University of Connecticut & UConn Health

Joint Audit & Compliance Committee Meeting

June 6, 2018

2:00 pm – 2:30 pm - Executive Session
2:30 pm – 4:00 pm - Public Session

University of Connecticut, Lewis B. Rome Commons Ballroom, 626 Gilbert Road Extension, Storrs, CT

Topic	Proposed Action	Tab
Executive Session to discuss: • 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)] • 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)] • C.G.S 1-200(6)(E) – Records, reports and statements privileged by the attorney-client relationship. [1-210(b)(10)] • 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)]	Review	None
Opportunity for Public Comments		None
Minutes of the March 1, 2018 JACC Meeting	Approval	1
Auditors of Public Accounts • Statewide Single Audit Report For the Year Ended June 30, 2017 Federal Student Financial Assistance Statewide Higher Education including UConn – Findings, Recommendations and Management's Response https://www.cga.ct.gov/apa/reports/statewide/STATEWIDE_20180329_FY2017.pdf , pages 286-302 • Report on University of Connecticut Health Center for the Fiscal Years Ended June 30, 2015 and 2016	Presentation	2
UConn & UConn Health Significant Compliance Activities	Update	3
UConn & UConn Health Significant Audit Activities • Status of Audit Assignments • Follow Up Activities	Update	4
Payment Card Industry Data Security Standards Update – Storrs and Regional Campuses	Update	5
UConn Health – HealthONE Update	Update	6
External Engagements • Status of External Engagements	Update	7
Informational/Educational Items • Certificate of Achievement for Excellence in Financial Reporting • Identity Theft Prevention – "Red Flags Rule" • Article – Practical Guidance for Health Care Governing Boards on Compliance Oversight	Information Only	8
Conclusion of Full Meeting		
Information Session with AMAS and OUC and External Auditors		

The next meeting of the JACC will be held on Thursday, September 20, 2018 at 10:00 am
University of Connecticut, Lewis B. Rome Commons Ballroom, 626 Gilbert Road Extension, Storrs, CT

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University of Connecticut
&
UConn Health

Joint Audit & Compliance Committee Meeting

TAB 1

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University of Connecticut & UConn Health

Joint Audit & Compliance Committee Meeting

DRAFT

Meeting Minutes from March 1, 2018

University of Connecticut, Lewis B. Rome Commons Ballroom, 626 Gilbert Road Extension, Storrs, CT

Attendees	
Trustees / Directors Present:	F. Archambault, R. Carbray, J. Freedman, J. Gouin, T. Holt, and D. Nayden
Staff Present:	D. Abromaitis, A. Agwunobi, C. Bianchi, C. Chiaputti, C. Eaton, K. Fearney, M. Frank, N. Gelston, J. Geoghegan, C. Gray, R. Hoagland, S. Jordan, M. Larson, R. Maric, A. Marsh, I. Mauriello, B. Metz, M. Mundrane, S. O'Donovan, J. Pufahl, K. Rourke, R. Rubin, R. Rudnick, J. Shoulson, E. Vitullo, B. White
State Auditors:	W. Felgate, B. Jordan
CohnReznick:	P. Ballasy, C. Kurth

The meeting of the Joint Audit and Compliance Committee (JACC) was called to order at 10:00 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] – 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)]
- 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)]
- C.G.S. 1-200(6)[E] – Records, reports and statements privileged by the attorney-client relationship. [1-210(b)(10)]
- 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)]

Executive Session was attended by the following: Joint Audit & Compliance Committee Members: F. Archambault, R. Carbray, J. Freedman, J. Gouin, T. Holt, and D. Nayden

Audit Staff members: C. Chiaputti, H. Hildebrandt, A. Marsh, G. Perrotti, A. Quaresima, and E. Zincavage; **Compliance Staff members:** K. Fearney, and E. Vitullo; **Senior Staff:** A. Agwunobi, J. Geoghegan, S. Jordan, R. Maric, R. Rubin, and J. Shoulson; **General Counsel:** N. Gelston, B. White; **Portions of Executive Session were also attended by:** M. Frank, C. Gray, M. Larson, B. Metz, M. Mundrane, J. Pufahl, and R. Rudnick.

The Executive Session ended at 10:30 a.m. and the JACC returned to open session at 10:32 a.m.
There were no public comments.

Tab 1 – Minutes of the Meeting

ON A MOTION made by Trustee Nayden and seconded by Trustee Gouin the minutes of the December 19, 2017, JACC meeting were approved.

Tab 2 – External Engagements

P. Ballasy and C. Kurth presented the CohnReznick Agreed-Upon Procedures on UCONN 2000 Construction Expenditures for Fiscal Year 2017 and Audit of UCONN 2000 Construction Projects Substantially Complete for Fiscal Year 2017.

Tab 3 – UConn and UConn Health Significant Compliance Activities

K. Fearney provided an update on the reorganization efforts of both centralized and decentralized compliance units.

University of Connecticut & UConn Health

Joint Audit & Compliance Committee Meeting

Meeting Minutes from March 1, 2018

University of Connecticut, Lewis B. Rome Commons Ballroom, 626 Gilbert Road Extension, Storrs, CT

Tab 4 – Storrs & UConn Health Significant Audit Activities

C. Chiaputti provided the JACC with an update on the status of audit assignments (Storrs and UConn Health). The JACC accepted three audits presented, in addition, Audit and Management Advisory Services had seventeen audits in progress during this reporting period.

Tab 5 – UConn Health - HealthONE

UConn Health CIO B. Metz provided a HealthONE update for the Epic EHR Project to the committee.

Tab 6 – Charters

ON A MOTION made by Trustee Nayden and seconded by Director Archambault the Joint Audit and Compliance Committee (JACC) Charter was approved.

ON A MOTION made by Trustee Nayden and seconded by Trustee Carbray the Office of Audit and Management Advisory Services (AMAS) Charter was approved.

ON A MOTION made by Trustee Nayden and seconded by Trustee Gouin the Office of University Compliance Charter was approved.

Tab 7 - Informational / Educational Items

The committee was provided with the following:
Compliance Newsletters –UConn Health

There being no further business, **ON A MOTION** made by Trustee Nayden and seconded by Director Archambault, the meeting was adjourned at 10:55 a.m.

Respectfully submitted,

Angela Marsh

University of Connecticut
&
UConn Health

Joint Audit & Compliance Committee Meeting

TAB 2

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University of Connecticut
Single Audit Report Excerpts
FYE 6/30/2017

- Issue Date – March 29, 2018

The audit was performed in accordance with auditing standards generally accepted in the United States of America, Government Auditing Standards for financial audits issued by the Comptroller General of the United States, and the audit requirements of Title 2 U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance)

- Complete Statewide Report -

  https://www.cga.ct.gov/apa/reports/statewide/STATEWIDE_20180329_FY2017.pdf

- Applicable University Federal Programs

  1) Research and Development
  2) Federal Student Financial Assistance (FSFA)

Federal Funds

- Total Federal Assistance Statewide - **$9,509,000,000**

  Type A Program Threshold

  (<$10B = Larger of $3m or FFA * .003) - **$28,527,000**

- Federal Assistance Expended at the University System:

  1. University R&D $ 83,600,000
  2. Health Center R&D $ 68,000,000
  3. Student FFA $230,000,000 (Storrs $213m UCHC $17m)

     TOTAL FFA **$381,600,000**

Audit Findings - FSFA

1. Special Tests: Verification (University) 2017-651

- Title 34 Code of Federal Regulations 668.53 requires an institution to establish policies for verifying information contained in a student aid population.

- Title 34 Code of Federal Regulations 668.56 requires that an institution must verify all Free Applications for Federal Student Aid (FAFSA) that have been selected for verification.

- Title 34 Code of Federal Regulations 668.58(a)(2)(iii)(B) states that, if an institution does not have reason to believe that an applicant's FAFSA information is inaccurate prior to verification, the institution may originate the Direct Subsidized Loan, but may not disburse loan proceeds until verification is completed.

  During our review of 10 students selected for verification testing, we noted 1 instance in which a Direct Subsidized Loan was disbursed before verification was completed.

  Agency Response – "We agree with this finding."

Audit Findings - FSFA

2. Special Tests: Return of Title IV Funds (University) 2017-653

- Title 34 Code of Federal Regulations 668.22 provides guidance regarding the treatment of Title IV funds when a student withdraws from an institution.

From a sample of 10 students selected for Return of Title IV Funds testing, we noted 2 instances in which UConn incorrectly calculated total institutional charges.

- In 1 instance, UConn excluded $120 in online course fees from the institutional charges in their return calculation. In another instance, UConn excluded $16 in summer activity fees from the institutional charges in their return calculation.
- After we brought these matters to the school's attention, UConn returned $15.13 in Parent Plus Direct Loans and $60 in Unsubsidized Direct Loans to the U.S. Department of Education.

Agency Response – "We agree with this finding."

Audit Findings - FSFA

3. Special Tests: Enrollment Reporting (University) 2017-654

- Title 34 Code of Federal Regulations 685.309(b)(2), requires that changes in enrollment to less-than-half-time, graduated, or withdrawn, must be reported within 30 days. However, if a roster file is expected within 60 days, the data may be provided on that roster file.

  We selected 10 students who separated from the university. We noted one instance in which a student's change in enrollment status was not correctly reported to the National Student Loan Data System. In this instance, the student's enrollment change was reported 1 day later than required.

  Agency Response – "We agree with this finding although we disagree with the repeat finding classification."

Audit Findings - FSFA

4. Special Tests: Student Loan Repayments - Repayments (University) 2017-655

- Title 34 Code of Federal Regulations 674.31(b)(2) states that repayment begins 9 months after the borrower ceases to be at least a half-time regular student at the institution.

- The 2016-2017 Federal Student Aid (FSA) Handbook states that a Perkins Loan borrower is entitled to an initial grace period of 9 consecutive months after dropping below half-time enrollment. If the borrower returns to school on at least a half-time basis before the 9 months have elapsed, the initial grace period has not been used. The borrower is entitled to a full initial grace period of 9 consecutive months from the date that he or she graduates, withdraws or drops below half-time enrollment again.

- The FSA Handbook further states that a grace period is always day specific, an initial grace period begins on the day after the day the borrower drops below half-time enrollment.

We selected 10 borrowers at the university who entered repayment during the audited period. From this sample we noted 8 instances in which the university reported the incorrect separation date to its third party service provider. In 7 instances, the separation dates reported were 1 day later than the actual separation dates; in 1 instance, the separation date reported was 8 days earlier than the actual separation date.

Agency Response – "We agree with this finding."

Audit Findings - FSFA

5. Special Tests: Student Loan Repayments – Default (University) 2017-656

- Title 34 Code of Federal Regulations 674.42(c) requires that an institution must contact a federal Perkins Loan borrower with a 9-month grace period at the 90-day, 150-day, and 240-day points of the grace period.

- The Federal Student Aid Handbook states, "Initial grace period – a nine-month period that immediately follows a period of enrollment and immediately precedes the date repayment is required to begin for the first time." The Handbook further states, "The borrower is entitled to a full initial grace period (nine consecutive months) from the date that he or she graduates, withdraws, or drops below half-time enrollment again."

  We selected 10 borrowers at the university whose loans went into default during the audited period and noted the following:

  - 2 instances in which the required 90-day contact letters were not sent to the borrowers.
  - 6 instances in which one or more of the required grace letters were not sent in a timely manner. These grace letters were mailed 2 to 11 days late.

Agency Response – "We agree with this finding."

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FEDERAL STUDENT FINANCIAL ASSISTANCE - DEPARTMENTS OF EDUCATION AND HIGHER EDUCATION – STATEWIDE

Federal Student Financial Assistance awards were made individually to the following institutions during the fiscal year ended June 30, 2017:

Institution	Office of Post-Secondary Education (OPE) ID
University of Connecticut	00141700
University of Connecticut School of Medicine	00141700
University of Connecticut School of Dental Medicine	00141700
Central Connecticut State University	00137800
Eastern Connecticut State University	00142500
Southern Connecticut State University	00140600
Western Connecticut State University	00138000
Charter Oak State College	03234300
Asnuntuck Community College	01115000
Capital Community College	00763500
Gateway Community College	00803700
Housatonic Community College	00451300
Manchester Community College	00139200
Middlesex Community College	00803800
Naugatuck Valley Community College	00698200
Northwestern Connecticut Community College	00139800
Norwalk Community College	00139900
Quinebaug Valley Community College	01053000
Three Rivers Community College	00976500
Tunxis Community College	00976400
A.I. Prince Technical High School	00982200
Bristol Technical Education Center	00927700
Bullard-Havens Technical High School	01149600
Eli Whitney Technical High School	00730000
Howell Cheney Technical High School	02245300
Norwich Technical High School	01184300
Platt Technical High School	02565000
W.F. Kaynor Technical High School	02300000

2017-650 Student Eligibility - Federal Supplemental Educational Opportunity Grants

Federal Supplemental Educational Opportunity Grants (CFDA 84.007)
Federal Award Agency: United States Department of Education
Award Year: 2016-2017

Background: When comparing the list of all students that received a Federal Supplemental Educational Opportunity Grant (FSEOG) to those students who also received a federal Pell Grant (Pell), we identified a number of students that were ineligible to receive FSEOG. The students were ineligible because they did not receive a federal Pell Grant in the same award year.

Criteria: Title 34 Code of Federal Regulations 676.10 establishes the eligibility requirements for a student to receive FSEOG. One of these requirements is that an institution must select students with the lowest Expected Family Contribution (EFC) who will also receive Pell in that year.

Condition: During our review of eligibility at Western Connecticut State University (Western), we noted that 1 out of 65 students received an FSEOG award that they were not eligible for because they did not also receive a Pell award the same award year.

During our review of eligibility at Gateway Community College (Gateway), we noted that 2 out of 1,896 students received FSEOG awards that they were not eligible for because they did not also receive a Pell award the same award year.

Context: *Western:* This condition does not appear to be a systemic issue during our audit period. We reviewed all 65 FSEOG awards totaling $164,709.

Gateway: This condition does not appear to be a systemic issue during our audit period. We reviewed all 1,896 awards totaling $213,133.

Questioned Costs: *Western:* $3,000. This was the amount disbursed to the ineligible student. The university returned these funds on July 14, 2017.

Gateway: $75. This was the total amount disbursed to 2 students who were not eligible. The college returned these funds on July 25, 2017.

Effect: *Western:* The student's FSEOG award totaled $3,000. Upon our discovery, the university rescinded the ineligible FSEOG award.

Gateway: The students' total FSEOG awards were $75. Upon our discovery, the college rescinded the ineligible FSEOG awards.

Cause: *Western:* Based on discussions with university personnel, it appears that the student reached the Pell Lifetime Eligibility Used and the reviewer did not notice and adjust the FSEOG award per the awarding requirements.

Gateway: The college informed us that these instances occurred due to differences between the income and tax information reported by the parent or student in award years 2017 and 2018.

Prior Audit Finding: *Western and Gateway:* We have not previously reported this finding.

Recommendation: Western Connecticut State University and Gateway Community College should award and disburse Federal Supplemental Educational Opportunity Grants in accordance with the requirements stipulated in Title 34 Code of Federal Regulations 676.10.

Views of Responsible Officials:

Western: "We agree with this finding. The finding was corrected upon notice. Although the student was otherwise needy and Pell eligible, they exhausted their lifetime eligibility. In the future, WCSU will ensure that all FSEOG recipients are also Pell award recipients in accordance with the requirements."

Gateway: "We agree with this finding. The college will reconcile the FSEOG Program annually and prior to year-end."

2017-651 Special Tests – Verification

Federal Supplemental Educational Opportunity Grants (CFDA 84.007)
Federal Work-Study Program (CFDA 84.033)
Federal Perkins Loan – Federal Capital Contributions (CFDA 84.038)
Federal Pell Grant Program (CFDA 84.063)
Federal Direct Student Loans (CFDA 84.268)
Federal Award Agency: United States Department of Education
Award Year: 2016-2017

Criteria: Title 34 Code of Federal Regulations 668.53 requires an institution to establish policies for verifying information contained in a student aid population.

Title 34 Code of Federal Regulations 668.56 requires that an institution verify all Free Applications for Federal Student Aid (FAFSA) that have been selected for verification.

Title 34 Code of Federal Regulations 668.58(a)(2)(iii)(B) states that, if an institution does not have reason to believe that an applicant's FAFSA information is inaccurate prior to verification, the institution may originate the Direct Subsidized Loan, but may not disburse loan proceeds until verification is completed.

Condition: During our review of 10 students selected for verification testing at the University of Connecticut (UConn), we noted 1 instance in which a Direct Subsidized Loan was disbursed before verification was completed.

Context: UConn initially verified the student in question in July 2016. At that time, the verification status was marked as completed and the university authorized the initial disbursement. Upon secondary review of the file, staff requested a Non-filer Form. A Non-filer Form is a verification document in which the student states the reason that they did not include a federal income tax return with their verification documentation.

The university credited the Direct Subsidized Loan to the student's account on August 22, 2016. UConn received the student's Non-filer Form on November 7, 2016.

Questioned Costs: $0

Effect: There was reduced assurance that the student and university met the loan requirements at the time of disbursement.

Cause: The university did not follow established verification procedures. It appears to be human error by the Financial Aid Office staff.

Prior Audit Finding: We have not previously reported this finding.

Recommendation: The University of Connecticut should review its procedures to ensure compliance with the federal regulations pertaining to verification.

Views of Responsible Officials:

"We agree with this finding. Although the July 2016 premature disbursement authorization was a result of human error, the Student Financial Aid Services Office conducted mandatory verification training sessions as part of the FY18 In-Service Training Program on January 17, 2017 and January 18, 2017. Additional supplemental training sessions were conducted on March 28, 2017 and March 29, 2017. Further, effective May 2017, every Student Financial Aid Services Office employee involved in the FY18 verification process was required to have successfully completed the formal verification training offered by the National Association of Student Financial Aid Administrators (NASFAA). Finally, effective November 1, 2017, the Student

Financial Aid Services Office conducts monthly verification reviews to ensure compliance with existing regulations."

2017-652 Special Tests – Disbursements

Federal Direct Student Loans (CFDA 84.268)
Federal Award Agency: Department of Education
Award Year: 2016-2017

Criteria: Title 34 Code of Federal Regulations 668.165(a)(2) requires, that, if an institution credits a student's account with Direct Loan funds, the institution must notify the student of the anticipated date and amount of the disbursement, the student's right to cancel all or a portion of the loan disbursement, and the procedures by which the student must notify the institution that he or she wants to cancel the loan or loan disbursement.

Condition: Notifications for the Spring 2017 semester were not distributed to any Direct Loan recipients.

Context: Eastern Connecticut State University (Eastern) disbursed Direct Loans to approximately 6,400 students during the audited period. None of the students who received a Direct Loan disbursement in the Spring 2017 semester received the required notification.

Questioned Costs: $0

Effect: Eastern did not notify students of their right to cancel their Direct Loans.

Cause: A major upgrade to the Outlook email system in January 2017 prevented the notification process from running at that time.

Prior Audit Finding: We have not previously reported this finding.

Recommendation: Eastern Connecticut State University should ensure that it distributes disbursement notifications to students as required by Title 34 Code of Federal Regulations 668.165.

Views of Responsible Officials:

"We agree with this finding. The Bursar's Office has instituted an audit system to monitor the notification process so errors can be quickly identified and remedied."

2017-653 Special Tests – Return of Title IV Funds

Federal Supplemental Educational Opportunity Grants (CFDA 84.007)
Federal Perkins Loan - Federal Capital Contributions (CFDA 84.038)
Federal Pell Grant Program (CFDA 84.063)
Federal Direct Student Loans (CFDA 84.268)
Federal Award Agency: United States Department of Education
Award Year: 2016-2017

Criteria: Title 34 Code of Federal Regulations 668.22 provides guidance regarding the treatment of Title IV funds when a student withdraws from an institution.

Condition: From a sample of 10 students selected for Return of Title IV Funds testing at the University of Connecticut (UConn), we noted 2 instances in which UConn incorrectly calculated total institutional charges.

- In 1 instance, UConn excluded $120 in online course fees from the institutional charges in their return calculation. In another instance, UConn excluded $16 in summer activity fees from the institutional charges in their return calculation.

- After we brought these matters to the school's attention, UConn returned $15.13 in Parent Plus Direct Loans and $60 in Unsubsidized Direct Loans to the U.S. Department of Education.

At Eastern Connecticut State University (Eastern), we noted the university's information system was not correctly prorating Pell Grant amounts for part-time students into return calculations. In certain situations, this could affect the amount of the institution's Title IV returns.

From a sample of 10 students who were selected for Return of Title IV Funds testing at Tunxis Community College (Tunxis), we noted 1 instance in which Tunxis did not return Title IV funds in a timely manner. Tunxis returned the funds 151 days later than required.

Context: *UConn:* The university performed 299 withdrawal calculations during the audited period. The sample, which is not statistically valid, consisted of 10 students who withdrew from the university.

Eastern: It appears that 15 part-time students withdrew during the audited period. Of these withdrawals, 6 students were Pell Grant recipients.

Tunxis: Based on discussions with college staff and our review, this condition does not appear to be systemic.

Questioned Costs: *UConn, Eastern, and Tunxis:* $0

Effect: Title IV funds that were due to be returned to the federal government were delayed or improperly calculated.

Cause: *UConn:* This condition can be attributed to human error due to staff transition and training matters.

Eastern: The information system at Eastern Connecticut State University is not capable of prorating part-time Pell Grant amounts. The university was unaware of this condition.

Tunxis: There was an unexplained delay in performing the refund calculation.

Prior Audit Finding: *UConn and Tunxis:* We have not previously reported this finding.

Eastern: We previously reported this as finding 2016-654.

Recommendation: The University of Connecticut, Eastern Connecticut State University, and Tunxis Community College should review their procedures to ensure compliance with the federal regulations contained in 34 CFR 668.22. In addition, Eastern Connecticut State University should revise its policies to include a procedure to manually review part-time Pell Grant recipients when performing Return of Title IV Funds calculations.

Views of Responsible Officials:

UConn: "We agree with this finding. The two instances in which the University incorrectly calculated total institutional charges were due to human error as a result of personnel changes in the department. Immediately after the University was made aware of these findings, financial aid adjustments were made and the funds were returned accordingly.

To help prevent such oversights in the future, the University has updated procedures specific to the review of the Return to Title IV Funds calculations. In addition, personnel in this area have been re-training."

Eastern: "We agree with this finding. The Financial Aid Office is now making manual adjustments to Pell amounts in the FAM system to ensure proper calculation. In addition, a manual calculation check is performed on these students to ensure the new process is working appropriately."

Tunxis: "We agree with this finding. The Director of Financial Aid will work along with the Associate Director to ensure any Return of Title IV Funds will be processed within the time frame allowed by the Department of Education.

We will have the Registrar run the Title IV Report weekly (SFRNOWD) every Friday once the grades for the semester have been frozen. Currently the grades are frozen approximately three weeks after the semester starts.

The Registrar will forward the SFNOWRD file as an electronic file to the Associate Director of Financial Aid and the Director of Financial Aid. The Associate Director will be responsible for completing the Return of Title IV Funds in Banner within 10 business days.

The Associate Director of Financial Aid will complete the R2T4 process.

Once the Associated Director of Financial Aid completes the R2T4 process, the Director of Financial Aid will review all R2T4 calculations for accuracy. The Director of Financial Aid will then have the Financial Aid Assistant review each student on the RPATIVC and ensure their Pell updates are accurate and locked on the RPAAWRD screen. The Financial Aid Assistant will review the Option Tab looking to see that any Pell changes located under the Award Schedule Tab have a Y in the Period Lock field. Once all students' locks have been verified, the Director of Financial Aid will ensure all COD files are extracted on the 10th business day and all R2T4 returns will be sent electronically to COD through the ED Connect Gateway."

2017-654 Special Tests – Enrollment Reporting

Federal Perkins Loans – Federal Capital Contributions (CFDA 84.038)
Federal Pell Grant Program (CFDA 84.063)
Federal Direct Student Loans (CFDA 84.268)
Federal Award Agency: United States Department of Education
Award Year: 2016-2017

Background: The National Student Loan Data System (NSLDS) is the United States Department of Education's central database for federal student aid disbursed under Title IV of the Higher Education Act of 1965, as amended. Among other things, NSLDS monitors the programs of attendance and the enrollment status of Title IV aid recipients.

Criteria: Title 34 Code of Federal Regulations 685.309(b)(2) requires changes in enrollment to less-than-half-time, graduated, or withdrawn, be reported within 30 days. However, if a roster file is expected within 60 days, the data may be provided on that roster file.

The NSLDS Enrollment Reporting Guide outlines the specific enrollment reporting requirements, including the valid enrollment status codes that each institution must use when reporting enrollment changes. A school must

correctly report students who have completed a program as "graduated" and not as "withdrawn."

Condition: We selected 10 students who separated from the University of Connecticut (UConn). We noted one instance in which UConn did not correctly report a student's change in enrollment status to the NSLDS. In this instance, UConn reported the student's enrollment change 1 day later than required.

We selected 10 students who separated from Southern Connecticut State University (Southern). We noted 3 instances in which the students' enrollment information reported to the NSLDS was incorrect. Southern reported each student's effective withdrawal date as 1 month later than it should have been.

Context: *UConn:* This appears to be an isolated instance. The university reported 3,342 students separated during the 2016-2017 award year. We were unable to determine how many of those students were academically dismissed. Three academically dismissed students were in our sample of 10 students. Our sample was not statistically valid.

Southern: Based on the response from Southern Connecticut State University, the condition does not appear to be a systemic issue. The institution reported 1,794 students who separated during the 2016-2017 award year. Our sample contained 10, 5 of whom had a status of withdrawn. Our sample was not statistically valid.

Questioned Costs: *UConn and Southern:* $0

Effect: The universities did not provide enrollment information to the NSLDS in a timely manner.

