that the disadvantages of using the time and effort reporting system for this purpose outweigh the advantages, it should develop a different method of obtaining a
quantitative measurement of the total percentage of effort faculty are devoting to research.

PURCHASING CARDS

**Background:** Under the University of Connecticut MasterCard Purchasing Card Program, cardholders can pay for goods and services using a University Purchasing Card, a credit card issued by JP Morgan Chase. This is a procurement tool that provides an alternative to the standard UConn procurement processes.

**Criteria:** Credit card purchases are not subject to the controls established for standard UConn procurement processes. Completion and approval of a monthly purchasing card log is a key compensating control. The log lists all purchases made and is signed by the cardholder and the record manager.

The cardholder signs the log, certifying that it, and by extension, the listed transactions, are consistent with UConn policies and procedures. Another staff member, designated as the record manager, then reviews and signs the report, attesting to the accuracy of the cardholder’s statement.

**Condition:** In our previous report, we noted that the record managers signing off on the purchasing logs were co-workers, subordinates, lower level staff or the cardholders themselves.

**Effect:** The effectiveness of this key control is greatly reduced when the individual reviewing and approving the purchasing card log has no authority over, or is under the authority of, the cardholder.

**Cause:** It is unclear why UConn does not require that the responsibility for signing off on purchasing card logs be assigned to staff with supervisory authority over the cardholders.

**Recommendation:** The University of Connecticut should require that purchasing card logs be approved by a staff member with supervisory authority over the cardholder. (See Recommendation 7.)

**Agency Response:** “As stated in the response within the previous report, the University has established robust controls and active oversight of the Purchasing Card (PCARD) Program and the reconciliation of program transactions. Additional controls have been implemented, including the re-enforcement of the separation of duties pertaining to financial activities within the system of record. Although the individuals fulfilling these roles within the financial system may not necessarily reflect an administrative supervisory
title/role, the established separation of duties, ensures that proper checks- and-balance controls exist, independent of the cited, suggested recommendation.”

**Auditors’ Concluding Comment:** Supervisory review of credit card usage is standard practice and an effective control. The university’s reluctance to institute this simple and effective control is difficult to comprehend.

**NON-COMPETITIVE PROCUREMENT**

**Criteria:** Section 10a-151b of the General Statutes requires constituent units of the state system of higher education to solicit competitive bids or proposals, when possible, when contracting for professional services. The statutory requirement for open, competitive procurement is intended to facilitate obtaining goods and services at the lowest prices, avoid favoritism and award public contracts in an equitable manner.

In some instances, there may be only one source for goods or services. If so, competition is not possible. This type of non-competitive procurement action is commonly referred to as a sole source purchase.

**Condition:** The university contracted with an engineering firm for design services in connection with the Reclaimed Water Facility Project at a proposed cost of $133,400. The university did not solicit competitive bids or proposals for this contract. Instead, it characterized this service as a sole source purchase.

Documentation on file provided a logical rationale for the university’s preference for engaging this firm. The firm had, under a previous contract, modeled and developed the initial design. The university concluded that, because of the firm’s familiarity with the project, it was “both cost and time effective to contract directly with them to complete the design, bidding and construction phases of the project.”

It appears that there were other engineering firms that could have provided the design services. The university’s preference for engaging this firm does not make it a sole source purchase or justify noncompliance with the statutorily mandated competitive procurement requirements established by Section 10a-151b.

**Effect:** This transaction did not comply with the provisions of Section 10a-151b. It is possible that the needed services could have been obtained at a lower price if an open, competitive procurement process had been followed. In
addition, other potential vendors were denied the opportunity to bid on the contract. Open access to state contracts is in the public interest.

**Cause:**
It appears the university felt that engaging the engineering firm was the best possible alternative. However, the university does not have the authority to put aside the competitive procurement requirements of Section 10a-151b.

**Recommendation:**
The University of Connecticut should comply with the competitive procurement requirements of Section 10a-151b of the General Statutes. Procurement actions should not be characterized as sole source purchases, unless no other source exists that is capable of meeting the requirements. (See Recommendation 8.)

**Agency Response:**
“The University does in fact comply with 10a-151b and has fully integrated the statutory requirements into its policies and procedures. Pursuant to Section 10a-151b (b), the University competitively procures purchases whenever possible. However, as the statute acknowledges, competitive procurement is not possible under all circumstances, as was the case with this procurement. Determinations as to whether competitive procurement is possible in any particular instance, including the determination documented in the cited instance, are made consistent with the statutory requirements and with established policies and procedures. As stated, the firm modeled and developed the initial design. If a new vendor was contracted with to carry that design forward, it would implicate questions about liability and insurance coverage in the event of a design defect. This would expose the University to a degree of risk that is generally unacceptable. For this reason, it is extremely unusual for one designer to modify the work of another. However, the documentation on file expresses this rationale imprecisely. The University should ensure that its sole source rationales are more precisely worded.”

**Auditors’ Concluding Comment:**
The performance of initial design work by one engineer does not preclude further development by another qualified engineer. In fact, if the original engineer was not available, further development would have to be handled by another engineer. Engaging the firm was convenient and the university may have felt that it made good business sense. However, the university is required to comply with Section 10a-151b of the General Statutes even if it does not feel that compliance would provide the best outcome from a business standpoint.
RECEIVING REPORTS FOR PREPAYMENTS

Criteria: Payments for goods or services should be supported by a documented confirmation by a responsible party as to the satisfactory receipt of goods or services.

Condition: UConn contracted with a performing arts provider on April 27, 2014, at the Jorgensen Center for the Performing Arts in the amount of $20,000. Payment was made in advance, which is common for this type of transaction. Staff did not prepare, subsequent to the event, a receiving report to document that the vendor had fulfilled its contractual obligations.

Effect: The lack of a receiving report lessens the assurance that the services were provided in accordance with the contract.

Cause: UConn procedures do not adequately address transactions that require payment prior to or at the time of service.

Recommendation: The University of Connecticut should prepare receiving reports when payment is required prior to a performance to document that the vendor has fulfilled its contractual obligations. (See Recommendation 9.)

Agency Response: “Jorgensen Center for the Performing Arts management will add an additional step to the existing controls, by entering a note in the Kuali Financial System (KFS) stating that the performance occurred and all services were rendered.”

ETHICS CERTIFICATIONS

Criteria: Pursuant to the General Statutes and executive orders of Governor M. Jodi Rell, certain state contracts must be accompanied by ethics certifications designed to encourage ethical behavior.

Condition: In our prior report, we noted that the required certifications were not obtained for purchases of library materials. We also found that the required certifications were not obtained for other purchases that were also handled at the department level, rather than processed through the purchasing department. During our current audit, we noted five instances in which certifications were not obtained as required. Two of the purchases pertained to library materials; however, three were processed through the purchasing department.

Effect: With respect to these transactions, the university did not comply with state requirements designed to encourage ethical behavior.
Cause: We were unable to determine the cause.

Recommendation: The University of Connecticut should comply with the applicable General Statutes and executive orders of Governor M. Jodi Rell regarding ethics certifications. (See Recommendation 10.)

Agency Response: “The University has begun to implement training programs and has further enhanced procurement procedural safeguards. For example, the University has implemented a procurement contracts application solution that will reduce such errors in the future.