Cause: *UConn:* UConn informed us that it manually provided its enrollment reporting service provider the enrollment information, but the provider did not report it to the NSLDS.

Southern: Southern did not follow established procedures. A member of the Registrar's staff incorrectly withdrew these students. This error created an enrollment record for the subsequent semester of attendance that the university transmitted to the NSLDS.

Prior Audit Finding: *UConn:* We previously reported this as finding 2016-656.

Southern: We have not previously reported this finding.

Recommendation: The University of Connecticut and Southern Connecticut State University should review their procedures to ensure that they submit enrollment status

changes to the NSLDS in a timely manner, via the National Student Clearinghouse, in accordance with federal regulations.

Views of Responsible Officials:

UConn: "We agree with this finding although we disagree with the repeat finding classification. Although the University reported the correct enrollment status to the National Student Clearinghouse, the status was not successfully updated/accepted on their end. The National Student Clearinghouse has since identified the cause for the unsuccessful update and the enrollment status for the student identified has been corrected. In order to confirm that additional enrollment submissions for students in this isolated category were updated/accepted correctly by the National Student Clearinghouse, the University will review each of the 2016/17 cases and will follow up with the Clearinghouse as necessary. Further, the Enrollment Reporting quality assurance process will be enhanced to include regular reviews of enrollment submissions for this isolated category to ensure timely updates as appropriate."

Southern: "We agree with this finding. Training was provided upon initial notification of the finding, including a review of existing withdrawal procedures, with the administrative staff responsible for processing withdrawal forms. The process documentation will be updated to include situational clarification regarding the effective date when a withdrawal is received between semesters."

2017-655 Special Tests – Student Loan Repayments - Repayment

Federal Perkins Loan – Federal Capital Contributions (CFDA 84.038)
Federal Award Agency: United States Department of Education
Award Year: 2016-2017

Background: Based on a finding in our previous report, Central Connecticut State University (Central) implemented a set of procedures to address noncompliance related to exit counseling. Central implemented these new procedures in October of 2016.

Criteria: Title 34 Code of Federal Regulations 674.31(b)(2) states that repayment begins 9 months after the borrower ceases to be at least a half-time regular student at the institution.

The 2016-2017 Federal Student Aid (FSA) Handbook states that a Perkins Loan borrower is entitled to an initial grace period of 9 consecutive months after dropping below half-time enrollment. If the borrower returns to school on at least a half-time basis before the 9 months have elapsed, the initial

grace period has not been exhausted. The borrower is entitled to a full initial grace period of 9 consecutive months from the date they graduate, withdraw or drop below half-time enrollment again.

The FSA Handbook further states that a grace period is always day specific. An initial grace period begins a day after the day the borrower drops below half-time enrollment.

Title 34 Code of Federal Regulations (CFR) Section 674.42(b) requires an institution to conduct exit counseling with the borrower either in person, by audiovisual presentation, or electronically before the student ceases to be enrolled on at least a half-time basis. If a borrower withdraws or fails to complete an exit counseling session, the institution must provide the exit counseling material to the borrower within 30 days after learning that the borrower did not complete the exit counseling.

Condition: We selected 10 borrowers at the University of Connecticut (UConn) who entered repayment during the audited period. From this sample, we noted 8 instances in which the university reported the incorrect separation date to its third-party service provider. In 7 instances, the separation dates reported were 1 day later than the actual separation dates; in 1 instance, the separation date reported was 8 days earlier than the actual separation date.

From a sample of 10 borrowers at Central who graduated in May 2017, and therefore entered repayment after October 2016, we noted 3 instances in which exit counseling was not initiated before the end of the semester. In these 3 instances, exit counseling was initiated 60 days after the end of the semester.

From a sample of 10 borrowers at Southern Connecticut State University (Southern) who entered repayment during the audited period, we noted 3 instances in which the university was aware that the borrower was graduating, yet exit counseling was initiated 11 days after the end of the semester.

Context: *UConn:* Based on the exception percentages and discussions with university staff, these findings appear to be systemic. UConn reported 894 students who entered repayment during the audited period. Our sample was not statistically valid.

Central: Based on discussions with university personnel, this finding appears to be an isolated incident. Central reported 121 Perkins Loans borrowers that graduated after October 2016. The sample was not statistically valid.

Southern: Based on discussion with university staff and review of the policies and procedures, this condition appears to be systemic. The university

had 57 borrowers enter repayment during the audited period. The sample was not statistically valid.

Questioned Costs: *UConn, Central, and Southern:* $0

Effect: These institutions did not comply with federal due diligence requirements.

Cause: *UConn:* The university's procedures do not comply with federal regulations governing repayment.

Central: Human error appears to be the cause of this condition.

Southern: The procedures at Southern Connecticut State University do not comply with federal regulations related to exit counseling. Delays in notification of student separations to the service provider caused the delay in issuing the exit counseling packages.

Prior Audit Finding: *UConn, Central, and Southern:* This was previously reported as finding 2016-657.

Recommendation: The University of Connecticut, Central Connecticut State University, and Southern Connecticut State University should ensure that policies and procedures regarding Perkins Loan repayments comply with federal regulations. In addition, Southern Connecticut State University should ensure that policies and procedures regarding Perkins Loan exit counseling comply with federal regulations.

Views of Responsible Officials:

UConn: "We agree with this finding. The seven instances, in which the University provided the third party servicer with incorrect separation dates, are related to a finding identified in the FY15-16 audit. As the University responded in the FY15-16 audit, the University had reported the commencement date as the last date of the semester not last date of finals, based on the understanding of the federal regulations. Using either the last date of finals or commencement date does not change the grace ending date, repayment date nor has financial implication. As stated in the FY15-16's audit response, in December 2016, the University changed the separation date reported to our third party servicer as the last day of finals, as per the audit recommendation. The seven instances occurred prior to December 2016. No corrective action is needed as our updated procedures have already been implemented.

The one instance in which the separation date reported was 8 days earlier than the actual separation date, was the result of the University reporting the last date of the Spring semester classes, rather than the last day of finals.

Again, as reported above, this occurrence was prior to the change made with the University's third party servicer to report the separation date as the last day of finals. As stated in the FY15-16's audit response, this change was implemented in Fall, 2016, therefore no correction active is needed."

Central: "We agree with this finding. In October of 2016, in response to a prior audit finding, the University changed the scheduling of a report that identifies pending graduates so that they could be separated with a future date to ensure that exit counseling occurred prior to graduation. The report was working as intended and the employee had been properly separating pending graduates. The three instances noted in this exception occurred on the same day and it appears that the employee was confused as to which report she was working with. This human error resulted in the students not being separated and therefore, not receiving the required counseling within the federal timeframes. The University will implement additional training on all of the reports used for this function coupled with a second person sign-off to mitigate the risk of human error, as well as enhance our ability to detect human errors."

Southern: "We agree with this finding. Procedures have been amended to initiate exit counseling before students graduate, when known in advance. The Registrar's Office will send the Student Accounts Office the pre-graduation list which will allow the office staff to initiate the interview process, with the students, in advance of their graduation."

2017-656 Special Tests – Student Loan Repayments - Default

Federal Perkins Loan – Federal Capital Contributions (CFDA 84.038)
Federal Award Agency: United States Department of Education
Award Year: 2016-2017

Criteria: Title 34 Code of Federal Regulations 674.42(c) requires that an institution contact a federal Perkins Loan borrower with a 9-month grace period at the 90-day, 150-day, and 240-day points of the grace period.

The Federal Student Aid Handbook states, "Initial grace period – a nine-month period that immediately follows a period of enrollment and immediately precedes the date repayment is required to begin for the first time." The Handbook further states, "The borrower is entitled to a full initial grace period (nine consecutive months) from the date that he or she graduates, withdraws, or drops below half-time enrollment again."

Condition: We selected 10 borrowers at the University of Connecticut (UConn) whose loans went into default during the audited period and noted the following:

- Two instances in which UConn did not send the required 90-day contact letters to the borrowers.

- Six instances in which UConn did not send one or more of the required grace letters in a timely manner. UConn mailed these grace letters 2 to 11 days late.

Context: Based on discussions with UConn staff, the 2 instances in which the required 90-day contact letters were not sent to the borrowers appear to be isolated instances.

Based on the exception percentages and discussions with university staff, the part of the finding related to untimely issuance of grace letters appears to be a systemic issue. The delays in grace letter mailings were due to the delay in the grace period start date. The university provided us a report of 87 borrowers whose loans went into default during the audited period. Our sample was not statistically valid.

Questioned Costs: $0

Effect: UConn did not comply with the federal due diligence requirements designed to minimize repayment defaults.

Cause: UConn's third party Perkins Loans servicer uses the first day of the following month to start the billing cycle for student loans. The servicer bases the grace letters on this date, rather than the actual start date of the grace period.

Prior Audit Finding: We previously reported this as finding 2016-658.

Recommendation: The University of Connecticut should ensure that it performs policies and procedures related to Perkins Loans due diligence requirements in accordance with federal regulations.

Views of Responsible Officials:

"We agree with this finding. One of the two instances in which borrowers were not sent the 90-day grace letter was associated with University's withdrawal date definition. In the past, the University's Dean of Students Office (DOS) was using the last date of attendance as the withdrawal date. However, since the University is a non-attendance taking institution, beginning Fall 2016, it was determined upon further review, that the DOS would change the withdrawal date using the date of notification. Regional campuses changed procedures as well, beginning Fall 2017. As the student's "last date of attendance" may date prior to Dean of Students being notified as in this finding, changing the withdrawal date to the date of notification will prevent such delays and allow for the grace letter to be sent in accordance with federal regulations.

The second instance in which a 90-day grace letter was not sent was the result of the University's anticipated graduation reconciliation process. Although this borrower was properly separated as part of our census reconciliation in December 2014, the borrower was later captured as an anticipated graduate for Spring, 2015. At this point, the borrower was reenrolled and the separation date was revised to May, 2015. Upon completing the final graduation reconciliation, it was discovered that this borrower was no longer active which required the University again, to change the separation date back to December, 2014. As a result of these changes, the student did not receive the 90-day grace letter.

Going forward to prevent these isolated instances, the anticipated graduation reconciliation process will include the verification of an active enrollment status in the student administration system. This will eliminate the possibility of changing inactive borrower's separation date and allow for the 90-day grace letters to be sent in accordance with federal regulations.

The six instances identified in which one or more of the required grace letters were not sent in a timely manner are associated with the timing of the billing cycle of the University's third party servicer. The third party servicer establishes their repayment date as the first subsequent month following the expiration of the grace period. Grace period notification are sent when the billing calculation occurs rather than based upon the specific separation date.

The University reached out to the third party service provider in October, 2017, regarding the state auditors' interpretation of timeliness of sending the grace letters. At that time, based on guidance from their legal counsel, the third party service provider was reluctant to change procedures that had been audited annually by the Department of Education without exception. In December, 2017, the University reached out to DOE to confirm that the third party service provider is compliant with federal regulations. Upon further review, the DOE concluded that the University's third party service provider is not compliant with Title 34 Code of Federal Regulations 674.42(c). The DOE, recommended that the third party service provider move in line with the state auditor's recommended practice that grace letters be based on the actual start date of the grace period rather than based upon the billing cycle. In addition, DOE confirmed that because the third party service provider has not received prior audit findings specific to this regulation, schools, as well as the provider, will be held harmless for this past practice."

2017-657 Special Tests – Borrower Data Transmission and Reconciliation

Federal Direct Student Loans (CFDA 84.268)
Federal Award Agency: United States Department of Education
Award Year: 2016-2017

Criteria: Title 34 Code of Federal Regulations section 685.102(b) requires schools to perform the following functions as described in the Direct Loan School Guide: create a loan origination record, transmit the record to the servicer, receive funds electronically, disburse funds, create a disbursement record, transmit the disbursement record to the servicer, and reconcile on a monthly basis.

Condition: During our review of records supporting the monthly Direct Loan reconciliations at Tunxis Community College (Tunxis), we noted the following:

- There was no evidence to support that Tunxis performed a monthly Direct Loan reconciliation for the months of August 2016 through November 2016, and April 2017.

- There was no evidence to support that variances were resolved for the months of December 2016, February 2017, and March 2017.

Context: Based on the exception percentage, we believe this finding is systemic. Our sample consisted of all 11 months that required the college to perform a Direct Loan reconciliation. The college disbursed $796,427 in Direct Loan funds during the audited period.

Questioned Costs: $0

Effect: Tunxis did not comply with the federal regulations governing the Direct Loan Program.

Cause: Tunxis was unaware that it must document Direct Loan reconciliations and the resolution to any variances and retain them for review.

Prior Audit Finding: We have not previously reported this finding.

Recommendation: Tunxis Community College should ensure that it retains Direct Loan reconciliations and all related records and retains them for review.

Views of Responsible Officials:

"We agree with this finding. The Director of Financial Aid (DOFA) will run the DL Reconciliation Reports once the DL files are sent from COD which is

usually the first week of every month during the academic year. The reports will be run in the Financial Aid module of the Banner student system. Once the reports have run, the DOFA will print out a copy of the DL Reconciliation Reports and check them for any monetary discrepancies between the COD DL amount paid out to Tunxis CC and the Banner system DL amounts paid to date on students' accounts.

If the monthly totals between COD and Banner are the same, no action needs to be taken. The DOFA will sign and date the printed monthly report and put it into a three-ring binder.

If the monthly DL totals between COD and Banner differ, the DOFA will meet with the Director of Finance within 4 business days to research and see what is causing the discrepancy. Once the discrepancy is corrected, the DOFA will document in writing what the cause of the discrepancy was and how it was corrected. The DOFA will print out the document and have it signed by the Director of Finance and DOFA and date it – the document will be put into the DL Reconciliation Binder."

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STATE OF CONNECTICUT

AUDITORS' REPORT
UNIVERSITY OF CONNECTICUT HEALTH CENTER
FOR THE FISCAL YEARS ENDED JUNE 30, 2015 AND 2016

AUDITORS OF PUBLIC ACCOUNTS
JOHN C. GERAGOSIAN ❖ ROBERT J. KANE

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STATE OF CONNECTICUT

AUDITORS OF PUBLIC ACCOUNTS

JOHN C. GERAGOSIAN

State Capitol
210 Capitol Avenue
Hartford, Connecticut 06106-1559

ROBERT J.KANE

May 23, 2018

AUDITORS' REPORT
UNIVERSITY OF CONNECTICUT HEALTH CENTER
FOR THE FISCAL YEARS ENDED JUNE 30, 2015 AND 2016

We have audited certain operations of the University of Connecticut Health Center (UConn Health) in fulfillment of our duties under Section 2-90 of the Connecticut General Statutes. The scope of our audit included, but was not necessarily limited to, the years ended June 30, 2015 and 2016. The objectives of our audit were to:

1. Evaluate UConn Health's internal controls over significant management and financial functions;

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

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 UConn Health, 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 contracts, grant agreements, 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 various available sources including, but not limited to, UConn Health's management and the state's information systems, and was not subjected to the procedures applied in our audit of UConn Health. 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 Health.

COMMENTS

FOREWORD

The University of Connecticut and the University of Connecticut Health Center (UConn Health) operate primarily under the provisions of Title 10a, Chapter 185, where applicable; Chapter 185b, Part III; and Chapter 187c of the General Statutes. The university and health center are 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 of trustees makes rules for the governance of the university and health center and sets policies for the administration of the university and health center pursuant to duties set forth in Section 10a-104 of the General Statutes. The members of the board of trustees as of June 30, 2016, were:

Ex officio members:

Dannel P. Malloy, Governor
Steven K. Reviczky, Commissioner of Agriculture
Catherine H. Smith, Commissioner of Economic and Community Development
Dianna R. Wentzell, Commissioner of Education
Sanford Cloud, Jr., Chairperson of UConn Health's Board of Directors

Appointed by the Governor:

Lawrence D. McHugh, Middletown, Chair
Louise M. Bailey, West Hartford, Secretary
Andy F. Bessette, West Hartford
Charles F. Bunnell, East Haddam
Shari G. Cantor, West Hartford
Andrea Dennis-LaVigne, Simsbury
Marilda L. Gandara, Hartford
Thomas E. Kruger, Stamford
Rebecca Lobo, Granby
Denis J. Nayden, Stamford
Thomas D. Ritter, Hartford

Elected by alumni:

Donny E. Marshall, Coventry
Richard T. Carbray, Jr., Rocky Hill

Elected by students:

Jeremy L. Jelliffe, Willimantic
David Rifkin, Glastonbury

Other members who served during the audited period include the following:

Michael K. Daniels, Plainville
Juanita T. James, Norwalk
Stefan Pryor, Providence, Rhode Island

Section 10a-104 (c) of the General Statutes authorizes the Board of Trustees of the University of Connecticut to create a board of directors for the governance of UConn Health and delegate such duties and authority, as it deems necessary and appropriate. The members of the board of directors as of June 30, 2016, were:

Ex officio members:

Susan Herbst, President, University of Connecticut
Robert Dakers, designee of the Secretary of the Office of Policy and Management

Appointed by the Chair of the Board of Trustees:

Sanford Cloud Jr., Chairperson, Farmington
Andy F. Bessette, West Hartford
Richard T. Carbray Jr., Rocky Hill

Appointed by the Governor:

Kathleen D. Woods, Avon
Teresa M. Ressel, New Canaan
Joel Freedman, South Glastonbury

Members at Large:

Francis X. Archambault, Jr., Storrs
Richard M. Barry, Avon
Francisco L. Borges, Farmington
Cheryl A. Chase, Hartford
John F. Droney, West Hartford
Timothy A. Holt, Glastonbury
Wayne Rawlins, Cromwell
Charles W. Shivery, Avon

Other members who served during the audited period include the following:

Jewel Mullen, Hartford
Robert T. Samuels, West Hartford

Pursuant to Section 10a-108 of the General Statutes, the Board of Trustees of the University of Connecticut appoints a president of the university and health center to be the chief executive and administrative officer of the university, health center and the board of trustees. Susan Herbst served as the president of the University of Connecticut during the audited period.

The University of Connecticut Health Center Farmington complex houses the John Dempsey Hospital, the School of Medicine, the School of Dental Medicine, and related research laboratories. Additionally, the schools of medicine and dental medicine provide health care to the public, through the UConn Medical Group (including its UConn Health Partners unit) and the University Dentists, in facilities located at the Farmington campus and in neighboring towns.

The University of Connecticut Health Center Finance Corporation, a body politic and corporate, constituting a public instrumentality and political subdivision of the state, operates generally under the provisions of Title 10a, Chapter 187c of the General Statutes. The finance corporation exists to provide operational flexibility with respect to hospital operations, including the clinical operations of the schools of medicine and dental medicine.

The finance corporation is empowered to acquire, maintain, and dispose of hospital facilities and to make and enter into contracts, leases, joint ventures, and other agreements and instruments. It also acts as a procurement vehicle for the clinical operations of UConn Health. The Hospital Insurance Fund (otherwise known as the John Dempsey Hospital Malpractice Fund), which accounts for a self-insurance program covering claims arising from health care services, is administered by the finance corporation in accordance with Section 10a-256 of the General Statutes. Additionally, Section 10a-258 of the General Statutes gives the finance

corporation the authority to determine which hospital accounts receivable shall be treated as uncollectible.

The finance corporation acts as an agent for UConn Health and is administered by a board of directors, consisting of members appointed under the provisions of Section 10a-253 of the General Statutes. The members of the board of directors as of June 30, 2016, were:

Ex officio members:

Susan Herbst, President, University of Connecticut
Andrew Agwunobi, Executive Vice President for Health Affairs
Benjamin Barnes, Secretary of the Office of Policy and Management

Appointed by the Governor:

Lawrence D. McHugh, Chairman Middletown

Recent Legislation

During the period under review, legislation was enacted by the General Assembly affecting UConn Health. The most noteworthy items are presented below:

- Public Act 15-244, Section 22, allowed the Secretary of the Office of Policy and Management to transfer all or part of any General Fund appropriations for UConn Health in fiscal years 2016 and 2017 to the Department of Social Services' Medicaid account in order to maximize federal reimbursement. Public Act 15-244 also transferred $1,000,000 from the Biomedical Research Trust Fund to support the Connecticut Institute for Clinical and Translational Science in fiscal years 2016 and 2017.

- Public Act 15-1, June Special Session, Section 2, provided $25,000,000 of the information and technology capital investment bond fund to UConn Health for the purchase and implementation of an integrated electronic medical records system, effective July 1, 2015.

- Public Act 15-5, June Special Session, Section 416, allowed UConn Health to provide health care coverage for graduate assistants and others through the partnership plan (the state-administered plan for non-state public or nonprofit employers), provided that the related premiums and expenses were not charged to the state's General Fund.

- Public Act 15-1 December 2015 Special Session, Section 19, transferred $3,000,000 from UConn Health to the state's General Fund.

- Public Act 16-1, Section 11, required UConn Health to transfer $1,000,000 from the Hospital Insurance Fund to the General Fund.

- Public Act 16-2, May Special Session, Section 9, provided $1,300,000 of the Biomedical Research Fund to UConn Health for melanoma research and the Bladder Cancer Institute. Section 34 of the public act limited the Secretary of the Office of Policy and Management's allotment reductions to no more than 2% of the appropriations to UConn Health.

- Public Act 16-4 May Special Session, Section 208, provided $16,000,000 of the information and technology capital investment bond fund to UConn Health for the purchase and implementation of an integrated electronic medical records system, effectively July 1, 2016.

Enrollment Statistics

Statistics compiled by UConn Health's registrar present the following enrollments during the audited period and prior fiscal year.

Student Status	2013-2014		2014-2015		2015-2016	
	Fall	Spring	Fall	Spring	Fall	Spring
Medicine – Students	368	368	384	384	396	396
Medicine – Residents	645	645	650	650	659	655
Dental – Students	174	174	171	171	168	171
Dental – Residents	114	114	110	110	109	103
Totals	1301	1301	1315	1315	1332	1325

RÉSUMÉ OF OPERATIONS

Under the provisions of Section 10a-105 (a), of the General Statutes, fees for tuition were fixed by the university's board of trustees. The following summary presents annual tuition charges during the audited period and prior fiscal year.

Student Status	School of Medicine			School of Dental Medicine		
	2013-2014	2014-2015	2015-2016	2013-2014	2014-2015	2015-2016
In-State	$24,832	$27,074	$30,013	$23,363	$25,531	$28,231
Out-of-State	$52,312	$55,928	$60,021	$53,804	$57,494	$61,472
Regional	$43,456	$47,380	$52,523	$40,886	$43,930	$49,404

During the audited period, the State Comptroller accounted for UConn Health operations in:

- General Fund appropriation accounts.

- The University of Connecticut Health Center Operating Fund (Section 10a-105 of the General Statutes).

- The University of Connecticut Health Center Research Foundation Fund (Section 10a-130 of the General Statutes).

- The University Health Center Hospital Fund (Section 10a-127 of the General Statutes).

- The John Dempsey Hospital Malpractice Fund (Section 10a-256 of the General Statutes).

- Accounts established in capital project and special revenue funds for appropriations financed primarily with bond proceeds.

During the audited period, patient revenues were UConn Health's largest source of revenue, with John Dempsey Hospital patient revenues being the largest single component. Other operations that generated significant patient revenues were the Correctional Managed Healthcare Program and the UConn Medical Group.

Under the Correctional Managed Healthcare Program, UConn Health entered into an agreement, effective August 11, 1997, with the Department of Correction to provide medical care to inmates in the state's correctional facilities. Medical personnel at the correctional facilities, formerly paid through the Department of Correction, were transferred to the UConn Health payroll.

Under the agreement, while the program was to be managed by UConn Health, the commissioner of the Department of Correction retained the authority for the care and custody of inmates and the responsibility for the supervision and direction of all institutions, facilities, and activities of the department. The purpose of the program was to enlist the services of UConn Health to carry out the responsibility for the provision and management of comprehensive medical care.

The UConn Medical Group functions similarly to a private group practice for faculty clinicians providing patient services in a variety of specialties. The UConn Medical Group's operation is considered essential for the education and training of medical students of the School of Medicine.

Other significant sources of revenue included state General Fund operating support, federal and state grants, and payments for the services related to the Residency Training Program.

Under the Residency Training Program, interns and residents appointed to local health care organizations are paid through the Capital Area Health Consortium. UConn Health reimburses the Capital Area Health Consortium for the personnel service costs incurred and is, in turn, reimbursed by the participating organizations.

Health care providers and support staff of UConn Health are granted statutory immunity from any claim for damage or injury, not wanton, reckless or malicious, caused in the discharge of their duties or within the scope of their employment. Any claims paid for actions brought against the state as permitted by waiver of statutory immunity have been charged against UConn Health's malpractice self-insurance fund. UConn Health has developed a methodology by which it allocates malpractice costs between the hospital, UConn Medical Group, and University Dentists. For the years ended June 30, 2015 and 2016, these costs are included in the statement of revenues, expenses, and changes in net assets.

UConn Health's financial statements are prepared in accordance with all relevant Governmental Accounting Standards Board (GASB) pronouncements. UConn Health utilizes the proprietary fund method of accounting, whereby revenue and expenses are recognized on the accrual basis.

UConn Health's financial statements are adjusted as necessary and incorporated in the state's Comprehensive Annual Financial Report. The financial balances and activity of UConn Health, including John Dempsey Hospital, are combined with those of the university and included as a proprietary fund.

UConn Health employment remained relatively stable during the audited period. UConn Health position summaries show that permanent full-time filled positions totaled 5,017 as of June 2014; 4,918 as of June 2015; and 4,939 as of June 2016.