Also, in 2013 a new unit was created to more effectively manage UConn Libraries’ (UCL) e-resources. One of the first priorities of this unit was the implementation of the open source Centralized Online Resource Acquisitions and Licensing System (CORAL) in order to create a comprehensive accounting of the complex and wide ranging types of electronic resources the UCL purchases and licenses, a capability currently lacking in KFS or Voyager.

The number of e-resources that need to be identified and entered into the CORAL system is significant and data entry work continues along with a systematic review of all relevant data in order to improve entry standards, workflows and to identify and remedy missing or inaccurate information.

Through CORAL customizations designed specifically for this purpose, the E-Resource Services Unit is now effectively storing and tracking CT State Certificates/Affidavits. Additionally, using KFS reports for FY14 expenditures by vendor, UCL identified e-resource vendors with FY15 projected costs that exceeded $50,000 (10) and those that exceeded $500,000 (3) and submitted requests for the required forms to all vendors.

CONSTRUCTION PROJECT ACCOUNTABILITY

Background: UConn 2000, a twenty-nine year, $4.6 billion capital project program, is administered by the university. The university’s Planning Architectural & Engineering Services is responsible for overseeing UConn 2000 construction projects.

Criteria: To enhance accountability, documentation of reviews performed by the department should clearly identify who conducted the review and prepared the related documentation. Minutes should be formally approved to provide an attestation as to their accuracy and completeness.

Condition: We reviewed construction project oversight conducted by Planning Architectural & Engineering Services. During our review, we noted that:
• Project coordination meeting minutes incorporated a statement that failure to object to their content within seven days of receipt would constitute acceptance. The minutes should be formally approved, providing an attestation as to their accuracy and completeness that the current negative confirmation process does not.

• Daily field reports did not always identify who conducted the reviews and prepared the report. This information should be included in each report.

**Effect:** Implementing these additional documentation standards would add accountability.

**Cause:** University personnel considered these control elements to be implicit in the processes.

**Recommendation:** The University of Connecticut’s Planning Architectural & Engineering should ensure that daily field reports always identify who conducted the review and prepared the report. Project coordination meeting minutes should be formally approved. (See Recommendation 11.)

**Agency Response:** “The Project Manual outlines the Contractor as responsible for organizing, chairing, recording and administering the Project Meetings. Planning Architectural and Engineering Services acknowledges there are slight variations to how minutes are structured and administered from Contractor to Contractor based on the project management software being utilized. Recognizing there may be variations, we will clarify within the Project Manual key elements that must be represented including the review of the minutes for consistency.

The Policies and Procedures outline the requirement for Daily Field reports and who the University Representative is for observing and reporting. Planning Architectural and Engineering Services acknowledge there may be slight variations to how the reports are structured. Recognizing these variations, we will clarify within our management documents the format required for these reports to clearly identify who the author is of the report.”
CASH HANDLING

Criteria: Section 4-32 of the General Statutes provides that each state institution receiving any money or revenue for the state shall deposit within twenty-four hours of its receipt the total of the sums received of five hundred dollars or more.

Condition: The Department of Dining Services Cash Accounting Office receives receipts on a daily basis from over ten retail locations. The Cash Accounting Office is staffed by two employees who are responsible for the change fund, cash counts, cash out reconciliation, recording the daily deposits to Dining Services internal system and posting the cash receipts to the university’s accounting system.

Based on our analysis of deposit transactions during the 2013-2014 fiscal year, we noted that, on average, deposits were made around 10 workdays late. The average amount of late deposits was approximately $70,000. A similar situation occurred during the 2012-2013 fiscal year. We noticed a pattern in which during the beginning of the fiscal year, deposits were significantly in arrears; the department then caught up during the summer, but fell behind again during the fall semester, caught up slightly over winter intersession, and then fell behind again during the spring semester. On June 2, 2014, there was approximately $120,000 on hand which was received during the period from April 30, 2014 through May 29, 2014.

Effect: The Department of Dining Services was not in compliance with state requirements for prompt deposit of cash receipts. Holding significant amounts of currency on hand instead of depositing it immediately, increases risk.

Cause: Per the Dining Services fiscal manager, delays occurred due to not having a sufficient number of cash account clerks to handle the large volume of deposits that resulted from the addition of several new retail outlets.

Conclusion: The executive director of Dining Services told us he took immediate corrective action. He informed us that, as of June 20, 2014, the department was up-to-date on deposits.
RECOMMENDATIONS

Status of Prior Audit Recommendations:

In our previous report on our audit examination of the University of Connecticut, we presented 15 recommendations pertaining to university operations. The following is a summary of those recommendations and the actions taken thereon:

- Establish compensation limits. This recommendation is not being repeated. The university is taking steps to address this finding.

- Seek clear statutory authority for the direct payment of wages to university food service operations employees and for their participation in separate retirement plans. This recommendation has been repeated. (See Recommendation 5.)

- Establish procedures for verifying work experience and credentials. This recommendation is not being repeated. It is our understanding that the Human Resources department is taking action to address this issue.

- Review payments for accrued compensated absences. This recommendation is not being repeated. The university has performed the recommended review.

- Hire Act. This recommendation is not being repeated. The university has taken steps to recover the funds.

- Implement a formal process that provides for the review, approval and documentation of all cost sharing – this recommendation has been restated and repeated. (See Recommendation 6.)

- Conduct formal, well documented, selection processes for all major software acquisitions. This recommendation is not being repeated. There were no major software acquisitions during our current audit.

- Develop structured methodology for major software implementation projects. This recommendation is not being repeated. There were no major software implementation projects during our current audit.

- Prepare a detailed plan addressing actions to be taken in the event a disaster interrupts key information technology services. This recommendation has been restated and repeated. (See Recommendation 2.)

- Make improvements to physical and logical information technology systems access controls. We are not repeating this recommendation, as the university taken corrective action.
• Require supervisory approval of purchasing card logs. This recommendation has been repeated. (See Recommendation 7.)

• Do not authorize contractors to begin work before contracts are executed. This recommendation is not being repeated. This issue was not noted during our current audit.

• Prepare receiving reports when advance payment is required. This recommendation has been restated and repeated. (See Recommendation 9.)

• Process all procurement transactions through the purchasing department. This recommendation has been restated and repeated. (See Recommendation 10.)

• Develop a comprehensive, centralized process for identifying affiliated organizations, determining the nature of the university’s interaction with the organizations, and verifying that the appropriate written agreements are in place. This recommendation is not being repeated. It is our understanding that the university’s general counsel is taking steps to address this finding.

Current Audit Recommendations:

1. The University of Connecticut should seek legislative authorization for the issuance of state bonds to refinance the TIAA-CREF loan when market conditions are appropriate. The cost savings that can be achieved will vary depending on both the state general obligation bond interest rate and, due to yield maintenance prepayment penalty on the TIAA-CREF loan, current Treasury rates.

Comment:

In December 2012, the university, acting through the University of Connecticut Health Center Finance Corporation, secured a $203,000,000 loan from TIAA-CREF. The TIAA-CREF loan bears interest at a rate of 4.809 percent. Interest payments over the life of the loan will total $158,595,860. In December 2012, the university issued special revenue refunding bonds with a total interest cost of 2.480 percent. If the TIAA-CREF loan bore the same interest rate, interest payments over the life of the loan would total $81,787,842, or $76,808,018 less. The TIAA-CREF loan is a debt instrument that the Attorney General has determined is a general obligation of the state, but bears a far higher interest rate than the state could have obtained through a standard bond issuance.
2. The University of Connecticut should make business continuity and disaster recovery planning a priority.