Operating Revenues

Operating revenue results from the sale or exchange of goods and services that relate to UConn Health's mission of instruction, research, and patient services. Major sources of operating revenue include patient services, federal grants, state grants, contracts, and other operating revenues. Operating revenue as presented in UConn Health's financial statements for the audited period and prior fiscal year, follows:

($ in thousands)	2013-2014	2014-2015	2015-2016
Student Tuition and Fees (net of scholarship allowances)	$ 15,794	$ 16,557	$ 15,728
Patient Services (net of charity care)	450,315	512,960	532,876
Federal Grants and Contracts	62,527	57,920	59,529
Non-Governmental Grants and Contracts	23,803	24,407	27,116
Contract and Other Operating Revenues	106,771	109,324	108,017
Total Operating Revenue	$ 659,210	$721,168	$743,266

The largest source of operating revenue, patient services, is derived from fees charged for patient care. Patient services revenue increased 13.9% in the fiscal year ended June 30, 2015 followed by an increase of 3.9% in fiscal year 2016. Increases in patient services revenue were

attributed to an increase in volume since the opening of the new outpatient pavilion in the 2015 fiscal year and the new hospital tower in the 2016 fiscal year. Billing rate increases of approximately 2% also contributed to the increase of patient service revenue.

Operating Expenses

Operating expenses generally result from payments made for goods and services to assist in achieving UConn Health's mission of instruction, research, and patient services. Operating expenses do not include interest expense or capital additions and deductions. Operating expenses include employee compensation and benefits, supplies, services, utilities, and depreciation and amortization.

Operating expenses by functional classification, as presented in UConn Health's financial statements for the audited period and prior fiscal year, follows:

($ in thousands)	2013-2014	2014-2015	2015-2016
Education and General			
Instruction	$ 152,618	$ 163,703	$ 168,299
Research	59,518	56,961	58,233
Patient Services	581,558	607,435	648,071
Academic Support	20,824	22,458	18,070
Institutional Support	66,416	83,260	80,638
Operations and Maintenance	31,548	35,363	38,714
Depreciation	32,780	37,830	41,469
Student Aid	50	32	84
Total Operating Expenses	$945,312	$1,007,042	$1,053,578

The largest source of operating expenses relates to patient services. Patient services expenses increased 4.4% in the fiscal year ended June 30, 2015 followed by an increase of 6.7% in fiscal year 2016. Instruction expenses, the second largest operating expense, increased 7.3% in the fiscal year ended June 30, 2015 and increased 2.8% in the fiscal year ended June 30, 2016. In addition to increases in patient volume, increases in salaries related to collective bargaining agreements, and fringe benefit rates also contributed to the increases of operating expenses.

Non-operating Revenues and Expenses

Non-operating revenues and expenses are neither operating revenues/expenses nor capital additions/deductions. Non-operating revenues and expenses include items such as the state's General Fund appropriation, gifts, investment income, and interest expense. Non-operating revenue (expenses) as presented in UConn Health's financial statements for the audited period and prior fiscal year follows:

($ in thousands)	2013-2014	2014-2015	2015-2016
State Appropriations (including fringe benefits)	$ 266,139	$ 280,645	$ 289,287
Gifts	7,300	7,175	6,865
Investment Income	93	176	141
Interest on Capital Assets – Related Debt	(1,007)	(3,820)	(10,487)
Net Non-operating Revenue	$ 272,525	$ 284,176	$ 285,806

State appropriations, which include fringe benefits, increased 5.5% in the fiscal year ended June 30, 2015 and 3.1% in the fiscal year ended June 30, 2016.

Investment income is derived primarily from UConn Health's unspent cash balances and endowments. The gifts component of non-operating revenue is comprised of amounts received from the University of Connecticut Foundation and other non-governmental organizations and individuals.

Other Changes in Net Assets

Other Changes in Net Assets, as presented in UConn Health's financial statements for the audited period and prior fiscal year, follows:

($ in thousands)	2013-2014	2014-2015	2015-2016
Capital Appropriations	$ 193,214	$ 159,810	$ 175,000
Loss on Disposal	(573)	(3,902)	(695)
Net Other Changes in Net Assets	$ 192,641	$ 155,908	$ 174,305

The capital appropriations amounts for the fiscal years ended June 30, 2015 and 2016 are primarily related to amounts allocated to UConn Health under the UCONN 2000 capital improvement program.

Net Assets

Net assets represent assets less liabilities. Net assets, as presented in UConn Health's financial statements for the audited period and prior fiscal year, follows:

($ in thousands)	2013-2014	2014-2015	2015-2016
Invested in Capital Assets, Net of Related Debt	$ 405,672	$ 579,241	$ 734,480
Restricted for Non-expendable:			
Scholarships	61	61	61

Restricted for Expendable:			
Research	547	(139)	(876)
Loans	104	1,348	953
Capital Projects	152,707	104,082	117,466
Unrestricted	17,703	(648,621)	(666,313)
Total Net Position	$ 576,794	$ 35,972	$ 185,771

Amounts listed above as invested in capital assets, net of related debt, reflect the value of capital assets such as buildings and equipment after subtracting the outstanding debt used to acquire such assets. Increases in this category were attributable to the construction of the outpatient pavilion, approximately $167 million, in the fiscal year ended June 30, 2015 and the completion of the University Tower at John Dempsey Hospital, approximately $175 million, in the fiscal year ended June 30, 2016. Restricted non-expendable assets are primarily comprised of permanent endowments. Restricted expendable assets are assets whose use by UConn Health is subject to externally imposed stipulations. Unrestricted assets are assets not subject to externally imposed restrictions. Significant decreases in unrestricted assets were the cumulative effect of recognizing pension liabilities, deferred outflows of resources, and deferred inflows of resources, which were required by the Governmental Accounting Standards Board (GASB) Statements No. 68 and No.71 starting in the 2015 fiscal year.

Related Entities

UConn Health did not hold significant endowment and similar fund balances during the audited period, as it has been UConn Health's longstanding practice to deposit funds raised with the University of Connecticut Foundation, Inc. The foundation provides support for the university and UConn Health. Its financial statements reflect balances and transactions associated with both entities, not only those exclusive to UConn Health.

A summary of the foundation's assets, liabilities, support, and revenues and expenditures for the audited period and prior fiscal year follows:

	University of Connecticut Foundation, Inc. Fiscal Year Ended		
($ in thousands)	June 30, 2014	June 30, 2015	June 30, 2016
Assets	$ 489,928	$ 481,944	$ 475,537
Liabilities	53,019	46,162	44,723
Net Position	436,909	435,782	430,814
Support and Revenue	91,426	53,422	48,815
Expenditures	68,004	54,422	53,892

STATE AUDITORS' FINDINGS AND RECOMMENDATIONS

We believe that the following matters require disclosure and management's attention.

Evaluation of Contract Proposals

Background: UConn Health frequently uses a request for proposal (RFP) process to determine how to award a contract of significant value. To assist with the bid evaluation process, UConn Health has established procurement initiation forms to outline the purchase needs, estimated budget, expected contract length and potential funding sources. UConn Health uses proposal evaluation forms to document the independent evaluations and scores of the contract selection committee members.

Criteria: It is essential to the integrity of the contract proposal evaluation process that evaluators certify their independence and objective review of contract proposals. Adherence to established procedures provides assurance that the evaluation process and award decisions are fair and based on objective criteria.

Requests for contract proposals should include scope of work and specifications that align directly with the contract expectations and results.

Condition: Our review of 65 expenditure transactions disclosed the following deficiencies:

- Evaluation documents of 4 contract proposals did not include evaluator names or signatures to certify their independent review and scoring of contract proposals. These proposal evaluations resulted in 4 contracts with a total potential value of $10,129,806.

- In 4 other proposal evaluations, a number of evaluators provided either no comments or inadequate comments on the proposals' strengths and weaknesses to support their scores on the proposals. These proposal evaluations resulted in 4 contracts with a total potential value of $39,803,143.

- Evaluation forms for 2 proposals were not completed to support the decision to award some vendors with contract values 3 to 4 times larger than the remaining vendors. These 2 proposals had contracts with total potential values of $4,452,980.

- A contract with an initially identified budget of $400,000 was publicly bid with insufficient scope of work information. A proposal was rejected during the preliminary process for being the highest bid and $150,000 more than the initially identified budget. In addition, because UConn Health did not specify the complete scope of work in its request for proposals, bidders submitted quotes that varied widely from the final contract. As of March 31, 2017, the contract value totaled $2,400,000, which was 6 times greater than the initially identified budget.

Effect: There was no assurance of the independence and reasonableness of UConn Health's bid evaluation process when evaluators neglected to certify their evaluations or provide comments supporting the scoring of bid proposals. Without bid evaluation forms, the reviewer could not determine whether some contractors were justifiably awarded contract values much larger than other contractors. Potential vendors could not provide accurate proposals when they lacked a scope of work or realistic contract budget.

Cause: UConn Health did not require proposal evaluators to provide adequate comments for the bid scores and to certify that they independently reviewed and evaluated the proposals. When all proposers were awarded some contract value, it was UConn Health's procurement practice to not complete proposal evaluation forms. Procurement staff often had to rely on the division requesting the contract to determine the contract budget and the scope of work. In addition, UConn Health substantially expanded its facilities during the audited period, which made it more challenging for purchasing employees to correctly forecast the final service needs.

Recommendation: The University of Connecticut Health Center should enforce its requirements for proposal evaluators to certify and adequately comment on contract proposal scores. UConn Health should rebid contracts when their value has become significantly higher than the initial contract budget. (See Recommendation 1.)

Agency Response: "UConn Health is committed to a public and transparent bid process that encourages competition and results in the selections that provide the best value for UConn Health and the State of Connecticut. We have reviewed our bid process and made some changes as a result of this finding; we will continue to periodically evaluate our process for other potential improvements.

In the past, the electronic copy of each evaluation form was saved under the evaluator's name, so names were easily identified when the forms were reviewed electronically. The Procurement Department has now revised its process to require the evaluator's name and date to be printed on the evaluation form itself, so that the evaluator can also be easily identified when a hard copy of the form is being reviewed.

UConn Health's instructions to selection committee members—including instructions printed on the evaluation form itself—state that evaluations are to be performed independently. In order to facilitate automated scoring and eliminate the need for a Buyer to retype scores (which can result in transcription errors), the Procurement Department prefers to have evaluation forms submitted in electronic Excel format, rather than in hard-copy format. We are not currently aware of a technical solution that would allow evaluators to easily sign their evaluation forms without eliminating the valuable automated scoring functionality; we will ask the IT Department to help us to determine if a cost-effective and user-friendly solution exists that meets both needs.

The Procurement Department will continue to review the evaluation forms submitted by the members of the selection committee to ensure that there is sufficient information to support the award. In addition to the evaluation forms themselves, a Procurement Summary and Recommendations form is prepared jointly by the Buyer and Selection Committee Chairperson to summarize the process and capture any relevant information that may not be reflected elsewhere. That document is signed by the Buyer, Selection Committee Chairperson and Director of Procurement at the end of the bid process. In cases of multiple awards, the reasons for any significant difference in the values awarded to each vendor are documented on the Procurement Summary and Recommendations form.

We agree that it is always best to have as much information as possible about a project's scope before a bid is released so that the proposers can submit tailored responses to meet UConn Health's needs. Sometimes, business needs and project deadlines make it necessary to seek a solution before all of the variables are known. In the instance cited by the auditors, the information available to the drafters of the RFP was limited by the fact that the buildings where the system would be used were still under construction, and the solution had to be piloted before it could be implemented on a larger scale."

Management of Purchase Orders

Criteria: State agencies should use a purchase order to encumber sufficient cash for invoice payments and to establish a written authorization for vendors to deliver goods and services at agreed-upon terms. According to its purchasing policy, UConn Health must make all purchases of goods and services using an approved purchase order or a written pre-approval from the Procurement Division.

UConn Health should identify late payment fees in a separate administrative account so that management can easily monitor and take actions to prevent additional penalties.

Condition: We reviewed 12 purchase orders and noted that 7 had been revised numerous times, including 1 that was revised 28 times. In all of these instances, the revisions occurred after purchase dates. UConn Health made the revisions after receiving invoices in order to encumber additional funds to pay for the purchases.

UConn Health incurred $3,134 in late payment fees when a lease purchase order did not encumber sufficient funds for payments. UConn Health did not code the late payment fees to a separate administrative cost account.

Effect: UConn Health did not use purchase orders as a written authorization for vendors to deliver goods. This practice increased the risk of inconsistencies between the contracted terms and the vendor invoice terms. It also increased the risk of not having sufficient funds to pay for the purchases.

Cause: The procurement office did not always receive advance notifications of the actual purchases. In order to save processing time, UConn Health intentionally revised some purchase orders after the receipt of invoices so that they could reflect the actual invoice amounts or the correct funding sources.

Recommendation: The University of Connecticut Health Center should improve the management of purchase orders so that they can reflect the correct contract terms and assist with the timely payment of invoices. UConn Health should record late payment penalties in a separate account to allow proper monitoring. (See Recommendation 2.)

Agency Response: “The controls in place for revising purchase orders are very similar to the controls we have for requesting a new purchase order; the same departmental reviews and approvals that must take place before a PO can be issued also have to take place prior to any PO

revisions. There are a number of legitimate business reasons why departments need to be permitted to add funds to an existing PO, but ultimately each department's spend is capped by the funds available in the department's budget. However, as a result of this comment, UConn Health will review its policies and procedures related to purchase order revisions, and add additional parameters and controls as needed."

Loss of Prompt Payment Discounts

Criteria: Prudent cash management practice requires a business entity to set aside sufficient funds prior to requesting a delivery of goods or services and to take advantage of prompt payment discounts.

Condition: Our review of 22 invoice payments to vendors offering prompt payment discounts showed that UConn Health did not take advantage of the discounts in 13 invoices, and lost a total savings of $46,424.

A furniture vendor received payments totaling $1,243,000 in the 2016 fiscal year without providing UConn Health with the prompt payment discount included in its contract proposal. In the invoices, the vendor required UConn Health to pay within a shorter period and requested late payment penalties of 1.5% on all invoices.

Effect: UConn Health lost savings opportunities when it did not take advantage of prompt payment offers.

Cause: In most instances, the accounts payable office did not receive the invoices until the prompt payment period had expired. Delays were also caused by purchase orders lacking sufficient funds for prompt payments.

Recommendation: The University of Connecticut Health Center should improve coordination among various departments to take advantage of prompt payment discounts. UConn Health should hold vendors to their payment and discount terms. (See Recommendation 3.)

Agency Response: "UConn Health maintains several mechanisms to enable it to capitalize on discount opportunities. Among these mechanisms are vendor level system settings that control when payments are issued to ensure discounts are taken and invoice prioritization in the AP Department to ensure timely entry. The findings herein typically represent either singular vendor opportunities or departmental delays on items requiring departmental sign off. UConn Health will work to better communicate singular vendor offers amongst

departments and all levels of review. At the same time, we will enhance our tracking of lost discounts so that meaningful feedback can be provided to departments and discount compliance improved."

Monitoring of Purchases and Contract Terms

Criteria: Proper purchasing procedures require that agencies maintain and consult contracted price lists, prompt discounts, and discount percentages during the purchase process and approval of invoices.

Condition: During our test of expenditures, we noted the following:

- UConn Health paid in excess of $6,200,000 to a vendor that provided information technology hardware and software. There was insufficient written documentation to confirm that UConn Health compared the vendor's invoices to its price list and correctly reflected the discount percentages agreed in the contract.

- We could not trace three invoices, totaling $1,035,591, to the vendor price lists or supporting employee timecards.

- Two purchase orders, totaling $555,720, referred to the state contracts when the invoice approvers indicated that they were using contracts procured by UConn Storrs. The state contracts had different price lists and competitive purchasing quote requirements than the contracts procured by UConn Storrs.

Effect: The risk of improper payments increased when the invoice approvers failed to document vendor price lists, applicable discount percentages, and did not follow the applicable contracts.

Cause: Invoice approvers did not retain a copy of the vendor price lists and timecards for the tested disbursements. References to incorrect contracts appeared to be an oversight and a miscommunication between the procurement office and the divisions approving the invoices.

Recommendation: The University of Connecticut Health Center should ensure that invoice prices and quantities are supported, and can be verified for accuracy and compliance with contract terms. (See Recommendation 4.)

Agency Response: "The UConn Health department that requests and receives goods/services is responsible for reviewing and approving the supplier's invoices prior to authorizing payment. However, as a result of this audit finding, we have implemented a new requirement that the Buyer review the quote submitted with the requesting department's purchase requisition to confirm that the quote references the correct contract discount."

Payment for Compensatory Leave Balances

Background: Payments for compensatory leave balances are only permitted when the relevant bargaining contract clearly provides for such allowance. These contracts often involve essential state employees who provide direct healthcare or work in public safety.

Criteria: The prevailing State of Connecticut policy on managerial compensatory time states, "Compensatory time earned during the twelve months of the calendar year must be used by the end of the succeeding calendar year and cannot be carried forward. In no event will compensatory time be used as the basis for additional compensation and shall not be paid as a lump sum at termination of employment." An agency can grant compensatory time when a manager is required to work a significant number of extra hours in addition to the normal work schedule. The policy disallows the granting of compensatory time if a manager works for an extra hour or two in order to complete normal work assignments.

The Maintenance & Service Unit (NP-2) and Administrative Clerical (NP-3) bargaining unit contracts state that compensatory time shall not be the basis for compensation on termination of employment.

Condition: We reviewed payments for compensatory leave balances during the audited period and found that payouts of compensatory leave balances were not consistent with the state policy and bargaining contracts.

- Active managers and confidential employees received payouts for 1,520 compensatory leave hours, totaling $76,461.

- Upon employment termination, managers and confidential employees received payouts for 1,419 compensatory leave hours, totaling $86,947.

- NP-2 and NP-3 bargaining unit employees received payouts at termination for 3,676 hours of compensatory time, totaling $83,368.

In addition to the payouts of compensatory leave balances, we identified 29 instances in which a manager was allowed to earn compensatory time for working an additional 2 hours or less on a regular workday.

Effect: UConn Health spent more than it should have on unused compensatory time. The practice of paying cash for compensatory leave balances of managerial employees and bargaining employees (Maintenance & Service Unit and Administrative Clerical) contradicted the state's policy and contractual agreements.

Cause: UConn Health has a more generous managerial compensatory time policy than other state agencies. Compensatory leave balances did not expire in accordance with the state prevailing policy. Instead, UConn Health paid additional compensation to employees whose bargaining contracts did not include an agreement for a cash payout.

Recommendation: The University of Connecticut Health Center should require that compensatory time be used within a reasonable time frame and should not include unused compensatory time in lump sum payments to managerial or certain bargaining contract employees. (See Recommendation 5.)

Agency Response: "UConn Health will adopt the practice and guidelines consistent with the University wide practice related to use and payout of compensatory time for managerial employees as well as use of compensatory time by bargaining unit covered employees except where this cannot be accomplished without adversely impacting patient safety and continuity of care. Where staff shortages related to patient safety and continuity of care necessitate compensatory time payout, Management reserves discretion, subject to appropriate guidelines and corresponding documentation, to authorize compensatory time payout or extend the time period by which the compensatory time must be used. Guidelines addressing these limited circumstances will be issued by January 31, 2018. In all other circumstances, UConn Health will follow the University-wide practice and guidelines."

Auditors' Concluding Comment: We reiterate the recommendation that UConn Health follow the statewide policy and not make cash payments for compensatory

leave balances to managerial employees or to employees whose bargaining contracts do not allow such payouts.

Payment for Long Term Disability Insurance

Background: In the prior audit report, we noted that UConn Health provided long-term disability coverage for employees who were members of the State of Connecticut State Employee Retirement System (SERS). We observed that this coverage was excessive because the SERS plan contains provisions for disability retirement.

Criteria: UConn Health should not incur unnecessary expenses for benefits beyond the state's comprehensive fringe benefits package.

Condition: Although UConn Health ceased long-term disability coverage for new managerial employees hired after November 1, 2011, it continued to provide long-term disability coverage for approximately 27 managerial employees hired prior to that date, which cost $10,115 per year.

Our review of state bargaining unit contracts and comparison with other state universities identified that only a very small segment of state university and Board of Regents employees received long-term disability insurance coverage. On the other hand, we found that UConn Health paid for long-term disability insurance of approximately 60% of its workforce, or 3,345 employees, during each fiscal year of the audited period. We observed that approximately 900 of these employees participated in SERS, which includes disability retirement benefits. Total payment for employee long-term disability insurance cost UConn Health $859,882 in the 2015 fiscal year and $831,629 in the 2016 fiscal year.

In the prior audit report, UConn Health responded that long-term disability insurance was part of the terms and conditions of hire for managerial employees. However, the office of Human Resources had not provided us with written contracts supporting UConn Health's agreement to pay for long-term disability coverage for the length of the manager's employment.

Effect: UConn Health provided disability insurance coverage beyond the benefits that the state provides to the majority of state employees.

Cause: UConn Health believes the coverage provided by SERS is inadequate and that long-term disability insurance was part of employment contracts of managerial and confidential employees.

Agreements with 2 bargaining units require long-term disability coverage for approximately 3,069 faculty and health professional members without distinguishing benefits afforded by different retirement plans.

Recommendation: The University of Connecticut Health Center should stop paying for long-term disability insurance for managerial employees. UConn Health should renegotiate bargaining contracts to avoid payments for benefits that are already part of the State Employee Retirement System. (See Recommendation 6.)

Agency Response: "We have discontinued offering this plan to managerial employees in SERS hired after November 1, 2011 and to faculty members in SERS, including those represented by the AAUP bargaining unit, hired after January 1, 2017. We will again attempt to renegotiate with the UHP bargaining unit at the next opportunity. We continue to be concerned about withdrawing a benefit that was part of the terms and conditions of hire for managerial employees hired before November 1, 2011 and creating a coverage gap for these employees."

Inaccurate Property Control Records

Background: UConn Health established a $5,000 threshold for the capitalization and amortization of depreciation expense over the useful life of equipment. Equipment valued at under $5,000 is expensed in the year purchased and is not added to the inventory of capitalized equipment. Equipment items with values under $5,000 that UConn Health believes to be sensitive, portable, and theft-prone are considered controllable property and should be tracked in a manner that facilitates accountability.

UConn Health has a capitalized equipment inventory containing an estimated 16,000 items with approximately 5,200 additional items listed as controllable property.

Criteria: Section 4-36 of the General Statutes provides that an inventory of property shall be kept in the form prescribed by the Comptroller. The Comptroller's State Property Control Manual requires that each agency maintain a written listing of controllable property.

Accurate inventory records are important for financial statement and insurance reporting purposes. They also assist in safeguarding equipment from theft, loss, and destruction. Periodic physical inspection of the condition and location of equipment items is a

standard technique to assist in maintaining an accurate equipment inventory.

Condition: During our tests of UConn Health equipment inventory records, we noted incomplete inventory records.

- Approximately 746 of 15,992 capital equipment items had not been located in more than 2 years. Even though UConn Health fully depreciated most of these items, the lack of complete records prevented UConn Health from timely detection of losses and the identification of the physical whereabouts of capital equipment.

- Approximately 1,116 of 5,217 controllable inventory items had not been located and inspected in more than 2 years. UConn Health acquired most of these items within the last 3 years. They had a total value of approximately $861,886. In addition, we found 198 newly purchased computer items, totaling $138,688, that were not included in the controllable assets listing. We also noted that UConn Health's controllable assets policy continues to be limited to computer items. Current controllable inventory practice does not provide similar accountability for other items with a value of less than $5,000 that are highly susceptible to theft.

Effect: UConn Health's ability to safeguard assets is compromised when inventory records do not reflect periodic inspection and confirmation of location. The potential for undetected loss or theft increases when full inventories do not occur in a timely manner.

Cause: UConn Health hired a consultant and took other corrective action to improve its property control records. However, a lack of responsiveness and effective communication between departments and a lack of consequences for lost assets affected UConn Health's ability to fully complete its inventory reconciliation and update its inventory listing.

Recommendation: The University of Connecticut Health Center should ensure that it appropriately tracks all capitalized and controllable assets. UConn Health should train managers so that they can fully understand the inventory recordkeeping process and are held responsible for missing equipment under their purview. (See Recommendation 7.)

Agency Response: "UConn Health takes asset stewardship very seriously. While assets purchased remain the responsibility of each individual department, each year staff from the Office of Logistics

Management (OLM) inventory all UConn Health facilities with a focus on assets within the two year scope of review. Inventory counts are reconciled against fixed asset listings and the reconciled results are shared with departments for further review and follow up. Unfound assets represent those which have been identified in the reconciliation process for additional tracking efforts, departmental investigation, or disposal. While we strive to locate and inventory every asset we know that this is not always feasible. Our goal is to reduce the number of unfound assets below 3% on an ongoing basis.

Office of Logistics Management has previously added fixed asset training to UConn Health's annual training requirements. OLM also provides training in the Management Development Program. In the current year, the OLM has begun rolling out new automated tools to assist departments with inventory management, transfers, and disposals. These tools include real time asset inventories by location and electronic forms and workflows. We feel these tools, along with continued departmental and administrative vigilance will move us closer towards our goal."

Disposal of Equipment

Criteria: UConn Health's policy requires that the in-charge Associate Vice President or Chief Executive Officer approve of disposal of equipment greater than $10,000.

UConn Health should remove items approved for disposal from its premises and inventory records. When missing items are located in a subsequent inventory, UConn Health should update records to reflect the current inventory status.

Condition: Items approved for disposal remained on the inventory records several years past their disposal dates. Our review disclosed that 46 items disposed of in the 2016 fiscal year, with a total value of $349,493, still showed inventory dates 2 to 536 days after their official disposal dates.

Our review of items disposed in the 2015 fiscal year showed that 316 items, with a total value of $1,391,932, remained on the inventory records 2 to 857 days after their disposal dates.

We reviewed the disposal forms for 6 items greater than $10,000 and found that 4 out of 6, totaling $161,742, were not approved by the Associate Vice President or the Chief Executive Officer. In one

of the disposal forms, the signature did not appear to be that of the former Associate Vice President of Research Finance.

Effect: This weakens internal controls pertaining to disposal and lost or missing equipment.

Cause: Equipment disposal policy was not enforced. When surplus items were recycled and put back in operation, the inventory system was incapable of identifying changes in their disposal status.

Recommendation: The University of Connecticut Health Center should strengthen internal controls over the disposition of equipment. All disposals must be properly authorized. (See Recommendation 8.)

Agency Response: "UConn Health Office of Logistics Management (OLM) has recently launched an Electronic Workflow Management system allowing us to improve the tracking and approval of forms submitted. Under this system, forms are electronically routed using a workflow process that only allows authorized users to promote them to the next level. The forms can also be connected to our live database of assets by location to facilitate quicker, more accurate completion.

The recycled assets noted were repurposed via our Surplus Equipment Program. The Surplus Equipment Program processes disposed equipment from UConn Health departments and makes it available to other departments, other State Agencies, and, where appropriate, public sale. This process allows items which are updated to a disposed status to remain on the premises in use for research, teaching, or other purposes at a lower cost than purchasing new equipment. The recycled equipment was inventoried due to the tags not being removed from equipment entering surplus. Going forward, UConn Health will attempt to remove inventory tags from items in our Surplus program and will update its scanning software to differentiate between items that are active on the inventory listing and items that have been surplused."

Excessive Paid Administrative Leave

Criteria: In accordance with the Professional Health Care Employees (P-1) and Paraprofessional Health Care Employees (NP-6) bargaining unit contracts, employees should not be placed on paid administrative leave for more than 2 months while the appointing authority investigates complaints of wrongdoing and determines disciplinary actions.

Condition: During the audited period, UConn Health placed 77 employees on paid administrative leave for a total of 12,722 hours. Approximately 42% of these hours were for the investigation of 8 employees, which lasted 3 to 5 months. Seven of these employees resigned in good standing after the conclusion of the investigations. The remaining employee returned to a regular pay schedule after the expiration of the paid administrative leave.

Effect: Investigations exceeding the 2-month period caused additional expenses. They also prevented prompt managerial responses and corrective action.

Cause: The nature of these investigations could be more complex. For the safety of its patients and employees, UConn Health could not allow employees to return to work before it completed the investigations.

Recommendation: The University of Connecticut Health Center should make an effort to complete disciplinary investigations in a timely manner. (See Recommendation 9.)

Agency Response: "Effective January 2017, UConn Health Human Resources has addressed this issue. Approval of an employee being placed on administrative leave now requires the employee's Vice President and the UConn Health Vice President of Human Resources joint approval. Additionally, UConn Health Vice President of Human Resources receives a weekly Administrative Leave Report from Employee and Labor Relations. The weekly report is used to monitor the progress of investigations and time that an employee is placed on administrative leave. We believe the above actions will allow the agency to monitor and manage this process in an efficient manner."

Rehire of Retired State Employees

Background: During the period from July 1, 2011 through June 30, 2016, UConn Health employed 167 retired state employees. UConn Health has a policy regarding the reemployment of retirees that is slightly different from Governor Rell's Executive Order 27-A.

Criteria: Governor Malloy's Executive Order No. 47 reaffirms Governor Rell's Executive Order 27-A, which limits the rehire of retirees to no more than two 120-day periods for any individual retiree. The Office of Policy and Management General Notice No. 2006-18 established a Core-CT job code (1373VR) to allow proper tracking of rehired retirees.

The UConn Health policy limits the rehire of retirees to no more than three 120-day calendar years. In addition, UConn Health disallows annual salary increases and the use of state appropriations to fund the reemployment of retirees. Rehired retiree compensation rates should not exceed 75% of the individual's preretirement salary or the established minimum salary, if the retiree works in a different position.

Condition: We reviewed the rehire of 8 retirees who remained active on UConn Health's payroll roster for 5 to 19 years after their retirement dates. The review disclosed that:

- All 8 retirees were employed for more than two 120-day periods. The job code classification in Core-CT was not accurate for 7 retirees.

- All 8 retirees had hourly wages exceeding 75% of their preretirement salary or the minimum salary of a position different than their former job.

- Retirement of 6 employees did not meet the definition of a bona fide separation of employment. A bona fide separation of employment occurs when both the employee and employer reasonably anticipate that the employee will not perform further services after the employee's retirement date. UConn Health rehired 4 of these employees the day after their retirement dates. The remaining 2 employees specified the terms of their reemployment in the letters informing UConn Health of their anticipated retirement.

We reviewed payments to all rehired retirees and noted 2 instances of faculty incentive payments, which generally are for contractual shares of clinical revenues for on-call hours, totaling $30,800 in the 2016 fiscal year.

Effect: UConn Health failed to comply with its policy on reemployment of retirees and Executive Order 27-A. The violation places additional burdens on the state retirement system because it encourages employees to retire early for free health insurance and pension benefits while maintaining a reduced work schedule. The State Comptroller's Office could not properly suspend the employees' retirement benefits, because UConn Health incorrectly coded their reemployment in Core-CT.

Cause: Some of the retirees were managers and professors whose skills and experience were valuable and necessary for UConn Health to

continue its operations during the transition phase to new management. UConn Health did not have adequate controls to enforce its policy on reemployment of these retirees after the transition to new management.

Recommendation: The University of Connecticut Health Center should reevaluate its practice of rehiring retirees and comply with Governor Rell's Executive Order 27-A. (See Recommendation 10.)

Agency Response: "UConn Health agrees that it did not use accurate job code classifications in Core-CT for all of its rehired retirees. UConn Health has properly re-coded these employees in Core-CT, therefore this condition has been fully rectified. UConn Health agrees that the 8 retirees identified worked more than two 120-day periods after their retirement, but states that such practice is permitted by University policy, which governs UConn Health in this area and reflects the University's need to extend these appointments in certain circumstances including to address patient care needs. The applicable University policy also permits these 8 individuals to be paid hourly wages exceeding 75% of their pre-retirement salaries, and UConn Health notes that all 8 such individuals are unclassified employees and seven of the eight were re-employed prior to the date that Executive Order 27-A went into effect. The eighth employee in fact did have her salary reduced to 75% of her pre-retirement wage."

Auditors' Concluding Comment: Governor Rell's Executive Order 27-A does not exempt employees who retired from state service prior to July 1, 2009. In addition to the extraordinary length of employment after their retirement dates, most retirees noted in this audit finding do not hold a healthcare position.

Student Activity Fund

Background: UConn Health imposes a $125 student activity fee on every enrolled student. UConn Health transfers the fee to a student activity fund and bank account for the use of the Medical Dental Student Government (MDSG). MDSG represents the medical and dental students and is responsible for planning extra-curricular activities, as well as allocating and disbursing monies to student organizations for these activities.

Criteria: The State Comptroller's Accounting Procedures Manual for Trustee Accounts, issued in accordance with Section 4-53 of the

General Statutes, establishes procedural requirements for student activity funds.

MDSG should account for income derived from social activities or similar events by using pre-numbered tickets as specified in the State Comptroller's Trustee Account Manual.

Condition: MDSG did not follow the State Comptroller's procedures for cash receipts associated with social events. There was no supporting documentation for MDSG revenue-generating events such as the annual winter formals, or rafting and ski trips. Deposits from these events totaled $81,057 and $55,361 in fiscal years 2015 and 2016, respectively.

Effect: The failure to properly account for receipts increases the risk that cash could go missing without being detected.

Cause: Because MDSG officers are students with 1-year election terms, the lack of continuity in MDSG leadership and the lack of UConn Health administrative assistance with recordkeeping caused the repeat of these audit conditions.

Recommendation: The University of Connecticut Health Center should clearly promulgate the State Comptroller's procedures relating to student activity funds. (See Recommendation 11.)

Agency Response: "UConn Health assists the MDSG with basic operational functions including providing a bank account to this organization. Each year, UConn Health meets with incoming officers and provides guidance on how to utilize UConn Health internal services and the associated requirements of being a part of UConn Health. The communicated requirements include a section on proper record keeping including receipts for any funds raised outside of those transferred from UConn Health.

UConn Health will continue to work with MDSG officers to highlight the importance of proper documentation and recordkeeping for revenue generating functions."

Late Deposits

Criteria: According to Section 4-32 of the General Statutes, agencies should deposit receipts of $500 or more within 24 hours. Total daily receipts of less than $500 may be held until the total receipts to date amount to $500, but not for more than a period of 7 calendar days.

Condition: We noted several instances in which funds were not deposited within 24 hours of receipt.

- In the review of the Graduate Medical Education Residency Program, we found that 21 out of 24 receipts greater than $1 million were deposited 1 to 5 days late. The late deposits totaled $30,629,847.
- In the review of the Medical Dental Student Government account, we found that 7 out of 15 receipts were deposited 1 to 3 days late. The late deposits totaled $113,347.
- In the review of the Creative Child Care account, we found that all 15 receipts were deposited 1 to 4 days late. The late deposits totaled $124,896.

Effect: The untimely deposits violated Section 4-32 of the General Statutes and increased the risk of loss.

Cause: Other departments that received funds at various locations did not forward them to the Bursar's Office in a timely manner. Recent workforce reductions prevented employees at these locations from bringing funds to the Bursar's Office in a timely manner. The Bursar's Office did not use remote deposit, which could eliminate the need to deliver checks to the bank.

Recommendation: The University of Connecticut Health Center should deposit all receipts in a timely manner and fully comply with Section 4-32 of the General Statutes. (See Recommendation 12.)

Agency Response: "UConn Health transacts business across a large number of facilities throughout the State and on its main campus in Farmington. At the same time, UConn Health utilizes only two institutional cashiers, located in different buildings on its Farmington campus. This decentralization, combined with staff responsibilities can make it difficult for departments to bring items to the cashier daily. UConn Health therefore requests, and receives, a waiver from the State Treasurer each year for additional time to make its deposits. UConn Health believes many of the deposits cited fall within the period covered by this waiver.

In regards to the additional late deposits noted, UConn Health will work with the departments noted in an attempt to decrease the lag on deposit times. UConn Health will also prepare and distribute information on timely deposits to the UConn Health community and create targeted training on deposit requirements."

Participation in Group Purchasing Organizations

Background: A group purchasing organization (GPO) is marketed to be an arrangement in which members expect to benefit from vendor discounts created by the collective purchasing power. A GPO ranks its members by tiers of monthly spending in order to provide higher discount percentages to members with larger monthly spending.

Criteria: To maximize savings, sound business practice requires UConn Health to perform regular qualitative and quantitative assessments of the benefits afforded by its participation in a GPO versus buying directly from manufacturers.

Condition: UConn Health purchased 2 pieces of medical equipment with values greater than $50,000 through GPOs without documentation of competitive pricing consideration. We did not find evidence that UConn Health performed periodic quantitative and qualitative assessments to evaluate the benefits from purchasing through GPOs rather than purchasing directly from other medical suppliers.

Effect: Continuous participation in GPOs without sufficient assessment of UConn Health's potential purchasing power and other available offers could result in higher costs.

Cause: Purchasing through GPOs was convenient due to established distribution channels and employees' familiarity with the ordering process. Limited procurement resources may have prevented UConn Health from reviewing other alternatives.

Recommendation: The University of Connecticut Health Center should perform periodic assessments of its purchasing power and available product offers to determine whether it is prudent to continue procuring from group purchasing organizations. (See Recommendation 13.)

Agency Response: "UConn Health's Procurement & Supply Chain Operations Department does periodic checks to confirm that we are receiving both competitive pricing and high quality products through our group purchasing organizations. In addition to outright cost savings, our participation in GPOs saves a significant amount of staff time and effort by enabling us to purchase off of pre-negotiated contracts. Our primary GPOs are utilized for purchases to support UConn Health's clinical operations. Because our clinical needs differ significantly from the needs of most other State of Connecticut agencies, UConn Health often has unique contracting requirements. In the past, the Procurement Department

has satisfied internal business needs through informal documentation of price benchmarking. Although it would not be cost-effective for us to formally document all of our price comparisons, as a result of this audit comment the Procurement Department will retain formal documentation of its comparisons of price and other factors (such as quality) for certain higher value purchases as well as some randomly-selected purchases made against GPO contracts. UConn Health will evaluate the results of this more formalized process to determine future actions."

Inadequate Independent Pricing of Contract Amendments and Segregation of Duties.

Criteria: UConn Health operates in an environment of limited resources and should take steps to avoid paying too much for goods and services.

Additionally, segregation of duties between the initiation, evaluation, and approval of transactions assists in ensuring that transactions are processed in accordance with management's intentions.

Condition: In November of 2013, UConn Health entered into a contractual agreement for the fit out of the UConn Health Outpatient Pavilion (formerly known as the Ambulatory Care Center) that established a guaranteed maximum price of $54,459,356. Upon completion of this project, UConn Health adjusted the contract price 34 times, with more than 200 changes, increasing the final price to more than $59,000,000.

When reviewing the process for additional price adjustments, we found no evidence that UConn Health purchasing professionals independently prepared or reviewed the reasonableness of the costs of construction changes.

Additionally, the UConn Health Campus Planning, Design and Construction Unit initiated the requests for construction changes and evaluated the proposals submitted for the changes. This division was also involved in assessing the reasonableness of the change order pricing and approved the work performed under amendments as acceptable.

Effect: The lack of involvement by purchasing professionals in the preparation and review of independent calculations of the reasonableness of contract amendments increases the risk of overpayments.

The lack of segregation of duties increases the risk that transactions can be processed in a manner inconsistent with UConn Health's intentions.

Cause: UConn Health appears to believe that the review performed by the architect for the project and the external construction manager is adequate to protect its interests.

Recommendation: The University of Connecticut Health Center should establish procedures that require a segregation of duties in the area of construction contract amendments and the pricing of such contract amendments by integrating state-employed purchasing professionals into a process that includes independent calculation and review of increases in construction project costs. (See Recommendation 14.)

Agency Response: "UConn Health does not rely solely on the review performed by the architect and the external construction manager to protect its interests. Rather there are additional critical internal review sources that are part of a comprehensive overall review process. In addition to being reviewed by the outside architect (who has a contractual obligation to review such documents on behalf of UConn and provide their professional opinion) and the Construction Manager, all construction Change Orders are reviewed by the UConn Health Project Manager, the Director of Construction Services, and the Associate VP of Campus Planning, Design & Construction. Each of these management individuals reviewing Change Orders on behalf of UConn Health is a construction professional, a licensed State of Connecticut Architect, with deep knowledge and experience in evaluating construction change proposals. For this project the change proposals were also reviewed by Jacobs Engineering's Senior Project Manager, and Budget Manager, again construction professionals with expertise in review of such matters.

UConn Health procurement professionals are also a critical part of the review process responsible for independently confirming that the total value of the change order(s) submitted by Campus Planning and attached to each HuskyBuy COR matches the amount of the requested increase or decrease to the Purchase Order but they do not possess the construction management expertise necessary to calculate or evaluate construction changes and related costs.

The expertise for construction management resides in the Campus Planning department, thus Campus Planning is responsible for

review and evaluation of construction change proposals. We believe the comprehensive review process we have in place is adequate to protect UConn Health interests."

Auditors' Concluding Comment: Our review of construction change orders did not reveal the level of thoroughness and segregation of duties sufficient to achieve the highest possible savings and lowest risks for UConn Health. We urge UConn Health to consider additional procedures to provide for a segregation of duties and involvement of state-employed purchasing professionals to ensure that change order costs are reasonable.

Potential Conflict of Interest

Criteria: In an effort to protect the financial interests of the state, anyone authorizing payments to contractors and certifying that work is complete, should be free from undue pressure to approve such payments.

Condition: During our testing of expenditures at UConn Health, we noted that in December 2014, UConn Health paid a consulting firm for one of its equity owners to serve as Interim Executive Vice President and Chief Executive Officer of UConn Health. UConn Health increased the consulting company's contract to $562,500 to pay for this arrangement.

Upon review of documents authorizing payments to the consulting company, we concluded that 1 of the 2 UConn Health employees authorizing the payments had his annual employee performance evaluation prepared by the Interim Executive Vice President for Health Affairs while he still worked for the consulting company. The Interim Executive Vice President for Health Affairs also approved salary increases for both of the UConn Health employees who authorized payments to the consulting company where he still worked.

Effect: Having a person who also works for a consultant prepare and approve an annual performance evaluation and salary increases of UConn Health employees who authorized payments to that consultant created a risk that the UConn Health employees may have felt compelled to authorize those payments.

Cause: UConn Health did not adequately consider the potential conflict of interest when allowing a consultant to approve 1 of the 2 UConn

Health employees' performance evaluations and both employees' salary increases.

Recommendation: The University of Connecticut Health Center should not allow a consultant to prepare performance evaluations and approve salary increases of the employees who authorize payments to the consultant. (See Recommendation 15.)

Agency Response: "UConn Health agrees with the recommendation of the Audit; however, would note several mitigating factors specific to the situation documented in this finding: a) The amounts approved for payment to the consulting company were agreed upon in advance of performance detailed in the contract amendment; b) The amounts paid were for the continuation of services that were already being provided by the consultant under contract – both the Finance Corporation Board and the Board of Directors approved the contract amendment to extend the engagement, having an opportunity to previously evaluate the services provided by the consultant; c) The performance review completed during that time by the Interim Executive Vice President for Health Affairs was at the tail of the engagement when discussions were already underway to retain him as a full-time UConn Health employee; and d) The raises approved by the consultant were within the range of raises for all eligible managerial employees at that time."

RECOMMENDATIONS

In the prior audit report, we presented 12 recommendations pertaining to University of Connecticut Health Center's operations. Six of the prior recommendations have been implemented, and the remaining 6 recommendations are being repeated in modified form. As a result of our current examination, we have included 15 recommendations.

Status of Prior Audit Recommendations:

- **The University of Connecticut Health Center should establish clear criteria upon which proposals for major construction contracts will be evaluated and integrate such criteria within the RFP prior to soliciting those proposals. Additionally, a selection committee should be established to evaluate and score the criteria.** This recommendation has been implemented.

- **The University of Connecticut Health Center should maintain custody of bids and proposals until they are opened publically.** This recommendation has been implemented.

- **The University of Connecticut Health Center should solicit competition among qualified parties prior to entering into significant contractual obligations.** This recommendation has been implemented.

- **The University of Connecticut Health Center should ensure that contracts for goods and services allow for verifiable pricing and that end users review such pricing to be in accordance with the applicable contract before approving invoices.** This recommendation is being restated and repeated. (See Recommendation 4)

- **The University of Connecticut Health Center should require managerial compensatory time be used within a reasonable time frame and should not include unused compensatory time in lump sum payments to managerial employees upon termination.** This recommendation is being restated and repeated. (See Recommendation 5)

- **The University of Connecticut Health Center should eliminate SERS managerial employees from their employer-provided long-term disability plan.** This recommendation is being modified and repeated. (See Recommendation 6.)

- **The University of Connecticut Health Center should ensure that all capitalized and controllable assets are appropriately tracked and should perform a physical inspection and confirmation of their location in a timely manner.** This recommendation is being repeated. (See Recommendation 7.)

- **The University of Connecticut Health Center should strengthen internal controls for equipment disposals and missing items. All disposals must be properly authorized and missing items must be investigated and reported to the Office of the State**

Comptroller and Auditors of Public Accounts on Form CO-853. UConn Health has taken action to submit Form CO-853; however, the current review found other deficiencies related to the disposals of equipment. This recommendation is being modified and repeated. (See Recommendation 8)

- **The University of Connecticut Health Center should establish an employee moving expense reimbursement policy that includes limits similar to the one established by UConn-Storrs.** We did not identify the conditions upon which this recommendation was based in the current audit. This recommendation is not being repeated.

- **The University of Connecticut Health Center should only make lump sum payments to employees in lieu of notification in instances in which the separating manager has no skill set that can benefit the institution.** We did not identify the conditions upon which this recommendation was based in the current audit. This recommendation is not being repeated.

- **The University of Connecticut Health Center should develop control procedures and minimum documentation standards to assist in ensuring the propriety of managerial salaries.** This recommendation has been implemented.

- **The University of Connecticut Health Center should improve communication on available cash balances among responsible parties and clearly promulgate the State Comptroller's procedures relating to student activity funds.** This recommendation is modified and being repeated. (See Recommendation 11)

Current Audit Recommendations:

1. **The University of Connecticut Health Center should enforce its requirements for proposal evaluators to certify and adequately comment on contract proposal scores. UConn Health should rebid contracts when their value has become significantly higher than the initial contract budget.**

   Comment:

   We found numerous instances in which the evaluation of contract proposals did not contain evaluator names, signatures, or adequate explanations to support proposal scores and contract award decisions. We also found an instance in which a contract budget was significantly lower than the contract award value.

2. **The University of Connecticut Health Center should improve the management of purchase orders so that they can reflect the correct contract terms and assist with the timely payment of invoices. UConn Health should record late payment penalties in a separate account to allow proper monitoring.**

Comment:

We noted instances in which UConn Health revised purchase orders multiple times because there were insufficient funds to pay the outstanding invoices. UConn Health did not record late payment penalties in a separate administrative account.

3. The University of Connecticut Health Center should improve coordination among various departments to take advantage of prompt payment discounts. UConn Health should hold vendors to their payment and discounts terms.

Comment:

UConn Health could not take advantage of many prompt payment discounts. UConn Health did not hold a vendor to its original offer of payment terms.

4. The University of Connecticut Health Center should ensure that invoice prices and quantities are supported, and can be verified for accuracy and compliance with contract terms.

Comment:

We noted instances in which we could not trace invoices to published price lists, discount percentages, or contracted employees' timecards. On other occasions, the invoice approvers used different contracts than those referenced in the purchase orders.

5. The University of Connecticut Health Center should require that compensatory time be used within a reasonable time frame and should not include unused compensatory time in lump sum payments to managerial or certain bargaining contract employees.

Comment:

UConn Health continued to pay cash for compensatory leave balances of managerial employees and other bargaining contract employees whose bargaining contracts did not authorize the payments.

6. The University of Connecticut Health Center should stop paying for long-term disability insurance for managerial employees. UConn Health should renegotiate bargaining contracts to avoid payments for benefits that are already part of the State Employees Retirement System.

Comment:

UConn Health continues to provide long-term disability coverage for approximately 27 managerial employees hired prior to November 1, 2011, and for union employees whose disability retirement benefits were included in the State Employee Retirement System.

7. **The University of Connecticut Health Center should ensure that it appropriately tracks all capitalized and controllable assets. UConn Health should train managers so that they can fully understand the inventory recordkeeping process and are held responsible for missing equipment under their purview.**

   Comment:

   We found incomplete recordkeeping of capital and controllable inventory. In addition, UConn Health policy does not include controllable items highly susceptible to theft other than computers and firearms.

8. **The University of Connecticut Health Center should strengthen internal controls over the disposition of equipment. All disposals must be properly authorized.**

   Comment:

   Approximately 60% of tested disposed items either did not have disposal forms or the disposal forms did not include the appropriate approval signatures. Items with a service status of discarded or obsolete remained on campus and continued to appear on the inventory records for up to 857 days after the disposal dates.

9. **The University of Connecticut Health Center should make an effort to complete disciplinary investigations in a timely manner.**

   Comment:

   Eight employees' paid administrative leave lasted 3 to 5 months during disciplinary investigations.

10. **The University of Connecticut Health Center should reevaluate its practice of rehiring retirees and comply with Governor Rell's Executive Order 27-A.**

    Comment:

    Eight retirees continued their employment in excess of limits established by UConn Health policy and Executive Order 27-A.

11. **The University of Connecticut Health Center should clearly promulgate the State Comptroller's procedures relating to student activity funds.**

    Comment:

    The Medical Dental Student Government (MDSG) was not following the State Comptroller's procedures for cash receipts associated with social events.

12. The University of Connecticut Health Center should deposit all receipts in a timely manner and fully comply with Section 4-32 of the General Statutes.

Comment:

We found several instances of late deposits.

13. The University of Connecticut Health Center should perform periodic assessments of its purchasing power and available product offers to determine whether it is prudent to continue procuring from group purchasing organizations.

Comment:

There were no periodic analytical procedures to prove that group purchasing organizations (GPOs) offered savings greater than direct purchases from medical suppliers. In its three-year agreement with a GPO distributor, there was no indication that UConn Health factored its plan for growth in its negotiation for a lower mark-up rate.

14. The University of Connecticut Health Center should establish procedures that require a segregation of duties in the area of construction contract amendments and the pricing of such contract amendments by integrating state-employed purchasing professionals into a process that includes independent calculation and review of increases in construction project costs.

Comment:

UConn Health purchasing professionals were not included in the review of change order costs on construction projects to ensure their reasonableness.

15. The University of Connecticut Health Center should not allow a consultant to prepare performance evaluations and approve salary increases of the employees who authorize payments to the consultant.

Comment:

UConn Health did not adequately consider a potential conflict of interest when allowing a person who worked for a consulting company to evaluate and approve salary increases of employees who authorized payments to the consulting company.

ACKNOWLEDGEMENT

The Auditors of Public Accounts would like to recognize the auditors who contributed to this report:

Frederick Armour
Tyler J. Flanagan
Thu Ann Phung
Samantha S. Smith
Linnette Stark

CONCLUSION

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

Thu Ann Phung
Principal Auditor

Approved:

John C. Geragosian
State Auditor

Robert J. Kane
State Auditor

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University of Connecticut
&
UConn Health

Joint Audit & Compliance Committee Meeting

TAB 3

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University of Connecticut & University of Connecticut Health Center

Joint Audit & Compliance Committee Meeting

SIGNIFICANT COMPLIANCE ACTIVITIES

OACE Reorganization Update

The Office of University Compliance has proposed a new compliance committee structure for the University community, focusing on the coordination of compliance activities across the University and UConn Health.

The new decentralized compliance unit for UConn Health has been named the Office of Healthcare and Regulatory Compliance. The structure for the new office includes focus on Clinical, Financial and Regulatory Compliance as well as Training and Education.

The Office of Privacy Protection & Management (OPPM) has begun to introduce itself and to collaborate with administrators, faculty, staff and partners across the University and UConn Health. Plans are underway to institute a new, comprehensive, university-wide privacy program with a more proactive approach towards a culture of information privacy compliance.