Comment:

Many information technology systems provide mission critical support functions. In our previous report, we noted that University Information Technology Services (UITS), which maintains the university’s core systems, did not have a disaster recovery plan on file.

We followed up on this issue on December 2, 2014. The university had not developed a business continuity plan and UITS was still working towards developing a disaster recovery plan.

3. The University of Connecticut should ensure that computer hard drives are securely erased by experienced personnel after they are transferred to Central Stores.

Comment:

When university departments transfer computers to Central Stores for redistribution, sale or disposal, the departments are required to remove all data from the hard drives prior to transfer. Removing all confidential data before computers leave the user department is a good practice. Securely erasing hard drives is not a regular departmental level procedure and some department personnel may lack sufficient expertise with this aspect of computer maintenance. A supplementary erasure should be performed by Central Stores when computers are received to safeguard confidential information.

4. The University of Connecticut should not pay performance bonuses without first developing a structured plan with criteria for determining when bonuses should be awarded and the amounts to be paid.

Comment:

We noted performance bonuses in the aggregate amount of $93,268 paid to six Finance and Budget Division employees. We were told that they were one time payments based on the employees’ current salaries and their work on the Kuali financial system implementation. The only documentation we were able to obtain supporting these payments consisted of payroll authorizations specifying the amounts to be paid. We were told that no plan existed.

5. The University of Connecticut should seek clear statutory authority for the direct payment of wages to its food service operations staff and for their participation in separate retirement plans.

Comment:

Section 3-25 of the General Statutes authorizes constituent units of the state system of higher education to pay certain claims directly, rather than through the State Comptroller.
However, Section 3-25 specifically excludes payments for payroll. Unlike other UConn employees, food service operations employees are paid directly by the university instead of through the State Comptroller. They also participate in separate retirement plans, although there is no clear statutory authority for this.

6. **The University of Connecticut should track voluntary uncommitted cost sharing in its time and effort reporting system.**

Comment:

UConn’s default functional classification on faculty effort is instruction. When voluntary uncommitted cost sharing is not broken out, the amount reported as spent on instruction will be overstated and the amount spent on research understated. University administrators, and others with oversight responsibilities, including the legislature, need accurate functional reporting to evaluate if state funds are being used prudently and as intended.

7. **The University of Connecticut should require that purchasing card logs be approved by a staff member with supervisory authority over the cardholder.**

Comment:

In our previous report, we noted that the record managers signing off on the purchasing logs were co-workers, subordinates, lower level staff, or the cardholders themselves. During our follow-up on November 2014, we noted that the university implemented additional controls. However, the additional controls do not include sign-off by someone with supervisory authority over the cardholder.

8. **The University of Connecticut should comply with the competitive procurement requirements of Section 10a-151b of the General Statutes. Procurement actions should not be characterized as sole source purchases unless no other source exists that is capable of meeting the requirements.**

Comment:

The university contracted with an engineering firm for design services in connection with the Reclaimed Water Facility Project at a proposed cost of $133,400. The university did not solicit competitive bids or proposals as required, characterizing it as a sole source purchase. It appears that there were other firms that could have provided the services. The university’s preference for engaging a particular firm does not make it a sole source purchase or justify noncompliance with the statutorily mandated competitive procurement requirements established by Section 10a-151b.

9. **The University of Connecticut should prepare receiving reports when payment is required prior to a performance to document that the vendor has fulfilled its contractual obligations.**
Comment:

The university contracted for a performance to be given on a future date. The university paid for the performance in advance, as is common for this type of transaction. However, staff did not prepare, subsequent to the event, a receiving report to document that the vendor had fulfilled its contractual obligations.

10. **The University of Connecticut should comply with the applicable General Statutes and executive orders of Governor M. Jodi Rell regarding ethics certifications.**

Comment:

In our prior report, we found that the required certifications were not obtained for purchases of library materials. We also found that the required certifications were not obtained for other purchases that were also handled at the department level, rather than processed through the purchasing department. During our current audit, we noted five instances in which certifications were not being obtained as required. Two of the purchases pertained to library materials; however, three were processed through the purchasing department.

11. **The University of Connecticut’s Planning Architectural & Engineering Services should ensure that daily field reports always identify who conducted the review and prepared the report. Project coordination meeting minutes should be formally approved.**

Comment:

We noted that project coordination meeting minutes incorporated a statement that failure to object to their content within seven days of receipt would constitute acceptance, but were not formally approved. We also noted that daily field reports did not always identify who conducted the reviews and prepared the report.
CONCLUSION

We wish to express our appreciation to the staff of the University of Connecticut for the cooperation and courtesies extended to our representatives during this examination.

Natercia Freitas  
Associate Auditor

Approved:

John C. Geragosian  
Auditor of Public Accounts

Robert M. Ward  
Auditor of Public Accounts
TAB 5
## The Office of Audit, Compliance & Ethics
### Status of External Audit Projects

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Area</th>
<th>Scope</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marcum, LLP</td>
<td>UConn Health</td>
<td>Audits of the John Dempsey Hospital and Dental Clinics (Clinical Programs Fund), including the OHCA filings, UConn Medical Group (UMG) and the University of Connecticut Health Center Finance Corporation for FY2015.</td>
<td>FY2015 engagement is underway.</td>
</tr>
<tr>
<td>McGladrey</td>
<td>Storrs, Regionals &amp; UConn Health</td>
<td>Audit of UCONN 2000 named projects substantially completed during FY2015, deferred maintenance projects with designated budgets substantially completed in FY2015 and agreed upon procedures performed on total UCONN 2000 expenditures (named projects, deferred maintenance and equipment) for FY2015.</td>
<td>OACE will request JACC approval to hire McGladrey for FY2015 at their September JACC Meeting.</td>
</tr>
<tr>
<td>BKD</td>
<td>Storrs Athletics</td>
<td>NCAA agreed upon procedures performed on all revenues, expenses, and capital expenditures for or on behalf of the University’s Athletics Program for FY2015.</td>
<td>OACE will request JACC approval to hire BKD for FY2015 at their September JACC Meeting.</td>
</tr>
</tbody>
</table>
TO: Members of the Joint Audit and Compliance Committee

FROM: David Galloway
Chief Audit and Compliance Officer

DATE: September 17, 2015

SUBJECT: APPOINTMENT OF AUDITORS – BKD

RECOMMENDATION

It is recommended that the Joint Audit and Compliance Committee approve the re-appointment of the accounting firm BKD to provide audit services for the year ended June 30, 2015. These services include reporting on the application of agreed-upon procedures in compliance with The National Collegiate Athletic Association (NCAA) Financial Reporting Requirements. The proposed fee for the above service is $23,828 plus out of pocket expenses that will not exceed 4%.

BACKGROUND AND METHODOLOGY

NCAA Constitution 3.2.4.16.1 requires that all revenues, expenses and capital expenditures for or on behalf of a Division I member institution's intercollegiate athletic programs, including those by any affiliated or outside organization, agency, or group of individuals (two or more) be subject to annual agreed-upon procedures. The agreed upon procedures report should be prepared by a qualified independent accountant who is not a staff member of the institution and who is selected either by the institution's chief executive or by an institutional administrator from outside the athletic department designated by the chief executive officer.