Training and Educational Initiatives

Overall completion percentage by UConn Health employees of the 2017 Annual Compliance Training is 99.4%. Storrs and Regional Campus Annual Compliance Training closed May 15th. Current completion percentage is 99.99%. Future trainings will be coordinated between the different compliance units, both central and decentralized, to ensure appropriate education specific to the job responsibilities of employees at all campuses.

New University Compliance Website

Launched on March 11th, compliance.uconn.edu features educational resources like animated training videos, podcasts, and a new matrix of Key Compliance Contacts. The following chart summarizes website activity of our top resources during period of March 12th - May 17th of this year.

Overall Page Views	Top Viewed Resources		
6,316	**1,064** Compliance Training	**507** Compliance Clips	**415** Key Compliance Contacts (Matrix)

Privacy Initiatives

New Privacy Website: The OPPM has also created a centralized website, http://privacy.uconn.edu to house privacy resources for the entire University community. The OPPM website is structured to allow visitors to access tools and guidance based upon their relationship with the University.

University of Connecticut & University of Connecticut Health Center

Joint Audit & Compliance Committee Meeting

SIGNIFICANT COMPLIANCE ACTIVITIES

New FERPA Prior Written Consent tools: Two new processes went live on May 15th that allow students and certain University offices to share student information more seamlessly with individuals of the student's choosing. Parents, students and University-staff alike have been requesting this functionality for quite some time. This project includes migration of the University's FERPA online resource tools under OPPM. For more information on these new tools visit http://ferpa.uconn.edu/sharemyinformation.

University of Connecticut
&
UConn Health

Joint Audit & Compliance Committee Meeting

TAB 4

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UConn & UConn Health

Joint Audit & Compliance Committee Meeting

Status of Assignments

Audit Project	UConn (UC) or UConn Health (UH)	Planning	Fieldwork	Pre-draft/ Draft Reporting	Final Draft/ Final Report Issued
Mandatory Training Compliance	UH				X
Faculty Consulting FY17	UC/UH				X
Office of the Fire Marshal & Building Inspector	UC/UH				X
UConn HealthONE Implementation – Testing Phase	UH				X
EPIC Contract – Report 2	UH				X
Hartford Campus Relocation – Report 3	UC				X
Deaf or Hard of Hearing Services – VRA 4th Report	UH				X
Radiation Oncology Therapy	UH		X		
Energy Services Performance Contract Project – Phase 1 Report 2	UC		X		
Dental Charge Capture and Billing	UH		X		
Financial Aid	UH		X		
Federal Grant Expenditures	UC		X		
Deaf or Hard of Hearing Services – VRA 5th Report	UH		X		
Software Licensing *	UC		X		
Building Access Controls*	UC		X		
Purchasing Card	UC		X		
Non-Purchase Order Business Disbursement	UC		X		
EPIC Contract – Report 3	UH		X		
UConn HealthONE Implementation – Post Go-Live Phase	UH		X		
Selected Contract – Gilbane	UC	X			
Center for Student Disabilities	UC	X			
ADA	UH	X			
International Student Revenue Sharing Model	UC	X			
Non UConn 2000 Construction Expenditures FY2018 AUP	UC/UH	X			
Workers Compensation	UH	X			
TOTAL AUDITS (25)		**(06)**	**(12)**	**(0)**	**7**

Special Projects/Consulting	UConn (UC) or UConn Health (UH)	Planning	Field Work	Review Pre-draft	Project Final
Athletics Travel	UC				X
Vendor Payments	UC				X
OR/Pharmacy	UH			X	
Study Abroad Israel	UC				X
School of Business Travel	UC				X
School of Business Compensatory Time					X
Dental Billing	UH		X		
Pharmacy Vault Controls	UH		X		
TOTAL SPECIAL PROJECTS/CONSULTING (08)		**(00)**	**(02)**	**(01)**	**(05)**

*on hold

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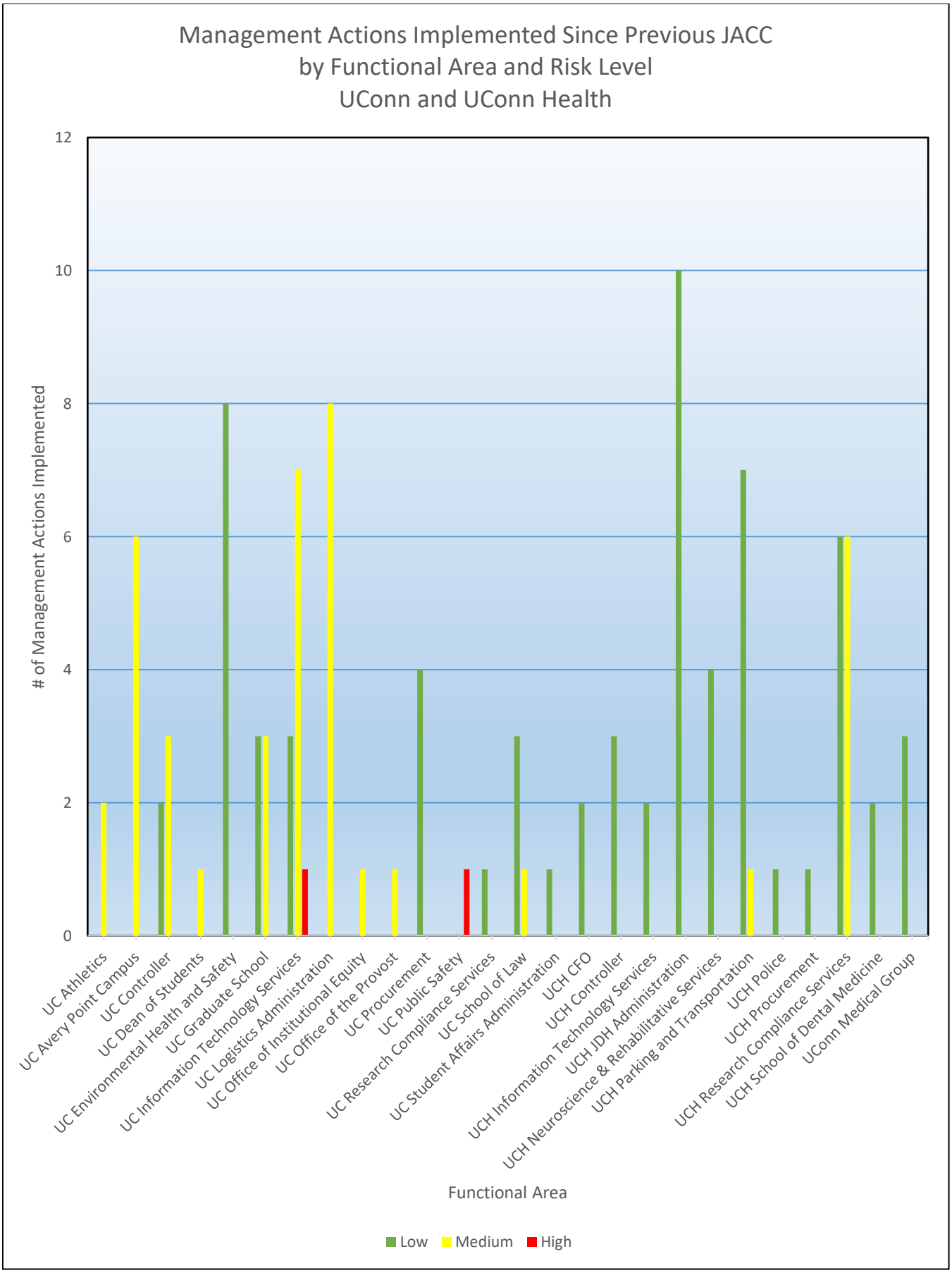
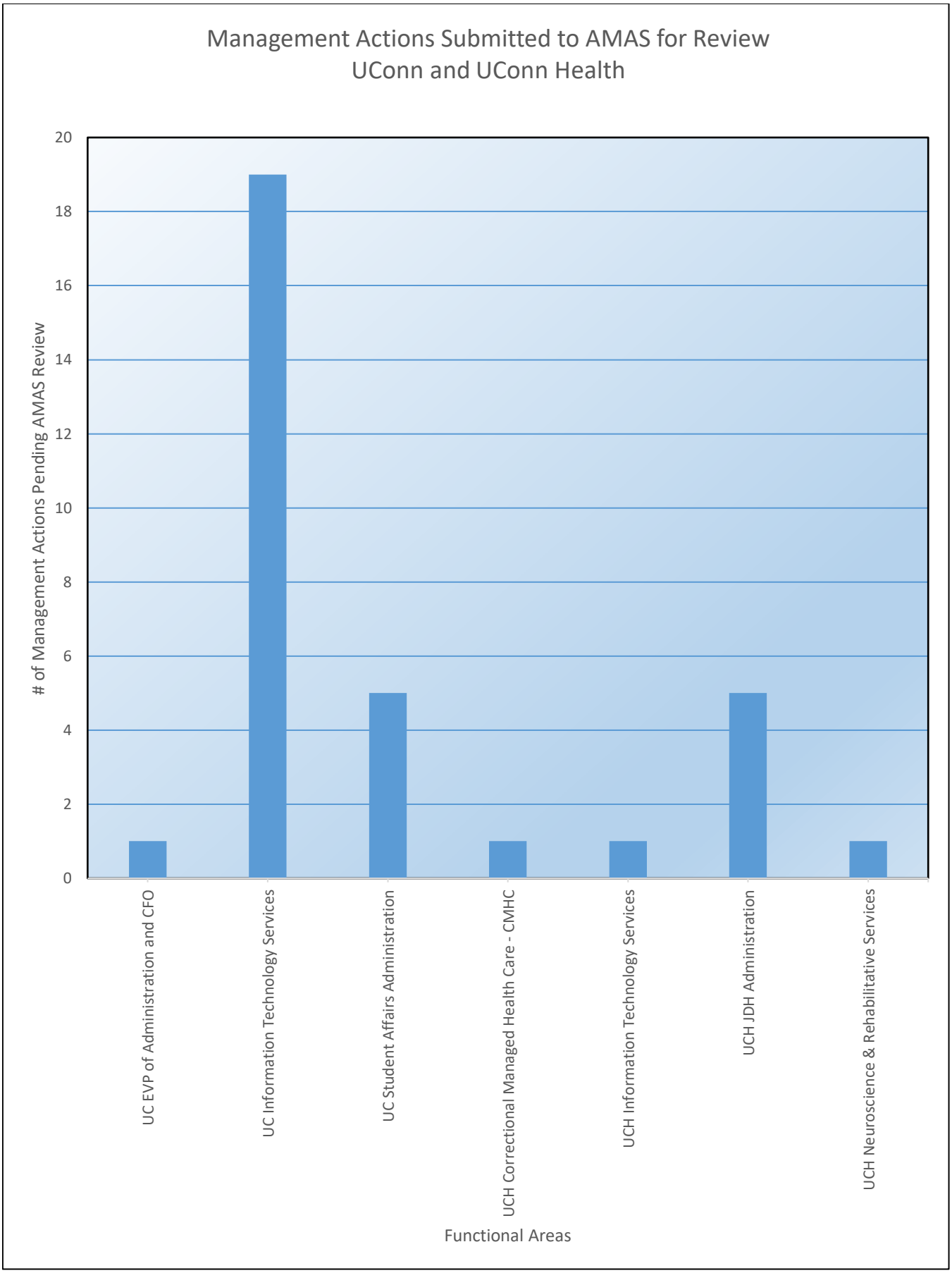
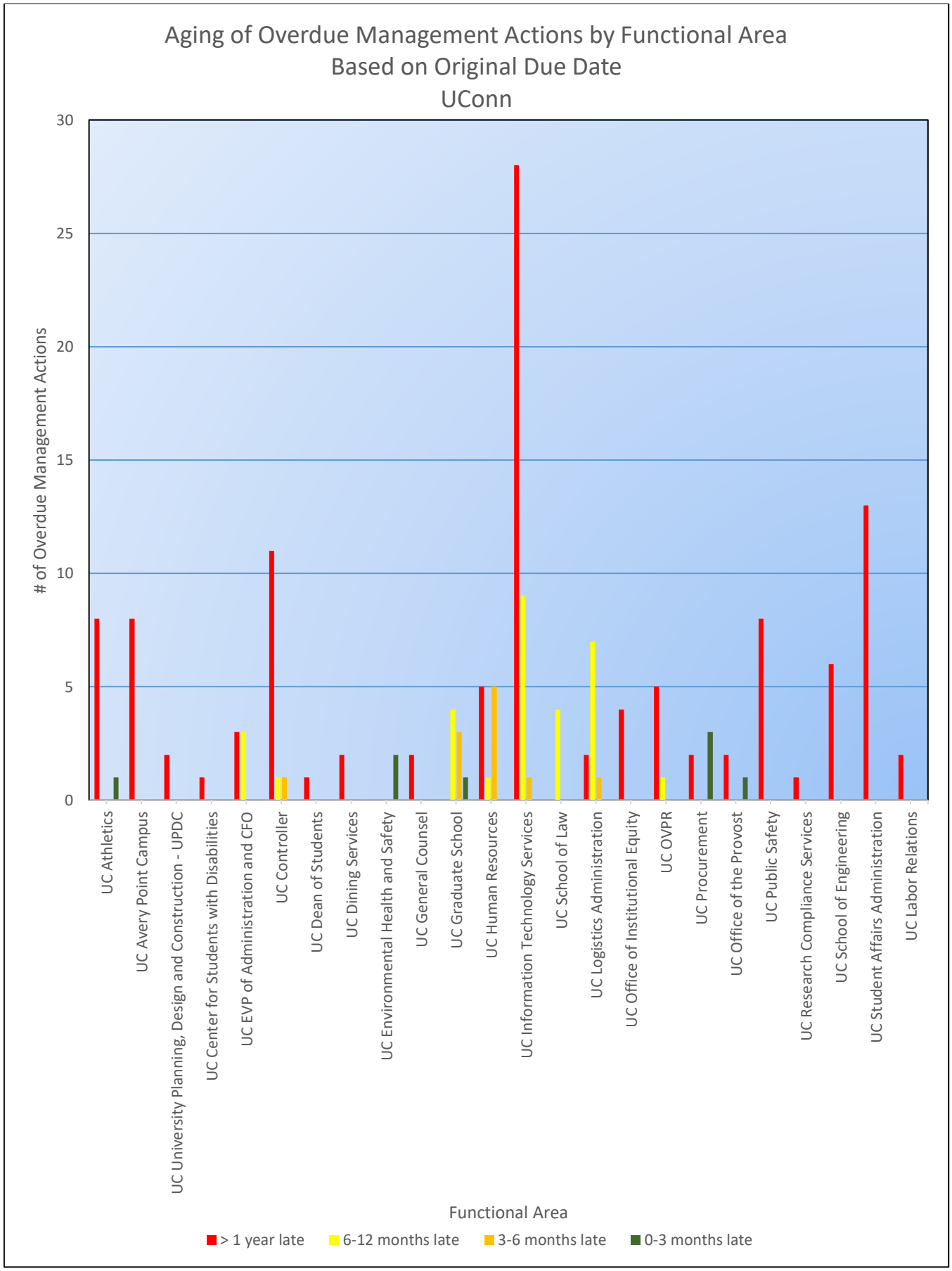
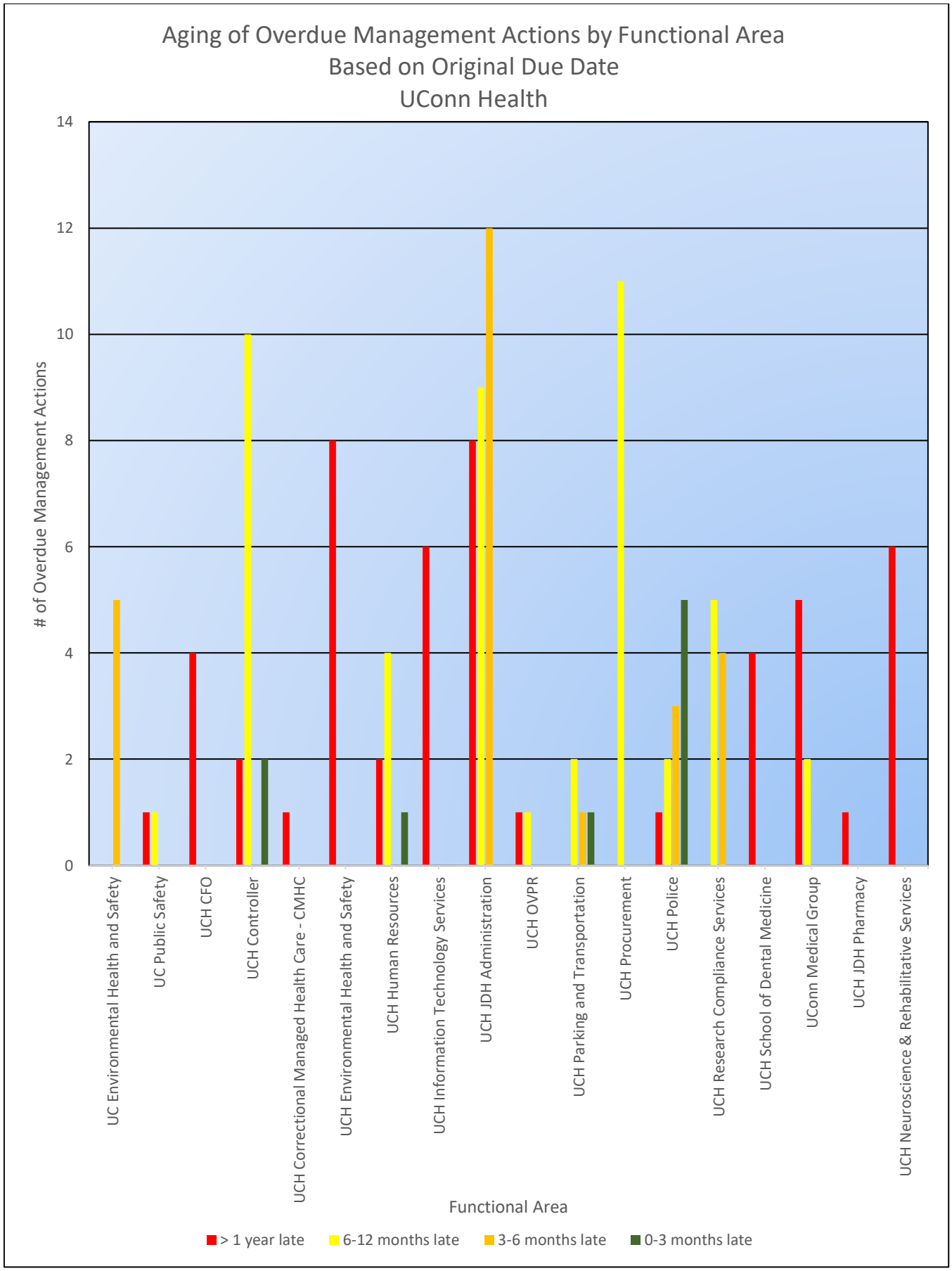
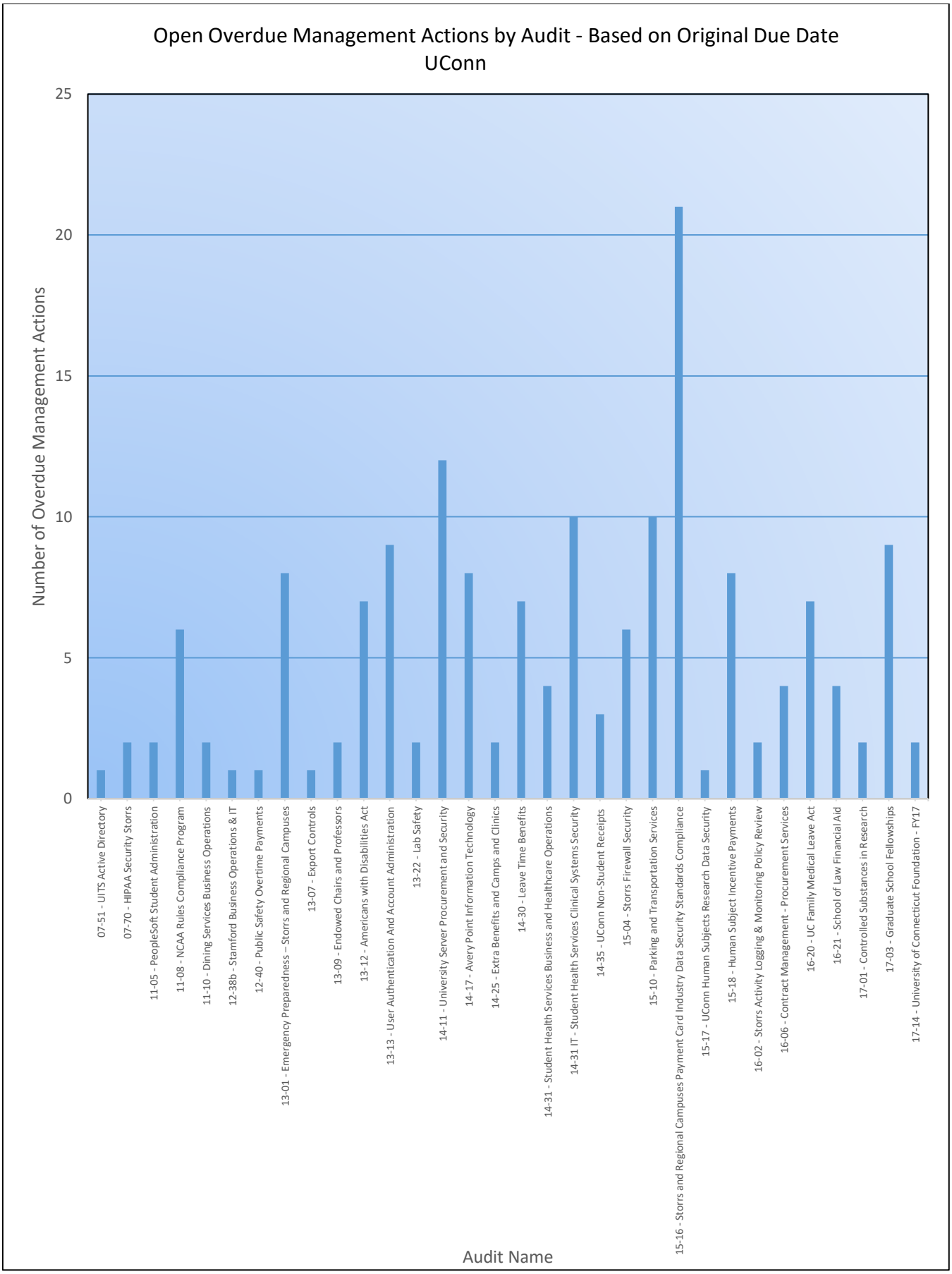
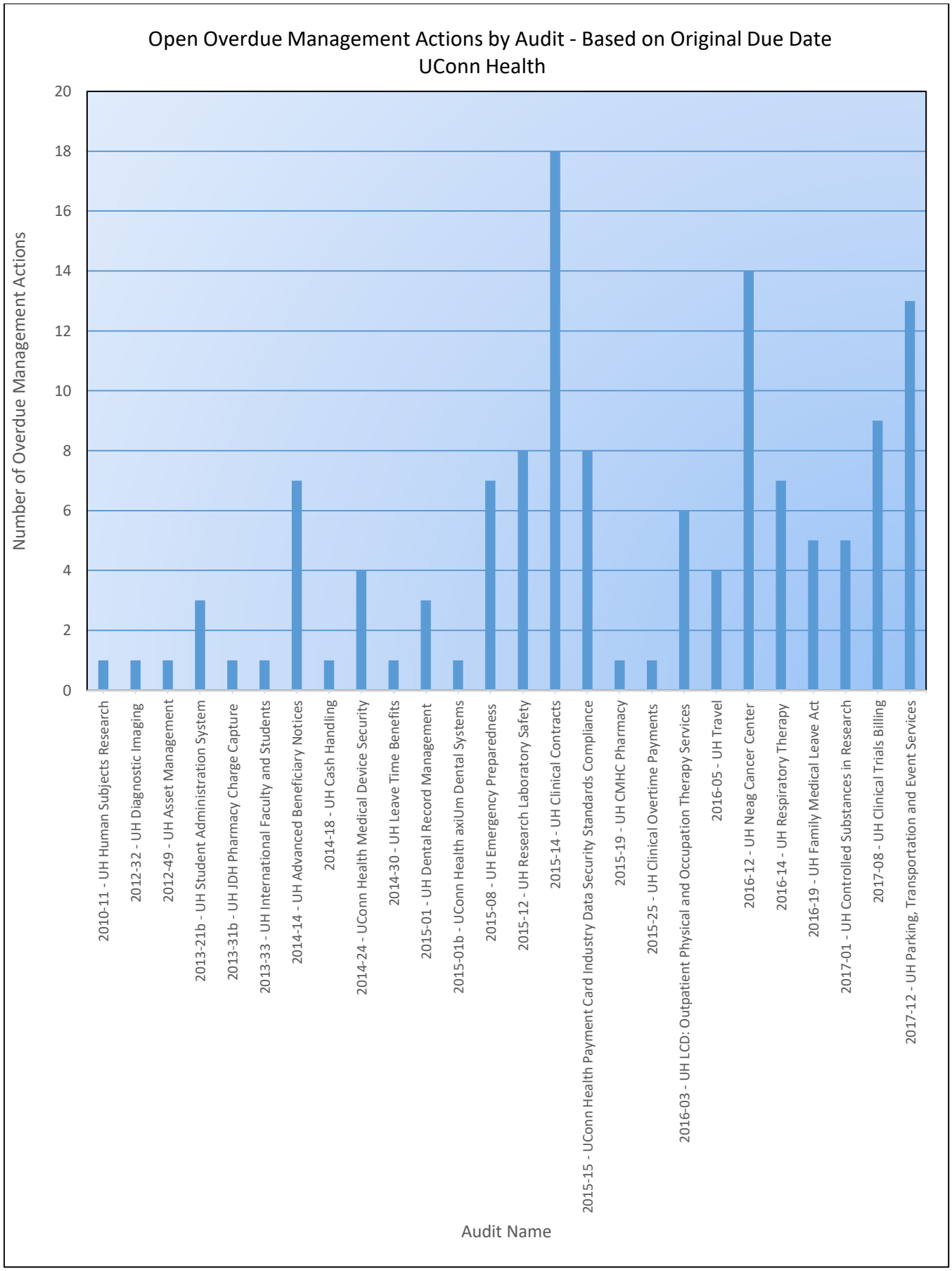

Management Actions Implemented Since Previous JACC
by Functional Area and Risk Level
UConn and UConn Health
# of Management Actions Implemented
0
2
4
6
8
10
12
UC Athletics
UC Avery Point Campus
UC Controller
UC Dean of Students
UC Environmental Health and Safety
UC Graduate School
UC Information Technology Services
UC Logistics Administration
UC Office of Institutional Equity
UC Office of the Provost
UC Procurement
UC Public Safety
UC Research Compliance Services
UC School of Law
UC Student Affairs Administration
UCH CFO
UCH Controller
UCH Information Technology Services
UCH JDH Administration
UCH Neuroscience & Rehabilitative Services
UCH Parking and Transportation
UCH Police
UCH Procurement
UCH Research Compliance Services
UCH School of Dental Medicine
UConn Medical Group
Functional Area
Low
Medium
High

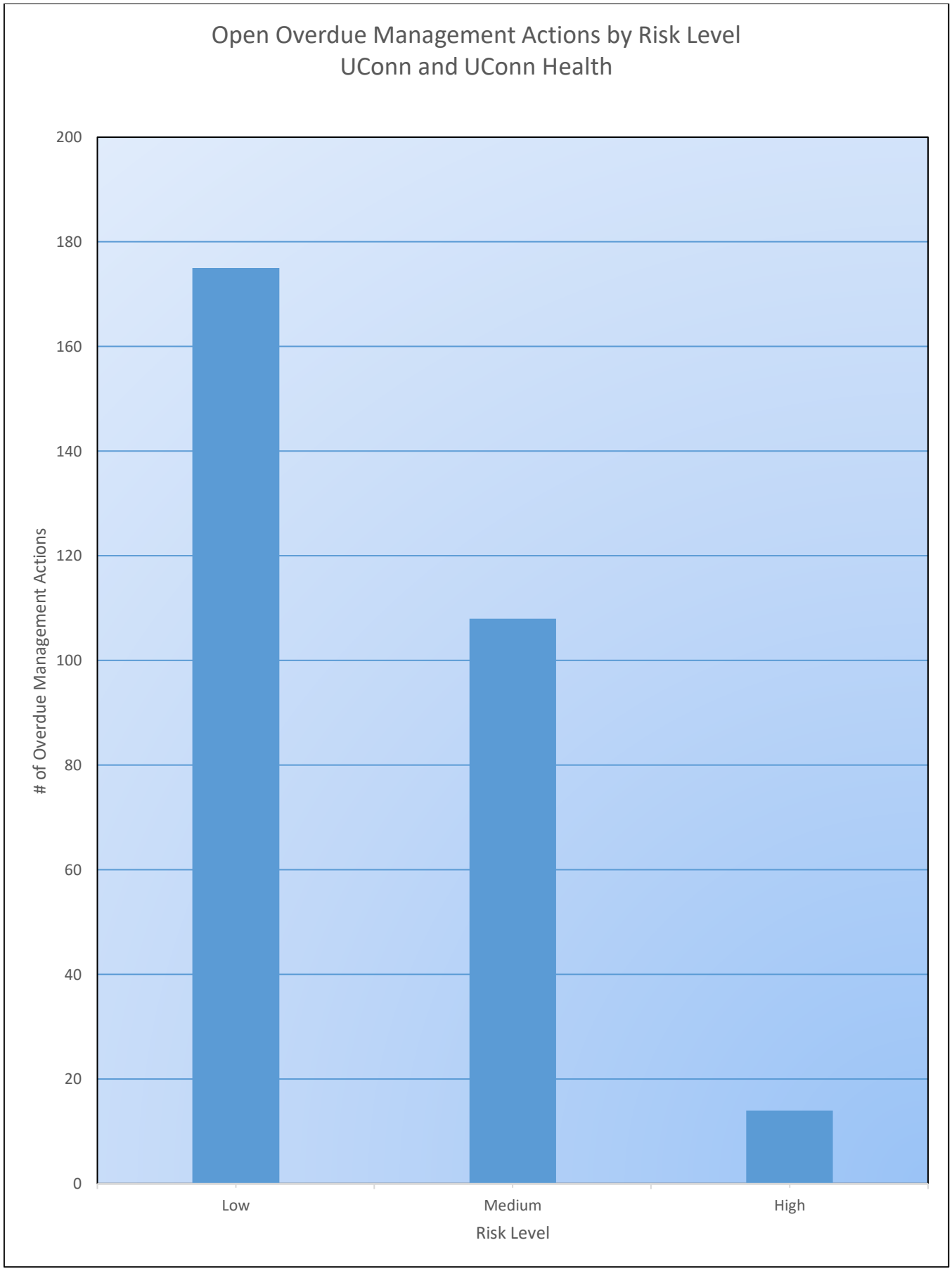

Management Actions Submitted to AMAS for Review
UConn and UConn Health
# of Management Actions Pending AMAS Review
0
2
4
6
8
10
12
14
16
18
20
UC EVP of Administration and CFO
UC Information Technology Services
UC Student Affairs Administration
UCH Correctional Managed Health Care - CMHC
UCH Information Technology Services
UCH JDH Administration
UCH Neuroscience & Rehabilitative Services
Functional Areas

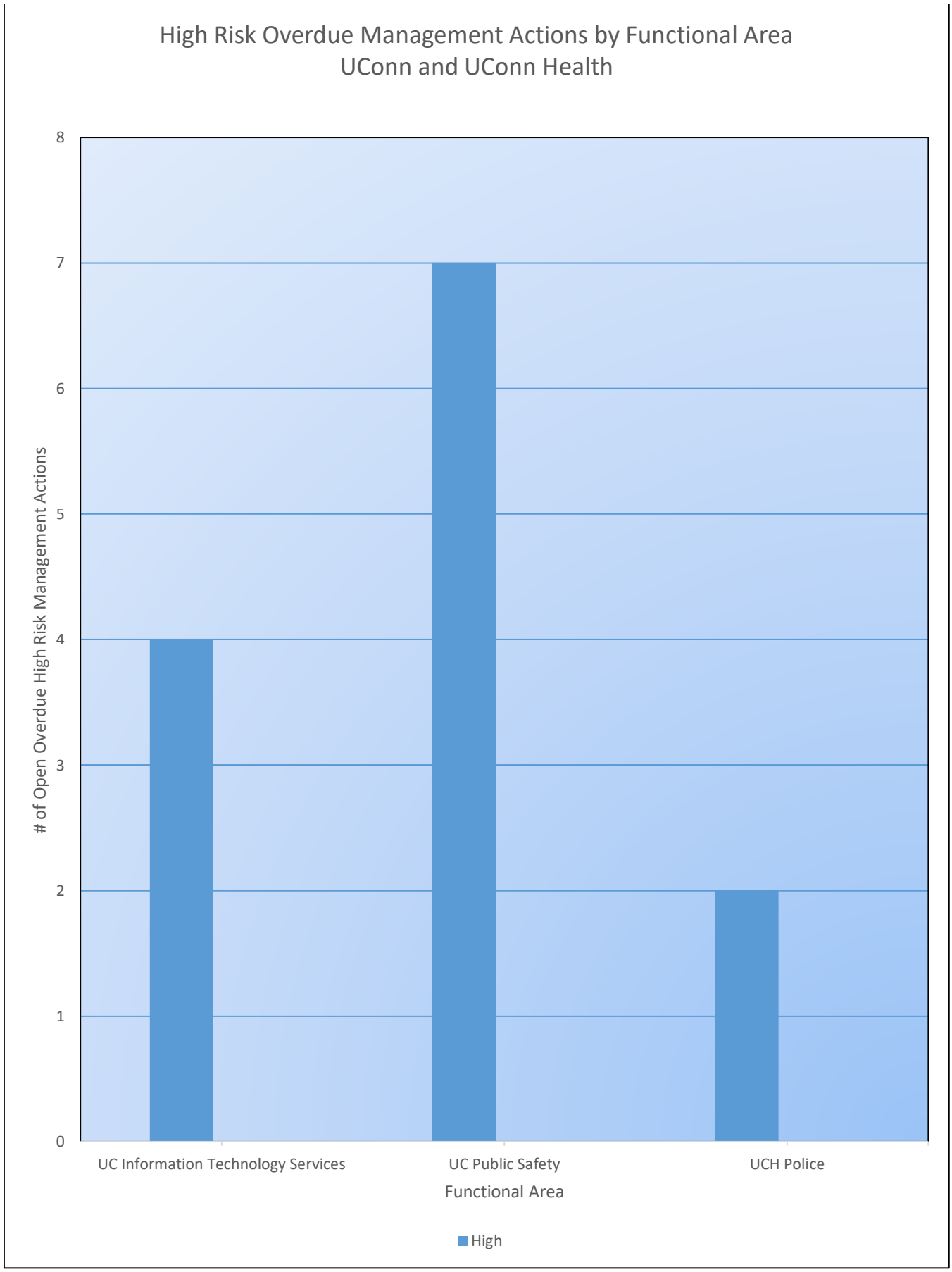

Aging of Overdue Management Actions by Functional Area
Based on Original Due Date
UConn
# of Overdue Management Actions
30
25
20
15
10
5
0
UC Athletics
UC Avery Point Campus
UC University Planning, Design and Construction - UPDC
UC Center for Students with Disabilities
UC EVP of Administration and CFO
UC Controller
UC Dean of Students
UC Dining Services
UC Environmental Health and Safety
UC General Counsel
UC Graduate School
UC Human Resources
UC Information Technology Services
UC School of Law
UC Logistics Administration
UC Office of Institutional Equity
UC OVPR
UC Procurement
UC Office of the Provost
UC Public Safety
UC Research Compliance Services
UC School of Engineering
UC Student Affairs Administration
UC Labor Relations
Functional Area
> 1 year late
6-12 months late
3-6 months late
0-3 months late

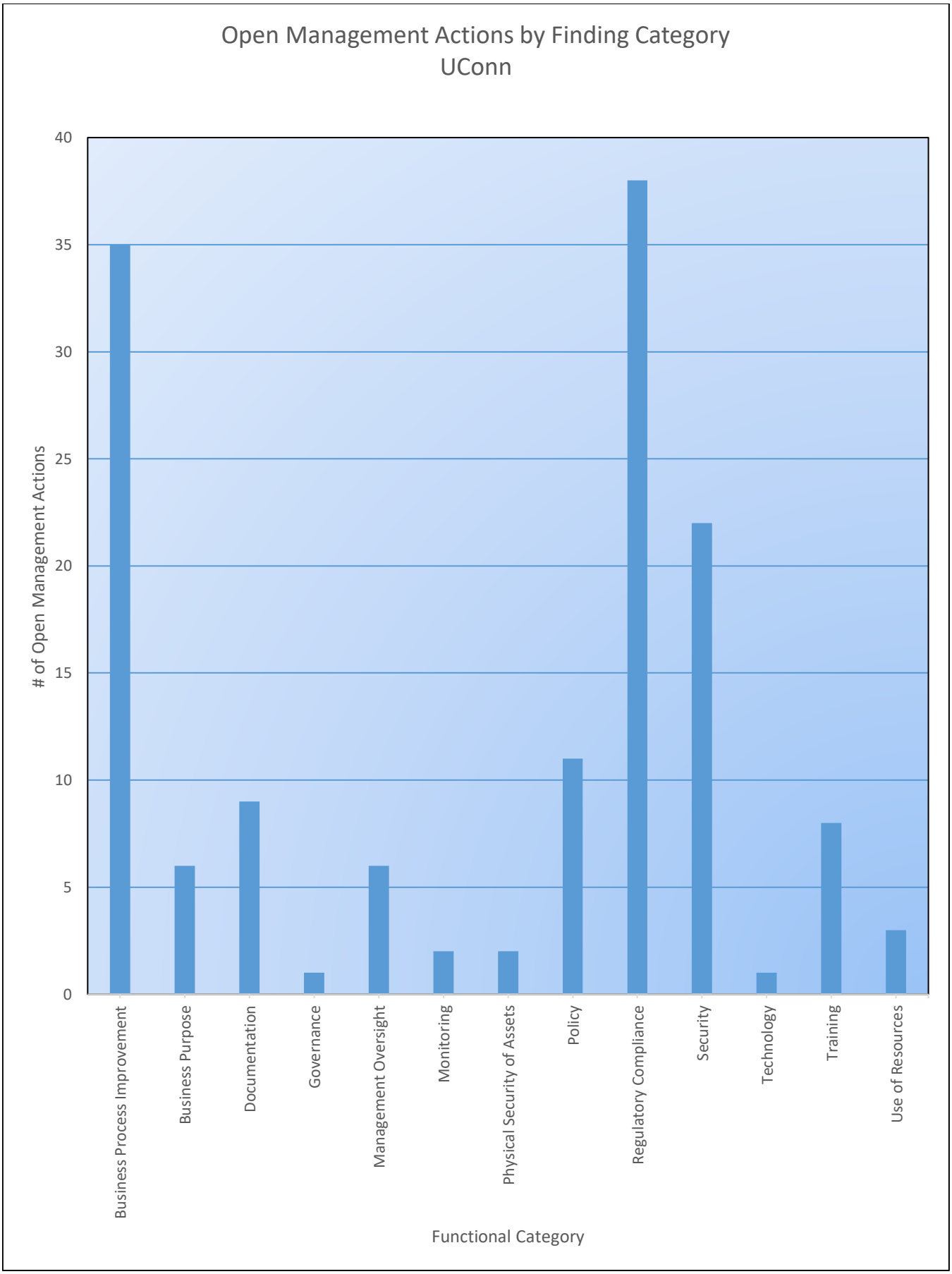

Aging of Overdue Management Actions by Functional Area
Based on Original Due Date
UConn Health
# of Overdue Management Actions
0
2
4
6
8
10
12
14
UC Environmental Health and Safety
UC Public Safety
UCH CFO
UCH Controller
UCH Correctional Managed Health Care - CMHC
UCH Environmental Health and Safety
UCH Human Resources
UCH Information Technology Services
UCH JDH Administration
UCH OVPR
UCH Parking and Transportation
UCH Procurement
UCH Police
UCH Research Compliance Services
UCH School of Dental Medicine
UConn Medical Group
UCH JDH Pharmacy
UCH Neuroscience & Rehabilitative Services
Functional Area
> 1 year late
6-12 months late
3-6 months late
0-3 months late

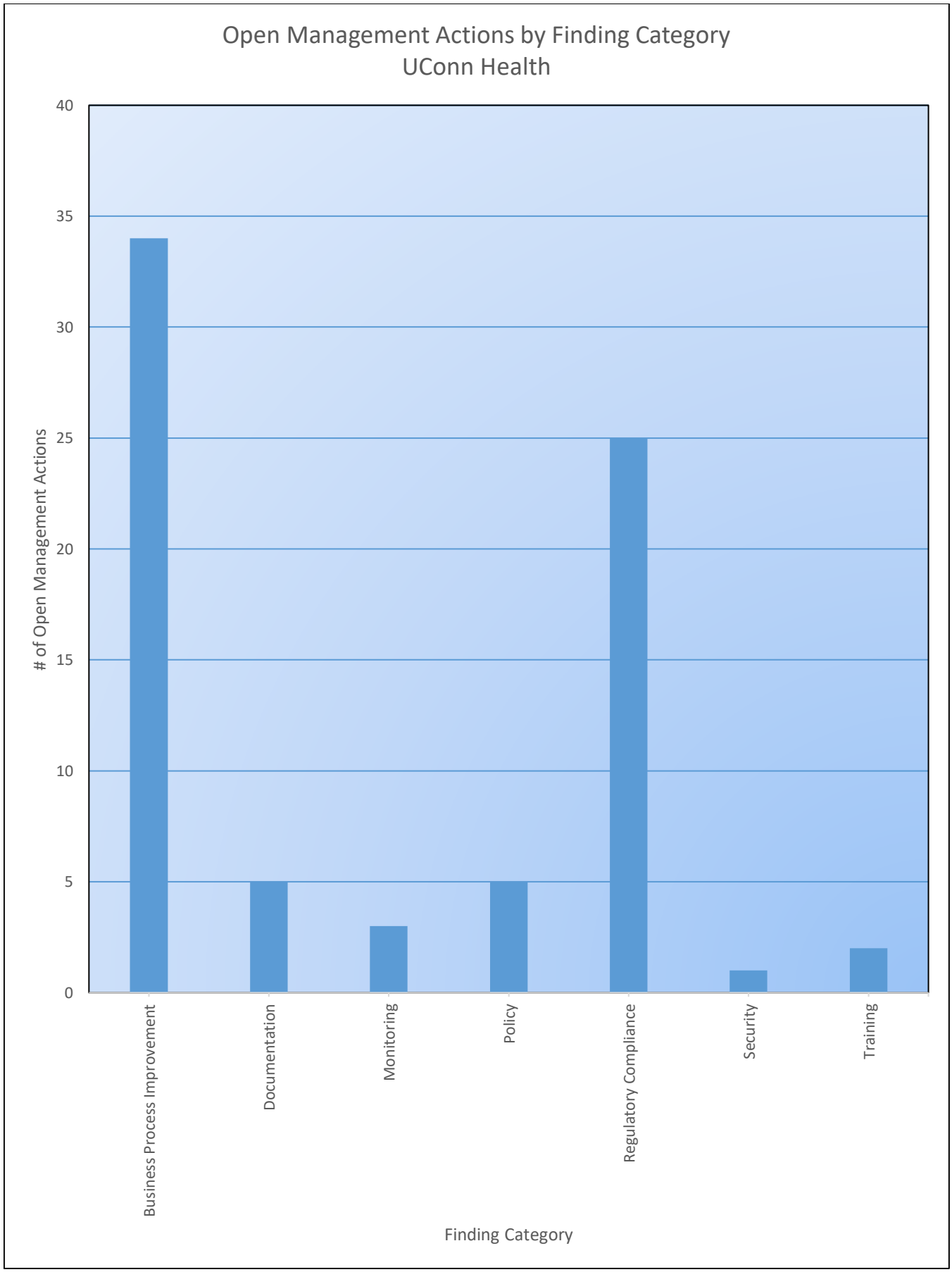

Open Overdue Management Actions by Audit - Based on Original Due Date
UConn
Number of Overdue Management Actions
0
5
10
15
20
25
07-51 - UITS Active Directory
07-70 - HIPAA Security Storrs
11-05 - PeopleSoft Student Administration
11-08 - NCAA Rules Compliance Program
11-10 - Dining Services Business Operations
12-38b - Stamford Business Operations & IT
12-40 - Public Safety Overtime Payments
13-01 - Emergency Preparedness – Storrs and Regional Campuses
13-07 - Export Controls
13-09 - Endowed Chairs and Professors
13-12 - Americans with Disabilities Act
13-13 - User Authentication And Account Administration
13-22 - Lab Safety
14-11 - University Server Procurement and Security
14-17 - Avery Point Information Technology
14-25 - Extra Benefits and Camps and Clinics
14-30 - Leave Time Benefits
14-31 - Student Health Services Business and Healthcare Operations
14-31 IT - Student Health Services Clinical Systems Security
14-35 - UConn Non-Student Receipts
15-04 - Storrs Firewall Security
15-10 - Parking and Transportation Services
15-16 - Storrs and Regional Campuses Payment Card Industry Data Security Standards Compliance
15-17 - UConn Human Subjects Research Data Security
15-18 - Human Subject Incentive Payments
16-02 - Storrs Activity Logging & Monitoring Policy Review
16-06 - Contract Management - Procurement Services
16-20 - UC Family Medical Leave Act
16-21 - School of Law Financial Aid
17-01 - Controlled Substances in Research
17-03 - Graduate School Fellowships
17-14 - University of Connecticut Foundation - FY17
Audit Name


Open Overdue Management Actions by Audit - Based on Original Due Date
UConn Health
Number of Overdue Management Actions
0
2
4
6
8
10
12
14
16
18
20
2010-11 - UH Human Subjects Research
2012-32 - UH Diagnostic Imaging
2012-49 - UH Asset Management
2013-21b - UH Student Administration System
2013-31b - UH JDH Pharmacy Charge Capture
2013-33 - UH International Faculty and Students
2014-14 - UH Advanced Beneficiary Notices
2014-18 - UH Cash Handling
2014-24 - UConn Health Medical Device Security
2014-30 - UH Leave Time Benefits
2015-01 - UH Dental Record Management
2015-01b - UConn Health axiUm Dental Systems
2015-08 - UH Emergency Preparedness
2015-12 - UH Research Laboratory Safety
2015-14 - UH Clinical Contracts
2015-15 - UConn Health Payment Card Industry Data Security Standards Compliance
2015-19 - UH CMHC Pharmacy
2015-25 - UH Clinical Overtime Payments
2016-03 - UH LCD: Outpatient Physical and Occupation Therapy Services
2016-05 - UH Travel
2016-12 - UH Neag Cancer Center
2016-14 - UH Respiratory Therapy
2016-19 - UH Family Medical Leave Act
2017-01 - UH Controlled Substances in Research
2017-08 - UH Clinical Trials Billing
2017-12 - UH Parking, Transportation and Event Services
Audit Name


Open Overdue Management Actions by Risk Level
UConn and UConn Health
# of Overdue Management Actions
200
180
160
140
120
100
80
60
40
20
0
Low
Medium
High
Risk Level


High Risk Overdue Management Actions by Functional Area
UConn and UConn Health
# of Open Overdue High Risk Management Actions
8
7
6
5
4
3
2
1
0
UC Information Technology Services
UC Public Safety
UCH Police
Functional Area
High


Open Management Actions by Finding Category
UConn
# of Open Management Actions
40
35
30
25
20
15
10
5
0
Business Process Improvement
Business Purpose
Documentation
Governance
Management Oversight
Monitoring
Physical Security of Assets
Policy
Regulatory Compliance
Security
Technology
Training
Use of Resources
Functional Category


Open Management Actions by Finding Category
UConn Health
# of Open Management Actions
40
35
30
25
20
15
10
5
0
Business Process Improvement
Documentation
Monitoring
Policy
Regulatory Compliance
Security
Training
Finding Category

University of Connecticut & UConn Health

Joint Audit & Compliance Committee Meeting

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.

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University of Connecticut
&
UConn Health

Joint Audit & Compliance Committee Meeting

TAB 5

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UCONN | UNIVERSITY OF CONNECTICUT

Office of the Bursar and ITS Security

Joint Audit and Compliance Committee

June 6, 2018

Why TouchNet Marketplace

Addresses recommendations from 2016 PCI Internal Audit and 2017 Trustwave PCI Fit-Gap Assessment

- Consolidate and streamline credit card processing across the University by offering integrated approach for on-line, in-person, and mobile payments
- Reduce number of merchant accounts (currently at 42 accounts)
- Centralize merchant account management
- Reduce number of third party vendors utilized for credit card processing
- Operate through existing TouchNet payment gateway (student fee bill payments)
  Addendum to current contract
- Upload daily credit card deposits from TouchNet Marketplace to KFS, eliminating individual department eDoc submission
- Reduce University's PCI Scope

Marketplace Suite

The Marketplace Suite is comprised of four solutions:

- uStores – Allows departments to open their own online storefront to sell products, accept registration payments, and more. Intended for smaller departments with lower volume activity and/or looking to accept credit cards for a one-time event.

- uPay – Links larger departments already using a TouchNet Ready Partner (such as third party systems used for event registrations, ticketing, applications, etc.) to use Marketplace only for the credit card processing. UConn is currently contracting with 8 different TouchNet Ready Partners. uPay also allows departments with their own internally developed and compliant systems to use Marketplace to process the payment.

- POS – Marketplace offers a P2PE POS solution for in-person payments

- Mobile – Marketplace is designed and formatted to be mobile-friendly. Departments can utilize a QR Code to direct customers directly to the uStore just by using their mobile phone.