BKD presented their final report on the NCAA Financial Agreed-Upon Procedures for fiscal year 2014 to the Joint Audit & Compliance Committee (JACC) at their December 11, 2014 meeting. In accordance with the terms of the contract, the University may elect to utilize BKD to provide NCAA financial audit services on an annual basis for up to five consecutive years; this engagement represents the 5th consecutive year that the University will utilize the services of BKD to conduct the NCAA Financial Agreed-Upon Procedures.

OACE seeks JACC approval to move forward with this engagement.
TO: Members of the Joint Audit & Compliance Committee

FROM: David Galloway
        Chief Audit & Compliance Officer

DATE: September 17, 2015

SUBJECT: APPOINTMENT OF AUDITORS – McGladrey

RECOMMENDATION

It is recommended that the Joint Audit and Compliance Committee approve the re-
appointment of the accounting firm of McGladrey as independent auditors of UCONN 2000
expenditures for the 2015 fiscal year. The engagement requires the audit of UCONN 2000
named projects and stand alone deferred maintenance projects substantially completed during
the 2015 fiscal year and agreed upon procedures performed on total UCONN 2000
expenditures, including deferred maintenance and equipment for the year ending June 30,
2015. The proposed fee for the above services is $160,000 plus out of pocket expenses that
will not exceed $14,000. The engagement will commence in September of 2015 and is
expected to be completed no later than May of 2016.

BACKGROUND

McGladrey presented their final audit and agreed upon procedures reports on UCONN 2000
expenditures for fiscal year 2014 to the Joint Audit & Compliance Committee at their May 7,
2015. In accordance with the terms of the contract and prevailing legislation, Section 10a-
109z of the Connecticut General Statutes, the University may elect to utilize the services
McGladrey to conduct audits of UCONN 2000 project expenditures on an annual basis for
five consecutive years. This engagement represents the 5th and final consecutive year that the
University will utilize the services of McGladrey to conduct audits of UCONN 2000 project
expenditures.

OACE seeks JACC approval to move forward with this engagement.
UCONN 2000 - Fiscal Year Ended June 30, 2015

Audit:

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected budget</td>
<td>$48,612,289</td>
<td>$33,971,069</td>
<td>$285,117,019</td>
<td>$96,354,980</td>
<td>$74,615,249</td>
</tr>
<tr>
<td>Reported Project Value</td>
<td>$41,278,460</td>
<td>$19,807,229</td>
<td>$147,042,128</td>
<td>$95,749,980</td>
<td>$74,615,249</td>
</tr>
</tbody>
</table>

| Number of DM | 15 | 6  | 9  | 7  | 12 |
| Number of Named Projects | 15 | 14 | 26 | 23 | 19 |
| Withdrawals | (1) | (3) | (2) | (3) | - |
| Total Number of Contracts | 29 | 17 | 33 | 27 | 31 |

| Fee     | $44,375 | $50,000 | $86,000 | $70,000 | $73,000 |
| Out of pocket expenses not to exceed | $6,000 | $6,000 | $7,000 | $7,000 | $7,000 |

Notes:

1. The audit fee has increased over 2014 due to the following:
   a. The current year number of contracts has increased by 4 contracts.
   b. The testing that will be performed on the current year expenditures will require McGladrey to sample from the larger contract population. This sample will take more time than in prior years based on the larger number of contracts. However, some of our overall testing was completed in the prior year based on procedures performed during the agreed upon procedures review.

2. The Agreed Upon Procedures fee has increased over 2014 due to the following:
   a. The AUP review has increased based on the percentage increase in contract expenditures. The samples that we select and test have a direct correlation with the dollar amount of expenditures.
   b. The proportional fee increase on contract expenditures was reduced based on anticipated economies of scale in testing.

3. Documentation of changes in policies and procedures at Storrs and the Health Center:
   a. 1 day at each location for the Audit Supervisor and Senior Associate.
Regulatory Spotlight

Patient Protection and Affordable Care Act Section 6402

Section 6402 of the Patient Protection and Affordable Care Act requires providers who participate in Medicare or Medicaid to report and refund known overpayments within 60 days. Overpayments are funds that a health care provider receives in excess of the amount that they are entitled to under law.

Overpayments can develop from many areas such as; duplicate payments, medically unnecessary services, missing or insufficient documentation, services provided by an unlicensed provider, Stark Law violations or incorrectly coded services, to name a few.

Failure to return known overpayments within 60 days may result in liability under the False Claims Act for which the current financial penalty is up to $11,000.00 per false claim. Providers can also be assessed Civil Monetary Penalties and/or excluded from participation in Medicare or Medicaid.

To address the overpayment requirements of Section 6402 of the Affordable Care Act, UConn Health has established an Overpayment Review Committee. The Committee meets bi-monthly and is tasked with evaluating potential overpayments. Members of the committee come from JDH and UMG Patient Financial Services, Reimbursement, Compliance and Internal Audit.

Once the committee validates that an overpayment has occurred, members of the committee work to quantify the amount of the overpayment, assure that the required refunds are made and implement education and/or on-going monitoring to prevent a future overpayment.

UConn Health’s policy regarding overpayments can be accessed at: http://www.policies.uchc.edu/policies/policy_2007_12.pdf

For questions or to request additional information, please contact Kim Bailot at 860-679-4746 or at Kbailot@uchc.edu.

Non-Discriminatory Practices to Ensure Equal Care

In the news this week, there is a voluntary resolution agreement between the U.S. Department of Health and Human Services’ Office for Civil Rights (OCR) and The Brooklyn Hospital Center (TBHC), who jointly announced that they have entered into a voluntary resolution agreement to ensure that transgender TBHC patients receive appropriate and equitable care and treatment. The voluntary resolution agreement resolves a complaint filed by a transgender individual alleging discrimination on the basis of sex in the assignment of patient rooms. OCR investigated the complaint under Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in any health program or activity, any part of which is receiving Federal financial assistance.

Although OCR made no formal finding of discrimination, TBHC agreed to take proactive steps to ensure that transgender patients are treated equitably and fairly and receive the full benefit of its services. A copy of The Brooklyn Hospital Center’s written commitments and OCR’s closure letter, along with more information about OCR’s enforcement of Title VI and other federal civil rights laws, can be found at www.hhs.gov/ocr.

The UConn Health community shares the commitment to treat all individuals in a fair and impartial manner, and will not tolerate discriminatory practices. To learn more, please see Policy #2002-44, Affirmative Action, Non-Discrimination, and Equal Opportunity.

For questions related to this policy, please contact Margaret DeMeo, Associate Compliance Office, at (860) 679-1226 or demeo@uchc.edu.
The Walk for HIPAA Compliance

UConn Health is launching “walk-throughs” in clinical areas as another method to assure compliance with HIPAA regulations and institutional policies. The monitoring is intended to educate our workforce, reinforce policies and correct deficiencies as needed.