Progress Update

- PO signed 12/28/2017, Implementation Kickoff 01/05/2018, Go-Live 04/23/2018

- Transitioned and closed all existing Office of the Bursar Payment Stores (103 items spanning 54 departments)

- Currently 26 uStores and 1 uPay site are open
  18 uStores and 2 uPay sites in-progress

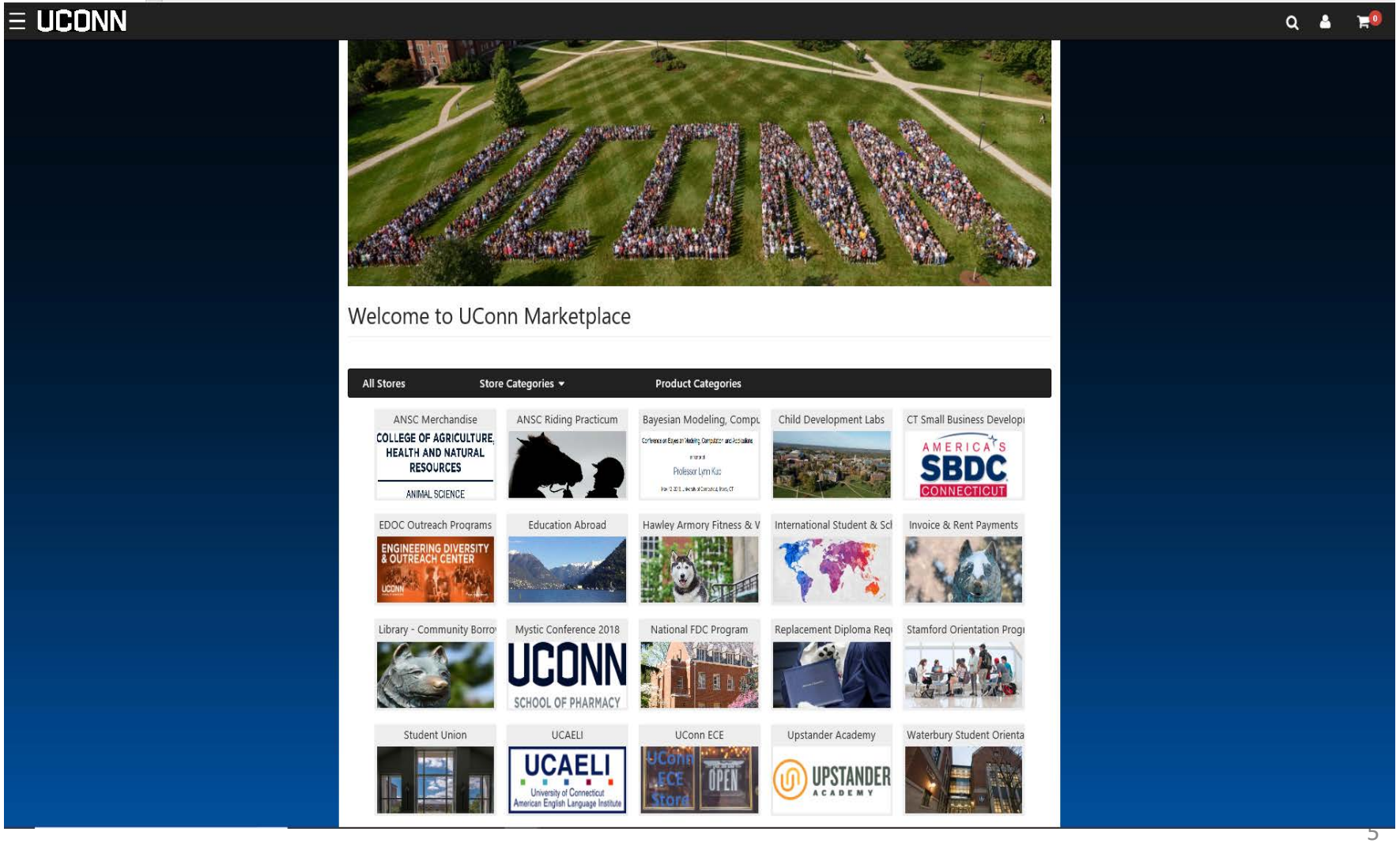
- In first month, 2,171 items sold totaling $197,607.96

- Next Steps:
  - Transition 6 existing merchants to uStores by end of 2018
  - Implement POS for 7 existing merchants by Fall 2018
  - Transition 8 existing TouchNet Ready Partner merchants to uPay by Spring 2019

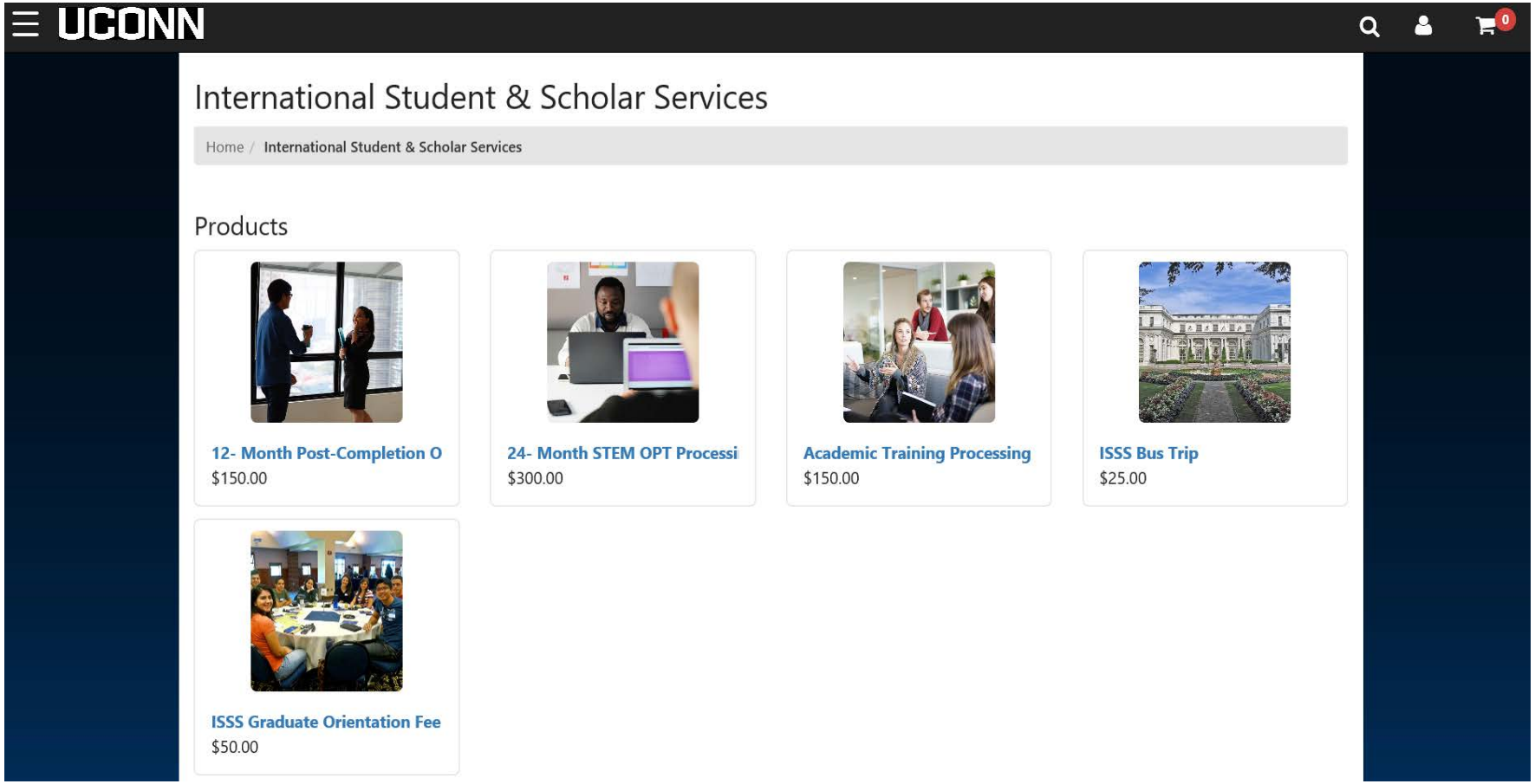
- By Spring 2019, expect to reduce number of open merchant accounts from 42 to 20

UConn Marketplace

https://secure.touchnet.com/C21646_ustores/web/index.jsp



Example: International Student & Scholar Services



Example: International Student & Scholar Services

ISSS Graduate Orientation Fee

Home / International Student & Scholar Services / **ISSS Graduate Orientation Fee**

Fee covers programmatic, administrative and staffing costs for required ISSS Grad Orientation. If you require an accommodation to participate in this event, please contact International Student & Scholar Services at international@uconn.edu by Monday, August 13th, 2018.

Price: $50.00

Add To Cart

Example: International Student & Scholar Services

ISSS Graduate Orientation Fee

Home / International Student & Scholar Services / ISSS Graduate Orientation Fee / **ISSS Graduate Orientation Fee - Options**

Fee covers programmatic, administrative and staffing costs for required ISSS Grad Orientation. If you require an accommodation to participate in this event, please contact International Student & Scholar Services at international@uconn.edu by Monday, August 13th, 2018.

*Indicates required information

Price: $50.00

ISSS Graduate Orientation Fee

Last Name *	First Name *	Email Address *	7-digit PeopleSoft Number *
		name@email.com	
(1–1,000 character[s])	(1–1,000 character[s])	(6–1,000 character[s])	(7 characters exactly)

Dietary Restrictions *

Select One

Continue

Example: Shopping Cart

Cart

Home / International Student & Scholar Services / ISSS Graduate Orientation Fee / **Shopping Cart**

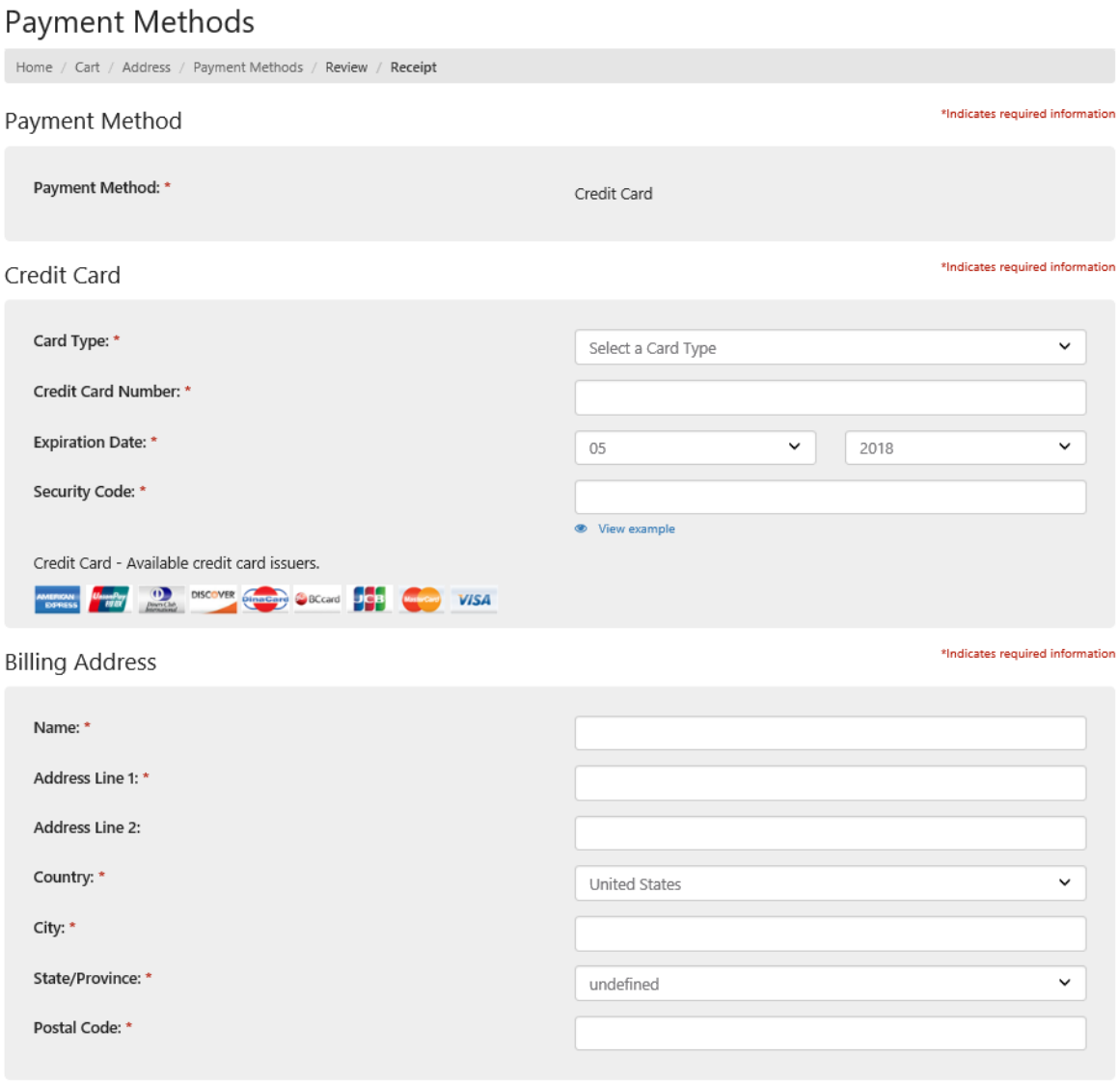
Items in your Cart

Item Name		Store	Remove	Amount
ISSS Graduate Orientation Fee		International Student & Scholar Services		$50.00
Last Name:	Husky			
First Name:	John			
Email Address:	John.Husky@uconn.edu			
7-digit PeopleSoft Number:	1234567			
Dietary Restrictions:	Vegetarian			

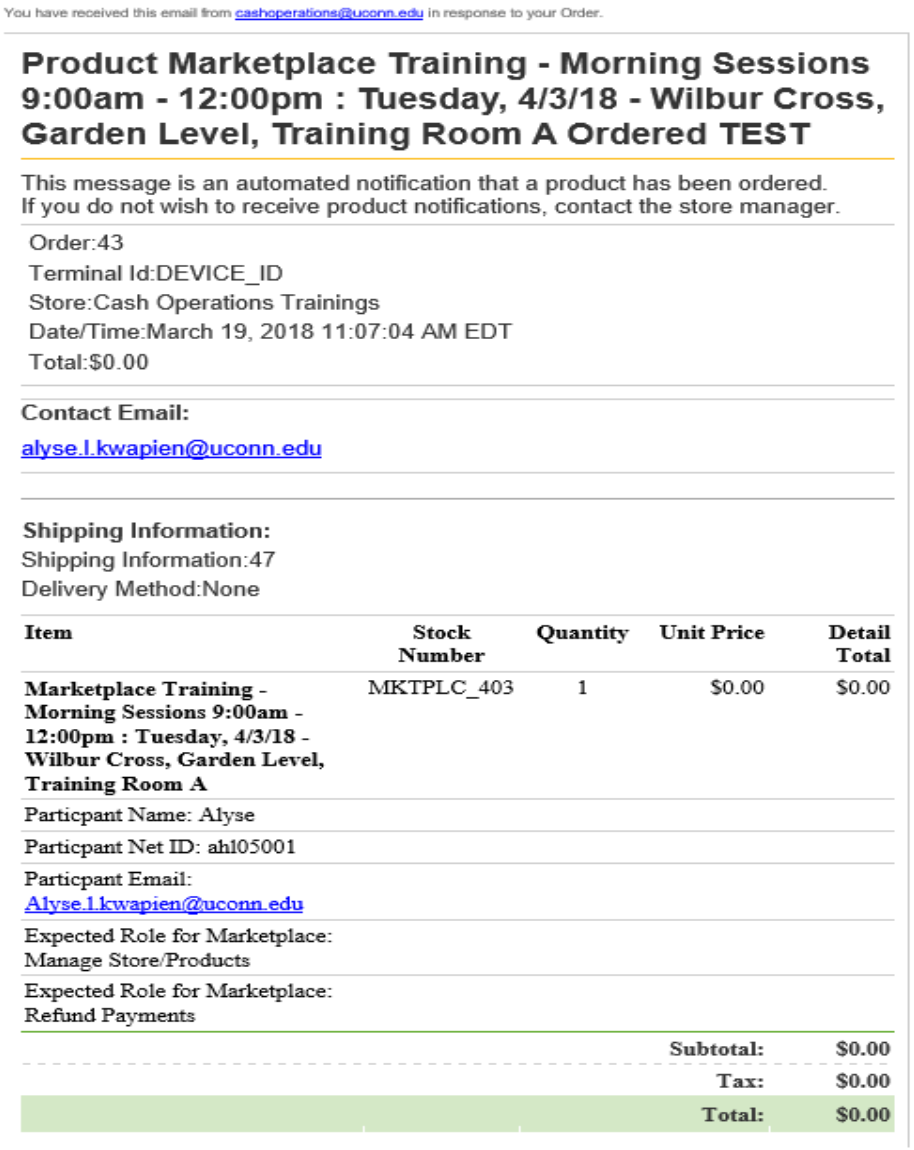
Total: $50.00

Continue Shopping | Update Cart | Checkout

Example: Payment Method & Billing Address



Example: Order Confirmation Email



You have received this email from cashoperations@uconn.edu in response to your Order.

Product Marketplace Training - Morning Sessions 9:00am - 12:00pm : Tuesday, 4/3/18 - Wilbur Cross, Garden Level, Training Room A Ordered TEST

This message is an automated notification that a product has been ordered.
If you do not wish to receive product notifications, contact the store manager.

Order:43
Terminal Id:DEVICE_ID
Store:Cash Operations Trainings
Date/Time:March 19, 2018 11:07:04 AM EDT
Total:$0.00

Contact Email:

alyse.l.kwapien@uconn.edu

Shipping Information:
Shipping Information:47
Delivery Method:None

Item	Stock Number	Quantity	Unit Price	Detail Total
Marketplace Training - Morning Sessions 9:00am - 12:00pm : Tuesday, 4/3/18 - Wilbur Cross, Garden Level, Training Room A	MKTPLC_403	1	$0.00	$0.00
Particpant Name: Alyse				
Particpant Net ID: ahl05001				
Particpant Email: Alyse.l.kwapien@uconn.edu				
Expected Role for Marketplace: Manage Store/Products				
Expected Role for Marketplace: Refund Payments				
			Subtotal:	**$0.00**
			Tax:	**$0.00**
			Total:	**$0.00**

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University of Connecticut
&
UConn Health

Joint Audit & Compliance Committee Meeting

TAB 6

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UConn Joint Audit and Compliance Committee Meeting:

HealthONE Update

Bruce A. Metz, Ph.D.
Vice President and Chief Information Officer, UConn Health

June 6, 2018

UCONN HEALTH ONE
One Place. One Record. One Reason. You.

HealthONE Update: Go-Live Status

- HealthONE cutover successfully completed at 5:17 am on April 28, 2018
- Over 4900 user accounts are active across inpatient, ambulatory and revenue cycle settings
- A three-tier activation model is supporting the end-user community providing 24x7 coverage
- At-The-Elbow (ATE) personnel have been reduced on a weekly basis from an initial number of about 360 ATEs in line with a planned tapering schedule
- Approximately 40 daily huddles including an executive team meeting are held to identify key issues and resolve problems
- More than 13,000 calls have been received by the Call Center with volumes regularly decreasing toward steady state levels
- Over 14,000 help desk tickets have been logged with nearly 80% resolved to-date
- The Epic system has performed as anticipated with important successes taking place in different areas of the enterprise
- The expected range of problems and challenges has occurred which is typical for a go-live of UConn Health's scale and complexity

UCONN HEALTH ONE
One Place. One Record. One Reason. You.

HealthONE Update: Go-Live Summary

- Notable Early Successes
  - On track to meet milestones and metrics established to monitor progress and determine go-live success
  - Hospital and inpatient areas as a whole have adapted quicker than expected
  - Ambulatory clinics that moved from a legacy EHR (e.g., NextGen) are reaching pre go-live productivity levels
  - For Revenue Cycle, cumulative billing charges are consistent with Epic benchmarks at this stage of the go-live
  - Clinical departments that took ownership of operationalizing Epic during implementation are having a smoother transition
  - Some providers have commented about the benefits of HealthONE (e.g., “HealthONE is way better than NextGen for doing orders/charts for the doctor. Takes me a quarter of the time to chart. Vast improvement!” Dr. Craig Rodner)
- Major Concerns and Outstanding Issues
  - Enterprise-wide adoption of converged and standardized ways of working represents a dramatic change
  - Effective and efficient operation of complex workflows has been challenging for some clinical areas
  - Ambulatory clinics that moved from paper are experiencing a range of system and process issues
  - Patient registration including the check-in/check-out process is not being completed from start to finish in all cases
  - Advanced Epic tools that increase provider productivity have not been deployed in all clinical areas
  - New hardware and device needs have emerged as a result of end-users experiencing the system
  - Focused efforts are underway and SWAT teams have been formed to resolve problems and hot-spot areas
- Key Next Steps
  - Continue to closely monitor the Go-Live, remediate problems and address challenges
  - Leverage go-live successes and lessons learned to help departments experiencing difficulties and adjustment issues
  - Develop a roadmap for stabilization including a plan for shifting to this phase as soon as the go-live period is complete
  - Recognize the huge effort from thousands of people who are making change of this magnitude possible
- Q & A

UCONN HEALTH ONE
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Joint Audit & Compliance Committee Meeting

TAB 7

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University of Connecticut & UConn Health

Joint Audit & Compliance Committee Meeting

Status of External Audit Projects

Vendor	Area	Scope	Comments
Marcum, LLP	UConn Health	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 FY2017, 2018 and 2019.	FY2017 engagement is complete. The FY2017 audited financial statements were presented at the December 2017 JACC meeting. FY2018 engagement is underway.
BKD	UConn Athletics	NCAA agreed upon procedures performed on all revenues, expenses, and capital expenditures for or on behalf of the University's Athletics Program for FY2016, 2017, and 2018.	The FY2017 engagement is complete. The FY2017 agreed upon procedures report was presented at the December 2017 JACC meeting.
CohnReznick, LLP	UConn & UConn Health	Annual audit of UCONN 2000 named projects substantially completed and deferred maintenance projects with designated budgets substantially completed in FY2016, 2017, and 2018, and annual agreed upon procedures performed on total UCONN 2000 expenditures (named projects, deferred maintenance and equipment) for FY2016, 2017, and 2018.	FY2017 engagement is complete. The FY2017 audit and the agreed upon procedures reports were presented at the March 2018 JACC meeting.

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University of Connecticut
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UConn Health

Joint Audit & Compliance Committee Meeting

TAB 8

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Government Finance Officers Association

Certificate of Achievement for Excellence in Financial Reporting

Presented to

University of Connecticut

For its Comprehensive Annual
Financial Report
for the Fiscal Year Ended

June 30, 2017

Christopher P. Morrill

Executive Director/CEO

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Government Finance Officers Association
Certificate of Achievement for Excellence in Financial Reporting

About the Award

The Certificate of Achievement for Excellence in Financial Reporting is the highest form of recognition in the area of governmental accounting and financial reporting, and its attainment represents a significant accomplishment by a government and its management. The Government Finance Officers Association (GFOA) established the certificate program in 1945 to encourage and assist state and local governments to go beyond the minimum requirements of generally accepted accounting principles. The program's objective is for governments to prepare comprehensive annual financial reports that evidence the spirit of transparency and full disclosure and then to recognize those that succeed in achieving that goal. Furthermore, the goal of the program is not to assess the financial health of participating governments, but rather to ensure that users of their financial statements have the information they need to do so themselves.

Reports submitted to the certificate program are reviewed by selected members of the GFOA professional staff and the GFOA Special Review Committee, which comprises individuals with expertise in public sector financial reporting and includes financial statement preparers, independent auditors, academics, and other finance professionals.

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Proposed Update to the University's Identity Theft Prevention

On November 7, 2007, the Federal Trade Commission (FTC), in conjunction with several other federal agencies, promulgated a set of final regulations known as the "Red Flags Rule" aimed at combating identity theft. After some clarifications and postponements of enforcement, the Red Flags Rule went into effect in 2010.

As an entity covered in part by the Red Flags Rule regulations, the University was obligated to establish an Identity Theft Prevention Program and properly document the review initial approval of the Program by its Board of Trustees. On behalf of the Board of Trustees, the Joint Audit & Compliance Committee reviewed and approved UConn's initial Program document on April 2, 2009.

Since that time, a multitude of laws and regulations aimed at enhancing privacy and information security and combatting identity theft and other related cyber and information-related crimes have been enacted. The Red Flags Rule regulations have become one of many regulatory and industry tools used to prevent, respond to, combat and mitigate the effects of identity theft.

Additionally since 2009, a multitude of changes have occurred at the University, including title changes, reorganizations, the re-branding of UConn Health and the creation of new internal committees, policies and structures to prevent and respond to privacy and data security incidents.

With these changes in mind, and to better coordinate the University's identity theft prevention and mitigation efforts with the University's new approach to privacy and data management, oversight of the University's Identity Theft Prevention Program has been moved under the Office of Privacy Protection & Management (OPPM). The OPPM has updated the Identity Theft Prevention Program document to reflect the evolution of the University's structure and reorganization. The revisions to the Program document are included in this packet for your review and information.

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University of Connecticut

IDENTITY THEFT PREVENTION PROGRAM

I. BACKGROUND

II. PURPOSE AND SCOPE

III. DEFINITIONS

IV. IDENTIFICATION & DETECTION OF RED FLAGS

V. APPROPRIATELY RESPONDING WHEN RED FLAGS ARE DETECTED

VI. CONSUMER REPORTS—ADDRESS VERIFICATION

VII. TRAINING

VIII. OVERSIGHT OF THIRD PARTY SERVICE PROVIDERS

IX. PROGRAM ADMINISTRATION

X. UPDATING THE PROGRAM

XI. BOARD APPROVAL

BACKGROUND

In response to the growing threats of identity theft in the United States, Congress passed the Fair and Accurate Credit Transactions Act of 2003 (FACTA), which amended a previous law, the Fair Credit Reporting Act (FCRA). This amendment to FCRA charged the Federal Trade Commission (FTC) and several other federal agencies with promulgating rules regarding identity theft. On November 7, 2007, the FTC, in conjunction with several other federal agencies, promulgated a set of final regulations known as the "Red Flags Rule". ~~The Red Flags Rule became effective November 1, 2008, however, the FTC has deferred its enforcement of the rule through May 1, 2009 in order to permit institutions additional time in which to develop and implement the written identity theft prevention programs required by the Red Flags Rule regulations.~~ After some clarifications and postponements of enforcement, the Red Flags Rule went into effect in 2010.

The Red Flags Rule regulations require entities with accounts covered by the Red Flags Rule regulations, including universities, to develop and implement a written Identity Theft Prevention Program (hereinafter, the "Program" or the "Identity Theft Program") for combating identity theft in connection with certain accounts. The Program must include reasonable policies and procedures for detecting, preventing and mitigating identity theft and enable the entity with covered accounts to:

1. Identify relevant patterns, practices, and activities, dubbed "Red Flags", signaling possible identity theft and incorporate those Red Flags into the Program;

2. Detect Red Flags;

3. Respond appropriately to any Red Flags that are detected to prevent and mitigate identity theft; and

4. Ensure the program is updated periodically to reflect changes in risks.

This document outlines the required Red Flags Rule Program of the University of Connecticut, but is extended to encompass not just financial or credit accounts, but any University account or database for which the University believes there is a reasonably foreseeable risk to the University, its students, faculty, staff, patients, constituents or customers from identity theft.

II. PURPOSE AND SCOPE

The purpose of this Program is to ensure the compliance of the University of Connecticut with the Red Flags Rule regulations, to identify risks associated with identity theft, and to mitigate the effects of identity theft upon the University, its employees, its students, its patients, its constituents and its customers.

The requirements of this Program apply to the University of Connecticut Storrs and Regional Campuses and ~~the University of Connecticut Health Center~~ UConn Health (collectively, "~~UCONN~~UConn"), to the employees of such campuses, and the third parties with whom ~~UCONN~~ UConn contracts to perform certain functions on its behalf.

III. DEFINITIONS

Account: Account means a continuing relationship established by a person with a financial institution or creditor to obtain a product or service for personal, family, household or business purposes. Account includes:

- An extension of credit, such as the purchase of property or services involving a deferred payment; and
- A deposit account.

Covered Account: The Red Flags Regulations define the term "covered account" to mean (1) "an account that a financial institution or creditor offers or maintains, primarily for personal, family, or household purposes that involves or is designed to permit multiple payments or transactions…" and (2) "any other account that the financial institution or creditor offers or maintains for which there is a reasonably foreseeable risk to customers, or to the safety and soundness of the financial institution, or creditor from identity theft, including financial, operational, compliance, reputation, or litigation risks."

> *For the purposes of the University's Identity Theft Program, the term "covered account" is extended to include any University account or database (financially based or otherwise) for which the University believes there is a reasonably foreseeable risk to the University, its students, faculty, staff, patients, constituents or customers from identity theft.*

Credit: "Credit" means "the right granted by a creditor to a debtor to defer payment of debt or to incur debts and defer its payment or to purchase property or services and defer payment therefor."

Creditor: "Creditor" means "any person who regularly extends, renews, or continues credit; any person who regularly arranges for the extension, renewal, or continuation of credit; or any assignee of an original creditor who participates in the decision to extend, renew, or continue credit."

Financial Institution: "Financial institution" means "a State or National bank, a State or Federal savings and loan association, a mutual savings bank, a State or Federal credit union, or any other person that, directly or indirectly, holds a transaction account belonging to a consumer."

Identity Theft: "Identity theft" means "fraud committed using the identifying information of another person."

Red Flag: "Red Flag" means "a pattern, practice, or specific activity that indicates the possible existence of Identity Theft."

Service Provider: "Service provider" means "a person that provides a service directly to the financial institution or creditor."

Transaction Account: "Transaction account" means "a deposit or account on which the depositor or account holder is permitted to make withdrawals by negotiable or transferable instrument, payment orders of withdrawal, telephone transfers, or other similar items for the purpose of making payments or transfers to third persons or others. Such term includes demand deposits, negotiable order of withdrawal accounts, savings deposits subject to automatic transfers, and share draft accounts."

IV. IDENTIFICATION & DETECTION OF RED FLAGS

A "Red Flag" is a pattern, practice, or specific activity that indicates the possible existence of identity theft. The following Red Flags are potential indicators or warning signs of potential or actual identity theft or similar fraud. Any time a Red Flag, or a situation resembling a Red Flag, is apparent, it should be investigated for verification. The examples below are meant to be illustrative. Any time an employee suspects a fraud involving personal information about an individual or individuals, the employee should assume that this Identity Theft Program applies and follow protocols established by his/her office for investigating, reporting and mitigating identity theft.

Examples of Red Flags:

Alerts, Notifications or Warnings from a Consumer Reporting Agency

1. A fraud or active duty alert is included with a consumer report.
2. A consumer reporting agency provides a notice of credit freeze in response to a request for a consumer report.
3. A consumer reporting agency provides a notice of address discrepancy.
4. A consumer report indicates a pattern of activity that is inconsistent with the history and usual pattern of activity of an applicant or customer, such as:
    a. A recent and significant increase in the volume of inquiries;
    b. An unusual number of recently established credit relationships;
    c. A material change in the use of credit, especially with respect to recently established credit relationships; or
    d. An account that was closed for cause or identified for abuse of account privileges by a financial institution or creditor.

Suspicious Documents

5. Documents provided for identification appear to have been altered or forged.

6. The photograph or physical description on the identification is not consistent with the appearance of the applicant or customer presenting the identification.

7. Other information on the identification is not consistent with information provided by the person opening a new covered account or customer presenting the identification.

8. Other information on the identification is not consistent with readily accessible information that is on file with the University, such as a signature card or a recent check.

9. An application appears to have been altered or forged, or gives the appearance of having been destroyed and reassembled.

Suspicious Personal Identifying Information

10. Personal identifying information provided is inconsistent when compared against external information sources used by the University. For example:

    a. The address does not match any address in the consumer report; or

    b. The Social Security Number (SSN) has not been issued, or is listed on the Social Security Administration's Death Master File.

11. Personal identifying information provided by the customer is not consistent with other personal identifying information provided by the customer. For example, there is a lack of correlation between the SSN range and date of birth.

12. Personal identifying information provided is associated with known fraudulent activity as indicated by internal or third-party sources used by the University. For example:

    a. The address on an application is the same as the address provided on a fraudulent application; or

    b. The phone number on an application is the same as the number provided on a fraudulent application.

13. Personal identifying information provided is of a type commonly associated with fraudulent activity as indicated by internal or third-party sources used by the University. For example:

    a. The address on an application is fictitious, a mail drop, or a prison; or

    b. The phone number is invalid, or is associated with a pager or answering service.

14. The SSN provided is the same as that submitted by other persons opening an account or other customers.

15. The address or telephone number provided is the same as or similar to the account number or telephone number submitted by an unusually large number of other persons opening accounts or other customers.

16. The person opening the covered account or the customer fails to provide all required personal identifying information on an application or in response to notification that the application is incomplete.

17. Personal identifying information provided is not consistent with personal identifying information that is on file with the University.

18. The person opening the covered account or the customer cannot provide authenticating information beyond that which generally would be available from a wallet or consumer report (such as answers to "challenge questions").

Suspicious Account Activity or Unusual Use of Account

19. Shortly following the notice of a change of address for a covered account, the University receives a request for a new, additional, or replacement card or a cell phone, or for the addition of authorized users on the account.

20. A new revolving credit account is used in a manner commonly associated with known patterns of fraud patterns. For example:

    a. The majority of available credit is used for cash advances or merchandise that is easily convertible to cash (e.g., electronics equipment or jewelry); or

    b. The customer fails to make the first payment or makes an initial payment but no subsequent payments.

21. A covered account is used in a manner that is not consistent with established patterns of activity on the account. There is, for example:

    a. Nonpayment when there is no history of late or missed payments;

    b. A material increase in the use of available credit;

    c. A material change in purchasing or spending patterns;

    d. A material change in electronic fund transfer patterns in connection with a deposit account; or

    e. A material change in telephone call patterns in connection with a cellular phone account.

22. A covered account that has been inactive for a reasonably lengthy period of time is used (taking into consideration the type of account, the expected pattern of usage and other relevant factors).

23. Mail sent to the customer is returned repeatedly as undeliverable although transactions continue to be conducted in connection with the customer's covered account.

24. The University is notified that the customer is not receiving paper account statements.

25. The University is notified of unauthorized charges or transactions in connection with a customer's covered account.

Alerts from Other

26. The University is notified by a customer, a victim of identity theft, a law enforcement authority, or any other person that it has opened a fraudulent account for a person engaged in identity theft.

V. APPROPRIATELY RESPONDING TO DETECTED RED FLAGS

Once potentially fraudulent activity is detected, an employee must act quickly as a rapid appropriate response can protect customers and the University from the effects of identity theft. The employee should inform his/her supervisor as soon as possible that he/she has detected an actual or potential Red Flag, or had identified a similar area of concern of identity theft. The supervisor should conduct any necessary inquiry to determine the validity of the Red Flag.

If it is determined that a situation of identity theft has occurred, the Division or Department Head should immediately contact the Office of Privacy, Protection & Management (OPPM) ~~Audit, Compliance & Ethics (OACE)~~ to inform them of the matter so that the matter is properly documented as part of the monitoring portion of this Program.

If the Red Flag indicates that a fraudulent transaction has occurred, the Division or Department Head should ensure that appropriate actions to mitigate the effects of the transaction are taken immediately. Appropriate actions will be dependent on the type of Red Flag identified, type of transaction, relationship with the victim of the fraud, availability of contact information for the victim of the fraud, and numerous other factors. However, by way of example, appropriate actions may include, but are not limited to:

1. Canceling the transaction;

2. Not opening a new account or closing the account in question;

3. Notifying and cooperating with appropriate law enforcement;

4. Notifying the ~~Office of the Attorney General~~ ,OPPM. ~~the OACE~~, ~~and Senior Administration of the University~~; and/or

5. ~~Utilizing~~ Activating the University's Information Security ~~Breach~~ Incident Protocol~~; and/or Security Breach Team by contacting the OACE;~~

~~6.~~5. Notifying the actual customer that fraud has been attempted or that it has occurred;

~~7.~~6. Changing any passwords or other security devices that permit access to relevant accounts and/or databases; and/or

~~8.~~7. Continuing to monitor the account or database for evidence of identity theft.

~~9.~~8. Alternatively, it may be determined that no response is warranted after appropriate evaluation and consideration of the particular circumstances.

In all situations where it is determined that a Red Flag has been positively identified, the office responsible for the account shall document what occurred, describe its review of the matter and any specific actions taken to mitigate the impact of the effects of the actual or potential identity theft discovered. Such documentation shall also include an description of any additional actions the office believes are systemically necessary within their office (such as updating policies and procedures) in response to identified Red Flag to handle or prevent similar situations in the future.

VI. CONSUMER REPORTS—ADDRESS VERIFICATION

Any University office that obtains and/or uses consumer reports from a Consumer Reporting Agency must ensure that it has reasonable policies and procedures in place to enable the office to form a reasonable belief that the consumer report the office has obtained relates to the consumer about whom it requested the report when the office receives a notice of address discrepancy. A notice of address discrepancy means that the office has received notice of a substantial difference between the address(es) for the consumer that the office provided to request the consumer report and the address(es) in the office's file on the consumer.

The office may reasonably confirm the accuracy of the consumer's address by:

1. Verifying the address with the consumer about whom it as requested the report;

2. Reviewing its own records (e.g., job applications, change of address notification forms, other customer account records) to verify the address of the consumer;

3. Verifying the address through third-party sources; or

4. Using other reasonable means.

The office must provide the consumer's address that it has reasonably confirmed to be accurate to the Consumer Reporting Agency as part of the information it regularly furnishes for the reporting period in which it establishes a relationship with the consumer.

VII. TRAINING

Staff training is required for all employees, officials and contractors for whom it is reasonably foreseeable that they may come into contact with accounts or personally identifiable information that may constitute a risk to the University or its customers.

The Division or Department Head of each office that maintains a covered account under this Program is responsible for ensuring that appropriate identity theft training for all requisite employees, officials and contractors occurs at least annually.

As part of the training, all requisite employees, officials and contractors should be informed of the contents of the University's Identity Theft Program, and be provided with access to a copy of this document. In addition, all requisite employees, official and contractors should be trained how to identify Red Flags, and what to do should he/she detect a Red Flag or have similar concerns regarding an actual or potential fraud involving personal information.

VIII. OVERSIGHT OF THIRD PARTY SERVICE PROVIDERS

It is the responsibility of the University to ensure that the activities of all service providers are conducted in accordance with reasonable policies and procedures designed to detect, prevent, and mitigate the risk of identity theft. Before the University may engage a service provider to perform an activity in connection with one or more of the University's covered accounts, the University must take the following steps to ensure the service provider performs its activities in accordance with reasonable policies and procedures designed to detect, prevent and mitigate the risks of identity theft:

1. The University must require by contract that the service provider has such policies and procedures in place; and

2. The University must require by contract that the service provider is aware of the University's Identity Theft Program, and will report any Red Flags it identifies as soon as possible to the OPPM. ~~OACE.~~

IX. PROGRAM ADMINISTRATION

Successful implementation of the Identity Theft Program ultimately is the responsibility of each office, the employees of each office that maintains accounts or databases covered by this Program, and the University community as a whole. As permitted by the Red Flags Rule regulations, responsibility for overseeing the administration of the Program has been delegated

by the Board of Trustees to the ~~Vice President and Chief Financial Officer~~ Office of Privacy Protection & Management of the University, ~~with compliance monitoring responsibility to be performed by the OACE~~ On an ongoing ~~annual~~ basis, and as part of the University's overall Compliance ~~M~~monitoring ~~P~~plans, the OPPM ~~OACE~~ will confer with the University offices that maintain covered accounts under the Program to review each office's list of covered accounts, training and policies, procedures and practices as they relate to preventing, detecting and mitigating identity theft, and any positively identified Red Flags or similar incidents documented by the offices who maintain covered account under this Program. The OPPM ~~OACE will create an annual report, based upon its annual conferences with the University offices that maintain covered accounts,~~ will assess~~ing~~ the effectiveness of the University's Identity Theft Program as a whole, ~~. As part of the report, the OACE OPPM will make recommendations for updating or modifying the~~ and modify and update the Program as appropriate. In coordination with the Office of University Compliance, T~~the annual~~ reports and/or necessary updates will be provided by the ~~OACE~~ OPPM to ~~the Vice President and Chief Financial Officer for his review and presentation to the Executive Compliance Committees and~~ the Joint Audit & Compliance Committee of the Board of Trustees (JACC).

X. UPDATING THE PROGRAM

~~On an annual basis, as part of the University's Compliance Monitoring Plan~~As appropriate, the Program will be re-evaluated to determine whether all aspects of the Program are up to date and applicable. This review will include an assessment of which accounts and/or databases are covered by the program, whether additional Red Flags need to be identified as part of the Program, whether training has been implemented, whether training has been effective. In addition, the review will include an assessment of whether mitigating steps included in the program remain appropriate, and/or whether additional steps need to be defined.

XI. APPROVAL BY THE BOARD OF TRUSTEES

Under the Red Flags Regulations, implementation and oversight of the Identity Theft Program is the responsibility of the governing body or an appropriate committee of such governing body. Approval of the initial plan must be appropriately documented and maintained. After its initial approval of the Program, however, the governing body may delegate its responsibility to implement and oversee the Identity Theft Program. As the governing body of the University of Connecticut, the Board of Trustees, through its JACC, ~~as of the date below, hereby~~ approved the initial Identity Theft Program on April 2, 2009. ~~Having made such initial approval, the Board of Trustees hereby delegates the responsibility for implementing, monitoring and overseeing the University's Identity Theft Program to the Vice President and Chief Financial Officer.~~

Approved by the Joint Audit & Compliance Committee of the Board of Trustees: April 2, 2009

Reviewed and updated to account for administrative reorganizations of University offices and structures: June 6, 2018

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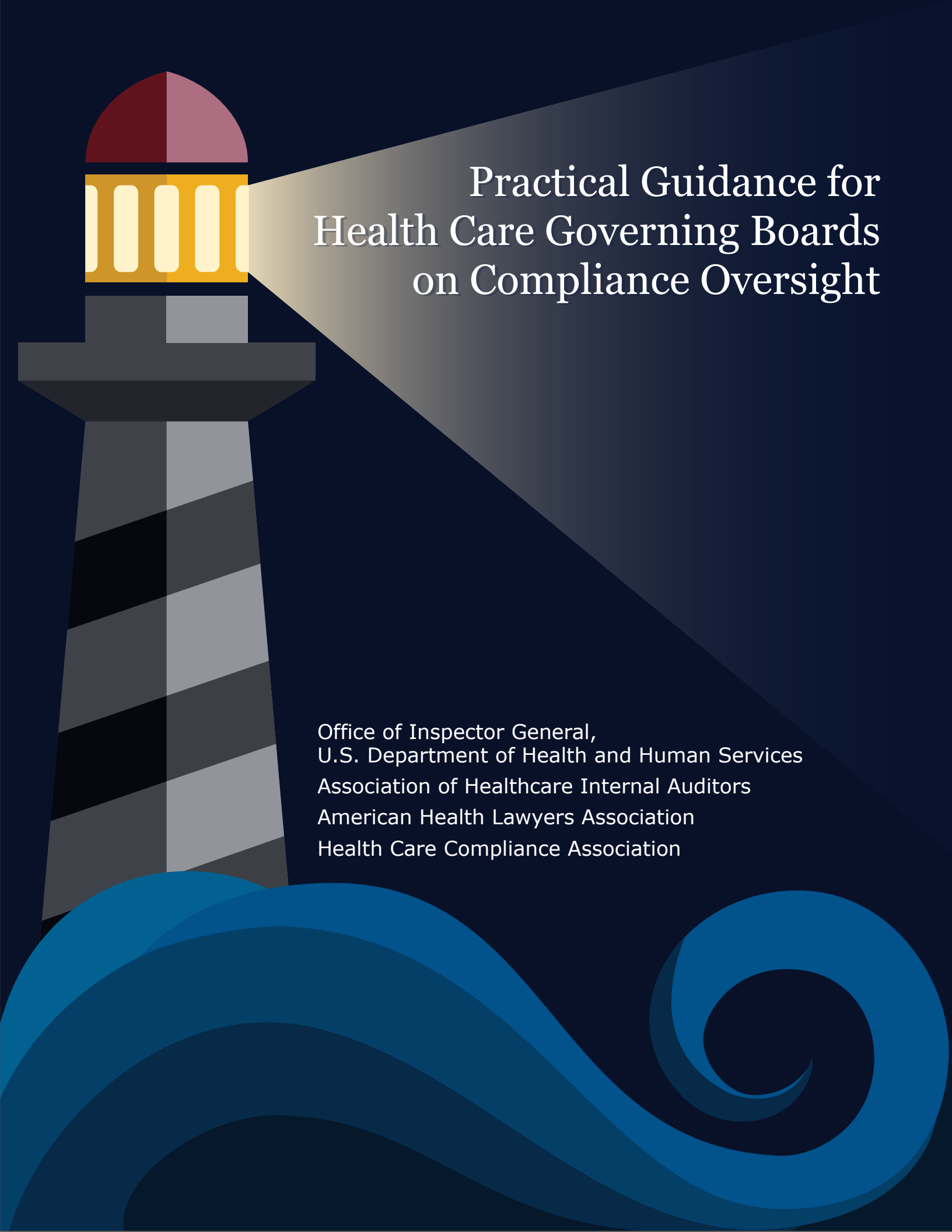

Practical Guidance for Health Care Governing Boards on Compliance Oversight

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.

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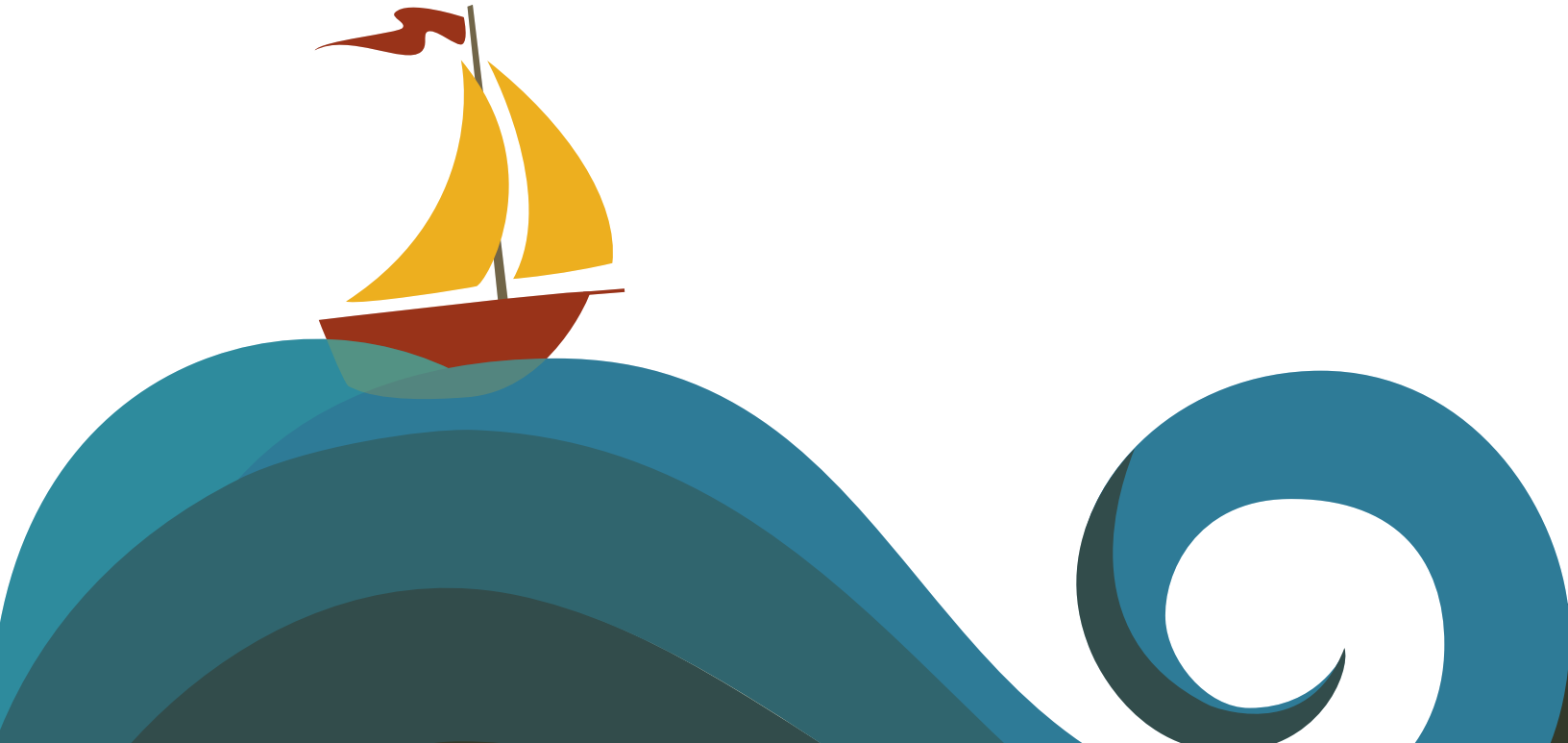

Introduction

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.

A critical element of effective oversight is the process of asking the right questions....

1 OIG and AHLA, *Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors* (2003); OIG and AHLA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors* (2004); and OIG and AHLA, *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors* (2007).

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.[2] 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),[3] OIG's voluntary compliance program guidance documents,[4] 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-police its own conduct through an effective compliance and ethics program."[5] 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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2 *In re Caremark Int'l, Inc. Derivative Litig.*, 698 A.2d 959 (Del. Ch. 1996).

3 U.S. Sentencing Commission, *Guidelines Manual* (Nov. 2013) (USSG), http://www.ussc.gov/sites/default/files/pdf/guidelines-manual/2013/manual-pdf/2013_Guidelines_Manual_Full.pdf.

4 OIG, *Compliance Guidance*, http://oig.hhs.gov/compliance/compliance-guidance/index.asp.

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....

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.[7] 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.[8] 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."[9] 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.[10]

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

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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.[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.[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.

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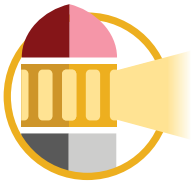
11 *See* Del Code Ann. tit. 8, § 141(e) (2010); ABA Revised Model Business Corporation Act, §§ 8.30(e), (f)(2) Standards of Conduct for Directors.

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,[13] 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.[14] 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.

14 *See* OIG and AHLA, *An Integrated Approach to Corporate Compliance: A Resource for Health Care Organization Boards of Directors*, 3 (2004) (citing Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998)).

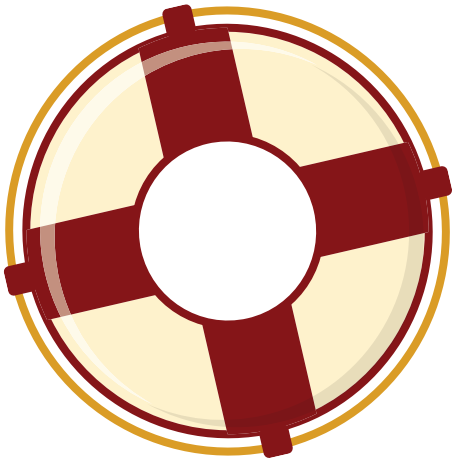
15 *See, generally, id.*

the same is true for internal audit.[16] 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.



16 Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8,987, 8,997 (Feb. 23, 1998) (auditing and monitoring function should "[b]e independent of physicians and line management"); Compliance Program Guidance for Home Health Agencies, 63 Fed. Reg. 42,410, 42,424 (Aug. 7, 1998) (auditing and monitoring function should "[b]e objective and independent of line management to the extent reasonably possible"); Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,302 (Mar. 16, 2000).

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

The Board should receive regular reports regarding the organization's risk mitigation and compliance efforts....

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."[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.[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.,

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17 *See* USSG § 8B2.1(b)(5).

18 *See* USSG § 8B2.1(c).

CMS physician payment data), and the Sunshine Rule[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.

Compliance is an enterprise-wide responsiblity.

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.[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

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19 *See* Sunshine Rule, 42 C.F.R. § 403.904, and CMS *Open Payments*, http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html.

20 Compliance Program Guidance for Nursing Facilities, 65 Fed. Reg. 14,289, 14,298-14,299 (Mar. 16, 2000).

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.[21] 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.[22] 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.

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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.[23] OIG believes that providers have legal and ethical obligations to disclose known violations of law occurring within their organizations.[24] 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

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23 *See* OIG, *Self-Disclosure Information*, http://oig.hhs.gov/compliance/self-disclosure-info.

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.

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