The walkthrough is a great way to observe how we are actually protecting privacy and security of protected health information (PHI). For example:

- **SWIPE FOR ACCESS:** We will survey for appropriate ID badges and whether workforce members are granting potential unauthorized access to individuals not wearing appropriate ID. For example, it may seem a courtesy to hold the door open but if you need to swipe for access to a secured area, this kindness may actually result in a violation of our HIPAA security policies.
- **DUMPSTER DIVING:** The trash is another interest on walk-throughs. Scrap papers or other documents may contain PHI and be inadvertently discarded in the regular trash. Policies require that all paper with PHI be discarded in secure shredding bins.
- **LIGHTS OUT:** We may conduct walk-throughs after office hours to check for security violations after employees have left. Office doors, filing cabinets and desks should be locked, and portable devices (e.g. laptops, flash drives etc.) should be secured.
- **WORKSTATIONS:** There is a lot of electronic and paper PHI that gets managed by our workforce in the course of business. We will see how well that PHI is secured and not accessible by unauthorized individuals and the public, including use of screensavers, PHI on portable devices. Access controls will also be checked to assure passwords are not written down or shared in work areas, and that log-in information matches the current user on a computer.
- **FAX/PRINTER/COPIER:** PHI cannot be left unsecured but that may happen if printers, copiers and fax machines are not placed in secure areas and attended properly.
- **STAFF INTERVIEWS:** To assure compliance with our policies, staff may be queried about common privacy scenarios as to faxing PHI, communicating with friends and family, release of information and observing minimum necessary standards to name a few.

UConn Health is committed to assure privacy of PHI. Walkthrough monitoring is a tool for education and policy reinforcement. We look forward to meeting staff and responding to any questions and concerns they may have as well.

For questions or additional information about this article, please contact Margaret DeMeo, Associate Compliance Officer, 860-679-1226 demeo@uchc.edu

Assignment and Use of Textbooks: 
Consider the State Code of Ethics

Assigning textbooks or other intellectual property for coursework in the Schools of Medicine and Dental Medicine or the Graduate Program is governed in part by the State Code of Ethics and University policy. Generally, the Code of Ethics prohibits state employees from using their positions to obtain financial gain for themselves, family members or businesses with which they are associated. In a course taught by a faculty member, assigning a required textbook or other intellectual property authored or prepared by that faculty member may be interpreted as acquiring personal financial gain.

According to University policy Assignment of Textbooks and other Intellectual Property, a faculty member who wishes to assign a textbook or intellectual property he or she has authored must receive prior approval. As an alternative, any financial gain associated with requiring students to use one’s own materials may be directed to a University of Connecticut student scholarship fund, in which case no review is necessary.

Also keep in mind the State Code of Ethics’ parameters for accepting gifts from “prohibited donors”, companies doing business or seeking to do business with UConn Health. Only textbooks or other educational materials valued at less than $10 may be personally accepted by UConn Health employees from such donors.

For questions related to this policy or other State Code of Ethics provisions, please contact Ginny Pack, UConn Health Ethics Liaison, at (860) 679-1280 or pack@uchc.edu
Protecting the confidentiality of patient information remains a top priority at UConn Health. The Privacy Office has updated its services and has begun some new initiatives designed to better meet the institution’s HIPAA Privacy needs.

Clinical area “walk-throughs” have started as an additional measure to assure compliance with HIPAA regulations and institutional policies. The Privacy Office staff plans to visit clinical areas on a rotating basis to educate workforce members, reinforce policies and improve processes as needed. Walk-throughs are a great way to gauge how well we are actually doing to protect the privacy and security of protected health information (PHI).

Random and “for cause” electronic access monitoring, including evaluating access to the records of “high-interest” and VIP patients, comparing access by employees in the same locations and roles, and reviewing access to patient records by new employees is ongoing. We will also soon begin monitoring email that has been flagged by the electronic filter which signals messages that are not properly secured to assure email users are complying with the policy for securing email communication.

The Privacy Office also recently launched a new electronic mailbox: PrivacyOffice@uchc.edu dedicated exclusively to privacy questions and for reporting HIPAA Privacy breaches. Our goal is to ensure prompt responses to your questions and follow-up regarding reported privacy breaches.

Lastly, annual and topic-specific education will be a primary focus in the upcoming months to assure that employees are up to date with changes in the HIPAA regulations and to highlight areas which may require specific training. The Privacy Office staff is available to provide department or unit-specific education or to attend staff meetings for informal discussions and Q & A.

Watch for Broadcast Messages for regular HIPAA Privacy tips and updates. For more information, please contact Iris Mauriello, HIPAA Privacy Officer at (860) 679-3501 or mauriello@uchc.edu

REPORTLINE
1-888-685-2637
To help dispel some of the myths surrounding ICD-10, the Centers for Medicare & Medicaid Services (CMS) recently talked with providers to identify common misperceptions about the transition to ICD-10. These five facts address some of the common questions and concerns CMS has heard about ICD-10:

1. **The ICD-10 transition date is October 1, 2015.** The government, payers, and large providers alike have made a substantial investment in ICD-10. This cost will rise if the transition is delayed, and further ICD-10 delays will lead to an unnecessary rise in health care costs. Get ready now for ICD-10.

2. **You don’t have to use 68,000 codes.** Your practice does not use all 13,000 diagnosis codes available in ICD-9. Nor will it be required to use the 68,000 codes that ICD-10 offers. As you do now, your practice will use a very small subset of the codes.

3. **You will use a similar process to look up ICD-10 codes that you use with ICD9.** Increasing the number of diagnosis codes does not necessarily make ICD-10 harder to use. As with ICD-9, an alphabetic index and electronic tools are available to help you with code selection.

4. **Outpatient E/M codes and office CPT procedure codes are not changing. All diagnosis coding for office visits will change to ICD 10.** The transition to ICD-10 for diagnosis coding and inpatient procedure coding only affects diagnosis coding and does not affect the use of CPT for outpatient and office coding. Your practice will continue to use CPT for procedure coding but will transition to ICD-10 for diagnosis coding.

5. **All Medicare fee-for-service providers have the opportunity to conduct testing with CMS before the ICD-10 transition.** Your practice or clearinghouse can conduct acknowledgement testing at any time with your Medicare Administrative Contractor (MAC). Testing will ensure you can submit claims with ICD-10 codes. During a special “acknowledgement testing” week to be held in June 2015, you will have access to real-time help desk support. Contact your MAC for details about testing plans and opportunities.

Keep Up to Date on ICD-10
Visit the CMS [ICD-10 website](#) for the latest news and resources to help you prepare.

For questions or additional information about this article, please contact Janice McDonnell, Compliance Specialist, x4093 jmcdonnell@uchc.edu
Practical Guidance for Health Care Governing Boards on Compliance Oversight

Office of Inspector General, U.S. Department of Health and Human Services
Association of Healthcare Internal Auditors
American Health Lawyers Association
Health Care Compliance Association
About the Organizations

This educational resource was developed in collaboration between the Association of Healthcare Internal Auditors (AHIA), the American Health Lawyers Association (AHLA), the Health Care Compliance Association (HCCA), and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS).

AHIA is an international organization dedicated to the advancement of the health care internal auditing profession. The AHLA is the Nation’s largest nonpartisan, educational organization devoted to legal issues in the health care field. HCCA is a member-based, nonprofit organization serving compliance professionals throughout the health care field. OIG’s mission is to protect the integrity of more than 100 HHS programs, including Medicare and Medicaid, as well as the health and welfare of program beneficiaries.

The following individuals, representing these organizations, served on the drafting task force for this document:

- **Katherine Matos**, Senior Counsel, OIG, HHS
- **Felicia E. Heimer**, Senior Counsel, OIG, HHS
- **Catherine A. Martin**, Principal, Ober | Kaler (AHLA)
- **Robert R. Michalski**, Chief Compliance Officer, Baylor Scott & White Health (AHIA)
- **Daniel Roach**, General Counsel and Chief Compliance Officer, Optum360 (HCCA)
- **Sanford V. Teplitzky**, Principal, Ober | Kaler (AHLA)

Published on April 20, 2015.

*This document is intended to assist governing boards of health care organizations (Boards) to responsibly carry out their compliance plan oversight obligations under applicable laws. This document is intended as guidance and should not be interpreted as setting any particular standards of conduct. The authors recognize that each health care entity can, and should, take the necessary steps to ensure compliance with applicable Federal, State, and local law. At the same time, the authors also recognize that there is no uniform approach to compliance. No part of this document should be taken as the opinion of, or as legal or professional advice from, any of the authors or their respective agencies or organizations.*
Introduction .......................................................................................................................... 1
Expectations for Board Oversight of Compliance Program Functions .......................................... 2
Roles and Relationships ........................................................................................................... 6
Reporting to the Board ............................................................................................................ 9
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Introduction

Previous guidance\(^1\) has consistently emphasized the need for Boards to be fully engaged in their oversight responsibility. A critical element of effective oversight is the process of asking the right questions of management to determine the adequacy and effectiveness of the organization’s compliance program, as well as the performance of those who develop and execute that program, and to make compliance a responsibility for all levels of management. Given heightened industry and professional interest in governance and transparency issues, this document seeks to provide practical tips for Boards as they work to effectuate their oversight role of their organizations’ compliance with State and Federal laws that regulate the health care industry. Specifically, this document addresses issues relating to a Board’s oversight and review of compliance program functions, including the: (1) roles of, and relationships between, the organization’s audit, compliance, and legal departments; (2) mechanism and process for issue-reporting within an organization; (3) approach to identifying regulatory risk; and (4) methods of encouraging enterprise-wide accountability for achievement of compliance goals and objectives.

Expectations for Board Oversight of Compliance Program Functions

A Board must act in good faith in the exercise of its oversight responsibility for its organization, including making inquiries to ensure: (1) a corporate information and reporting system exists and (2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course. The existence of a corporate reporting system is a key compliance program element, which not only keeps the Board informed of the activities of the organization, but also enables an organization to evaluate and respond to issues of potentially illegal or otherwise inappropriate activity.

Boards are encouraged to use widely recognized public compliance resources as benchmarks for their organizations. The Federal Sentencing Guidelines (Guidelines), OIG’s voluntary compliance program guidance documents, and OIG Corporate Integrity Agreements (CIAs) can be used as baseline assessment tools for Boards and management in determining what specific functions may be necessary to meet the requirements of an effective compliance program. The Guidelines “offer incentives to organizations to reduce and ultimately eliminate criminal conduct by providing a structural foundation from which an organization may self-policing its own conduct through an effective compliance and ethics program.” The compliance program guidance documents were developed by OIG to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. CIAs impose specific structural and reporting requirements to

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5 USSG Ch. 8, Intro. Comment.
promote compliance with Federal health care program standards at entities that have resolved fraud allegations.

Basic CIA elements mirror those in the Guidelines, but a CIA also includes obligations tailored to the organization and its compliance risks. Existing CIAs may be helpful resources for Boards seeking to evaluate their organizations’ compliance programs. OIG has required some settling entities, such as health systems and hospitals, to agree to Board-level requirements, including annual resolutions. These resolutions are signed by each member of the Board, or the designated Board committee, and detail the activities that have been undertaken to review and oversee the organization’s compliance with Federal health care program and CIA requirements. OIG has not required this level of Board involvement in every case, but these provisions demonstrate the importance placed on Board oversight in cases OIG believes reflect serious compliance failures.

Although compliance program design is not a “one size fits all” issue, Boards are expected to put forth a meaningful effort to review the adequacy of existing compliance systems and functions. Ensuring that management is aware of the Guidelines, compliance program guidance, and relevant CIAs is a good first step.

One area of inquiry for Board members of health care organizations should be the scope and adequacy of the compliance program in light of the size and complexity of their organizations. The Guidelines allow for variation according to “the size of the organization.”\(^6\) In accordance with the Guidelines,

\(^6\) USSG § 8B2.1, comment. (n. 2).
OIG recognizes that the design of a compliance program will depend on the size and resources of the organization. Additionally, the complexity of the organization will likely dictate the nature and magnitude of regulatory impact and thereby the nature and skill set of resources needed to manage and monitor compliance.

While smaller or less complex organizations must demonstrate the same degree of commitment to ethical conduct and compliance as larger organizations, the Government recognizes that they may meet the Guidelines requirements with less formality and fewer resources than would be expected of larger and more complex organizations. Smaller organizations may meet their compliance responsibility by “using available personnel, rather than employing separate staff, to carry out the compliance and ethics program.” Board members of such organizations may wish to evaluate whether the organization is “modeling its own compliance and ethics programs on existing, well-regarded compliance and ethics programs and best practices of other similar organizations.” The Guidelines also foresee that Boards of smaller organizations may need to become more involved in the organizations’ compliance and ethics efforts than their larger counterparts.

Boards should develop a formal plan to stay abreast of the ever-changing regulatory landscape and operating environment. The plan may involve periodic updates from informed staff or review of regulatory resources made available to them by staff. With an understanding of the dynamic regulatory environment, Boards will be in a position to ask more pertinent questions of management.

7 Compliance Program for Individual and Small Group Physician Practices, 65 Fed. Reg. 59434, 59436 (Oct. 5, 2000) ("The extent of implementation [of the seven components of a voluntary compliance program] will depend on the size and resources of the practice. Smaller physician practices may incorporate each of the components in a manner that best suits the practice. By contrast, larger physician practices often have the means to incorporate the components in a more systematic manner."); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289 (Mar. 16, 2000) (recognizing that smaller providers may not be able to outsource their screening process or afford to maintain a telephone hotline).

8 USSG § 8B2.1, comment. (n. 2).

9 Id.

10 Id.
and make informed strategic decisions regarding the organizations’ compliance programs, including matters that relate to funding and resource allocation. For instance, new standards and reporting requirements, as required by law, may, but do not necessarily, result in increased compliance costs for an organization. Board members may also wish to take advantage of outside educational programs that provide them with opportunities to develop a better understanding of industry risks, regulatory requirements, and how effective compliance and ethics programs operate. In addition, Boards may want management to create a formal education calendar that ensures that Board members are periodically educated on the organizations’ highest risks.

Finally, a Board can raise its level of substantive expertise with respect to regulatory and compliance matters by adding to the Board, or periodically consulting with, an experienced regulatory, compliance, or legal professional. The presence of a professional with health care compliance expertise on the Board sends a strong message about the organization’s commitment to compliance, provides a valuable resource to other Board members, and helps the Board better fulfill its oversight obligations. Board members are generally entitled to rely on the advice of experts in fulfilling their duties.\(^\text{11}\) OIG sometimes requires entities under a CIA to retain an expert in compliance or governance issues to assist the Board in fulfilling its responsibilities under the CIA.\(^\text{12}\) Experts can assist Boards and management in a variety of ways, including the identification of risk areas, provision of insight into best practices in governance, or consultation on other substantive or investigative matters.

\(^\text{11}\) See Del Code Ann. tit. 8, § 141(e) (2010); ABA Revised Model Business Corporation Act, §§ 8.30(e), (f)(2) Standards of Conduct for Directors.

\(^\text{12}\) See Corporate Integrity Agreements between OIG and Halifax Hospital Medical Center and Halifax Staffing, Inc. (2014, compliance and governance); Johnson & Johnson (2013); Dallas County Hospital District d/b/a Parkland Health and Hospital System (2013, compliance and governance); Forest Laboratories, Inc. (2010); Novartis Pharmaceuticals Corporation (2010); Ortho-McNeil-Janssen Pharmaceuticals, Inc. (2010); Synthes, Inc. (2010, compliance expert retained by Audit Committee); The University of Medicine and Dentistry of New Jersey (2009, compliance expert retained by Audit Committee); Quest Diagnostics Incorporated (2009); Amerigroup Corporation (2008); Bayer HealthCare LLC (2008); and Tenet Healthcare Corporation (2006; retained by the Quality, Compliance, and Ethics Committee of the Board).
Roles and Relationships

Organizations should define the interrelationship of the audit, compliance, and legal functions in charters or other organizational documents. The structure, reporting relationships, and interaction of these and other functions (e.g., quality, risk management, and human resources) should be included as departmental roles and responsibilities are defined. One approach is for the charters to draw functional boundaries while also setting an expectation of cooperation and collaboration among those functions. One illustration is the following, recognizing that not all entities may possess sufficient resources to support this structure:

**The compliance function** promotes the prevention, detection, and resolution of actions that do not conform to legal, policy, or business standards. This responsibility includes the obligation to develop policies and procedures that provide employees guidance, the creation of incentives to promote employee compliance, the development of plans to improve or sustain compliance, the development of metrics to measure execution (particularly by management) of the program and implementation of corrective actions, and the development of reports and dashboards that help management and the Board evaluate the effectiveness of the program.

**The legal function** advises the organization on the legal and regulatory risks of its business strategies, providing advice and counsel to management and the Board about relevant laws and regulations that govern, relate to, or impact the organization. The function also defends the organization in legal proceedings and initiates legal proceedings against other parties if such action is warranted.

**The internal audit function** provides an objective evaluation of the existing risk and internal control systems and framework within an organization. Internal audits ensure monitoring functions are working as intended and identify where management monitoring and/or additional
Board oversight may be required. Internal audit helps management (and the compliance function) develop actions to enhance internal controls, reduce risk to the organization, and promote more effective and efficient use of resources. Internal audit can fulfill the auditing requirements of the Guidelines.

**The human resources function** manages the recruiting, screening, and hiring of employees; coordinates employee benefits; and provides employee training and development opportunities.

**The quality improvement function** promotes consistent, safe, and high quality practices within health care organizations. This function improves efficiency and health outcomes by measuring and reporting on quality outcomes and recommends necessary changes to clinical processes to management and the Board. Quality improvement is critical to maintaining patient-centered care and helping the organization minimize risk of patient harm.

Boards should be aware of, and evaluate, the adequacy, independence, and performance of different functions within an organization on a periodic basis. OIG believes an organization’s Compliance Officer should neither be counsel for the provider, nor be subordinate in function or position to counsel or the legal department, in any manner. While independent, an organization’s counsel and compliance officer should collaborate to further the interests of the organization. OIG’s position on separate compliance and legal functions reflects the independent roles and professional obligations of each function;¹⁵

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¹³ Evaluation of independence typically includes assessing whether the function has uninhibited access to the relevant Board committees, is free from organizational bias through an appropriate administrative reporting relationship, and receives fair compensation adjustments based on input from any relevant Board committee.


¹⁵ See, generally, id.
the same is true for internal audit. To operate effectively, the compliance, legal, and internal audit functions should have access to appropriate and relevant corporate information and resources. As part of this effort, organizations will need to balance any existing attorney-client privilege with the goal of providing such access to key individuals who are charged with the responsibility for ensuring compliance, as well as properly reporting and remediating any violations of civil, criminal, or administrative law.

The Board should have a process to ensure appropriate access to information; this process may be set forth in a formal charter document approved by the Audit Committee of the Board or in other appropriate documents. Organizations that do not separate these functions (and some organizations may not have the resources to make this complete separation) should recognize the potential risks of such an arrangement. To partially mitigate these potential risks, organizations should provide individuals serving in multiple roles the capability to execute each function in an independent manner when necessary, including through reporting opportunities with the Board and executive management.

Boards should also evaluate and discuss how management works together to address risk, including the role of each in:

1. identifying compliance risks,
2. investigating compliance risks and avoiding duplication of effort,
3. identifying and implementing appropriate corrective actions and decision-making, and
4. communicating between the various functions throughout the process.

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Boards should understand how management approaches conflicts or disagreements with respect to the resolution of compliance issues and how it decides on the appropriate course of action. The audit, compliance, and legal functions should speak a common language, at least to the Board and management, with respect to governance concepts, such as accountability, risk, compliance, auditing, and monitoring. Agreeing on the adoption of certain frameworks and definitions can help to develop such a common language.

**Reporting to the Board**

The Board should set and enforce expectations for receiving particular types of compliance-related information from various members of management. The Board should receive regular reports regarding the organization’s risk mitigation and compliance efforts—separately and independently—from a variety of key players, including those responsible for audit, compliance, human resources, legal, quality, and information technology. By engaging the leadership team and others deeper in the organization, the Board can identify who can provide relevant information about operations and operational risks. It may be helpful and productive for the Board to establish clear expectations for members of the management team and to hold them accountable for performing and informing the Board in accordance with those expectations. The Board may request the development of objective scorecards that measure how well management is executing the compliance program, mitigating risks, and implementing corrective action plans. Expectations could also include reporting information on internal and external investigations, serious issues raised in internal and external audits, hotline call activity, all allegations of material fraud or senior management misconduct, and all management exceptions to the organization’s
code of conduct and/or expense reimbursement policy. In addition, the Board should expect that management will address significant regulatory changes and enforcement events relevant to the organization’s business.

Boards of health care organizations should receive compliance and risk-related information in a format sufficient to satisfy the interests or concerns of their members and to fit their capacity to review that information. Some Boards use tools such as dashboards—containing key financial, operational and compliance indicators to assess risk, performance against budgets, strategic plans, policies and procedures, or other goals and objectives—in order to strike a balance between too much and too little information. For instance, Board quality committees can work with management to create the content of the dashboards with a goal of identifying and responding to risks and improving quality of care. Boards should also consider establishing a risk-based reporting system, in which those responsible for the compliance function provide reports to the Board when certain risk-based criteria are met. The Board should be assured that there are mechanisms in place to ensure timely reporting of suspected violations and to evaluate and implement remedial measures. These tools may also be used to track and identify trends in organizational performance against corrective action plans developed in response to compliance concerns. Regular internal reviews that provide a Board with a snapshot of where the organization is, and where it may be going, in terms of compliance and quality improvement, should produce better compliance results and higher quality services.

As part of its oversight responsibilities, the Board may want to consider conducting regular “executive sessions” (i.e., excluding senior management) with leadership from the compliance, legal, internal audit, and quality functions to encourage more open communication. Scheduling regular executive sessions creates a continuous expectation of open dialogue, rather than calling such a session only when a problem arises, and is helpful to avoid suspicion among management about why a special executive session is being called.
Identifying and Auditing Potential Risk Areas

Some regulatory risk areas are common to all health care providers. Compliance in health care requires monitoring of activities that are highly vulnerable to fraud or other violations. Areas of particular interest include referral relationships and arrangements, billing problems (e.g., upcoding, submitting claims for services not rendered and/or medically unnecessary services), privacy breaches, and quality-related events.

The Board should ensure that management and the Board have strong processes for identifying risk areas. Risk areas may be identified from internal or external information sources. For instance, Boards and management may identify regulatory risks from internal sources, such as employee reports to an internal compliance hotline or internal audits. External sources that may be used to identify regulatory risks might include professional organization publications, OIG-issued guidance, consultants, competitors, or news media. When failures or problems in similar organizations are publicized, Board members should ask their own management teams whether there are controls and processes in place to reduce the risk of, and to identify, similar misconduct or issues within their organizations.

The Board should ensure that management consistently reviews and audits risk areas, as well as develops, implements, and monitors corrective action plans. One of the reasonable steps an organization is expected to take
under the Guidelines is “monitoring and auditing to detect criminal conduct.”}\(^\text{17}\) Audits can pinpoint potential risk factors, identify regulatory or compliance problems, or confirm the effectiveness of compliance controls. Audit results that reflect compliance issues or control deficiencies should be accompanied by corrective action plans.\(^\text{18}\)

Recent industry trends should also be considered when designing risk assessment plans. Compliance functions tasked with monitoring new areas of risk should take into account the increasing emphasis on quality, industry consolidation, and changes in insurance coverage and reimbursement. New forms of reimbursement (e.g., value-based purchasing, bundling of services for a single payment, and global payments for maintaining and improving the health of individual patients and even entire populations) lead to new incentives and compliance risks. Payment policies that align payment with quality care have placed increasing pressure to conform to recommended quality guidelines and improve quality outcomes. New payment models have also incentivized consolidation among health care providers and more employment and contractual relationships (e.g., between hospitals and physicians). In light of the fact that statutes applicable to provider-physician relationships are very broad, Boards of entities that have financial relationships with referral sources or recipients should ask how their organizations are reviewing these arrangements for compliance with the physician self-referral (Stark) and anti-kickback laws. There should also be a clear understanding between the Board and management as to how the entity will approach and implement those relationships and what level of risk is acceptable in such arrangements.

Emerging trends in the health care industry to increase transparency can present health care organizations with opportunities and risks. For example, the Government is collecting and publishing data on health outcomes and quality measures (e.g., Centers for Medicare & Medicaid Services (CMS) Quality Compare Measures), Medicare payment data are now publicly available (e.g.,

\(^\text{17}\) See USSG § 8B2.1(b)(5).
\(^\text{18}\) See USSG § 8B2.1(c).
CMS physician payment data), and the Sunshine Rule\textsuperscript{19} offers public access to data on payments from the pharmaceutical and device industries to physicians. Boards should consider all beneficial use of this newly available information. For example, Boards may choose to compare accessible data against organizational peers and incorporate national benchmarks when assessing organizational risk and compliance. Also, Boards of organizations that employ physicians should be cognizant of the relationships that exist between their employees and other health care entities and whether those relationships could have an impact on such matters as clinical and research decision-making. Because so much more information is becoming public, Boards may be asked significant compliance-oriented questions by various stakeholders, including patients, employees, government officials, donors, the media, and whistleblowers.

**Encouraging Accountability and Compliance**

Compliance is an enterprise-wide responsibility. While audit, compliance, and legal functions serve as advisors, evaluators, identifiers, and monitors of risk and compliance, it is the responsibility of the entire organization to execute the compliance program.

In an effort to support the concept that compliance is “a way of life,” a Board may assess employee performance in promoting and adhering to compliance.\textsuperscript{20} An organization may assess individual, department, or facility-level performance or consistency in executing the compliance program. These assessments can then be used to either withhold incentives or to provide bonuses.


based on compliance and quality outcomes. Some companies have made participation in annual incentive programs contingent on satisfactorily meeting annual compliance goals. Others have instituted employee and executive compensation claw-back/recoupment provisions if compliance metrics are not met. Such approaches mirror Government trends. For example, OIG is increasingly requiring certifications of compliance from managers outside the compliance department. Through a system of defined compliance goals and objectives against which performance may be measured and incentivized, organizations can effectively communicate the message that everyone is ultimately responsible for compliance.

Governing Boards have multiple incentives to build compliance programs that encourage self-identification of compliance failures and to voluntarily disclose such failures to the Government. For instance, providers enrolled in Medicare or Medicaid are required by statute to report and refund any overpayments under what is called the 60 Day Rule. The 60-Day Rule requires all Medicare and Medicaid participating providers and suppliers to report and refund known overpayments within 60 days from the date the overpayment is “identified” or within 60 days of the date when any corresponding cost report is due. Failure to follow the 60-Day Rule can result in False Claims Act or civil monetary penalty liability. The final regulations, when released, should provide additional guidance and clarity as to what it means to “identify” an overpayment. However, as an example, a Board would be well served by asking management about its efforts to develop policies for identifying and returning overpayments. Such an inquiry would inform the Board about how proactive the organization’s compliance program may be in correcting and remediating compliance issues.

21 42 U.S.C. § 1320a-7k.

22 Medicare Program; Reporting and Returning of Overpayments, 77 Fed. Reg. 9179, 9182 (Feb. 16, 2012) (Under the proposed regulations interpreting this statutory requirement, an overpayment is “identified” when a person “has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment.”) disregard or deliberate ignorance of the overpayment.”); Medicare Program; Reporting and Returning of Overpayments; Extensions of Timeline for Publication of the Final Rule, 80 Fed. Reg. 8247 (Feb. 17, 2015).
Organizations that discover a violation of law often engage in an internal analysis of the benefits and costs of disclosing—and risks of failing to disclose—such violation to OIG and/or another governmental agency. Organizations that are proactive in self-disclosing issues under OIG’s Self-Disclosure Protocol realize certain benefits, such as (1) faster resolution of the case—the average OIG self-disclosure is resolved in less than one year; (2) lower payment—OIG settles most self-disclosure cases for 1.5 times damages rather than for double or treble damages and penalties available under the False Claims Act; and (3) exclusion release as part of settlement with no CIA or other compliance obligations. OIG believes that providers have legal and ethical obligations to disclose known violations of law occurring within their organizations. \(^{23}\) Boards should ask management how it handles the identification of probable violations of law, including voluntary self-disclosure of such issues to the Government.

As an extension of their oversight of reporting mechanisms and structures, Boards would also be well served by evaluating whether compliance systems and processes encourage effective communication across the organizations and whether employees feel confident that raising compliance concerns, questions, or complaints will result in meaningful inquiry without retaliation or retribution. Further, the Board should request and receive sufficient information to evaluate the appropriateness of management’s responses to identified violations of the organization’s policies or Federal or State laws.

**Conclusion**

A health care governing Board should make efforts to increase its knowledge of relevant and emerging regulatory risks, the role and functioning of the organization’s compliance program in the face of those risks, and the flow and elevation of reporting of potential issues and problems to


\(^{24}\) See *id.*, at 2 ("we believe that using the [Self-Disclosure Protocol] may mitigate potential exposure under section 1128J(d) of the Act, 42 U.S.C. 1320a-7k(d.")")
senior management. A Board should also encourage a level of compliance accountability across the organization. A Board may find that not every measure addressed in this document is appropriate for its organization, but every Board is responsible for ensuring that its organization complies with relevant Federal, State, and local laws. The recommendations presented in this document are intended to assist Boards with the performance of those activities that are key to their compliance program oversight responsibilities. Ultimately, compliance efforts are necessary to protect patients and public funds, but the form and manner of such efforts will always be dependent on the organization’s individual situation.

Bibliography


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